Louisiana Department of Health

Premium Pay Request Form (C. S Rule 6.16a)

Office: **Facility**:

Job Title(s):

Positions Affected:

Amount Requested: **Frequency**:

Reason for premium payment:

Please provide the justification for your request below (attach additional sheets if necessary):

Funds are available for implementation on proposed effective date:

REQUESTED BY (APPOINTING AUTHORITY OR DESIGNEE):

Signature **Date**

APPROVED BY (HR DIRECTOR OR DESIGNEE):

Signature **Date**