STATE OF NEW YORK - DEPARTMENT OF CORRECTIONS AND COMMUNITY SUPERVISION

PAYROLL ADJUSTMENT FORM

NAME: _____ DIN: _____ H.U.: _____

I have recommended that you not be paid for your assignment of _____
(am) (pm) (eve) (L-eve) for the date of _____ for the reason stated below:
(The explanation must be stated clearly and completely, describing all remedial measures or counseling attempted.)

_____

_____

_____

_____

_____

_____

The Program Chairperson will review this recommendation, and will advise you whether payment of wages is to be withheld. You have the right to appeal withholding of wages to the Deputy Superintendent for Program Services.

I. Area Supervisor Review/Recommendation: I ___ agree ___ disagree.

Comments: _____

_____

_____

II. Program Chairperson Decision: Incentive allowance withheld ___ yes ___ no

Amount: $ _____

Program Chairperson: _____ Date: _____
Signature

Dist.: Original to Program Chairperson/Inmate Accounts
1st copy to Payroll Supervisor
2nd copy to Guidance Unit
3rd copy to Inmate (following final decision)

FORM 2758 (10/11)