# STAFF RELOCATION INCENTIVE PAYMENT APPROVAL REQUEST FORM (MEDICAL CENTERS)

### SUMMARY

**Intent**

As authorized by [Administrative Policy Statement 34.2](http://www.washington.edu/admin/rules/policies/APS/34.02.html), a lump sum relocation incentive payment may be approved when it is necessary to successfully recruit a qualified candidate who will have to make a domiciliary move in order to accept an academic appointment or staff position.

**Approval Authority**

Professional staff and classified staff lump sum relocation incentive payments must be approved by the director of recruiting and medical center associate administrator, or other position with equivalent administrative authority. For classified non-union staff the University President must approve lump sum relocation incentive payments (WAC 357-28-310).

**Approval Authority for Exceptional Payments**

Relocation payments in excess of $50,000 or 25% of the employee’s first year full-time annualized salary, whichever is greater, must be approved in advance by the Vice President for Human Resources, or designee.

**Repayment**

If within one year of the date of appointment the employee voluntarily terminates employment, or engages in behavior that makes termination of employment necessary, the full amount of the relocation incentive payment must be repaid to the University. Employment offer letters must include notification of the repayment provision.

# STAFF RELOCATION INCENTIVE PAYMENT APPROVAL REQUEST FORM (MEDICAL CENTERS)

Use this form to obtain approval for all medical centers staff relocation incentive payments in accordance with Administrative Policy Statement 34.2. After departmental approval, return to the medical centers’ employment representative. For all incentive payment requests for classified non-union employees, Human Resources will use this form to obtain approval from the University President. For all exceptional payment requests, Human Resources will use this form to obtain approval from the Vice President for Human Resources.

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| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Employee Last Name: | | | | First Name: | | | Middle: | |
| Supervisory Org: | | | | | Phone:    -   - | | | |
| Appointment Type:  Professional Staff  Contract Classified  Classified Non-Union | | | | | Employee ID: | | | |
| Business Title: | | | Relocation Incentive Payment Amount:  $ | | Starting Salary: $ | | | FTE:       % |
| Job Profile: | | If Classified Staff: Salary Range       Salary Step | | | | If Pro. Staff: Salary Grade | | |
| Statement of reasons for requesting approval for relocation incentive payment: | | | | | | | | |
|  | Attach copy of draft job offer letter confirming notification of the repayment obligation for leaving the position with less than one year’s service. | | | | | | | |
|  | Check if moving expenses are being paid in addition to the proposed relocation incentive payment. *Moving expense requirements are described in APS 34.1.* | | | | | | | |
|  | Check if the proposed relocation incentive payment exceeds $50,000 or 25% of the first year’s full-time annualized salary, whichever is greater:  State the reason(s) for the exceptional payment: | | | | | | | |

|  |  |  |
| --- | --- | --- |
| Signatures **For all requests:** | | |
| Hiring Manager Name: | | Hiring Manager Signature: Date: |
| Director of Recruiting Name: | | Director of Recruiting Signature: Date: |
| Name of Medical Centers Associate Administrator, or Administrative Authority: | | Signature of Medical Centers Associate Administrator, or Administrative Authority: |
|  |  | Date: |

## For all exceptional requests:

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| --- | --- |
| VP of Human Resources Signature:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Date: |

## For all CNU requests:

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| VP of Human Resources Signature:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Date: |
| President  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Date: |

# STAFF RELOCATION INCENTIVE EMPLOYEE AGREEMENT (MEDICAL CENTERS)

This section is completed by the employee.

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| --- | --- |
| Name of Employee | Employee ID |
| Origin Address: | |
| Destination (current) address: | |
| I acknowledge that I will be receiving a Relocation Incentive payment because I have changed residence as documented above.  In the event that I terminate or cause termination of my employment with the University of Washington within one (1) year of the date of employment, I agree to reimburse the entire Relocation Incentive amount which has been paid and hereby authorize the University to withhold any sums due to me as a part or full payment of such costs in conformance with RCW 43.03.120. Should repayment be necessary, the University of Washington can withhold the full or partial repayment amount from your final paycheck. | |
| Signature of Employee Date | |
|  | |
| Authorized Agency Head Date | |
|  | |