

Payroll Change Notice

Current Information:

Name: _____ Employee #: _____

Position: _____ Supervisor: _____

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

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

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

Effective 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/Buyout	Dental Insurance

Note: Disability premium changes are effective the first of the month following your change in rate. Health/Dental/Buyout rate 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: _____
 Copy to Payroll: _____

If Applicable
 BOC Signature: _____