

**RECOMMENDATION FOR COMPENSATION INCREASE FORM
FOR CSUB AUXILIARY FOR SPONSORED PROGRAM ADMINISTRATION EMPLOYEES**

Employee Name: _____ Department: _____

CSU Classification and Working Title:

Date of Last Performance Evaluation: _____ Overall Rating of Last Performance Evaluation: _____

SALARY INFORMATION

Current Salary: _____ Recommended % Increase: _____ \$ Amount of Increase: _____

New Salary: _____ Recommended Effective Date of Increase: _____

Requested By: _____ Date Requested: _____
Name of Requesting Supervisor/Manager (Print)

Signature

TYPE OF SALARY INCREASE

___ MERIT (PERFORMANCE – BASED) ___ EQUITY

___ RECLASSIFICATION OR SKILL LEVEL CHANGE ___

EMPLOYEE NAME: _____

DEPARTMENT: _____

REQUIRED APPROVAL SIGNATURES

Principal Investigator/Department Head:

Date: _____

Associate Provost for Grants and Resource Management:

Date: _____

Provost and Vice President for Academic Affairs:

Date: _____

HUMAN RESOURCES REVIEW AND APPROVAL OF ACTION (for HR Use Only)

Approved Percentage: _____

Approved Amount \$: _____

Approved Salary \$: _____

Effective Date: _____

Director of Human Resources Approval: _____

Date: _____