

PAYROLL ACTION FORM/ EMPLOYEE INFORMATION

Effective Date: _____

REASON FOR CHANGE		
<input type="checkbox"/> New Hire	<input type="checkbox"/> Merit Increase	<input type="checkbox"/> Address/Phone Number change
<input type="checkbox"/> Re-Hire	<input type="checkbox"/> Retirement	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Promotion	<input type="checkbox"/> Voluntary Termination	
<input type="checkbox"/> Demotion	<input type="checkbox"/> Involuntary Termination	
<input type="checkbox"/> Transfer	<input type="checkbox"/> Re-evaluation of current job	

Name: _____ SSN: _____

Address: _____ City: _____ Zip: _____

Telephone: () _____ Cellular: () _____ Birthdate: _____

CA DL#: _____ Exp. Date: _____ Ins Co: _____ Exp. Date: _____

EMERGENCY CONTACT INFORMATION	
Name: _____	Relationship: _____
Telephone: () _____	

	FROM/NEW HIRE	TO
JOB TITLE		
FACILITY		
STATUS	<input type="checkbox"/> SALARIED EXEMPT <input type="checkbox"/> SALARIED NON-EXEMPT <input type="checkbox"/> HOURLY (F/T) <input type="checkbox"/> PART-TIME	<input type="checkbox"/> SALARIED EXEMPT <input type="checkbox"/> SALARIED NON-EXEMPT <input type="checkbox"/> HOURLY (F/T) <input type="checkbox"/> PART-TIME
PAY	<input type="checkbox"/> ANNUAL \$ _____ <input type="checkbox"/> PER HOUR \$ _____	<input type="checkbox"/> ANNUAL \$ _____ <input type="checkbox"/> PER HOUR \$ _____

LEAVE OF ABSENCE	
Begin Leave: _____	Expected Date of Return: _____
<input type="checkbox"/> Short-term Disability <input type="checkbox"/> Personal <input type="checkbox"/> FMLA/CFRA (if applicable)	<input type="checkbox"/> Pregnancy Disability <input type="checkbox"/> Workman's Compensation <input type="checkbox"/> Other: _____

TERMINATION	
Reason for Termination: <input type="checkbox"/> Did not complete "Introductory Period" <input type="checkbox"/> Other [reason listed below]	

Last day worked: _____	

Authorization Signatures:

Employee: _____ Date: _____

Immediate Supv./Mgr.: _____ Date: _____

Final Approval: _____ Date: _____