

Ambassador Health Care, Inc.
Wage Increase Authorization

Today's Date: _____
Facility Name: _____
Employee Name: _____
Hire Date: _____ Current Position: _____
Current Salary: _____ per hour/ annual
Increase Amount: _____ per hour/ annual % of Increase: _____
New Salary: _____ per hour/ annual
Effective Date: _____
Reason for the Increase: _____
Date of Last Increase: _____ Amount of Last Increase: _____
Reason for Last Increase: _____

Approvals

Administrator: _____ Date: _____
COO: _____ Date: _____
(If greater than 3%)
CEO: _____ Date: _____
(If greater than 5%)

After the necessary approval(s) is obtained, please fax this request to (940) 384-1702