



**DEPARTMENT OF HUMAN RESOURCES  
ACTING CAPACITY AUTHORIZATION FORM**

Date: \_\_\_\_\_

Check One: Original Request \_\_\_\_\_ Request for Extension \_\_\_\_\_

Department: \_\_\_\_\_

Name and Current Title of Employee: \_\_\_\_\_

Current Classification Status: Check One: Exempt \_\_\_\_\_ Non-exempt: \_\_\_\_\_

Current Salary: \_\_\_\_\_

Acting Capacity Title: \_\_\_\_\_

Acting Capacity Salary: \_\_\_\_\_

Reason for designating employee to serve in Acting Capacity:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Date employee begins serving in Acting Capacity: \_\_\_\_\_

Date compensation for Acting Capacity will begin: \_\_\_\_\_

Date compensation for Acting Capacity will end: \_\_\_\_\_

Anticipated length of time employee will be serving in Acting Capacity is: (Check one):

Three months: \_\_\_\_\_ 6 months: \_\_\_\_\_ One year \_\_\_\_\_ Other: \_\_\_\_\_

Department Head Signature: \_\_\_\_\_

Print/Type Name and Title: \_\_\_\_\_

President or Designee's Signature: \_\_\_\_\_

**The form should be returned to the Department of Human Resources prior to the date acting capacity compensation will begin.**