Division of Continuing Education
SELF FUNDED PROGRAM PAYMENT REQUEST

Today's Date: _____

Dept. Contact: Name: _____Phone:_____ Fax:_____E-mail:_____

PAYEE'S NAME	**UFID**	**TITLE**

COLLEGE	DEPARTMENT	ADDRESS

Dates of Service: _____to_____ Number of Hours: _____

Supervisors' Name:_____UFID:_____

____New hire to UF (*paperwork attached*) ____Current UF Employee
____Retiree (*attached Rehire Retiree Exception Form*) ____Terminate appointment after payment
____Extra State Comp **OR** ____LSP

Services associated with: ____Credit Course ____Non-Credit Course

DEPT ID	**FLEXFIELD**	**EARNINGS AMOUNT**	**GOAL AMOUNT**

SERVICES PROVIDED:

DO NOT WRITE IN THIS SPACE

HRAC: _____

HR600 on file_____

The above service(s) have been completed and I authorize payment.

_____/_____ _____/_____
Department Chair Signature Date DCE Signature Date
_____ ___Barbara Bennett_____
Printed Name Printed Name
_____/_____
College of DCP, Assoc Dir of Admin Date
____Kutonya Sowell_____
Printed Name

Revised 03/27/2017