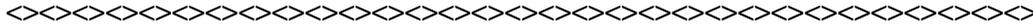


## New Employee/Employee Change Form

Date: \_\_\_\_\_ Department \_\_\_\_\_  
Employee Name: \_\_\_\_\_ S.S. #: \_\_\_\_\_  
Employee Number: \_\_\_\_\_ Position #: \_\_\_\_\_  
Effective Date: \_\_\_\_\_ Employment Date: \_\_\_\_\_



### Salary Department Changes

New Hire     Transfer     Position Change     Salary Change     Other

#### **New Hire or Current Status**

Department Name \_\_\_\_\_

Range \_\_\_\_\_ Grade/Step \_\_\_\_\_

Position Number \_\_\_\_\_

Annual Salary \_\_\_\_\_

Hourly Rate \_\_\_\_\_

Replacing what employee: \_\_\_\_\_

Longevity Pay # of years \_\_\_\_\_

Longevity Pay \_\_\_\_\_

Telephone Ext. \_\_\_\_\_

#### **Transfer or change to the following:**

Department Name \_\_\_\_\_

Range \_\_\_\_\_ Grade/Step \_\_\_\_\_

Position Number \_\_\_\_\_

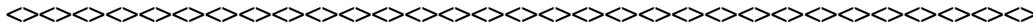
Annual Salary \_\_\_\_\_

Hourly Rate \_\_\_\_\_

Annual Salary \_\_\_\_\_

Total Salary \_\_\_\_\_

New Telephone Ext. \_\_\_\_\_



### Termination Information

Last actual day of work: \_\_\_\_\_

Please check appropriate reason for termination:

Resignation     Retirement     Discharge     Death

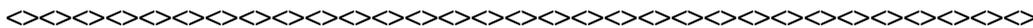
Lay-Off     Disability     Inability to perform duties

Please verify all eligibility for leave time compensation with the payroll office before submitting this form. List additional compensation due to the employee on their final check ( list number of hours due, and other dollar amount).

\_\_\_\_\_ Comp Time    \_\_\_\_\_ Partial Pay    \_\_\_\_\_ Vacation

\_\_\_\_\_ Other

**\* Notice of Employee Separation must be completed and faxed to Human Resources for all terminations.\***



### Other Employee Change Information

Please check appropriate reason and list start and end dates:

Administrative Leave     Family Medical Leave Act     Sick Pool

Workers Comp     Military Leave

Start Date: \_\_\_\_\_ End Date: \_\_\_\_\_

**\*FML notification form and certification of Physician must be completed and faxed to Human Resources.\***

#### **Remarks:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Approved by: \_\_\_\_\_ Title \_\_\_\_\_ Date: \_\_\_\_\_

*Original copy to Human Resources Department  
Original copy to Auditors Office for all/any Salary Changes.*