GEORGETOWN UNIVERSITY PERSONNEL TRANSACTION FORM

I. ACTION TO BE TAKEN: [ ] Hire/Rehire* [ ] Salary Adjustment* [ ] Distribution Change Today's Date:
Complete Reason Code [ ] Promotion, Demotion, Transfer [ ] Other*: Effective Date of Change:

CURRENT CENSUS DATA	II. NEW CENSUS DATA
SSN: Start Date:	SSN:
Name (L,F,MI):	Name (L,F,MI):
Suffix: Title: Status:	Suffix: Title: Status:
Street Address: City, State, Zip:	Street Address: City, State, Zip:
Home Phone: Work Phone: Department Number: Department Name:	Home Phone: Work Phone: Department Number: Department Name:
Work Address (Room/Floor/Building): Street Address: City, State: Zip: Zip ext.: Box #:	Work Address (Room/Floor/Building): Street Address: City, State: Zip: Zip ext.: Box #:
Birth Date: Citizen: Clergy: Race: Sex: Disability: Veteran's Status:	Birth Date: Citizen: Clergy: Race: Sex: Disability: Veteran's Status:

CURRENT EMPLOYMENT DATA	III. NEW EMPLOYMENT DATA
PIN: Class Code: Area:	PIN: Class Code: Area:
Employment Category:	Employment Category:
Manner of Pay: Temp: Grade/Level: Class Title: Tenure Status: 10 Month Code: EEO Code:	Manner of Pay: Temp: Grade/Level: Class Title: Tenure Status: 10 Month Code: EEO Code (required for Academic positions only):
# Hours per Week: Expiration Date: % FTE: Rate of Pay: Fellowship Amount: Annual Salary: Fellowship Limit: FTE Annual Rate: Probation Date: Compa Ratio: Pay Group:	# Hours per Week: Expiration Date: % FT: Rate of Pay: Fellowship Amount: --- Fellowship Limit: --- Probation Date: --- ---

Comments:	*Reason Code:

CURRENT DISTRIBUTION DATA					IV. NEW DISTRIBUTION DATA				
Cost Center Name	PIN	% of Effort	Cost Center #	Func. Code	Cost Center Name	PIN	% of Effort	Cost Center #	Func. Code
1									
2									
3									
4									
5									
6									
7									
8									
9									
10									

I certify that I have first-hand knowledge of (or have suitable means of verifying) work performed by this individual and that the salary distribution prior to the effective date of this change is reasonable in relation to the work performed.

_____ Department: _____

Employee Signature/date (required for RX accounts only) Department Signature/Date

For RX Allocations: Is there voluntary cost sharing greater than 5%? [ ] Yes [ ] No. If yes, complete the PERSONNEL TRANSACTION FORM ADDENDUM.

V. COMMENTS:

VI. APPROVAL SIGNATURES

Executive Vice President/Date:

Human Resources/Date:

PERSONNEL TRANSACTION FORM ADDENDUM FOR RX ACCOUNTS ONLY
VOLUNTARY COST SHARING BASED ON EFFORT

VII. VOLUNTARY COST SHARING

Cost Center Name	PIN	% of Effort	Cost Center Number	Function Code
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				

VIII. APPROVAL SIGNATURES

Employee/Date:

Department/Date:

Sponsored Accounting/Date: