



UNIVERSITY OF SOUTH ALABAMA
USA HEALTHCARE MANAGEMENT, LLC
UNIV OF SOUTH AL HEALTH CARE AUTHORITY
PERSONNEL ACTION FORM

Date Prepared _____
 Contact Person _____
 Telephone _____

This form must be completed in Adobe.

1. EMPLOYEE INFORMATION
 Name _____ SS# (last 4 digits) _____
Last First Middle Init
 Address _____ J# J
Street City State Zip

2. REASON FOR ACTION (Check all that apply.)

Appointment Resignation Layoff Labor Distribution Change

Salary Change Retirement Transfer Other _____

Promotion Termination One Time Payment

PTRJCRE

3. CURRENT EMPLOYEE STATUS (Check one from a, b, and c.)

a. Regular b. Full-time c. Faculty Administrative

Temporary Part-time Coach Staff Exempt

Staff Non-Exempt

d. Check if applicable.
 Contract (Non-Faculty)

INSTRUCTIONAL EMPLOYEES ONLY

9 month Other _____

12 month Temporary Faculty

Position # _____ Position Title _____ Position Class _____ Out of Class

Department/Unit Name _____ Timesheet Organization _____

FTE _____ Total Annual Full-Time Salary _____ Hourly Rate _____ One-Time Payment _____

SALARY COMPONENTS BASE _____

		BANNER				% EMP SALARY	DOLLAR AMOUNT
		FUND	ORGN	ACCT	PROG		
STIPEND	<input type="text"/>						
	ACLS/EQUIV. <input type="text"/>						
DEGREE	<input type="text"/>						
	NATL CERT <input type="text"/>						
LPN	<input type="text"/>						
	CHARGE <input type="text"/>						
CLN LVL	<input type="text"/>						
	OTHER <input type="text"/>						
TOTALS							

4. PROPOSED EMPLOYEE STATUS (Check one from a, b, and c.)

a. Regular b. Full-time c. Faculty Administrative

Temporary Part-time Coach Staff Exempt

Staff Non-Exempt

d. Check if applicable.
 Contract (Non-Faculty)

INSTRUCTIONAL EMPLOYEES ONLY

9 month Other _____

12 month Temporary Faculty

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LPN	<input type="text"/>						
	CHARGE <input type="text"/>						
CLN LVL	<input type="text"/>						
	OTHER <input type="text"/>						
TOTALS							

5. COMMENTS

6. EFFECTIVE DATES

EFFECTIVE DATE	END DATE
<input type="text"/>	<input type="text"/>

7. APPROVALS

DIRECTOR/SUPERVISOR _____ DATE _____	PRESIDENT / DIVISION HEAD _____ DATE _____
DEPARTMENT HEAD/CHAIRPERSON _____ DATE _____	BUDGET OFFICE _____ DATE _____
DEAN / HOSP ADMIN _____ DATE _____	ASST. VP, HUMAN RESOURCES _____ DATE _____

HR USE ONLY

E CLASS	COMPENSATION
BENEFITS	EMPLOYMENT
ACTIVE	RETIRED
<input type="checkbox"/> YES	<input type="checkbox"/> YES
<input type="checkbox"/> NO	<input type="checkbox"/> NO