County of Goliad

Employee Status Change Form

Employee Full Name: _____

Physical Address: _____ **City:** _____ **State:** _____ **Zip Code:** _____

Mailing Address: _____ **City:** _____ **State:** _____ **Zip Code:** _____

D.O.B. _____/_____/_____ **Home Phone:** _____-_____-_____

Social Security Number: _____/_____/_____ **Cell Phone:** _____-_____-_____

Department: _____ **Hire Date:** _____/_____/_____ **Begin Date:** _____/_____/_____

Status _____**Full Time** _____**Part Time**

LEAVE OF ABSENCE

Begin Date: _____/_____/_____ End Date: _____/_____/_____

Reason For Leave (Circle One)

Educational Personal FML Short Term Disability

Long Term Disability Other: _____

SEPERATION- Include documentation of resignation/termination

Separation Date: _____/_____/_____ Last Day Worked: _____/_____/_____

_____ Voluntary _____ Involuntary _____ Possible Rehire

Notice of Cobra Rights Provided On: _____/_____/_____ Election of Cobra ____Yes ____ No

Start Date of Cobra Coverage: _____/_____/_____

Additional Comments:

_____

_____

_____

_____

Employee Signature: _____ Date: _____

Supervisor Signature: _____ Date: _____

County Judge Signature: _____ Date: _____

DATE FILED: _____/_____/_____