GALION CITY HEALTH DEPARTMENT
CELL PHONE STIPEND REQUEST

The Galion City Health Department (GCHD) will pay a monthly stipend to compensate GCHD Exempt Employees and/or GCHD Eligible Employees for the use their personal cellular telephones for GCHD business; in accordance with the GCHD Cell Phone Stipend Policy.

Name: _____
Last First Middle Initial

Exempt Employee: ☐Yes ☐No Eligible Non-Exempt Employee: ☐Yes ☐No

I have a cellular phone and contract with _____ which shall be utilized in accordance with the GCHD Cell Phone Stipend Policy.

Subsidy Requested:

☐$40/month with data subsidy

☐Other (specify): _____

I authorize the City of Galion Auditor's Office to add the approved subsidy amount to my regular pay. I understand this subsidy will be considered taxable income and all applicable taxes will be withheld.

_____ _____
Signature of Employee Date

I approve the cell phone subsidy for the above-named employee in accordance with the Galion City Health Department's Cell Phone Stipend Policy.

_____ _____
Signature of Department Head Date

_____ _____
Signature of Board of Health Rep Date

Any changes to service provider, requested amount, or reason for subsidy requires a new cell phone subsidy request form.

A copy of employee's cell phone bill must be attached for verification of plan type.