EMPLOYEE STATUS CHANGE FORM

ACMC
ASHLEY COUNTY MEDICAL CENTER

Effective Change Date			☐ Change	☐ Leave	
Employee Name					
	(Last)		*(First)*		*(Middle)*
Social Security #			Department		

CHANGES FOR CURRENT EMPLOYEE

TYPE OF CHANGE	FROM	TO
☐ Name **		
☐ Address		
☐ Telephone #		
☐ Job Title		
☐ Department		
☐ Wage		
☐ Pay Type *(hourly/salary)*		
☐ Status *(full/part/PRN/PRN Level II)*		

Change Reason:

** Must present new Social Security Card in order to make change

LEAVE OF ABSENCE/VACATION

Begin Leave *(date)*		Return from Leave *(date)*	
☐ Personal	☐Medical	☐ Vacation	☐ Other -

ACKNOWLEDGEMENT

Manager Signature		Date	
HR Director Signature		Date	
CEO Signature		Date	
Benefits Coordinator Signature		Date	
Payroll Processor Signature		Date	

ADDITIONAL COMMENTS