

Office of Human Resources

Print Form

Designation of Employee to Function in an Acting Capacity

Name of Employee Designated: _____

Current Classification: _____

Classification to be filled on Acting Basis: _____

Beginning Date of Acting Basis: _____

Additional Compensation: _____

Date Additional Compensation Effective: _____

Date Additional Compensation to End: _____

IMPORTANT NOTICE
The employee shall be eligible for acting capacity pay beginning on the 21st consecutive calendar day of working in the acting capacity retroactive to the first day that the employee served in the acting capacity.
This form must be returned to the Office of Human Resources prior to the date acting capacity compensation will begin.

Reason for Designating Employee to Work in an Acting Capacity

Temporary Absence of Incumbent

Name of Incumbent _____

Reason for Absence _____

Vacant Position

Name of Former Incumbent _____

Reason Unable to Fill Position _____

Other

Please Explain _____

Employee Qualifications

Does the employee meet the minimum qualifications for the acting class? ☐ Yes ☐ No If No, explain: _____

Has this employee previously been assigned acting capacity status? ☐ Yes ☐ No If Yes, what classification and when? _____

Approvals/Signatures

Employee Signature / Date

Supervisor Signature / Date

Department Head / Date

Office of Human Resources / Date

President's or Designee's Signature / Date