

EMPLOYEE ACTION FORM

Employee Name _____ Date _____
 Department _____ Manager _____

COMOT I		COMOT III		PAT I		PAT III		LTC	
COMOT II		COMOT IV		PAT II		PAT IV		POLE	

SELECT ACTION

New Hire Effective Date FT/PT
 Re-Hire Pay Rate PT hours

Job Title

Complete Payroll Fund &Line #

Termination Effective Date

Voluntary

New Job
 Medical
 Family
 School
 Personal
 Retire

Involuntary

Attendance
 Performance
 Policy

Payout Vacation Sick Comp

Payroll Change Effective Date

From Complete Payroll Fund &Line #
 Pay Rate

To Complete Payroll Fund &Line #
 Pay Rate

Department Head Signature _____ Date _____

Human Resources Signature _____ Date _____

NOTE: Department head or Hiring Authority - Please return completed form to Colleen Kempf, Auditor's office.
 This form must be completed with each employee change and turned in prior to the effective date.