RECOMMENDATION FOR SALARY SUPPLEMENT FOR EMPLOYEE TEMPORARILY ASSIGNED ADDITIONAL OR REPLACEMENT DUTIES

Employee Name:	
Employee ID#:	Position #:
Facility/Office:	Job Title and Pay Grade:

ADDITIONAL OR REPLACEMENT POSITION

JOB TITLE:_____ POSITION #:_____

NOTE: If position is misclassified/flagged, attach a copy of the letter from the Central Personnel Administration Job Evaluation Analyst.

REASON(S) FOR THE REQUEST

Check One:

_____BEGIN PAYMENT _____ END PAYMENT Effective _____

Requested Period for Supplement to be Paid: _____(Months). Requested Amount of Supplement: _____(percentage).
NOTE: If period is unspecified, payment period will not exceed 90 days.

RECOMMENDATION FOR FLSA STATUS BY LOCAL OFFICE, UNIT, OR FACILITY

While position # _____ is assigned additional or replacement duties, the recommended FLSA status is:
[(circle one) **N, A, E**]. The supporting rationale for proposing an exemption of A or E is (attach additional sheet if necessary):

(Print) Name of Appointing Authority	
Signature of Appointing Authority	**Date:**

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CENTRAL PERSONNEL ADMINISTRATION USE ONLY

Supplement start date_____deactivate supplement on _____and notify field personnel contact

CPA recommendation for position #_____during approved supplement period is: [**N, A, E** (circle one)].

Job Evaluation Unit notified to review FLSA Status at end of supplement _____

Retention: Retain permanently in local and official personnel files.