**REQUEST FOR EMCP IN-GRADE COMPENSATION ADJUSTMENT**

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| TO: | Click here to enter Appointing Authority |
| VIA: | Click here to enter Departmental Human Resource Officer |
| FROM: | Click here to enter Requestor |

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| Permanent In-Grade | | Temporary In-Grade: From Click here To Click here | | |
| Employee Name: | Click here to enter | | Job Title: | Click here to enter |
| Department: | Click here to enter | | Job Code: | Click here to enter |
| Division/Branch: | Click here to enter | | Salary Range: | Click here to enter |
| Position No.: | Click here to enter | | Current Monthly Salary: | $Click here to enter |
|  |  | | Recommended Salary: | $Click here to enter |

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. **Assumption of Higher Level Duties** |
| 1. Provide a position description reflecting the significant change to the predominant duties of the position. |
| 1. What significant changes have been assigned and documented in the position description with respect 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 |
| 3. 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:*** | |
| *I certify that the above recommendation has been reviewed by the 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 |

Effective Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (See guidelines to determine appropriate effective date)

*DHRO shall email copies of all approved and disapproved requests to DHRD Compensation within ten (10) calendar days of the Appointing Authority’s decision.*