

**ADDED COMPENSATION REQUEST
FOR PROFESSIONAL STAFF ONLY
Fiscal Year 2019-2020**

Submit Completed Form to:
Human Resources and Labor Relations

Date of Request _____

When properly signed, this form gives official approval for \$_____ per hour extended payment covering more than a two-week pay period. No Payment for \$_____ per hour for additional services will be made without this form officially approved by the Assistant Superintendent for Human Resources and Labor Relations. This form is not to be used for incidental day-by-day payments.

Name of Staff Member to Receive Payment _____

Building _____

Total Hrs. Requested _____ x Hrly Pay of \$_____ = Total Amt. Added Comp. \$ _____

Dates of Additional Services _____

Reason for Additional Services _____

Account # _____

Employee Signature _____

Signature of Principal/Supervisor _____

Signature of Assistant Superintendent _____

(To Be Completed by Administrative Office)

Approved _____
Name

Title

Approved _____
Assistant Superintendent for
Human Resources & Labor Relations

Date _____

Approved Finance _____

Date of Approval _____

Reason (If Denied) _____

Approved _____
Superintendent

_____ Date _____

Date of Approval _____

APPROVAL IS SUBJECT TO MASTER AGREEMENT PROVISIONS