NORTHWEST HEALTH DISTRICT

PERSONNEL ACTION REQUEST

CURRENT POSITION NUMBER	CURRENT POSITION TITLE	EFFECTIVE DATE
EMPLOYEE NAME	EMPLOYEE ID (PERSONNEL OFFICE USE)	SOCIAL SECURITY NUMBER
POSITION HOME BASE SITE	BUDGET / SUB-BUDGET	PROJECT NUMBER
SUPERVISOR'S SIGNATURE (middle supervisors' initials)	AUTHORIZED SIGNATURE (i.e., Co. Manager, Program Head, etc.)	DATE

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*** Note - Write a complete justification for establishment, reallocation, promotion, recruitment, salary change, budget change, or project number change on the back of this form in the space provided.**

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POSITION ACTION

(Attach Ga Gain Job Desc. and, if salaried, Proposed Performance Management Form)

___ Establish - Job #_____

___ Reallocate To_____Job #_____

RECRUITMENT

(Attach Recruitment Information Sheet, Form # PERS/015)

___ In-House Advertise (REQUIRED)

___ Newspapers _____

___Other _____

Contact Person:_____

Contact Phone:_____

SEPARATION

(Attach Documentation)

___Resignation ___ Retirement ___ Release

___ Transfer Out To_____

___ Other _____

LAST DAY ON DUTY _____

COMMENTS

_____

_____

_____

_____

APPOINTMENT

(Attach Application Form MS 27-1 and, if full time, two health forms MS 10-50 and MS 10-51)

___ Salaried ___ Hourly (Max. 80 hrs/mo)

___ Transfer in From _____

___ Promotion To _____ Job #_____

___ Full Time ___ Part Time _____%

___ Time Status Change From _____% To _____%

LEAVE OF ABSENCE

(Attach Documentation)

Please check pay status for Family Leave:

___ Regular ___ Contingent ___ Family - ___ with pay ___ without pay

___ Short Term Leave (30 days or less)
___Authorized ___Unauthorized

Last Day on Duty_____

Anticipated Return Date _____

___ RETURN FROM LEAVE OF ABSENCE

SALARY

(MONTHLY or HOURLY Amounts)

Salary: $_____ Grade _____

___ Salary Change

From: $ _____ Grade _____

To: $ _____ Grade _____

_____	

JUSTIFICATION:

_____

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SIGNED: _____

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FOR ADMINISTRATION OFFICE ONLY

MANAGEMENT TEAM SIGNATURES:

FISCAL MANAGER: Recommended/Not Recommended_____/_____
Date

PROGRAM SUPERVISOR: Recommended/Not Recommended_____/_____
Date

MEDICAL DIRECTOR:
Approved/Denied_____/_____
Date

COMMENTS:_____

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