

UW Mobile Communication Device Allowance Authorization Form

Employee Name: _____ Employee ID: _____ (not W#)

Employee Job Title: _____ Position #: _____

Department Name: _____ Dept. Phone #: _____

PISTOL account to charge allowance: _____
(will be charged to 120000 Account) Fund Org Project Budget Ref.

Allowance Start Date: _____ Allowance End Date: _____
(If no end date is specified, it will end December 31st of the current year)

This is a: New Allowance Change in an existing allowance

Total monthly allowance: \$ _____ (Attach a copy of the summary page for the phone # receiving the allowance; if you are on a family plan, please also attach the Overview of Lines page)

Note: An employee may receive no more than one voice allowance, one text plan allowance and one data plan allowance regardless of the number of MCDs an employee chooses to own or operate.

Select one equipment option (if allowed):

One-time equipment allowance: \$ _____ (attach copy of purchase invoice)

Monthly equipment allowance: \$ _____ (attach copy of Equipment Charges page)

Please list your Current Plan features:

Mobile service provider: _____ Monthly Base Charge: \$ _____

Device telephone number: _____

Description of plan features: _____

I have read the Mobile Communication Device Policy and agree to follow all employee responsibilities as described. I have also registered the above device with the UW Alert System.

Employee Signature: _____ **Date:** _____

Supervisory certification of the business purpose for this allowance (mark all that apply):

- This employee is a key staff member needed in the event of an emergency
- This employee is frequently away from access to traditional land-based phone services
- This employee is involved in frequent off-hours/on-call activity
- The nature of this employee's work is critical and immediate response is required
- The related cost is justified when compared with alternative communication choices
- Other – If not listed above, please state why the device is necessary, why it is essential in carrying out job responsibilities and why job responsibilities could not be carried out without it

Approval Signature: _____ **Date:** _____

Department Head or Director

Retain a copy of this form and send the original, with plan information and purchase invoice for equipment (if needed), to the Payroll Office, Wyo Hall, Room 162.