University of Washington | Human Resources | Compensation Office

### PROFESSIONAL STAFF TEMPORARY PAY INCREASE (TPI) or

### PROFESSIONAL STAFF ADMINISTRATIVE SUPPLEMENT (ADS) – APPROVAL REQUEST

**For instructions on completing this form in MS Word see:** <http://www.washington.edu/admin/hr/forms/instructions.html>

**Please answer all of the questions–incomplete requests cannot be processed**. PLEASE NOTE–By submitting this request to the Compensation Office you are signifying that you have the appropriate concurrence of your Dean, Vice President, Medical Centers CEO, or their delegated designee.

**NOTE–Assumption of additional and/or higher level responsibilities on a temporary basis must be for a minimum of ten working days**.

**When requesting an extension of this TPI/ADS, please maintain the original information. Changes should be entered in the extension request section only (page 2) in order to maintain the history of this TPI.**

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Section I – information | | | | | | | | | | | | |
| Employee Last Name: | | | | | | First Name: | | | | | | Middle: |
| Job Code: | | | | | | Payroll Title: | | | | | | |
| Home Dept. Name: | | | | | | Home Dept. Budget: | | | | | | |
| UW ID Number:    -   - | | | | | | Employee’s Current Regular (Base) FTE Salary: $      per month | | | | | | |
| Indicate the type of temporary salary increase requested by checking either *Temporary Pay Increase*  *(TPI)* ***OR*** *Administrative Supplement (ADS)* box below and completing the information for that action: | | | | | | | | | | | | |
| Temporary Pay Increase (TPI) | | | | | | | | Administrative Supplement (ADS) | | | | |
| Proposed Monthly TPI/ADS Amount (above employee’s base salary):  **REFLECTING\***       % increase over base salary | | | | | | | | $      per month | | | | |
| *[****\**** *TPIs are approved as a dollar amount only. Base salary changes will not result in an automatic change to the TPI amount. Contact your Compensation Consultant for assistance.]* | | | | | | | | | | | | |
| Effective Start Date of Proposed Action: mm/dd/yyyy | | | | | | | | Effective End Date of Proposed Action: mm/dd/yyyy | | | | |
| **For Medical Centers only:** Start date must be the 1st or 16th of the month. End date must be with a pay period end date. | | | | | | | | | | | | |
| Justification for Proposed Action (please be specific): | | | | | | | | | | | | |
| Name of Department Contact (print or type): | | | | | Phone:    -   - | | | | | Email: | | |
| Department Contact Job Title: | | | | | | | | | | | | |
| Email Notification (email addresses):  fspay@uw.edu | | | | | | | | | | | | |
| **(Check this box):** I confirm that I have all appropriate approvals as required by the Dean, Vice President, Medical Centers CEO, or their delegated designee of my major organization for this request. These approvals are on file with my records on this action and available for review if requested. | | | | | | | | | | | | |
| Completed requests should be submitted to the UW Compensation Office by email at [ocpsp@u.washington.edu](mailto:ocpsp@u.washington.edu).  Compensation Office approval and instructions for entry of this action into the OPUS system will be sent by email to the contact(s) listed on this request form. | | | | | | |  | | COMPENSATION OFFICE Approved by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_  Name Date | | | |
|  | | | | | | | | | | | | |
| section II – extension request | | | | | | | | | | | | |
| Complete this section only if requesting an extension or change to an existing TPI or ADS.  Use your original electronic TPI/ADS request form (or most recent extension form), complete the Extension/Change information below, and submit it to the Compensation Office via email at [ocpsp@u.washington.edu](mailto:ocpsp@u.washington.edu).  **For your extension request, please complete ALL columns EXCEPT the “CHANGES TO TPI” column.**  **For your TPI change request, complete “CHANGES TO TPI” and “REASON FOR EXTENSION/CHANGE” columns to propose a change to the TPI percentage or amount.** | | | | | | | | | | | | |
|  | | | | | | | | | | | | |
| **CONFIRM APPROVAL:** Check this box to indicate that you have continued appropriate approvals as required by the Dean, Vice President, Medical Centers CEO, or their delegated designee of your major organization for this request.  **EXTENSION ONLY:** Check this box to confirm that all other terms will continue as originally requested.  **EXTENSION END DATE**:  Enter the new end date.  **REASON FOR EXTENSION/CHANGE:** Indicate the specific reason for the extension or change.  “Continued coverage for an employee who is on maternity leave” is not specific enough.  Provide the name of the employee being covered, the employee’s payroll title/ working title, and the major duties that will be covered.  **CHANGE(S) ONLY:** See explanation above.  All terms not noted will continue as originally requested. | | | | | | | | | | | | |
|  | | | | | | | | | | | | |
| **EXT**  **NO.** | **CONFIRM**  **APPROVAL** | **EXT**  **ONLY** | **EXTENSION**  **END DATE:** | **REASON FOR EXTENSION/CHANGE:** | | | | | | | **CHANGES TO TPI:** | |
| #1. |  |  | mm/dd/yyyy |  | | | | | | |  | |
| #2. |  |  | mm/dd/yyyy |  | | | | | | |  | |
| #3. |  |  | mm/dd/yyyy |  | | | | | | |  | |
| #4. |  |  | mm/dd/yyyy |  | | | | | | |  | |