



**FULL-TIME FACULTY OVERLOAD PAY REQUEST FORM**

TERM \_\_\_\_\_ YEAR \_\_\_\_\_

<b>Faculty Name</b>	<b>Hours over 24</b>	<b>Amount to be Paid</b>	<b>Charge Account No.</b>

Department Head's signature: \_\_\_\_\_ Date: \_\_\_\_\_

Dean's signature: \_\_\_\_\_ Date: \_\_\_\_\_

Provost's initial: \_\_\_\_\_