

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://www2.montana.edu/policy/itc/FINAL%20Policy%20on%20Mobile%20Comm%20Devices.htm>

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):

- This employee is a key staff member needed in the event of an emergency (cabinet, etc.)
- This employee is frequently away from access to traditional land-based phone services.
- This employee is involved in frequent off hours/on-call activity.
- This 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 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: _____
Department Head or Director

Date: _____

Retain a copy of this form and route the original to Human Resources Room 19, MT Hall.