

PAYROLL CHANGE NOTICE

Co. _____

Name: _____ SS#: ____/____/____ Change Effective: _____ ID# _____

Title: _____ Dept #: _____ DOB: _____ Hire Date: _____

STATUS

Salary Hourly FT PT Temporary Assignment

PERFORMANCE REVIEWS

90 Day 6 Month Annual Review Completed: _____ Next Review Due: _____

CHANGES

New Hire Rehire Promotion Transfer Demotion

Department From _____ To _____

Rate From _____ To _____

Position From _____ To _____

Name From _____ To _____

Other From _____ To _____

Address Change: Old New
Street _____
City, State, Zip _____
Phone _____

LEAVE OF ABSENCE

{ Paid Unpaid } FMLA Medical Personal Military Jury Duty Worker's Comp
Beginning Date _____ Ending Date _____

SEPARATION

Resignation Termination Layoff Other _____

Last Day Worked: _____ Required Notice Given: Yes No

GRANTED TIME BALANCE: _____ **ELIGIBLE FOR REHIRE:** Yes No

REMARKS/EXPLANATIONS:

| | | | |
|-------------------------------|-------------|-------------------------------|-------------|
| Program Manager/Coord. | Date | Administrator/Director | Date |
| Operations Officer | Date | Human Resources | Date |
| VP/Clinical Director | Date | | |