HUMAN RESOURCES
EMPLOYEE SEPARATION FORM

NAME (Print):	EMPLOYEE Banner ID:	HIRE DATE:
POSITION TITLE:	DEPARTMENT:	MANAGER/SUPERVISOR NAME:

INSTRUCTIONS (Please read before completing the form):

1. Employee shall notify their manager/supervisor of their resignation or retirement prior to or concurrent with notification to Human Resources.
2. Employee shall complete this form and route it to individuals listed below for signature. Forward completed form to HR for separation processing, a District Property Separation Checklist and Employee Separation Survey will be provided (if applicable).
3. Contact Benefits at (909) 274-4225 to schedule a meeting to review your health & welfare benefits (if applicable).
4. To obtain detailed information regarding your retirement, contact the appropriate agency listed below:
   a. CalPERS: http://www.calpers.ca.gov/ or call 888-225-7377
   b. CalSTRS: http://www.calstrs.com/ or call 800-228-5453
   c. National Benefits Services (NBS) (FICA Alternative Retirement Plan): www.nbsbenefits.com/403b or call 1-800-274-0503
5. Complete the following section(s). **Note: If retiring, complete both the Resignation and Retirement sections.**

☐ RESIGNATION:	☐ RETIREMENT:
Date of Resignation:	Date of Retirement*:
Last day of Paid work:	
Reason for Resignation:	****Use date as specified by your retirement system. Retirement date must be at least one day after date of resignation***

6. Do you intend to continue to work for the District in another capacity (e.g. adjunct)? ☐ Yes ☐ No Position:_____
7. Provide future contact information necessary for mailing W-2 tax form and other important information:

Address: _____
Street City State Zip

Telephone Number: _____ Email: _____

By my signature below, I certify the information furnished herein, and I hereby give notice of my separation as a Mt. San Antonio Community College District employee. I understand that in accordance with AP 7350, resignations accepted by the College President/CEO are final and may not be rescinded.

Employee's signature: _____ Date: _____

Required Acceptance/Approval Signatures:

Manager/Supervisor: _____ Date: _____

Vice President: _____ Date: _____

President/CEO or Designee: _____ Date: _____

For Human Resources Use Only

Entitled to: Lifetime Medical Benefits? ☐ Yes ☐ No Dependent Lifetime Medical Benefits? ☐ Yes ☐ No

Board Approved: _____ Benefit Specialist Verified/Date: _____

Copy to: HR Benefits _____ Payroll _____ Fiscal _____ Employee _____