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For Medical Centers only

### PROFESSIONAL STAFF TEMPORARY PAY INCREASE (TPI) or

### PROFESSIONAL STAFF ADMINISTRATIVE SUPPLEMENT (ADS) – APPROVAL REQUEST

**Please answer all 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.

Assumption of additional and/or higher-level responsibilities on a temporary basis must be for a minimum of ten working days.

When requesting an extension of this TPI/ADS, please maintain the original information. Changes should be entered in the extension request section only (page 2) in order to maintain the history of this TPI**.**

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Section I – information | | | | | | | | | | |
| Employee Last Name: | | | | | | | First Name: | | | Middle: |
| Job Code: | | | | | | | Payroll Title: | | | Position #: |
| Home Dept. Name: | | | | | | | Home Dept. Budget: | | | |
| UW ID Number: | | | | | | | Employee’s Current Regular (Base) FTE Salary: $ per month | | | |
| Indicate the type of temporary salary increase requested by checking either *Temporary Pay Increase*  *(TPI)* ***OR*** *Administrative Supplement (ADS)* box below and completing the information for that action: | | | | | | | | | | |
| Temporary Pay Increase (TPI) | | | | | | Administrative Supplement (ADS) | | | | |
| Proposed Monthly TPI/ADS Amount (above employee’s base salary):  **REFLECTING\***  % increase over base salary | | | | | | $ per month | | | | |
| *[****\**** *TPIs are approved as a dollar amount only. Base salary changes will not result in an automatic change to the TPI amount. Contact your Compensation Consultant for assistance.]* | | | | | | | | | | |
| Effective Start Date of Proposed Action: | | | | | | Effective End Date of Proposed Action: | | | | |
| **Note:** Start date must be the 1st or 16th of the month. End date must be with a pay period end date. | | | | | | | | | | |
| Justification for Proposed Action (please be specific):  Click or tap here to enter text. | | | | | | | | | | |
| Name of Department Contact (print or type): | | | | | Phone: | | | | | Email: |
| Department Contact Job Title: | | | | | | | | | | |
| Email Notification:    **Compensation Office approval will be sent by email from Workday** | | | | | | | | | | |
| **(Check this box):** 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.   |  |  |  | | --- | --- | --- | | **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) | | | | | | | | | | | |  |
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| section II – extension request | | | | | | | | | | |
| Complete this section only if requesting an extension or pay change to an existing TPI or ADS  Use your original electronic TPI/ADS request form (or most recent extension form)  **Complete the Extension/Pay change information below:**  **CONFIRM APPROVAL:** Check this box to indicate that you have continued appropriate approvals as required by the UW Medicine CHSO, Hospital Executive Director, UW Medicine CFO, or their delegated designee  **EXTENSION:** Check this box to extend the end date of the existing TPI or ADS  **PAY CHANGE:** Check this box to change the amount of the existing TPI or ADS  **EFFECTIVE DATE**:  Enter the effective date of the changes  **NEW TPI/ADS AMT (If applicable):** Enter the new pay rate of the existing TPI or ADS  **END DATE (If applicable)**:  Enter the new end date of the existing TPI or ADS  **REASON FOR EXTENSION/CHANGE:** Indicate the specific reason for the extension or pay change including details of what is changing | | | | | | | | | | |
|  | | | | | | | | | | |
| **EXT**  **NO.** | **CONFIRM**  **APPROVAL** | **EXT** | **PAY CHANGE** | **EFFECTIVE**  **DATE (Pay change only)** | | | | **NEW TPI/ADS AMOUNT** | **END DATE** | **DETAILS AND REASON FOR EXTENSION/CHANGE** |
| #1. |  |  |  |  | | | |  |  |  |
| #2. |  |  |  |  | | | |  |  |  |
| #3. |  |  |  |  | | | |  |  |  |
| #4. |  |  |  |  | | | | . |  |  |