REQUESTS FOR AUTHORITY TO PAY MOVING EXPENSES

AGENCY NAME:

NAME OF EMPLOYEE	**SOCIAL SECURITY NUMBER**

TYPE OF APPOINTMENT

☐ Original ☐ Promotion ☐ Reassignment ☐ Demotion ☐ Reinstatement

	FROM	TO
CLASS TITLE		
PLACE OF WORK		

ANTICIPATED DATE OF MOVE: __/__/____________________________________

POUNDS: (not to exceed 15,000 pounds maximum gross weight) _____________________________

ESTIMATED COST: $ 0.00____

JUSTIFICATION: Payment of moving expenses for this employee is in the best interest of the State of Florida for the following reasons:

ACTION TAKEN: ☐ Approved ☐ Disapproved

Agency Authorized Signature

(Print Name) *(Sign)* Date

DP-A-4 Revised 5/97