

## STAFF PAYROLL AUTHORIZATION

### 10 OR 11 MONTH POSITION PAID OVER 12 MONTHS

NAME: \_\_\_\_\_

SOCIAL SECURITY NUMBER: \_\_\_\_\_

DEPARTMENT: \_\_\_\_\_

I understand that by participating in this program my fiscal year salary will be paid over a 12-month period, on a BI-weekly basis, beginning in August and ending on the last payroll of July 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: \_\_\_\_\_