**RETENTION 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 |
| Dept/Div/Br:  | Click here to enter | Job Code:  | Click here to enter |
| Position Number:  | Click here to enter | Subzone:  | Click here to enter |
|  |  | Effective Date: | Click here to enter date |

|  |  |
| --- | --- |
| Current Monthly Base Pay: | $ Click here |
| Shortage Differential (if applicable): | $ Click here |
| Existing In-band amount(s) (in total, if any): | $ Click here |
| ***Proposed Retention In-band Adjustment:*** | **$ 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 offer letter with the salary offer from another employer and any other pertinent documentation of a valid job offer.
2. 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. Describe the contributions made by the employee and benefits to the program/department/State in retaining the employee, including identification of the employee’s bona fide occupational qualifications, and the special expertise, skill or knowledge that is critical to retention at the program/department/State; and identify any anticipated difficulties in securing a qualified replacement.

Click here to enter |
| 1. Describe the impact of Retention In-band adjustment on employees in comparable positions requiring the same bona fide occupational qualification, special expertise, skill or knowledge.

Click here to describe 1. Provide any other relevant information or justification in support of the request.

Click here to enter |

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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).*

*Note: The effective date shall be on the first day of the pay period immediately following the date of the Appointing Authority’s approval.*