Carolina Family Health Centers, Inc.

Payroll Advance Request

Employee Name: _____ Date: _____

Position: _____ Department: _____

Amount of payroll advance: _____

By signing below, I authorize Carolina Family Health Centers, Inc. to deduct the total amount of the payroll advance from my next scheduled paycheck in order to repay the advance.

_____ _____
Employee Signature Date

For Administration Use

Dates of *all* advances for calendar year: _____

Amount of request is equal to or less than 50% of the employee's biweekly net pay:

☐Yes / ☐No

_____ _____
Finance Department Signature Date

Approved by:

_____ _____
Chief Financial Officer Date