



COMP TIME AUTHORIZATION FORM

Employee Information

Name: _____ Employee ID No: _____

Campus/Dept.: _____ Position: _____

Reason for Extra Time: _____

Location of Extra Time: _____

Hours per Day: _____ Hourly Rate: _____

Start Date: _____ End Date: _____

Employee Acceptance of Terms: I understand I will accrue hours (as accounted for on my time sheet) at the hourly rate noted above and that I am eligible for comp time hours to accrue at time-and-a-half, in accordance with the Fair Labor Standards Act, if I work over 40 hours within the work week. I further understand that I should use any accrued comp time prior to the end of my contract period.

Employee Signature: _____ Date: _____

Administrator/Supervisor Signature: _____

Administrator/Supervisor Printed Name: _____

Note: It is the responsibility of the administrator/supervisor to monitor the comp time hours accrued for the employee and have sufficient general fund monies to allocate toward payment of comp time upon resignation, termination, or retirement. If funds have not been previously allocated for such, it is the responsibility of the Administrator/Supervisor to prepare a budget amendment and submit to the Chief Financial Officer.