**INTERNAL ALIGNMENT IN-GRADE 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 | Pay Grade:  | Click here to enter |
|  |  | Effective Date\* (*HR use only*): | Click here to enter date |

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| --- | --- |
| Current Monthly Base Pay: | $ Click here |
| ***Proposed Internal Alignment In-grade Adjustment:*** | $ Click here |
| Shortage Differential (if applicable): | $Click here |
| **Total Salary** (Base Pay + In-grade adj) + SD, if applicable: | **$ Click here** | (Shall not exceed the pay grade 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 (e.g., same or lower pay grade within the relevant work unit). Include the following in the quantitative analysis: salaries, years of service in the State and in the EMCP, educational level, relevant work experience (years, type and quality), and other qualification requirements.

Click here to enter or attach a separate sheet1. Provide any other relevant information or justification in support of the request.

Click here to enter |
| ***Note: Internal alignment in-grade adjustments shall not be used to match an employee who received a retention in-grade adjustment.*** |

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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 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 within 10 days of the appointing authority’s approval.*

*\*The effective date shall be on the first day of the pay period immediately following the date of the appointing authority’s approval.*