WORK STUDY TRANSFER| TERMINATION| CASH REDUCTION FORM Training Services Division, Office of Human Resources	☐ TRANSFER ☐ TERMINATION ☐ CASH REDUCTION

EMPLOYEE INFORMATION

EMPLOYEE NAME (LAST, FIRST, MIDDLE INITIAL)	WORKDAY #: Home Phone #: Office Phone #: Email:
HOME ADDRESS, CITY, STATE, ZIP	
ADMINISTRATION NAME AND MAILING ADDRESS (Spell/No acronym)	

TRANSFER TO NEW MARYLAND DEPARTMENT OF HEALTH ADMINISTRATION

NEW SUPERVISOR NAME	**PHONE NO:**
NEW ADMINISTRATION NAME AND MAILING ADDRESS	**POSITION START DATE:**

TERMINATION FROM THE MARYLAND DEPARTMENT OF HEALTH/CASH REDUCTION OPTION

I will be separating from the Maryland Department of Health on:	
I WOULD LIKE THE OPTION TO REDUCE MY OBLIGATED SERVICE CASH REPAYMENT AMOUNT	☐ Yes ☐ No
NOTICE: This Option is only available if submitted and approved prior to the employee's termination from the Maryland Department of Health.	Annual leave balance I would like to be applied:

RETURN TO STATE SERVICE NOTICE

I have returned to a full-time merit position within three years from my termination date, and I am not in a probationary period. I would like to resume repaying obligated repayment in service hours.

Starting or Remaining Cash Balance: Date of Departure: Date of Return:

EMPLOYEE OFFICE APPROVALS

PRINT APPOINTED AUTHORITY NAME & TITLE	Appointed Authority Signature	Date
PRINT SUPERVISOR NAME & TITLE	**Supervisor Signature**	**Date**
PRINT EMPLOYEE NAME & TITLE	**Employee Signature**	**Date**

++++++++++++++++++++++++++++ **TSD USE ONLY** ++++++++++++++++++++++++++++++

TOTAL ANNUAL/PERSONAL LEAVE HOURS TO DEDUCT	OBLIGATED SERVICE CASH BALANCE	CASH REPAYMENT BALANCE FORWARD $

Return to Obligated Service Cash Repayment Conversion to Hours:		
☐ **APPROVED** ☐ **DENIED**	**DATE:**	
APPROVER/TRAINING SERVICES DIVISION: **SIGNATURE:**	**201 W. Preston Street, Room 106** **Baltimore, Maryland 21201**	**Phone Number** **410-767-1605**