

The School District of Escambia County  
**INSTRUCTIONAL SUPPLEMENT CHANGE FORM**

*To Be Completed By School/Department Before Date Of Change*

SCHOOL/DEPARTMENT: \_\_\_\_\_

EMPLOYEE NAME: \_\_\_\_\_ SSN: \_\_\_\_\_

Add Supplement       Delete Supplement       Change Funding Source For Supplement

SUPPLEMENT NAME: \_\_\_\_\_

IF FACULTY UNIT SUPPLEMENT, NUMBER OF UNITS (1 = \$100, 2 = \$200, etc.): \_\_\_\_\_

EXPLANATION OF CHANGE (IF APPLICABLE):  
\_\_\_\_\_  
\_\_\_\_\_

**Examples:** 1. Delete supplement; she transferred to another school. 2. Add supplement; John Smith had been receiving the supplement but he quit. 3. Change funding from SAI to General Fund; Dean position which had been budgeted from SAI was earned at 10-day count and no longer needs to be paid from SAI.

EFFECTIVE DATE (*Actual date that supplement activity will begin, end or change*): \_\_\_\_\_

\_\_\_\_\_  
SIGNATURE OF APPROVAL (Principal/Department Head) \_\_\_\_\_ Date \_\_\_\_\_

*To Be Completed By Human Resource Services Department*

SUPPLEMENT NUMBER: \_\_\_\_\_ ANNUAL PAYMENT FOR SUPPLEMENT: \_\_\_\_\_

\_\_\_\_\_  
SIGNATURE OF APPROVAL (Human Resource Services Department) \_\_\_\_\_ Date \_\_\_\_\_

*To Be Completed By Budgeting Department*

BUDGETARY CODING:

\_\_\_\_\_  
%      Fund      Function      Object      Cost Center      Project

\_\_\_\_\_  
SIGNATURE OF APPROVAL (Budgeting Department) \_\_\_\_\_ Date \_\_\_\_\_

*Entered By Payroll Department*

\_\_\_\_\_  
Initial \_\_\_\_\_ Date \_\_\_\_\_