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| C:\Documents and Settings\sharkins\Local Settings\Temporary Internet Files\Content.Outlook\5M52DODR\UM mark (2).jpg | **EXEMPT REGULAR STAFF** **INCREASED RESPONSIBILITIES AND SUPPLEMENTAL COMPENSATION REQUEST** **EMPL CLASS 33** **Pre-Approval Required Before Work Begins**Please return completed approved form to Compensation. Contact Compensation at (410) 706-6338 for questions. |

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| **Employee Information:** |
| Name: |       | Employee ID# |       | Annual Salary: |       |
| Title: |       | Regular (33) [ ]   | Current FTE % must be 100%  |
| **Paying Department Information:** |
| Paying Dept. Name: |       | School/Adm Dept Name: |       |
| Department Contact: |       | Contact Phone: |       |
|  Supplemental work will be performed between      :       am/pm to      :       am/pm on       (days).Supplemental work must be performed outside of normal working hours or documentation of alternative work schedule/use of leave must be provided. |
|  Location supplemental work will be performed is      .  |
| **Home Department Information**  |
| Home Dept Name: |       | School/Adm Dept Name: |       |
| Department Contact: |       | Contact Phone: |       |
|  Normal work hours are between       :       am/pm to       :       am/pm on       (days). |
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| **Request Type: check applicable and indicate Earnings Code (All Staff Supplemental Pay are outside current job description and performed outside normal work hours and days as defined in UMB Policy VII.9.11 (A)** |
| [ ]  EARNINGS CODE- **SEC:** Secondary Employment | Start Date: |       | End Date: (max. of 6 mo.) |       |
| [ ]  EARNINGS CODE- **SEJ**: Faculty appointment  | Start Date: |       | End Date: (max. of 6 mo.) |       |
| [ ]  EARNINGS CODE- **\_\_\_\_**: Assigned by Compensation  | Start Date: |       | End Date: (max. of 6 mo.) |       |
| **Increased Responsibilities:**   |
| **[ ]  Justification**  **Attached**  | Please attach justification describing the supplemental work responsibilities and duties that are not within the employee’s duties and responsibilities as a full-time employee.  |

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| **Payment Information**  |
| Total Payment Amount:  |  $      | If more than the number of payments listed below, please attach a payment schedule to include the pay period end date, amount, funding source, and project ID/SOAPF. Payment amount must be daily rate. |
| **Pay Period End Date:** | **Amount:** | **Funding Source:** | **Project ID or SOAPF #:** |
|       |        | State [ ]  Grant [ ]  Other [ ]  |       |
|       |       | State [ ]  Grant [ ]  Other [ ]  |       |
|       |       | State [ ]  Grant [ ]  Other [ ]  |       |
|       |       | State [ ]  Grant [ ]  Other [ ]  |       |

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| **Required Approvals:**  |
| By signing in the designated areas below, I am verifying this request is in accordance with **VII - 9.11(A) – UMB Policy on Increased Responsibilities and Supplemental Compensation for Exempt Staff.** |
| Employee Signature:  |   | Printed Name: |       | Date: |       |
| Paying Department Authorized Signature: |  | Printed Name: |       | Date: |       |
| Paying Department Dean/VP Signature: |  | Printed Name: |       | Date: |       |
| Home Department Authorized Signature:(if different from Paying Dept) |  | PrintedName: |       | Date: |       |
| Home Department Dean/VP Signature:(if different from Paying Dept) |  | PrintedName: |       | Date: |       |
| HRS-Compensation Signature: |  | Printed Name: |       | Date: |       |
| President or Designee Signature: |  | Printed Name: |       | Date: |       |
| **APPROVED FORMS WILL BE RETURNED TO PAYING DEPARTMENT CONTACT FOR PROCESSING; COPY OF THIS APPROVED FORM WITH ATTACHED, SIGNED PAYROLL ADJUSTMENT FORM SHOULD BE SUBMITTED TO FS-PAYROLL FOR PROCESSING.** |