**PROFESSIONAL GROWTH IN-BAND ADJUSTMENT FORM**

Date: Click here to enter date

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| --- | --- | --- | --- |
| Employee Name: | Click here to enter | Job Title: | Click here to enter |
| Position No.: | Click here to enter | Job Code: | Click here to enter |
| Dept./Div./Br.: | Click here to enter | Subzone: | Click here to enter |
|  |  | Effective Date: | Click here to enter date |

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| --- | --- | --- | --- | --- | --- | --- |
| **Increased Scope and Complexity of Work** | | | **Increased Competencies** | | | |
| Permanent | Temporary | From Click here to Click here | Permanent | | Temporary | From Click here to Click here |
| Current Monthly Base Pay: | | | $ Click here | | | |
| Shortage Differential (if applicable): | | | $ Click here | | | |
| Existing In-band amount(s) (in total, if any): | | | $ Click here | | | |
| ***Proposed Professional Growth In-band Adjustment***  *(4% of base pay rounded to the nearest dollar):* | | | **$ Click here** | | | |
| **Total Salary** (Base Pay + SD + In-band(s)): | | | **$ Click here** | (Shall not exceed the subzone maximum) | | |

Required Justification/Rationale:

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| 1. Attach a copy of the last performance evaluation from the immediately preceding rating period. The evaluation must reflect a minimum overall performance rating of “Meets Expectations.” |
| 1. **Increased Scope and Complexity of Work** |
| 1. Provide a position description reflecting the significant change to the predominant duties of the position. |
| 1. What significant changes have been assigned to the scope of responsibility and accountability, expectations in critical thinking and problem solving, changes in decision-making, and how expectations in communication changed?   Click here to explain |
| 1. What new knowledge, skill and expertise are being required to perform assigned position duties and responsibilities:   Click here to explain |
| 1. **Increased Competencies** |
| Describe the personal growth of the employee relative to increased knowledge, skills, abilities, etc. and explain how these competencies have benefited the program/agency/department. Click here to explain |
| 4. Provide any other relevant information or justification in support of the request. Click here to explain |

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**Certification:**

*I certify that the program can accommodate the additional funding associated with this request within its existing budget. The additional funding required can be covered in future budgets without an increase in the level of funding.*

*I certify that an assessment of the impact has been made and that this request complies with applicable equal opportunity laws, rules, regulations and policies.*

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| Name of Supervisor/Manager | Signature | Date |

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| Name of Division/Administrator | Signature | Date |

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| ***Departmental Personnel Office:*** | |
| Recommend Approval | |
| Recommend Approval with Changes | New recommended monthly rate: \_\_\_\_\_\_\_\_ |
| Approval not Recommended | |

Comments: .

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| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Name of DHRO | Signature | Date |

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| ***Director/Appointing Authority:*** | |
| Approved | |
| Approved with Changes | New recommended monthly rate: \_\_\_\_\_\_\_\_ |
| Not Approved | |

Comments: .

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| Name of Director/Appointing Authority | Signature | Date |

*Reminder: Please forward a copy of the request to DHRD Compensation, and to HGEA (included employees only).*