

Classified staff temporary hourly/salary increase approval request (Medical Centers)

Instructions

Please provide all requested information as incomplete requests will not be processed. Please enter full-time (1.0 FTE) rates only. Workday will automatically pro-rate for part-time employees.

Supervisors are responsible for completing this form and ensuring it routes to the appropriate WMS email address:

- hruwmc@uw.edu for UW Medical Center (Montlake and NW)
- hrhmc@uw.edu for Harborview Medical Center
- hrwms@uw.edu for Shared Services

Section 1: Employee information

1. Employee name:
2. Employee ID:
3. Position number:
4. Job title:
5. Dates of temporary increase (**Start dates are limited to the 1st or the 16th. End dates are limited to 15th or the last day of the month.**):
 - a. Start date:
 - b. End date:

Complete this section only if the employee's status is regular hourly

6. Current hourly rate (in USD):
7. Current step:
8. Proposed percent increase:
9. Proposed hourly rate increase (in USD):
10. Proposed total hourly rate (in USD):

Complete this section only if the employee's status is regular salary

11. Current full time monthly salary rate (in USD):
12. Current Step:
13. Proposed percent increase:
14. Proposed monthly increase (in USD):

Revised: 4/9/2026

Contact: medcomp@uw.edu

15. Proposed full-time salary rate (in USD):

Justification for temporary increase

16. Describe the specific higher-level tasks that the employee has been assigned:

17. If the employee is performing the work of another position, complete the following:

a. Job title:

b. Is the position vacant? Yes No

 i. If yes, is recruitment underway? Yes No

 ii. Provide the position number of the vacant position, if applicable:

c. Is the employee who normally does this work on leave? Yes No

 i. Name of employee:

 ii. Expected leave end date:

18. If the employee is not performing the work of another position, but is performing other higher-level duties, please explain:

Section 2: Supervisor details and attestation

19. Supervisor's name:

20. Supervisor's Job title:

21. Supervisor's email:

- I confirm that I have all necessary approvals as required by the UW Medicine President, Hospital CEO, UW Medicine CFO, or other designee. These approvals are on file with my records on this action and available for review if requested.

22. Attestation date:

Section 3: Extension request

Complete this section only when requesting an extension to the initial request described above. **Extension end dates are limited to the 15th or last day of each month.**

Extension #	Extension end date	Reason for extension
#1		
#2		
#3		