SequoiaSD

Part of the AssuranceSD family

DIRECT CARE PROFESSIONAL CHANGE OF STATUS FORM

Direct Care Professional Name: ____

Effective Date: _______ / _______ / ________

Today's Date: ______ / ______ / ________

Instructions: Check the appropriate box and fill in the information below:

EMPLOYMENT CHANGE

Termination

Wage Change

Resignation; Reason for Resignation:

FMLA

Leave of Absence

____

New Classification

Full-Time

If resigning, please include a resignation letter.

New Wage Rate: $ ___________

SIGNATURES

On-Site Employer: ____ Date: ______ / ______ / ________

Employee: ____ Date: ______ / ______ / ________

To be completed by Human Resources

Changes Completed By: ____ Date: _____ / ______ / ________

Payroll Updated By: ____ Date: _____ / ______ / ________