|  |  |
| --- | --- |
|  |  REQUEST FOR AUTHORITY TO PAY MOVING EXPENSES |
|  |
| DEPARTMENT NAME       |
| NAME OF EMPLOYEE      | SOCIAL SECURITY NUMBER      |
| TYPE OF APPOINTMENT:[ ]  Original [ ]  Promotion [ ]  Reassignment [ ]  Demotion [ ]  Reinstatement |
|  | FROM | TO |
| CLASS TITLE |       |       |
| PLACE TO WORK |       |       |
|  |  |
| ANTICIPATED MOVE DATE: |       |
|  |  |
| POUNDS: (not to exceed 15,000 pounds maximum gross weight) |  |
|       |  |
|  |  |
| ESTIMATED COST: |       |
|  |
|  |  |
| JUSTIFICATION: Payment of moving expenses for this employee is in the best interest of the State of Florida for the following reasons:      |
| ACTION TAKEN: | [ ]  Approved [ ]  Disapproved |  |
|  |  |  |
| Agency Authorized Signature: |  |  |
|  |  |  |
|       |  |  |  |  |
| *(Print Name)* |  | *(Sign)* |  | *(Date)* |