

PURCHASE ADDITIONAL LEAVE (PAL) SCHEME APPLICATION FORM

Employee No: _____ School/Unit: _____

Surname: _____ First Name: _____ Ext: _____

Position: _____ HEW Level: _____ Choose Your Level

Ongoing: _____ Fixed Term: _____

Commenced Employment: _____ Contract Period: _____

Contract Commenced: _____

End date: _____

(Please Note: Applicants must have completed 12 months of continuous employment prior to the proposed commencement of the PAL Scheme.)

Total number of requested PAL Leave weeks: _____ *(Maximum 8 weeks)*

Commencement date: _____ *(Maximum 12 month period)*

End date: _____

Have you participated in the PAL Scheme previously? YES NO

Reason for leave request: _____

Leave Plan:

Include all proposed PAL and Annual Leave to be taken within the 12 month period. If proposing to take single days each week, provide this information below.

Leave Type	First Day of Leave	Last Day of Leave	Total Working Days	Comments
Choose Leave Type				
Choose Leave Type				
Choose Leave Type				
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Choose Leave Type				

Applicant's Statement

- I have read the PAL Scheme Policy and agree to abide by the conditions therein.
- I have completed a 12 month Leave Plan as required.
- I agree to annualisation of my salary as detailed in the PAL Scheme Policy.

Superannuation is based on position fraction immediately prior to commencing the PAL Scheme.

- I will continue to pay superannuation at the base rate of pay - that is, my salary prior to the adjustment for annualisation arrangements. Under this arrangement, I will pay my full fortnightly employee superannuation contribution and the University will pay its full contribution.
- I will contribute superannuation at the annualised pay rate - that is, the fortnightly rate of pay after adjustment for annualisation arrangements. Under this arrangement, I will pay the reduced fortnightly contribution. The Employer contribution to superannuation during the period of the Scheme will still be calculated at the base rate of pay prior to adjustment for annualisation and the University will continue to pay its full contribution.

(Signature of Employee)

(Date)

Recommended Not Recommended

Supervisor:
(Name)

(Signature)

(Date)

Comment:

Approved Not Approved

(Signature of Delegated Officer)

(Date)

Comment:

OPC USE ONLY:

Application entered: _____ Checked By and Date: _____

Annual Leave Balance @ ____ / ____ / ____ = _____