Employee Termination Form

** Updated July 2022*

This form must be completed, by the department, whenever an employee leaves employment. The form must be submitted to the County Board Office and Payroll Office ***within 24 hrs*** *of the event. (i.e.: notice given, terrmination, etc.) The original letter of resignation must be attached to this form.*

Employee Name:	
Social Security #:	
Current Address:	
Phone Number:	
Personal Email:	
Department:	
Job Title:	

Reason for Separation *(circle one)*	termination	laid off	probation	deceased	retired	unapproved hire
	leave of absence		disability	seasonal	resigned	

Term Type: _____ ***Voluntary*** _____ ***In-voluntary***

Status of Employee: *(circle one)*	FT	PT	Temp
	Seasonal	Intern	PRN

Eligible for Re-hire: _____ yes _____ no

Last Day Worked: _____ **If FMLA Last Day Pay Status:** _____

Term Date: _____ **Last Pay day/Payroll period:** _____

Work Email Shutdown Date: _____ **Work Email Address:** _____

Two weeks notice given if applicable: _____ yes _____ no

PAID TIME COMING (Hours): COMP: _____ VACATION: _____ SICK TIME: _____ OTHER: _____
PERSONAL: _____ OVERTIME: _____

Explain "Other" Time: _____

Insurance Termination Date: _____

Insurance Plan Type:	HOPE 1000	HOPE 4000	HRP
	Dental/Vision		

Name of person completing this form: _____

Title: _____ **Date Completed:** _____

Office Use Only:		
1095-C information updated	Yes	No
W2-Address Updated	Yes	No
IT Notified of Email Shutoff	Yes	No
Employee deactivated from SafetySource	Yes	No