



Galion City Health Department Personnel Action Form

Employee's Name _____ **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: _____
Salary Rate _____ Date Commencing _____

Department Head Approval Board of Health Approval

Date Date

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

