

**Southern Medical Corporation  
Employee Change Form**

**Employee Name:** \_\_\_\_\_

**Department:** \_\_\_\_\_

**STATUS CHANGE:**

(check one)

Full time to Part time \_\_\_\_\_

Part time to Full time \_\_\_\_\_

Full/Part time to PRN \_\_\_\_\_

PRN to Full time \_\_\_\_\_

PRN to Part time \_\_\_\_\_

Effective date: \_\_\_\_\_

**WAGE INCREASE:**

From \_\_\_\_\_ To \_\_\_\_\_

Effective Date: \_\_\_\_\_

**EMPLOYEE TERMINATION:**

Last date worked: \_\_\_\_\_

Reason: \_\_\_\_\_

Supervisor: \_\_\_\_\_

Date: \_\_\_\_\_