



IFAS Faculty Supplemental Compensation Plan (FSCP) Application Form

Name _____ UFID _____

Title: _____ Unit: _____

Current base salary: _____ Percent to be placed on grants: _____ Proposed duration: _____

List projected funding source(s) for non-state funds. UF Foundation/SHARE funds may not be used. Indicate project number(s) and account(s). If more than one, give specific allocation.

The faculty member's signature verifies agreement to the following statements and is required prior to the implementation of a Faculty Supplemental Compensation Plan (FSCP):

- I have read and understand the attached guidelines regarding the FSCP.
- Participation in the FSCP is strictly voluntary.
- Initial approval and annual continuation will be based on annual performance evaluations.
- Eligibility for the SCP requires a performance ranking of at least commendable in all mission categories with no decrease in performance from the previous year's evaluation. For example (not all inclusive):
 - Maintain or increase graduate student support
 - Maintain or increase postdoctoral associate support
 - Extension program must remain responsive to clientele
 - Maintain or increase publication rate
 - Maintain or improve teaching performance level
- Effort reporting and cost-sharing obligations must be considered and addressed.

Faculty member (signature and date)

REVIEW:

REVIEWER (Printed name)	REVIEWER'S SIGNATURE	APPROVED	DISAPPROVED	DATE
CHAIR OR DIRECTOR				
LEAD DEAN				
DEAN				
DEAN				
SENIOR VICE PRESIDENT Jack M. Payne				