

STAFF PAYROLL AUTHORIZATION
10 MONTH POSITION PAID OVER 10 MONTHS

NAME: _____

SOCIAL SECURITY NUMBER: _____

DEPARTMENT: _____

I understand that by participating in this program my fiscal year salary will be paid over a 10-month period, on a bi-weekly basis, beginning in August and ending in May of the subsequent year. I further 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 1st of any given year.

SIGNATURE: _____

DATE: _____

