ARKANSAS DEPARTMENT OF VETERANS AFFAIRS

Authorization to Earn Compensatory Time

Veterans Services ☐ **Veterans Home** ☐

Employee Name: (print) **Social Security Number:**
- -

I respectfully request authorization to earn Compensatory Time:

From: (Month/Day/Year) **To: (Month/Day/Year)**
/ / ☐ **AM** ☐ **PM** / / ☐ **AM** ☐ **PM**

Justification for Compensatory Time:

Employee's Signature: _____ **Date:** _____
Employee's Position _____
Approved by Administrator: _____ **Date:** _____
Approved by Deputy Director: _____ **Date:** _____

Note 1: The Deputy Director's signature is required ONLY if the Compensatory Time accrued, as a result of overtime approved on this authorization, will exceed 240 hours.
Note 2: A separate authorization must be approved for each pay period.

DATE	STARTING TIME	ENDING TIME	HOURS	MINUTES	APPROVED BY SUPERVISOR

Total Overtime Worked (Hours):_____