

COMPENSATION DISCLOSURE FORM

Post Date:

Select one:

Name

Address

Email

Telephone

POSITION INFORMATION

Position Title:

Class/Grade:
(if applicable)

Position

Location:

Schedule
(select):
Other schedule
(describe here):

WAGE/SALARY AND COMPENSATION INFORMATION

Choose one:

Hourly

Min. Hourly Rate:

Max. Hourly Rate:

Salaried

Min. Annual Salary:

Max. Annual Salary:

Other arrangement [describe]:

OTHER COMPENSATION: This position is eligible for the following (check all that apply):

Overtime

Tips

Commission

Comp. time

Shift
Differential

Other Premium
Pay

Other [describe]:

BENEFITS

This position is eligible for the following [check all that apply]:

Health insurance

Dental insurance

Vision insurance

Other
insurance
(describe)

Single

Single

Single

Family

Family

Family

Vacation [Amount]:

Sick Leave [Amount]:

Holidays [Number]:

Parental/
Family [Amount]:

Other leave [describe]:

Pension

Other benefit [describe]:

401(k)