ALGONQUIN COLLEGE

REQUEST FOR ALLOCATION OF CONTINGENCY FUNDS

Department _____

Reason for Request

_____

_____

_____

Leave Replacement

Reason for Request:

- ☐ Medical Reasons
- ☐ Health And Safety Committee
- ☐ Union Business
- ☐ Maternity/Paternity Leave

Name Of Full Time Employee Being Replaced _____

Position Number _____

Cost Centre _____

Start Date _____ End Date _____

End Date must not go beyond Fiscal Year End (March 31).

_____ Replacement Costs (please attach copy of pay authority)

_____ Less Full Time Savings (Support Staff if applicable) = (Annual Salary / 261 days x # of days on STD x 25%)

$ 0.00 Sub-Total

_____ Fringe Benefits (Applicable rate * Sub-total)

$ 0.00 Total Amount Requested (Replacement Costs - Savings + Fringe Benefits)

General Contingency: Details of Expenses Incurred

Cost Centre	Object Code	Description	Amount

Total $ 0.00

The amount requested should be equal to the cost of the item being replaced.
If available, attach copy of requisitions or purchase order. If applicable, appropriate certification of the condition of the equipment must be attached.

Request prepared by _____ Name _____ Date _____

Dean/Director approval _____ Name _____ Signature _____ Date _____

Vice President approval _____ Name _____ Signature _____ Date _____

Finance Use Only

Reviewed by _____ Date _____

Director of Finance approval _____ Date _____