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 Rate of Pay _____

LEAVE OF ABSENCE

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

Reason For Leave (Circle One)

Educational Personal FML Short Term Disability

Long Term Disability Other: _____

DEPARTMENT TRANSFER _____TO/FROM_____

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: _____/_____/_____