**DEPARTMENTAL AGREEMENT FORM**

**UNIVERSITY SYSTEM EMPLOYEES**

**EMPLOYMENT COMPENSATION AGREEMENT DEPARTMENTS**

1. **REQUESTING DEPARTMENT ________________________ PROVIDING DEPARTMENT____________________________**

2. **REQUESTING DEPARTMENTS’S NEED for and description of services to be performed (attach additional sheets if necessary).**

3. **REQUESTING DEPARTMENTS’S JUSTIFICATION for obtaining part-time services from another Gordon State College employee in lieu of obtaining such services from a person not presently employed by the College (attach additional sheet if necessary).**

4. **EMPLOYEE’S CERTIFICATION: Employee to perform services as (mark one):**

   - NAME _______________________________________________   _____Chaplain   _____Fireman   _____Dentist
   - _______________________________________________   _____Registered Nurse   _____Licensed Practical Nurse
   - _______________________________________________   _____Licensed Physician   _____Psychologist
   - SOCIAL SECURITY #____________________________                    _       _ Certified Oral or Manual Interpreter for Deaf Person
   - EMPLOYED BY _______________________________________  _____Teacher or Instructor of an evening or night course or program
   - EMPLOYEE’S SIGNATURE______________________________________  _____Professional holding a doctoral or masters degree from an accredited college or university
   - DATE___________________________________                  ___       ______  Other

5. **SOURCE OF PAYMENT: ______ Requesting Department _____ Providing Department**

6. **NUMBER OF COURSES scheduled to teach at home institution _______ (Optional)**

7. **METHOD OF PAYMENT: Subject to performance of services.**

   - Account Number    ____________________________
   - Estimated Reimbursable Expense  ____________________________
   - Total Estimated Cost   ____________________________
   - Projected Dates of Service  ____________________________

8. **CONTACT INFORMATION:**

   - **REQUESTING DEPARTMENT**
     - Name: _______________  Phone: _______________  E-mail: _______________
   - **PROVIDING DEPARTMENT**
     - Name: _______________  Phone: _______________  E-Mail: _______________

9. **PROVIDING INSTITUTIONS CERTIFICATION OF AVAILABILITY OF EMPLOYEE:**

   I certify that the above person is available to perform the described services and that the performance of these services will not detract from nor have a detrimental effect on the performance of the person’s employment at our institution.

   ____________________________  Date

10. **APPROVED BY:**

    - **Requesting Department Head**
      - ____________________________  Date
    - **Providing Department Head**
      - ____________________________  Date

   *(REV 05/2008)*