SequoiaSD
Part of the AssuranceSD Family

DIRECT CARE WORKER CHANGE OF STATUS FORM

Direct Care Worker Name: _____

Effective Date: _____ Today's Date: _____

Instructions: Please check the appropriate box and fill in the information below.

EMPLOYMENT CHANGE

☐ New Wage Rate: _____

☐ Leave of Absence

☐ Termination; Reason for Termination:

☐ *Resignation; Reason for Resignation:

**If resigning, please include a resignation letter.*

SIGNATURES

Employee Full Name: _____ Date: _____

Employee Signature: _____

Employer Full Name: _____ Date: _____

Employer Signature: _____