Human Resources Received:

Payroll Change Notice

Current Information:

Name: _____ Employee #: _____

Position: _____ Supervisor: _____

Non-Exempt/Hourly: $_____ Exempt/Biweekly: $_____

Shift: ☐ 1st ☐ 2nd ☐ 3rd | Part Time Biweekly Hours: _____ | Location #: _____

Change:
Effective Date: _____

Payment to be issued within two pay cycles of employee acknowledgement with signature and date

☐ Annual Evaluation

☐ Change in Biweekly Scheduled Hours From: _____ to: _____

☐ Department Transfer To: _____ ☐ Shift Change To: _____

☐ Position Title Change: _____ ☐ Non-Exempt ☐ Exempt

☐ Promotion ☐ Demotion ☐ Lateral Transfer To: _____

Location #: _____ Supervisor Change To: _____

Next Evaluation Date: _____

☐ Temporary Assignment Outside of Class Per PPP | Start Date: _____ End Date: _____

☐ Stipend Reason: _____ Amount: $_____ Start: _____ End: _____

☐ Paid Administrative Leave ☐ Unpaid Administrative Leave - Start Date: _____

Comments: _____

_____

New Hourly Rate: _____ or **Biweekly Salary:** _____ **Grade:** _____

New Semi-monthly Premiums:

Short Term Disability	Long Term Disability	Health Insurance	Dental Insurance

Note: Disability premium changes are effective the first of the month following your change in rate. Health/Dental premium changes take effect in the payroll during which the change occurs.

Employee Signature: _____ Date: _____

LTC Department Head Initials:_____

O/DD: _____ Date: _____

Director of HR: _____ Date: _____

HR Use Only
HR Initials: _____
Put on Q: Drive:
_____

If Applicable
BOC Signature: _____ _____ _____

Last Revised: 04/09/2018