



For internal use only: PT no.

Faculty Salary Request Form

** Please attach with your checklist **

Principal Investigator (PI): _____ Department: _____

Originating Sponsor Name (Agency, Corporation, Foundation, etc.) _____

Project title: _____

I have confirmed eligibility of faculty salary support from the sponsor / program with OSR.

Note:
- Salary supplements are funds requested on top of a faculty member's regular salary;
- Salary replacement is a portion of a faculty member's salary paid by the sponsor that then allows McGill to release a portion of institutional funds. **For physicians only:** Clinical income replacement (to reimburse physicians for clinical activities).

1. _____ Faculty member name	_____ Department	_____ \$: _____ Annual % of effort/time on the project = Salary + Benefits	Is this a multi-year salary request ? No <input type="radio"/> Yes <input type="radio"/> Supplement <input type="radio"/> Replacement <input type="radio"/> Clinical Income Replacement <input type="radio"/> (for physicians only)
Signature of Chair	Signature of Dean	Please PRINT Name: _____	Date _____

2. _____ Faculty member name	_____ Department	_____ \$: _____ Annual % of effort/time on the project = Salary + Benefits	Is this a multi-year salary request ? No <input type="radio"/> Yes <input type="radio"/> Supplement <input type="radio"/> Replacement <input type="radio"/> Clinical Income Replacement <input type="radio"/> (for physicians only)
Signature of Chair	Signature of Dean	Please PRINT Name: _____	Date _____

3. _____ Faculty member name	_____ Department	_____ \$: _____ Annual % of effort/time on the project = Salary + Benefits	Is this a multi-year salary request ? No <input type="radio"/> Yes <input type="radio"/> Supplement <input type="radio"/> Replacement <input type="radio"/> Clinical Income Replacement <input type="radio"/> (for physicians only)
Signature of Chair	Signature of Dean	Please PRINT Name: _____	Date _____

Note: This information will be provided to the Office of the Provost & Vice-Principal (Academic)-Academic Personnel Office.

OSR Review:



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Faculty Salary Additional Form

** Please attach with your checklist **

Principal Investigator (PI): _____ Department: _____

Originating Sponsor Name (Agency, Corporation, Foundation, etc.) _____

Project title: _____

I have confirmed eligibility of faculty salary support from the sponsor / program with OSR.

Note:
- Salary supplements are funds requested on top of a faculty member's regular salary;
- Salary replacement is a portion of a faculty member's salary paid by the sponsor that then allows McGill to release a portion of institutional funds. **For physicians only:** Clinical income replacement (to reimburse physicians for clinical activities).

4	_____	_____	_____	\$: _____	Is this a multi-year salary request ? No <input type="radio"/> Yes <input type="radio"/>
	Faculty member name	Department	Annual % of effort/time on the project = Salary + Benefits		Supplement <input type="radio"/>
	_____	_____	_____	_____	Replacement <input type="radio"/>
	Signature of Chair	_____	Signature of Dean	_____	Clinical Income Replacement <input type="radio"/>
	_____	_____	_____	_____	(for physicians only)
	Please PRINT Name:	Date	Please PRINT Name:	Date	

5	_____	_____	_____	\$: _____	Is this a multi-year salary request ? No <input type="radio"/> Yes <input type="radio"/>
	Faculty member name	Department	Annual % of effort/time on the project = Salary + Benefits		Supplement <input type="radio"/>
	_____	_____	_____	_____	Replacement <input type="radio"/>
	Signature of Chair	_____	Signature of Dean	_____	Clinical Income Replacement <input type="radio"/>
	_____	_____	_____	_____	(for physicians only)
	Please PRINT Name:	Date	Please PRINT Name:	Date	

6	_____	_____	_____	\$: _____	Is this a multi-year salary request ? No <input type="radio"/> Yes <input type="radio"/>
	Faculty member name	Department	Annual % of effort/time on the project = Salary + Benefits		Supplement <input type="radio"/>
	_____	_____	_____	_____	Replacement <input type="radio"/>
	Signature of Chair	_____	Signature of Dean	_____	Clinical Income Replacement <input type="radio"/>
	_____	_____	_____	_____	(for physicians only)
	Please PRINT Name:	Date	Please PRINT Name:	Date	

Note: This information will be provided to the Office of the Provost & Vice-Principal (Academic)-Academic Personnel Office.

OSR Review: