

Employee Transfer Form – HR 3

This form is to be completed in all cases when an Employee is moving from one location to another within the HSE.

Sections 1 – 9 to be Completed by the Employee																							
Section 1 – Employee Details										Personnel Number													
Title	Last Name				First Name				Known As														
Maiden Name				Initials		Nationality																	
HSE Start Date				D	D	M	M	Y	Y	Y	Y	Current Appointment Start Date				D	D	M	M	Y	Y	Y	Y
HSE email address: _____ @hse.ie										Computer Login Name: _____													
Gender: Male <input type="checkbox"/> Female <input type="checkbox"/>				Date of Birth				D	D	M	M	Y	Y	Y	Y								
Marital Status: Single <input type="checkbox"/> Married <input type="checkbox"/> Civil Partnership <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Co-Habiting <input type="checkbox"/>																							
Relevant Certificate/s attached: Yes <input type="checkbox"/> No <input type="checkbox"/>				PRSI Class		PPSN																	
Section 2 – Home Address																							
Street Address																							
Town/City																							
County				Post Code				Country															
Home Phone No.												Mobile Phone No.											
Section 3 – Address for Correspondence [if different from above]																							
Street Address																							
Town/City																							
County				Post Code				Country															
Home Phone No.												Mobile Phone No.											
Email address for correspondence/ online payslip _____																							
Section 4 – Next of Kin [Emergency Contact Details]																							
Surname				First Name				Relationship to you															
Street Address								Town/City															
County				Post Code				Country															
Phone Number												Mobile Phone Number											

Employee Name _____ PPS No. _____

Section 5 – Bank Details

Bank Name					Bank Address																	
Bank Identifier Code (BIC)																						
International Bank Account Number (IBAN)																						
Payee Name																						

Section 6 – Professional Registration

Note: only applies to Medical & Dental, Health & Social Care Professionals & Nursing. If this section does not apply to you go to section 7. If you have multiple registrations please complete Appendix 1.

Name on Registration					Issued by														
Professional Registration/Membership Number																			

Section 7 – Qualification Details

										Official Use Only									
Name of Qualification		Date From				Proficiency / Grade Awarded				Qualification Code [if applicable]				Validated					
		D	D	M	M	Y	Y	Y	Y							Yes <input type="checkbox"/>	No <input type="checkbox"/>		
		D	D	M	M	Y	Y	Y	Y							Yes <input type="checkbox"/>	No <input type="checkbox"/>		
		D	D	M	M	Y	Y	Y	Y							Yes <input type="checkbox"/>	No <input type="checkbox"/>		
		D	D	M	M	Y	Y	Y	Y							Yes <input type="checkbox"/>	No <input type="checkbox"/>		
		D	D	M	M	Y	Y	Y	Y							Yes <input type="checkbox"/>	No <input type="checkbox"/>		

Section 8 – Irish Language Proficiency

Oral Irish										Validated	
Native <input type="checkbox"/> Intermediate <input type="checkbox"/> Fluent <input type="checkbox"/> Beginner/Novice <input type="checkbox"/> None <input type="checkbox"/> Unknown / Untested <input type="checkbox"/>										Yes <input type="checkbox"/> No <input type="checkbox"/>	
Written Irish										Validated	
Advanced <input type="checkbox"/> Intermediate <input type="checkbox"/> Basic <input type="checkbox"/> None <input type="checkbox"/> Unknown / Untested <input type="checkbox"/>										Yes <input type="checkbox"/> No <input type="checkbox"/>	

Section 9 – Employee Declaration

I declare that the above information is accurate and correct on the date indicated below. I undertake to notify my employer of any changes to this information by completing and submitting the appropriate form.

Signature					Date		D	D	M	M	Y	Y	Y	Y
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Employee Name _____ PPS No. _____

Sections 10 – 16 to be completed by Line Manager / Human Resources in Current Location

Section 10 - Transfer Details

Current Work Location	Last Date in Current Location	D	D	M	M	Y	Y	Y	Y
New Work Location	Start Date in New Location	D	D	M	M	Y	Y	Y	Y

Employed as (Grade)	Contracted hours
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Transferring from :

HSE South <input type="checkbox"/>	HSE West <input type="checkbox"/>	HSE North East <input type="checkbox"/>	HSE DML – South West <input type="checkbox"/>
HSE South East <input type="checkbox"/>	HSE North West <input type="checkbox"/>	HSE Northern Area <input type="checkbox"/>	HSE DML – Midlands <input type="checkbox"/>
HSE Shared Services <input type="checkbox"/>	HSE Mid West <input type="checkbox"/>	HSE Corporate <input type="checkbox"/>	HSE DML – East Coast <input type="checkbox"/>

Transferring to :

HSE South <input type="checkbox"/>	HSE West <input type="checkbox"/>	HSE North East <input type="checkbox"/>	HSE DML – South West <input type="checkbox"/>
HSE South East <input type="checkbox"/>	HSE North West <input type="checkbox"/>	HSE Northern Area <input type="checkbox"/>	HSE DML – Midlands <input type="checkbox"/>
HSE Shared Services <input type="checkbox"/>	HSE Mid West <input type="checkbox"/>	HSE Corporate <input type="checkbox"/>	HSE DML – East Coast <input type="checkbox"/>

Section 11 - Objects on Loan (if Applicable)

Please list HSE property items on loan below. [eg Laptop, Mobile Phone, Keys, travel pass etc.]

Item	Employee Initials	Line Managers Initials	Date of Return							
			D	D	M	M	Y	Y	Y	Y
			D	D	M	M	Y	Y	Y	Y
			D	D	M	M	Y	Y	Y	Y
			D	D	M	M	Y	Y	Y	Y

Have Items on loan been recovered Yes No

If no, please ensure that items are recovered before the employee departs.

Section 12 - Leave Details

Leave Due to the Employee	Leave Entitlement (Hours)	Leave Taken (Hours)	Hours Due															
Annual Leave (Confirmed)																		
Public Holidays (Confirmed)																		
Parental Leave (Confirmed)																		
Sick Leave taken in last 4 years	Leave taken (days/hours):																	
Sick Leave Record attached	Yes <input type="checkbox"/> No <input type="checkbox"/>																	
Career Break taken (Confirmed)	Dates From	D	D	M	M	Y	Y	Y	Y	To	D	D	M	M	Y	Y	Y	Y
Force Majeure Leave taken (Confirmed)	Leave taken (days):																	

Section 13 - Travel and Subsistence Claim Information

Car CC:	Date of last claim	D	D	M	M	Y	Y	Y	Y	Last date claimed	D	D	M	M	Y	Y	Y	Y
Rate being paid	Miles to date	Documents provided		Yes <input type="checkbox"/>	No <input type="checkbox"/>													

Employee Name _____ PPS No. _____

Section 14 – Recovery of monies owed by employee

Note: Please ensure that you notify payroll of any monies owing from the employee

Leave owed by employee	Leave entitlement (Hours)	Leave Taken (Hours)	Leave overtaken (Hours)
Annual Leave (Confirmed)			
Public Holidays (Confirmed)			
Does Employee owe monies for Payroll Rationalisation / Technical Adjustment?	Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>		
Has Payroll detail been updated to take account of Technical Adjustment recovery?	Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>		
Does employee owe monies to HSE under Free Fees Initiative (FFI) Funding?	Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>		
Has interim payment been ceased?	Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>		
Is employee availing of the Cycle to Work Scheme?	Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>		
Is employee availing of a Commuter Ticket?	Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>		
Is employee repaying an overpayment?	Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>		
Is employee forfeiting annual leave re HRA via payroll deduction?	Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>		

Section 15 – Pension Details

Is this employee eligible for membership of a superannuation scheme	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>		
Superannuation Classification to be completed in all cases	New Entrant	<input type="checkbox"/>	Non New Entrant	<input type="checkbox"/>		
NON NEW ENTRANT	Officer		Non-officer			
	PRSI Class A	PRSI Class D				
1956 Scheme	<input type="checkbox"/>	120	<input type="checkbox"/>	120	<input type="checkbox"/>	200
1977 (Revision Scheme) – Main Scheme	<input type="checkbox"/>	160	<input type="checkbox"/>	140	<input type="checkbox"/>	220
Spouses' & Children's	<input type="checkbox"/>	320	<input type="checkbox"/>	320	<input type="checkbox"/>	420
Widows' & Orphans'		N/A	<input type="checkbox"/>	300	<input type="checkbox"/>	400
NEW ENTRANT	Officer / Non-officer					
HSE Employee Superannuation Scheme - Main Scheme			<input type="checkbox"/>			165
Spouses' & Children's			<input type="checkbox"/>			325
Public Service Pensions [Single Scheme]			<input type="checkbox"/>			170

Section 16 – Line Manager's Declaration

1. I confirm that I have notified payroll in relation to the recovery of monies as outlined above	<input type="checkbox"/>								
2. I declare that the above information is accurate and correct	<input type="checkbox"/>								
Signature	Date	D	D	M	M	Y	Y	Y	Y
Name	Grade								
Contact Number	Email address								

Employee Name _____ PPS No. _____

Section 17 – 19 to be completed by the Payroll Manager in Current Location

Section 17 Pay Details

Annual Salary	Level (point on scale)								Amount			
Next increment due	D	D	M	M	Y	Y	Y	Y	Payslip distribution	Internal <input type="checkbox"/>	External <input type="checkbox"/>	Online <input type="checkbox"/>
Payment Frequency	Weekly <input type="checkbox"/>		Fortnightly <input type="checkbox"/>				4 Weekly <input type="checkbox"/>		Monthly <input type="checkbox"/>			

Section 18 – Payroll Deductions

VHI Membership No.:	Annual Amount:
Trade Union:	Period Amount or %:
AVCS:	Amount or %:

Please detail all other voluntary deductions and attach mandates or declarations

Section 19 – P45 & Certificate of tax cut off and PRD45

P45/Certificate of Tax cut off / PRD45 forwarded to appropriate Payroll Department Yes No

Section 20 - Payroll Managers Declaration

I declare that the above information is accurate and correct

Signature:	Date	D	D	M	M	Y	Y	Y	Y
Contact Tel No:	Email address:								

Employee Name _____ PPS No. _____

Section 21 – 26 to be completed by Line Manager / Human Resources in NEW Location

Section 21 - New Appointment Details

Employed As [Grade]					Position Number															
Org Unit No					Org Unit Name															
Cost Centre					Care Group					Personnel Area										
Work Address																				
Employee Group		Permanent <input type="checkbox"/>					Temporary <input type="checkbox"/>					Officer <input type="checkbox"/>					Non-Officer <input type="checkbox"/>			
Employee Sub Group		Wholetime <input type="checkbox"/>			Part-time <input type="checkbox"/>			Casual <input type="checkbox"/>			Fees/ Sessions <input type="checkbox"/>			Job Share <input type="checkbox"/>			Flexible Working <input type="checkbox"/>			
Reason for Transfer		National Transfer <input type="checkbox"/>					Local Transfer <input type="checkbox"/>					Redeployment <input type="checkbox"/>								
Replaced Employee Details		Name					Position Number					Personnel Number								

Section 22 – Contract

Contract Type		Indefinite Duration <input type="checkbox"/>					Indefinite Duration Std T&C's <input type="checkbox"/>					Fixed Term <input type="checkbox"/>					Specified Purpose <input type="checkbox"/>					Specified Purpose Std T&C's <input type="checkbox"/>				
Consultant Contract Type		Type A <input type="checkbox"/>					Type B <input type="checkbox"/>					Type C <input type="checkbox"/>														
Expiry Date of Temporary contract [if applicable]		D	D	M	M	Y	Y	Y	Y	Probation to be served Yes <input type="checkbox"/> No <input type="checkbox"/>																
1 st probationary review date		D	D	M	M	Y	Y	Y	Y	2 nd probationary review date		D	D	M	M	Y	Y	Y	Y							

Section 23 – Allowances

Allowance	Amount / Unit	Wage Type / Pay code Official Use Only
1		
2		

Section 24 – Work Pattern

Note: If an employee works a Monday to Friday roster they are classified as 5/5. These employees will never be paid Saturday allowance, Sunday premiums or Public Holiday premiums. Alternatively if an employee may work on a Saturday or Sunday they are classified as 5/7 – this will allow them be paid the relevant allowance and premium payments.

Standard Full Time Hours for this grade		Contract Hours [use decimals]			Working Week Mon – Fri 5 / 5 <input type="checkbox"/>		Mon – Sun 5 / 7 <input type="checkbox"/>		
Work Schedule Rule [if employee is casual enter HRPD]				Start week of rotational roster					

Section 25 – Pay Details

Annual Salary					Level [Point on Scale]					Amount														
Next increment due		D	D	M	M	Y	Y	Y	Y	Payslip distribution Internal <input type="checkbox"/>			External <input type="checkbox"/>			Online <input type="checkbox"/>								
Payment Frequency					Weekly <input type="checkbox"/>					Fortnightly <input type="checkbox"/>					4 Weekly <input type="checkbox"/>					Monthly <input type="checkbox"/>				

Section 26 Line Manager Declaration

I declare that the above information is accurate and correct. I confirm that the above employee transferred employment on the date stated above and approve set up on the appropriate payroll system.

Signature					Date					D	D	M	M	Y	Y	Y	Y
Name					Grade					Email							
Contact Number					Decision Number (if applicable)												