MEDICAL CENTER REALLOCATION REQUEST FORM – PATIENT SERVICES SPECIALIST 1-TRAINEE (PSS1) TO PATIENT SERVICES SPECIALIST 2 (PSS2)

Purpose: This form may be used in lieu of submitting a Classified Position Review Questionnaire for requests that ONLY apply to reallocation from PSS1-Trainee to PSS2, to facilitate & expedite the reallocation process. Email the completed and signed form to the Compensation Office at medcomp@uw.edu.

EMPLOYEE/POSITION INFORMATION			
Last Name:	First Name:	Middle:	Employee ID #:
Home Dept. Budget #:	Home Dept.:		Employee Phone:

CONFIRMATION CHECKLIST:

- ☑ the employee has completed the initial 6 month probationary period from: to
- ☑ the employee has successfully completed the PSS1 training; and,
- ☑ the employee is performing PSS2-level job duties.

Please do not submit this form unless **all three (3)** of the statements above apply to the employee named.

VERIFICATION OF LEAVE TAKEN DURING THE PROBATION PERIOD:

Per applicable collective bargaining agreements, paid and unpaid leave taken during the employee's initial 6-month probation period will adjust the probation end date. Indicate your Payroll Coordinator (below) who will be contacted to confirm any/all leave hours taken and determine the revised probation period end date, if applicable:

Name of Payroll Coordinator:	Phone:

You must include total number of hours of paid and unpaid leave taken during the initial 6 month probationary period:

EFFECTIVE DATE AND PAY ADJUSTMENT RULES:

- Effective date of this reallocation will be the date following completion of the 6-month probation period in accordance with the applicable collective bargaining agreement;
- Pay adjustment as a result of reclassification to PSS2 will be in accordance with the applicable collective bargaining agreement pertaining to reallocations.

SIGNATURES		
Employee Name (print and sign) _____ Employee Signature	Title	Date
	Employee Email:	
Supervisor/Manager Name (print and sign) _____ Supervisor/Manager Signature	Title	Date
	Supervisor/Manager Email:	
Department Head Name (print and sign) _____ Department Head Signature	Title	Date
	Dept. Head Email:	

FOR COMPENSATION OFFICE ONLY					
Reference #:	Effective Date:	Job Class Code:	New Pay Table/Range/Step: - -	New Mo. Salary:	Comp. Eval.