Reset Form

Print Form

College of Medicine
Salary Increase Request Form

(**Scan and email to:** COMFS-SPI-RCL@comfs.ufl.edu)

UFID: _____ **Name:** _____

Department: _____ **Department ID:** _____

Current Position Title: _____

Proposed Title (if applicable): _____

Position Number (if applicable): _____ FTE: _____

Pay Status (select one): _____

Current Salary (if hourly-paid enter hourly rate): $ _____ **Proposed Salary: $** _____

Increase Amount: $ _____ **Percentage of Increase:** _____

Salary Increase Category (select one): _____

Justification (attach additional sheets if necessary):

Please provide the reason(s) for the requested salary increase. Refer to the College of Medicine's Salary Increase Policy for information that must be submitted with the request.

Approved:

_____
Supervisor Date

_____
Department Chair Date

_____
Dean, College of Medicine Date

Required for Faculty:

_____
Senior Vice President, Health Affairs, University of Florida President, UF Health Date