

# Central State Hospital

## Employee Clearance Form

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

Name: \_\_\_\_\_ Employee ID /Social Security # \_\_\_\_\_

Job Title: \_\_\_\_\_ Department/Unit: \_\_\_\_\_

Office Room # \_\_\_\_\_ Novell/GroupWise User ID: \_\_\_\_\_

Supervisor: \_\_\_\_\_ Final Work Day: \_\_\_\_\_

Retirement
  Termination of Employment (Resignation, Dismissal, Retirement, etc.)
  Transferring to another State Job

**\*\*Note to Employees: This form must be completed by representatives from the following CSH departments. A map of the CSH Campus is available upon request. Once completed, the form may then be presented to HRM in exchange for the final paycheck.**

DEPARTMENT	AUTHORIZED SIGNATURE	DATE CLEARED
Assigned Department/Unit		
Business Office (Work Area Specific)		
Data Management (Novell/GroupWise & Computer equipment users)		
Facility Operations (State Housing Occupants)		
Health Information Management (Applies to HIMD Staff and Direct Care Staff involved in Medical Records documentation)		
Nursing Services (Applies to RNs/LPNS)		
Procurement/Property Control/ Telecommunications (Applies to Employees who have assigned Pagers, Visa Cards, Telephone Credit Cards, Blackberries or other related devices.		
Mimbs Wellness Center (Access/ID cards)		

**HUMAN RESOURCE MANAGEMENT**

I.D. Card	ERS/Georgia Defined Contribution Refund Application
Exit Interview ( ) Declined ( ) Participated on Line ( ) Completed Word Document	Insurance Continuation Procedure Explained, if Applicable

**Disposition of last check(s):**

Mailing Address [for W2 Tax Form(s)]: \_\_\_\_\_

\_\_\_\_\_

Phone#: \_\_\_\_\_

Comments: \_\_\_\_\_

\_\_\_\_\_  
Employee Signature: \_\_\_\_\_ Date

\_\_\_\_\_  
Human Resources Representative Signature: \_\_\_\_\_ Date

I Certify that I have returned all CSH property from my possession to the designated locations or persons.