DATE PAF COMPLETED

COMPANY NAME
PAF - PERSONNEL PAYROLL ACTION FORM
(please use black ink)

STORE # / CORP. DEPT# / EMPLOYEE #

TO: HUMAN RESOURCES

NEW

EMPLOYEE'S LEGAL NAME *(LAST, FIRST, and MIDDLE INITIAL)*	EMPLOYEE SOCIAL SECURITY NO	q FULL TIME q PART TIME q PROBATIONARY q TEMPORARY
ADDRESS *(STREET)*	JOB CODE	JOB TITLE
(CITY, STATE, ZIP)	*(COUNTRY)*	CHANGE OF:
BIRTHDATE	PHONE / EMERGENCY PHONE	q RESIDENT q NON-RESIDENT *(PERSON TO CONTACT)* / q NAME q ADDRESS *(RELATIONSHIP)*
DATE HIRED *(FIRST DAY OF WORK)*	ANNIVERSARY DATE / PREVIOUS EMPLOYMENT DATE	ELIGIBILITY FOR REHIRE CHECKED? *(VERIFIER)* / *(MGT. APPROVAL)*
PAY *(HOURLY)* / *(BIWEEKLY / ANNUALLY)* / *(COMMISSION)*		FLSD STATUS q EXEMPT q NON-EXEMPT / EDUCATION COMPLETED / YEARS

PAY CHANGE:

q PERFORMANCE INCREASE *(Evaluation Attached)* q PROMOTION q OTHER *(Attach Written Reason)*

FROM: *(HOURLY)*	*(BIWEEKLY/ANNUALLY)*	*(COMMISSION)*	TO: *(HOURLY)*	*(BIWEEKLY/ANNUALLY)*	*(COMMISSION)*

EFFECTIVE DATE *(1st Day of New Pay Period)*	DATE OF LAST REVIEW	DATE OF NEXT REVIEW

POSITION CHANGE:

FROM: *(Job Code)*	*(Job Title)*	
TO: *(Job Code)*	*(Job Title)*	EFFECTIVE DATE *(First Day in New Position)*

STATUS CHANGE:

q FT q PT q TEMP. q EXEMPT
q W/C q PL q LOA q NON-EXEMPT

Effective Date of Status Change

TRANSFER: (Circle as Appropriate)

From Store/Corp./Dept. from _____ To Store/Corp./Dept. to _____

Transfer Effective Date ____/____/____

LEAVES: *(Leave Request/Forms Attached)*

Type of Leave Requested (Check One)

q Personal Medical (FMLA)
q Family Medical (FMLA)
q Personal (Attach written reason) _____
q Military
q Other _____

LEAVE OF ABSENCE (FMLA)

A. q 1st Request q 2nd Request q 3rd Request
B. Leave Requested From ____/____/____ to ____/____/____
C. Date of Expected Return ____/____/____
D. Leave Extended From ____/____/____ to ____/____/____
E. FMLA Leave Remaining _____ *(# of days)* *(hours)*
F. Work Comp. Injury? _____
G. q Returned From Leave ____/____/____

OFFICE USE ONLY

RECEIVED HUMAN RESOURCES

PROCESSED _____

COBRA ELIG q YES q NO q S q F q W

MED _____ DENTAL _____

DATE NOTIFIED _____

TO PAYROLL _____

PAYROLL USE ONLY

S / M / MS	FED	STATE
SUP	ADD W/H	

DIRECT DEP. ATTCH

PROCESS DATE / VERIFICATION DATE

DATE TO HUMAN RESOURCES

DATE FILED / INITIALS

TERMINATION:

Eligible for Rehire q Yes q No _____ *Mgt. Initials*

Last Day Worked _____ Termination Date _____

_____ *Term Code* _____ *Reason*

Medical Benefits at Termination? q Yes q No

_____ *Paid Time Off Due (Days)*

q Separation Checklist attached.

TIME OFF USE:

REQUESTED *Days / Home*	FROM	TO
AVAILABLE *Days / Home*	APPROVED *Days / Home* q Paid q Unpaid	REMAINING *Days / Home*

APPROVALS: *(Original Signatures Only)*

Employee *Date*

Manager *Date*

Human Resources *Date*

Department Head / District Manager *Date*

Executive Officer *Date*

Original -- Corporate HR Yellow -- District Manager Pink -- Store File