

MOBILE COMMUNICATION DEVICE ALLOWANCE AUTHORIZATION FORM

Employee Name: _____

Employee ID: _____

Employee Job Title: _____

Job Position #: _____

Department Name: _____

Department Telephone #: _____

Note: The allowance will be charged to the same index es that the employee is paid from, and will show as a benefit expense; however,

IF THE EMPLOYEE IS PAID IN WHOLE OR IN PART FROM A GRANT, YOU MUST SPECIFY A NON-GRANT INDEX NUMBER TO WHICH THE ALLOWANCE WILL BE CHARGED: _____

Allowance Start Date: _____

(should the plan be cancelled or the business use change, a new form must be submitted promptly)

Monthly Allowance Amount: (please check one)

_____ \$12.00 Limited use

_____ \$15.00 Low business use

_____ \$25.00 Moderate business use

_____ \$40.00 High business use

_____ \$ _____ Other*

* Enter amount requested per month and attach explanation for amounts over \$40.00.

The monthly allowance covers recurring service plan charges. If a device must be purchased, the department may choose to reimburse the employee for the device cost through the normal BPA process.

Please list your CURRENT PLAN features:

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

Device Telephone number: _____

Distinguishing service characteristics _____

As a general rule, the university will pay up to the amount an employee would have incurred under a state plan sufficient to meet the employee's business needs.

For more information refer to <http://www.montana.edu/wwwitc/telephoneservices/mobile.html>

I have read the Mobile Communication Devices Policy and agree to follow all employee responsibilities as described.

Employee Signature: _____ Date: _____

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

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

[Empty box for additional notes]

Approval Signature: _____
Department Head or Director

Date: _____

Retain a copy of this form and route the original to HR/ Personnel & Payroll Services; Room 19, MT Hall.