# Dual Employment/Extra Service Approval Form

**STATE OF NEW YORK**  
**OFFICE OF THE STATE COMPTROLLER**  
**BUREAU OF STATE PAYROLL SERVICES**

**DUAL EMPLOYMENT/EXTRA SERVICE APPROVAL FORM**  
**REQUEST FOR APPROVAL TO SERVE WITH ANOTHER STATE AGENCY**

SEND APPROVALS TO:  
Office of the State Comptroller  
Bureau of State Payroll Services

## TO BE COMPLETED BY EMPLOYEE

### PRESENT EMPLOYMENT:

- **Name**: .................................................................  
  **Agency (where employed)**: .............................................
- **Title**: .................................................................  
  **Dept. ID**: .................................................................
- **Email Address**: .................................................................  
  **Last 4 Digits of Social Security Number**: .......................

### ADDITIONAL EMPLOYMENT REQUEST:

I request approval to render additional service to the [Name of Agency]  
[Dept. ID] at [Location of Employment], for the period from [Start Date] through [End Date]  
for the purpose of [Brief Description of Work to be Performed].

☐ I do not render additional service in any other agency.  
☐ I render additional service in another agency. The name of that agency is [Name of Agency]  
[Dept. ID]

This requested additional service will not interfere with my regular duties.

**Date**: .................................................................  
**Signature**: .................................................................

## ACTION BY HEAD OF DEPARTMENT OR AGENCY WHERE REGULARLY EMPLOYED

- ☐ *Approved*  
  - ☐ Disapproved (Do not forward to Office of the State Comptroller)
- ☐ Approved through .................................................................
- ☐ Approved with the following limitations: .................................................................
  
  This additional service will not interfere with the performance of the employee's regular duties.
  
  **Name of Agency Department Head**: .................................................................
  **By**: .................................................................

* *ALL APPROVALS WITHOUT A LIMITING DATE WILL EXPIRE CLOSE OF BUSINESS ON MARCH 31st OF THE FISCAL YEAR.*  
**Signature & Title of Authorized Designee**: .................................................................

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A Signed Original of this Form Must Be Forwarded to the Bureau of State Payroll Services Before Payments Can Be Processed.