



# INTERNAL SUPPLEMENTAL COMPENSATION APPROVAL Policy 2.3.20

THIS FORM IS NOT REQUIRED TO APPROVE PAYMENT FOR INSTRUCTIONAL DUTIES ASSIGNED THROUGH A  
PART-TIME FACULTY ASSIGNMENT CONTRACT.

THE ASSIGNMENT CONTRACT SERVES AS THE COMPENSATION APPROVAL.

A FLEXIBLE WORK ARRANGEMENT REQUEST MAY BE NECESSARY  
IF THE INSTRUCTIONAL DUTIES ARE TO OCCUR DURING A STAFF MEMBER'S REGULAR POSITION'S SCHEDULED WORK TIME.

Please refer to Policy 2.3.20, *Supplemental Compensation Involving Work Within the College*. Contact the Office of Human Resources with questions.

Name: \_\_\_\_\_ Employee ID: \_\_\_\_\_

Home Department: \_\_\_\_\_

Department Requesting Services: \_\_\_\_\_

Description of Services:

Hours to be spent on supplemental activity Weekly: \_\_\_\_\_ Total for AMCP Year: \_\_\_\_\_

Period of supplemental activity From: \_\_\_\_\_ To: \_\_\_\_\_

Requested compensation: \_\_\_\_\_

### Calculation of AMCP Year Compensation Limit

(A) Individual's base compensation for current AMCP Year \$ \_\_\_\_\_

(B) Total supplemental compensation for current AMCP Year \$ \_\_\_\_\_

**B divided by A = \_\_\_\_\_%** Total supplemental compensation should not exceed 20%

*I hereby certify that during the course of this supplemental activity, my primary duties, responsibilities, and professional development will not be adversely affected.*

Employee Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Requesting Department Approval Signature: \_\_\_\_\_  
Include printed name after signature

Home Department Approval Signature: \_\_\_\_\_  
Include printed name after signature

Human Resources Approval Signature: \_\_\_\_\_  
Include printed name after signature