

10 MONTH STAFF AUTHORIZATION

TO DISCONTINUE PAYMENT OF SALARY OVER 12 MONTHS

NAME: _____

SOCIAL SECURITY NUMBER: _____

DEPARTMENT: _____

I want to **discontinue** having by fiscal salary paid out over a 12 month period, on a bi-weekly basis, beginning with the first payroll in August and ending on the last payroll of July of the subsequent year.

I authorize payroll to issue salary payments to me over a 10 month period, to coincide with my work schedule.

I understand that this agreement is binding for one fiscal year and it will continue for each fiscal year thereafter unless Payroll is notified of my desire to have this agreement discontinued. Such notice must be given in writing to the payroll section of Human Resources by July 15th of any given year.

SIGNATURE : _____ **DATE:** _____