CLEAR FORM

# REQUEST FOR OVERTIME PAY AND COMPENSATORY TIME
# COLLEGE OF HEALTH SCIENCES

***Note: This form must be submitted by the Division Director and approved by the Department Chair <u>prior to working the overtime or compensatory time requested</u>. Failure to do so may result in non-payment of overtime hours or compensatory hours worked.***

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CHECK THE APPROPRIATE BOX: G Request for Overtime
G Request for Compensatory Time:

DATE OF REQUEST: _____

DIVISION DIRECTOR SUBMITTING: _____

NAME OF EMPLOYEE TO COMPLETE WORK: _____

DATE(S) WORK WILL BE PERFORMED: BEGIN_____ END_____

TOTAL ESTIMATED NUMBER OF HOURS TO BE WORKED: _____

DESCRIPTION OF TASK(S) TO BE PERFORMED:

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***For Department use only:***

Date received: _____

( ) Approved

( ) Disapproved

_____ _____
Department Chair Date