



Personnel Additions and Changes

Employee Name/Title _____ Effective Date: _____

Changes Authorized By: _____ Program: _____

Reason for Change(s):

- | | | | |
|---|--------------------------------------|---------------------------------------|--|
| <input type="checkbox"/> Hired | <input type="checkbox"/> Replacement | <input type="checkbox"/> New Position | <input type="checkbox"/> Second Pay Rate |
| <input type="checkbox"/> Re-evaluation of Current Job | | | <input type="checkbox"/> Eligible for Benefits |
| <input type="checkbox"/> Promotion | | | <input type="checkbox"/> Name Change |
| <input type="checkbox"/> Demotion | | | <input type="checkbox"/> Address Change |
| <input type="checkbox"/> Step/Merit Increase | | | <input type="checkbox"/> Telephone Number Change |
| <input type="checkbox"/> Cost of Living Adjustment | | | <input type="checkbox"/> Layoff |
| <input type="checkbox"/> Department Transfer: To: _____ From: _____ | | | <input type="checkbox"/> Resignation |
| <input type="checkbox"/> Fingerprint Clearance | | | <input type="checkbox"/> Termination |
| | | | <input type="checkbox"/> Substitute |

Employee Information

Employment Type Exempt Non-Exempt

Employee Number: _____

Name: _____

Social Security Number: _____

Address: _____

Address (2): _____

Telephone Number: _____

Hire Date: _____

Salary: _____

Date of Birth: _____

Termination Date: _____

Sex: Male Female

Ethnicity: _____

Leave Status:

- Maternity/Paternity Leave _____ To _____
- Medical Leave _____ To _____
- Worker's Compensation Leave _____ To _____
- Family Medical Leave _____ To _____

Benefit Status:

Medical:

- Continue at **Employee's** Expense Effective Date: _____ To _____
- Continue at **Employer's** Expense Effective Date: _____ To _____
- Cancel Effective Date: _____

Dental:

- Continue at **Employee's** Expense Effective Date: _____ To _____
- Continue at **Employer's** Expense Effective Date: _____ To _____
- Cancel Effective Date: _____

Additional Information
