Clear Form

Galion City Health Department
Personnel Action Form

Kim Ponziani — **Employee's Name**

8/5/2022 — **Date**

1. _____ New Home Address _____ New Phone Number

2. _____ New Classification _____ Effective Date _____ Range _____ Step

3. Marital Change Status: ☐ M ☐ D ☐ W Effective Date: _____

4. Leave of Absence: _____ Type _____ Dates

5. Resignation: _____ Reason _____ Effective Date

6. Merit Increase: _____ Classification _____ Anniversary Date

   _____ Range _____ Step $_____ From $_____ To

7. Termination: _____ Reason _____ Effective Date

8. Suspension: _____ Reason _____ Effective Date

9. Change in person to notify in case of emergency: _____ Name

   _____ Address _____ Phone Number

10. Appointment: $23.00 Salary Rate — 8/10/22 Date Commencing

Department Head Approval _____ Date

Board of Health Approval _____ Date

Additional Comments (please use other side if more space is needed):