



SUPPLEMENTAL PAY FORM
Payroll Department
3201 Arch St., 4th Floor, Suite 402
Phone: 215-895-2885
Fax: 215-895-1615 or 215-895-1753

RETURN TO PAYROLL FOR PROCESSING

Employee of **Drexel University**
 Drexel University College of Medicine

Employee Information	
Date Prepared:	Employee Position Number:
Employee Name:	Employee Position Title:
Employee Identification Number:	Initiator Name:
Employee Home Organization (number/description):	Initiator Phone:

Supplemental Pay Information		
Payment Reason:	Date(s) Worked:	
Hours Worked:	Hourly Rate:	Dollar Amount:
Comments:		
(Comments must be completed and describe reason for payment.)		

Funding Source					
Fund Code (6 digits)	Org Code (4 digits)	Acct. Code (4 digits)	Activity Code (4 digits)	Cost Center Title	Amount
				Total	
*Activity Code is Optional					Must be 100%

Approvals		
P.I./Cost Center Administrator Name:	Signature:	Date:
Director/Dean Name:	Signature:	Date:
Vice President Name:	Signature:	Date: