

College of Southern Idaho

Notice of Change of Employment

Employee Name _____ Employee ID# or SS # _____

Additional Position:

Position/Job Title _____ Rate of Pay \$ _____

Dept/Acct Number to be charged # _____ Effective Date _____

Change of Employment:

Effective Date of Change _____

Change of Salary or Hourly rate from \$ _____ to \$ _____
(All full-time changes to this must be approved by the President's Office)

Change of Department Number from # _____ to # _____

Change of Job Title from _____ to _____

Change in Exempt Status? Yes ___ No ___ (Must verify with Human Resources)

Change in work hours? Yes ___ No ___ New hours: _____

Change in contract months? Yes ___ No ___ New contract length _____

Change in Benefits? Yes ___ No ___

_____ Health/Dental Insurance	Eligible employees
_____ Retirement	Eligible employees
_____ Life/Disability	Eligible employees
_____ Vacation	Eligible employees
_____ Sick Leave	Eligible employees
_____ Comp Time	Eligible non-exempt employees

Termination of Employee:

Termination Date _____ Last day pay will be earned _____ Vacation Hours to be Paid _____

Reason for Termination _____

Comments: _____

Approval

Director/Dept Chair's Signature Date Dean's Signature Date

Vice-President's Signature Date President's Signature Date

Employee's Signature Date