CONCORDIA COLLEGE

REQUEST FOR SALARY PAYMENT

BIWEEKLY EMPLOYEES – Support Staff & Adjunct Faculty

BIWEEKLY PAYROLL DATE (Month/Date/Year): _____/_____/_____

DESCRIPTION OF REQUEST: _____

DEPARTMENT: _____

FOAP: _____

FULL LEGAL NAME	CONCORDIA ID# (Required)	AMOUNT

_____ _____

REQUESTED BY SIGNATURE DATE

_____ _____

AUTHORIZED SIGNATURE SIGNATURE DATE

If there are questions concerning this payment, please contact _____ at _____.

This form is to be used for payments that are to be processed through the PAYROLL system. For Payments processed through the Accounts Payable system, please contact the Business Office

For Payroll Office use only:

Date entered: _____ Initials: _____

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