Determination of Workload Requirements for Obtaining Private Sector Temporary Help Services

Attach the description of the Work or Task Required.

Please check one of the following that apply:

☐ This is a new request. Work is anticipated to last 120 workdays or less in a 24-month period.
☐ This is an extension of a previous request. Current number of days worked______. Work will last an additional____workdays (may not exceed 240 workdays total in a 24-month period). If you are requesting the same individual/firm, please provide justification below.

Please check all of the following that apply:

☐ Need is due to absence of employee for emergency, accident, illness, parental or family responsibilities, or mandatory jury duty, but not including vacation or other non-critical circumstances.
☐ Work may not be delayed due to critical need.
☐ Work/task cannot be completed by current staff; detail; or hiring new permanent, temporary or term staff.
☐ Work is not supervisory or managerial in nature.
☐ Contracting out for this work will not displace a Federal employee.
☐ Contracting out for this work is not being used to circumvent controls on employment levels.

Attach the justification for extension of same individual/firm. (Include importance of work being performed, impact of delay, or interruption and actions taken to find other solution)

Contracting Officer’s Representative Certification:

_________________________________________ ______________________ ______________________
Contracting Officer’s Representative Organization Code Telephone Number

_________________________________________ ______________________ ______________________
Signature of Contracting Officer’s Representative Date

Human Resources Certification:

☐ Information above has been verified against human resources records/files.
☐ Need cannot be met through temporary employment or other employment means.
☐ Need cannot be met by appointing a surplus or displaced employee under the Career Transition Assistance Plan (CTAP) or Interagency Career Transition Assistance Plan (ICTAP).

_________________________________________ ______________________ ______________________
Human Resources Personnel Organization Code Telephone Number

_________________________________________ ______________________ ______________________
Signature of Human Resources Personnel Date

This Appendix, with original signatures must be submitted with the requisition to the servicing acquisition office.