



University of Massachusetts

Retro Funding Adjustment Form

Contact:	_____
Phone:	_____
E-mail:	_____

Employee Name: _____
(Last) (First) (MI)

Employee ID: _____ Empl Rec #: _____

Funds to be Changed in Department ID: _____

Begin Date:

	/		/	
mm		dd		yy

End Date:

	/		/	
mm		dd		yy

All Earnings Base Salary Only Overtime

HR Account Code	Account Name	Allocation (%)*
		%
		%
		%
		%
		%

*Sum must equal 100%

Total 100%

Signature of Department Head: _____ Date: _____

Signature of Principal Investigator: _____ Date: _____

HRMS – Office Use Only		
Run Control: _____	Process DT: _____	Pay Period End: _____