

EMPLOYMENT TERMINATION NOTICE (VOLUNTARY OR INVOLUNTARY)

Name: _____

Position: _____

Department: _____

Hire Date (Month/Day/Year): _____

Termination Date (Month/Day/Year): _____

Effective Date (Month/Day/Year): _____

REASON FOR TERMINATION

- ☐ Voluntary Resignation
☐ Discharge/Layoff
☐ Leave of Absence with Return Date of _____
☐ Retirement

Remarks and/or Reason: _____

COMPANY PROPERTY RETURNED

Item _____ Cost \$ _____

☐ Returned ☐ Not Returned Why Not? _____

☐ Useable ☐ Not Useable Why Not? _____

Item _____ Cost \$ _____

☐ Returned ☐ Not Returned Why Not? _____

☐ Useable ☐ Not Useable Why Not? _____

Item _____ Cost \$ _____

☐ Returned ☐ Not Returned Why Not? _____

☐ Useable ☐ Not Useable Why Not? _____

(Attach separate sheet of paper for recording of additional company property returned/not returned.)

I verify that the above information is correct to the best of my knowledge.

Authorized Company Representative (Print Name)

Date (Month/Day/Year)

Authorized Company Representative's Signature

Title

FINAL PAYCHECK(S) AND NOTICE DISTRIBUTION

FINAL PAYCHECK(S)

		AMOUNT	HOURS PAID
<input type="checkbox"/> Final Paycheck For Period Ending	_____/_____/_____	\$ _____	_____
<input type="checkbox"/> Vacation Pay		\$ _____	_____
<input type="checkbox"/> Severance Pay Through	_____/_____/_____	\$ _____	_____

☐ Other – Specify _____ \$ _____

NOTICES

Form DE 2320: EDD Unemployment Insurance Pamphlet

Health Insurance Premium Payment Notice – HIPP

Notice to Employee – Change in Relationship

Appropriate COBRA Notices (20 or more employees)*

Appropriate Cal-COBRA Notices (2-19 employees)*

401(k) Plan or Pension Information

METHOD OF DISTRIBUTION

☐ Given

☐ Mailed

Month/Day/Year

☐ Given

☐ Mailed

Month/Day/Year

☐ Given

☐ Mailed

Month/Day/Year

☐ Given

☐ Mailed

Month/Day/Year

☐ Given

☐ Mailed

Month/Day/Year

☐ Given

☐ Mailed

Month/Day/Year

CHANGE OF ADDRESS FOR W-2

Address

City

State

Zip Code

Note: Items in ***bold italics*** are required by **ALL** California employers.

Note: Items marked with a “*” are required for employers who provide health insurance.

ACKNOWLEDGMENT

I, ***(Employee's Name)*** _____, received a copy of this notice on ____/____/____.
I further acknowledge receipt of all final monies due me, on this date, and a copy of all notices as indicated above.

Employee's Signature

Date (Month/Day/Year)

*If employee refuses to sign, write “Refused to Sign,” write your initials and date on Employee's Signature line.

Supervisor's Signature

Date (Month/Day/Year)

Witness's Signature

Date (Month/Day/Year)

ADMINISTRATIVE USE ONLY

If employee is unavailable on termination date, I certify that this Employment Termination Notice along with all applicable notices and monies due will be retained, unless the employee specifically authorizes mailing and provides, in writing, the address to which the final check is to be mailed.

Authorized Company Representative (Print Name)

Date (Month/Day/Year)

Authorized Company Representative's Signature

Title

Distribution: Original to Employee Personnel File, Copy to Employee