

EMPLOYEE STATUS CHANGE

PLEASE TYPE OR PRINT

Employee Name: _____ Effective Date of Change ____/____/____
(Last) (First) (MI)

Employee Social Security Number: _____ - _____ - _____

Client Company Name: _____ Client Company Code: _____

PAY RATE CHANGE	JOB STATUS CHANGE	WORKERS' COMP. CODE CHANGE
\$ _____ Per Hour Per Pay Period	Full-time* to Part-time Part-time to Full-time* Regular to Temporary Temporary to Regular * Full-time = 30 hours or more per week	From: _____ To: _____ New Job Title and Job Description _____ _____ _____

TRANSFER*	LEAVE OF ABSENCE
New Department _____ New Location _____ *Does this change affect the employee's workers' comp classification? If so, please complete the <u>Workers' Comp Code Change</u> information above.	Family & Medical Leave Act (FMLA) (Please complete and attach separate FMLA documentation, including Employee Request for FMLA Leave, Employer Response to Request for FMLA Leave, and FMLA Medical Certification (if applicable)). Medical Workers' Compensation Other: _____ Expected Return Date: ____/____/____

FOR EMPLOYEE TERMINATIONS/SEPERATIONS (PLEASE COMPLETE AND SUBMIT SEPARATE EMPLOYEE SEPARATION REPORT)

OTHER PERSONAL CHANGES

New Name: _____ **Note: Must attach court order document**
(Last) (First) (MI) "Prior" name should appear at the top of this form

New Address: _____

City: _____ State: _____ Zip: _____

New Emergency Contact Name: _____ Home Phone: _____

Relationship: _____ Work Phone: _____

Change Social Security #: ____/____/____ **Note: Must attach copy of new and old Social Security card**

Employee's Signature (required for Other Personal Changes): _____ Date: ____/____/____

Supervisor's Signature: _____ Date: ____/____/____