

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 Dates: _____
 Paid Suspension Unpaid Suspension Start Date: _____ End 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 Initials: _____
 HR Dir Initials: _____
 PR Initials: _____
 PR Date: _____

If Applicable

BOC Signature: _____