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 _____ (Last) _____ (First) _____ (Middle Init) J# _____

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

☐ Appointment ☐ Resignation ☐ Layoff ☐ Labor Distribution Change
☐ Salary Change ☐ Retirement ☐ Transfer ☐ Other _____
☐ Promotion ☐ Termination ☐ One-Time Payment

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

a. ☐ Regular ☐ Temp / PRN
b. ☐ Full-time ☐ Part-time
c. ☐ Faculty ☐ Coach ☐ Administrative ☐ Staff Exempt ☐ Staff Non-Exempt

Position # _____ Position Title _____ Department/Unit Name _____
FTE _____ Total Annual Full-Time Salary $ 0 _____ Hourly Rate _____ One-Time Payment _____

Salary Components
(Whole Dollars/Full-Time)

BASE
STIPEND
OTHER

BANNER				% EMP SALARY	DOLLAR AMOUNT
FUND	ORGN	ACCT	PROG		
				0.00	$ 0.00
				0.00	$ 0.00
				0.00	$ 0.00
				0.00	$ 0.00
			TOTALS	0.00	$ 0.00

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

a. ☐ Regular ☐ Temp / PRN
b. ☐ Full-time ☐ Part-time
c. ☐ Faculty ☐ Coach ☐ Administrative ☐ Staff Exempt ☐ Staff Non-Exempt

Position # _____ Position Title _____ Department/Unit Name _____
FTE _____ Total Annual Full-Time Salary $ 0 _____ Hourly Rate _____ One-Time Payment _____

Salary Components
(Whole Dollars/Full-Time)

BASE
STIPEND
OTHER

BANNER				% EMP SALARY	DOLLAR AMOUNT
FUND	ORGN	ACCT	PROG		
				0.00	$ 0.00
				0.00	$ 0.00
				0.00	$ 0.00
				0.00	$ 0.00
			TOTALS	0.00	$ 0.00

5. COMMENTS

6. EFFECTIVE DATES

EFFECTIVE DATE	END DATE

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