Job Labor Redistribution Form

Mississippi State University

MSU ID #: _____ **Effective Date:** _____

Name: _____ **Title:** _____

First Middle Last

Position Number & Suffix	Account Name	Accounting Distribution Fund	Org	Account	Program	Activity	Semimonthly/ Hourly Rate	Annual Rate	Workload %
Totals							$0.00	$0.00	0

Instructions

1. *This form must be signed by the budgetary or unit head.*
2. *Forward the completed form to Human Resources*

Approval Signatures:

Department Head: _____ Date: _____

(Grants/Contracts) Principal Investigator: _____ Date: _____

Prepared by: _____ Phone No. _____ **Director (if necessary):** _____ Date: _____