

Langston University

AUTHORIZATION TO RECEIVE COMPENSATORY TIME/OVERTIME

(Prior approval must be obtained seven (7) Workdays before OT hours are worked)

EMPLOYEE NAME: _____

DEPARTMENT: _____

CWID or last 4 digits of SSN: _____

I approve overtime work as follows:

_____ Overtime Pay	_____ Compensatory Time	_____ Acct#
Date(s)	Number of OT hours to be worked.	
_____	_____	
_____	_____	
_____	_____	

Reason for overtime: _____

Approved by: _____
 Supervisor's Signature Date

Approved by: _____
 Department Head's Signature Date

Approved by: _____
 Dean's Signature Date

Approved by: _____
 Vice President's Signature Date

A Time and Attendance form must be submitted in order for employee to be paid.

FOR OFFICIAL USE ONLY – PLEASE DO NOT WRITE BELOW THIS LINE

_____ + _____ - _____ = _____
 Beginning Balance New Hours Ended Hours Taken Ending Balance