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For Medical Centers only

### CLASSIFIED STAFF TEMPORARY SALARY/HOURLY INCREASE – APPROVAL REQUEST

PLEASE NOTE – By submitting this request, you are signifying that you have the appropriate concurrence of the UW Medicine President, Hospital CEO, UW Medicine CFO, or their delegated designee.

**Please provide all of the requested information. Incomplete requests may not be processed.**

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **SECTION I – INFORMATION** | | | | | | | | | | | | |
| Employee’s Last Name: | | | | First Name: | | | | | Middle Name: | | Position #: | |
| UW ID Number: | | Job Code & Title: | | | | | | | | | | |
| Department: | | | | | | Increase Start Date:  Choose an item. of Choose an item.Choose an item. | | | | | Increase End Date:  Choose an item. of Choose an item. Choose an item. | |
| **If Employee Status is Regular:** | | | | | | **If Employee Status is Regular-Hourly:** | | | | | | |
| Current **Full Time** Monthly Salary Rate | Range:  Step:  Amount: | | | | | Current Hourly Rate | | | | | Range:  Step:  Amount: | |
| Proposed Monthly Increase  \*amount will be pro-rated for part-time employees | Amount\*:  Percentage: | | | | | Proposed Hourly Rate Increase | | | | | Amount:  Percentage: | |
| Total **Full Time** Monthly Salary Rate Following Increase | Amount: | | | | | Total Hourly Rate Following Increase | | | | | Amount: | |
| Describe the specific higher level tasks that the employee has been assigned:  Click or tap here to enter text. | | | | | | | | | | | | |
| If the employee is performing the work of another position, complete the following: | | | | | | If the employee is **not** performing the work of another position, but is performing other higher-level duties, please explain: | | | | | | |
| Job Title: | | | | | | Click or tap here to enter text. | | | | | | |
| The position is vacant.  If vacant, is recruitment underway?  Yes  No  Position # of vacant position: | | | | | |
| The employee who normally does the work is on leave:  Name:  Leave end date: | | | | | |
|  | | | | | | | | | | | | |
| Department Contact’s Name: | | | Job Title: | | | | | Phone: | | | | Email: |
| **(Check this box):** I confirm that I have all appropriate approvals as required by the UW Medicine President, Hospital CEO, 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. | | | | | | | | | | | | |
| **SECTION II – EXTENSION REQUEST** | | | | | | | | | | | | |
| To request an extension of this temporary salary increase, please complete the following information on a copy of the original request. | | | | | | | | | | | | |
| **EXTENSION #** | | **EXTENSION END DATE** | | | | | **REASON FOR EXTENSION** | | | | | |
| #1 | | Choose an item. of Choose an item. Choose an item. | | | | |  | | | | | |
| #2 | | Choose an item. of Choose an item. Choose an item. | | | | |  | | | | | |
| #3 | | Choose an item. of Choose an item. Choose an item. | | | | |  | | | | | |
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| **ROUTING INFORMATION** | | | | | | | | | | | | |
| **Medical Centers HR – Workforce Management System (WMS)** | | | | | | | | | | | | |
| **UW Medical Center**  **(Montlake and NW)** | | | | | **Harborview Medical Center** | | | | | **Shared Services** | | |
| [hruwmc@uw.edu](mailto:hruwmc@uw.edu) | | | | | [hrhmc@uw.edu](mailto:hrhmc@uw.edu) | | | | | [hrwms@uw.edu](mailto:hrwms@uw.edu) | | |
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