**INTERNAL ALIGNMENT IN-BAND ADJUSTMENT**

Date: Click here to enter date

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 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 | Band: | Click here to enter | |
|  |  | Effective Date *(for HR use only)*: | | Click here to enter date |

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| --- | --- | --- |
| Current SR & Step: | Click here to enter | |
| Monthly Base Pay: | $ Click here | |
| SD (if applicable): | $ Click here | |
| Existing In-band amount(s) (in total if any): | $ Click here | |
| ***Proposed Internal Alignment In-band Adjustment:*** | ***$ Click here*** | |
| **New Total Salary (including SD + In-band(s)):** | **$ Click here** | **(shall not exceed the in-band 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. Describe the employee’s responsibilities, education, expertise, skills, years of service, and/or accomplishments (performance).   Click here to describe |
| 1. Provide an analysis of the salaries including differentials among the employees in comparable and relevant positions (same career group, same band, and similar duties and responsibilities). Include the following in the quantitative analysis: salaries, years of service in the State and in the bargaining unit, educational level, relevant work experience (years, type and quality), other qualification requirements, etc.   Click here to enter or attach separate sheets   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 email copies of all approved and disapproved requests to DHRD-Compensation, and to HGEA (if the employee is included); within ten (10) calendar days of the Appointing Authority’s decision.*

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