

### REQUEST FOR EXTENSION/PAY CHANGE

### PROFESSIONAL STAFF TEMPORARY POSITION (PSTP)

MEDICAL CENTERS ONLY – CAMPUS PSTP APPROVAL REQUEST IS IN WORKDAY: <https://isc.uw.edu/user-guides/request_comp_change_sc/>

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

Extensions and pay changes for existing temporary professional staff hourly limited-term positions and monthly project positions require the approval of the Compensation Office.

**Please answer all of the questions – incomplete requests cannot be processed.** PLEASE NOTE – By submitting this request, you are signifying that you have the appropriate concurrence of your UW Medicine CHSO, Hospital Executive Director, UW Medicine CFO, or their delegated designee.

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Section I – employee information | | | | | | |
| UWHIRES Requisition ID Number: | | | | Position #: | | |
| Employee Last Name: | | First Name: | | Middle: | | UW ID Number:     -   - |
| section II – extension information | | | | | | |
| This request is for (Check one only please): | | | | | | |
|  | **EXTENSION ONLY** and I confirm that all other terms (such as rate of pay, number of hours worked per week/position % of FTE, and general duties) for this temporary position will continue as originally requested.  The requested extended end date is: mm/dd/yyyy | | | | | |
|  | **EXTENSION AND CHANGE(S)** as identified below and I confirm that all terms not noted below (such as rate of pay, number of hours worked per week/position % of FTE, and general duties) for this temporary position will continue as originally requested.  The requested extended end date is: mm/dd/yyyy Changes are effective: mm/dd/yyyy | | | | | |
|  | **CHANGE(S) ONLY** as identified below; I confirm that no extension of this temporary position is being requested at this time and that all terms not noted below (such as rate of pay, number of hours worked per week/position % of FTE, and general duties) for this temporary position will continue as originally requested.  Changes are effective: mm/dd/yyyy | | | | | |
| Reason for Extension and/or Identification of and Reason for Change(s): | | | | | | |
| Section III – department information | | | | | | |
| Appointing Department Name: | | | Appointing Department Budget Number: | | | |
| Primary Department Contact Name: | | Phone:     -   - | | | Email Address: | |
| Department Contact Name: | | Phone:     -   - | | | Email Address: | |
| Department Contact Name: | | Phone:     -   - | | | Email Address: | |
| I confirm that I have all appropriate approvals as required by the UW Medicine CHSO, Hospital Executive Director, UW Medicine CFO, or their delegated designee for this request. These approvals are on file with my records on this action and available for review if requested. | | | | | | |

**Compensation Office approval will be sent by email to the department contact(s) listed on this request form.**

**Additional information regarding Professional Staff Temporary Positions can be found on the web at:**

[**http://www.washington.edu/admin/hr/roles/mgr/hire/prostaff-temp/index.html**](http://www.washington.edu/admin/hr/roles/mgr/hire/prostaff-temp/index.html)

|  |  |  |
| --- | --- | --- |
| **ROUTING INFORMATION** | | |
| **Medical Centers HR – Workforce Management Systems (WMS)** | | |
| **Employee Type** | **UW Medical Center** | **Harborview Medical Center** |
| Nursing | [nurspers@uw.edu](mailto:nurspers@uw.edu) | [hmcnurse@uw.edu](mailto:hmcnurse@uw.edu) |
| Non-Nursing | [hruwmc@uw.edu](mailto:hruwmc@uw.edu) | [hrhmc@uw.edu](mailto:hrhmc@uw.edu) |