**PROFESSIONAL STAFF COMPENSATION CHANGE REQUEST FORM**

Return completed form to the Human Resources Compensation Office.

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| Section a - PERSONAL INFORMATION | | | | | | | | | | | | | | | | | | |
| Last Name: | | First Name: | | | | | | | | Middle: | | | | | | Employee ID #: | | |
| Home Department Name: | | | | | | Home Department Budget #: | | | | | | | | | | | Position #: | |
| Job Code: | Payroll Title: | | | | | | | Grade/Range: | | | | | | FT Monthly Salary: $ | | | | |
| Has an ingrade or promotional salary increase been awarded in the past 12 months? | | | | | | | | | | | ☐ Yes ☐ No | | | | | | | |
| Has a performance evaluation been conducted within the past year? | | | | | | | | | | | ☐ Yes ☐ No | | | | | | | |
|  | | | | | | | | | | | | | | | | | | |
| section b - review type (choose one) | | | | | | | | | | | | | | | | | | |
|  | | | | | | | Complete Sections A, B, **C**, F & G | | | | | | | | | | | |
|  | | | | | | | Complete Sections A, B, **D**, F & G | | | | | | | | | | | |
|  | | | | | | | Complete Sections A, B, **E**, F & G | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | |
| section c – ingrade salary adjustment (med centers only) | | | | | | | | | | | | | | | | | | |
| **Campus ingrades are requested in Workday:** https://isc.uw.edu/user-guides/ | | | | | | | | | | | | | | | | | | |
| **Ingrade Salary Adjustment Reasons (Select One)** | | | | | | | | | | | | **Proposed Salary Adjustment** | | | | | | |
|  | | |  | | | | | | | | | Effective Date: | | | | | | |
|  | | |  | | | | | | | | | FT Monthly Salary: $ | | | | | | |
|  | | |  | | | | | | | | | FT Annual Salary: *(Select & Press* [F9] *to auto – calculate) $*  *0* | | | | | | |
|  | | |  | | | | | | | | | *(Select & Press* [F9] *to auto – calculate)*  % Pay Increase: -100.00% | | | | | | |
|  | | | | | | | | | | | | | | | | | | |
| section d – position review | | | | | | | | | | | | | | | | | | |
| Proposed Job Code: | | | | Proposed Payroll Title: | | | | | | | | | | | Proposed Grade: | | | |
| **Professional Staff Position Review -or-** | | | | **Research Scientist/Engineer Review** | | | | | | | | | | | **Proposed Salary Adjustment** | | | |
| **Review packet includes:**   * Professional Staff Compensation Change Request Form (this document) * Professional Staff Position Description, Contacts/Interactions and Organization Chart Form * Employee Signature Form * Research Activities Form (*if applicable*) | | | | **Review packet includes:**   * Professional Staff Compensation Change Request Form (this document) * Research Scientist/Engineer Job Questionnaire * Employee Signature Form | | | | | | | | | | | Effective Date: | | | |
|  | | | |  | | | | | | | | | | | FT Monthly Salary: $ | | | |
|  | | | |  | | | | | | | | | | | *(Select & Press* [F9] *to auto – calculate)*  Annual Salary: $ 0 | | | |
|  | | | |  | | | | | | | | | | | *(Select & Press* [F9] *to auto – calculate)*  % Pay Increase: **!Zero Divide** | | | |
| For current faculty employee submitting the review for consideration as a professional staff position, I confirm that a faculty recruitment occurred when the incumbent filled the position. | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | |
| Section e – Payroll Title Change Only | | | | | | | | | | | | | | | | | | |
| Effective Date: | | | | Proposed Job Code: | | | | | | | | | Proposed Payroll Title: | | | | | |
|  | | | | | | | | | | | | | | | | | | |
| Section f – Justification for Request | | | | | | | | | | | | | | | | | | |
| For position reviews and payroll title changes, describe what has changed. For ingrade salary adjustments, please expand on the reason selected in Section C. The field below will expand to accommodate the justification written. | | | | | | | | | | | | | | | | | | |
| Click or tap here to enter text. | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | |
| Section g – Approvals | | | | | | | | | | | | | | | | | | |
| **Email Approval Notification Box**  Only those listed in this box will be notified of approval by email; include name and email address for up to four contacts. Do not include the employee; the employee will not be notified by the HR Compensation Office regarding this request. | | | | | | | | | | | | | | | | | | |
| Name: | | | | | | | | | Email Address: | | | | | | | | | |
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| authorizing signatures | | | | | | | | | | | | | | | | | | |
| This request should be submitted to the Compensation Office with appropriate concurrence signatures. | | | | | | | | | | | | | | | | | | |
| **Manager/Supervisor** | | | | |  | | | | | | | | | | | | |  |
| Name:  Title: | | | | | Signature | | | | | | | | | | | | | Date |
| **Additional Approver (per organization policy)** | | | | |  | | | | | | | | | | | | |  |
| Name:  Title: | | | | | Signature | | | | | | | | | | | | | Date |
| **Department Chair/Administrator/Manager** | | | | |  | | | | | | | | | | | | |  |
| Name:  Title: | | | | | Signature | | | | | | | | | | | | | Date |
| **Dean/VP/Med Ctr COO/Delegated Authority** | | | | |  | | | | | | | | | | | | |  |
| Name:  Title: | | | | | Signature | | | | | | | | | | | | | Date |

**Distribution**: Return to the Human Resources Compensation Office.