



Cellular Communication Equipment Reimbursement Request

Name: _____ **UIN:** _____
(Last) (First) (MI)

ADLOC: _____ **Unit:** _____ **Work Phone:** _____

Work Address: _____ **Email:** _____
(include mail stop)

Justification: _____

Reimbursement Amount: \$ _____

*Reimbursement amount may not exceed the lower of \$100 or the actual cost of the equipment.
 For reimbursement, the receipt must be attached to this form.*

Required Equipment Reimbursement Funding Information:						
PIN	System Part #	Account #	Support Account #	Accounting Analysis	Object Code	Pay Code
					1940	39

I have read SAGO Regulation 25.99.09, *Cellular Communication Devices and Services*, and AgriLife Research Procedure 25.99.09.A1 or AgriLife Extension Service Procedure 25.99.09.X1, *Cellular Communication Devices and Services*. I understand the associated employee responsibilities as defined in both System regulations and agency procedures.

I certify that any changes which cause me to receive more than the actual cost of the communication equipment will be refunded to the appropriate departmental account.

Additionally, I understand that these allowances are considered taxable compensation subject to required tax withholdings, and are not part of my base salary.

Employee Signature *Date*
(required)

Department Head Signature *Date*
(required)

Office of Sponsored Research Services *Date*
(required if using grant funds)

Administrative Approval *Date*
(required)