



## Supplemental Compensation Request Form

**INSTRUCTIONS** This form is used to request approval for payment of extra compensation in accordance with [Standard Administrative Procedure 31.01.99.M0.02, Supplemental Compensation and Dual Employment](#). Individuals who have been deemed as an Independent Contractor do not need to complete this form. To determine if an individual is an Independent Contractor, please complete the [Worker Classification Questionnaire](#). This form **MUST** be completed and submitted to the HROE Classification and Compensation office **PRIOR** to services being performed and entered in Workday. Class & Comp will determine if the extra compensation will be processed as a One-Time Payment, Add Additional Job or other salary action in Workday. Faculty and Graduate Assistant positions are excluded from this form.

Employee Name	Employee UIN	
Employee Title	Employee Position Number	
Proposed Duration of Service (From and Thru Dates)	Proposed Work Schedule	
Explanation of (Proposed) Services		
(Proposed) Total Amount of One-Time Payment and Frequency (If Applicable)		
Additional Comments		
Department Contact Name	Department Contact Email	Department Phone Number

If approved, this form certifies that the employee has taken the appropriate leave (if applicable) in accordance with relevant University leave requirements while performing additional work and the guidance provided by the HROE Classification and Compensation office is followed. Approval is in place if the circumstances of the situation remain unchanged.

The information on this form is subject to change per the HROE Classification and Compensation offices review. Once Classification and Compensation has reviewed the form, it will be sent back to the department contact listed above with a payment determination. If extra compensation is determined to be processed as an Add Additional Job, Classification and Compensation can provide guidance on position attributes to be used in Workday.

\_\_\_\_\_  
Primary Department Head Name (Print)

\_\_\_\_\_  
Primary Department Head Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Proposed Department Head Name (Print)

\_\_\_\_\_  
Proposed Department Head Signature

\_\_\_\_\_  
Date

**HUMAN RESOURCES APPROVAL AND COMMENTS:**

**SUBMIT FORM TO:**  
HROE Classification and Compensation [hrcomp@tamu.edu](mailto:hrcomp@tamu.edu)

**QUESTIONS:**  
Phone (979) 845-4170 | [hrcomp@tamu.edu](mailto:hrcomp@tamu.edu)