South Carolina Department of Disabilities and Special Needs
Temporary Employment Agreement

I, _____, understand that I am compensated as temporary staff and that my hours of work should not exceed _____ hours per week. My assignment can be terminated at any time due to lack of funds, discontinuance of the program, the return to duty of a permanent full-time employee, or for any other reason at the discretion of the South Carolina Department of Disabilities and Special Needs (DDSN). I understand that I have no paid Annual Leave, Sick Leave, Military Leave, or Holiday Leave entitlements as a result of this Temporary agreement.

If I am offered employment in a permanent position, I realize the time in this temporary status will not be made retroactive for the sake of compensated leave (Annual or Sick) accrual, nor will it impact State-regulated probationary period requirements. *(The preceding sentence does not apply to working retirees in that, should you become permanent, you would accrue leave based on your previous years of service.)*

I understand that the effective date of this assignment is _____. I will be compensated for hours worked at the hourly pay rate of $_____, and in accordance with the State Comptroller General's Pay Day Schedule. My hours worked should not exceed _____ hours per week.

I am aware that this part-time temporary assignment cannot exceed 12 continuous months with DDSN; and therefore, will be terminated on or before _____. This Temporary Staff Agreement is not a guarantee or contract for permanent employment with DDSN, and may be terminated at any time at the discretion of the Agency.

_____ Date: _____
Signature

_____ Date: _____
Area Supervisor

_____ Date: _____
Director of Human Resources

Central Office
Regional Facility