

STATE TIME-OFF AWARD

NAME _____ EIN _____ DATE _____

WORK LOCATION _____

SUPERVISOR'S NAME _____

NUMBER OF HOURS AWARDED _____ RECOMMENDED DATE USED _____

AWARD JUSTIFICATION:

RECOMMENDATION MADE BY _____ DATE _____

SUPERVISOR SIGNATURE _____ DATE _____

DIRECTORATE SIGNATURE _____ DATE _____

ELIGIBILITY APPROVAL – HRO STATE MGMT OFC _____ DATE _____

APPROVING AUTHORITY SIGNATURE _____ DATE _____

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Additional criteria:

1. A reward may be recommended by any person.
2. Up to 8 hours must be approved by the Deputy Adjutant General.
3. Awards of over 8 hours must be approved by the Adjutant General.
4. Time-off award expires one year from date of issue.
5. Award is to be recorded as OR (Other-Reward) on time sheet and time sheet must be accompanied a copy of the award.
6. Total awards per employee shall not exceed 40 hours per fiscal year.
7. **Supervisor/employee must attach a copy of the award to the time sheet when award is used, or each time a portion is used over more than one pay period.***

Original - Employee Personnel File

Copy Furnished:

Employee's Supervisor
Payroll Clerk

***Date(s) award used:** _____