



enriching lives...realizing dreams

STARPOINT PERSONNEL ACTION FORM

EFFECTIVE DATE:

Employee Number: _____

EHS POLICY COUNCIL APPROVAL
DATE _____

JOB TITLE: _____

NAME: _____

HOURLY RATE/SALARY:

ADDRESS: _____

Exempt Non-Exempt

PHONE: _____

WORK SCHEDULE: _____

SSN: _____

CLASSIFICATION: _____

DATE OF BIRTH: _____

HOURS PER WEEK: _____

SEX: Male Female

PROGRAM/GRANT: _____

MARITAL STATUS: S M

LOCATION: _____

PERSON TO BE NOTIFIED IN CASE OF EMERGENCY:

NAME: _____

ACKNOWLEDGEMENT

ADDRESS: _____

EMPLOYEE SIGNATURE

DATE

PHONE: _____

APPROVED

ACTION

Employment

SUPERVISOR

DATE

Promotion

Personal Data Update

SECOND LEVEL SUPERVISOR

DATE

End of Introductory Period

Termination –

Voluntary Involuntary

HR DEPARTMENT

DATE

OTHER:

CHIEF EXECUTIVE OFFICER/
CHIEF ADMINISTRATIVE OFFICER

DATE

Interim: From _____ to _____

COBRA: _____

FOR OFFICE USE ONLY:

Department _____

Job Title _____