IDEAL HR
Your HR Pros

Please return to IDEAL HR within 24 hrs

Employee Change Form

EFFECTIVE DATE: _____

Status/ Wage / Address

Employee Information

Client Company _____
Last Name_____
First Name_____
Middle_____

Address Change

Address:_____
City:_____
State:_____ Zip code_____

Phone:_____
Email:_____

Status/Wage/Department/Job Title Change

(Check those that apply)

☐ Hourly ☐ Exempt ☐ Part-time
☐ Salaried ☐ Non-Exempt ☐ Full-Time

Average hours per day_____ per week_____

Wage Amount: From_____ To_____

Reason for wage increase:
_____

New Department _____

New Job Title _____

Who will Manage the employee?

Who will the employee manage?

Leave of Absence

Type of Leave:
☐ FMLA ☐ Personal/Discretionary
☐ Jury Duty ☐ Other

Start Date:_____
Return Date:_____

Requires a medical release to return: ☐ Yes ☐ No

Reason for Leave: _____
_____

Does this change effect:

Will continue to earn Accruals ☐ Yes ☐ No
Will continue to receive Vacation ☐ Yes ☐ No

Does the employee have Health or Supplemental Insurance? ☐ Yes ☐ No

If Yes, How will the premiums be paid while the employee is on leave? _____
_____
_____

Please contact our Benefits Department for any questions or concerns (864)286-9009

I have authorized the above changes to be made as of the effective date listed above.

_____ _____
Signature of the Person Completing Date

_____ _____
Signature - Additional Authorization Date