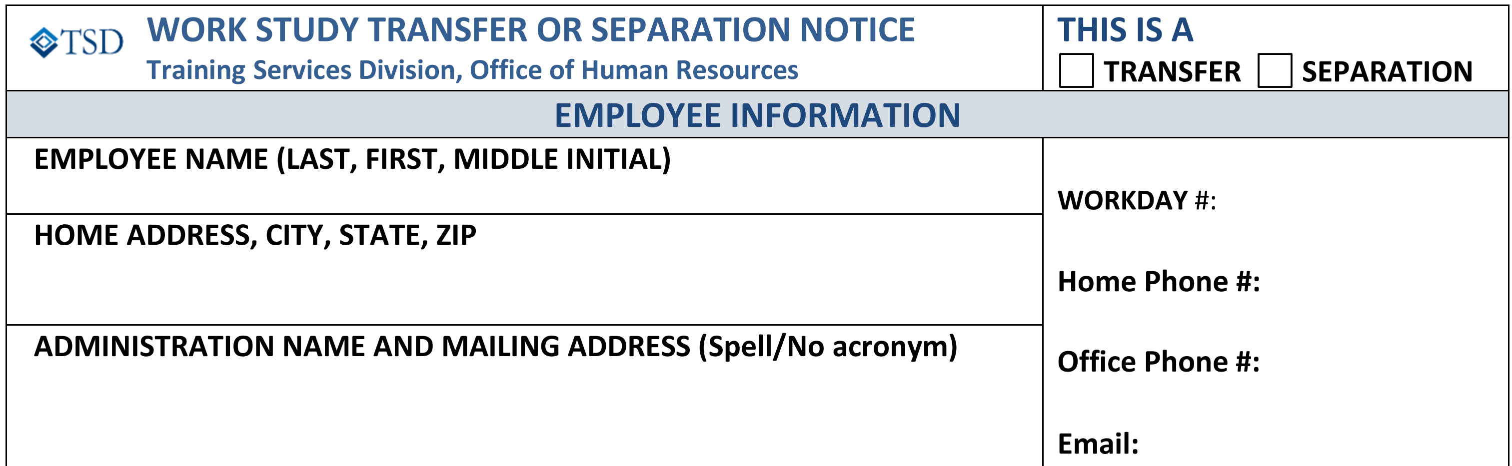

TSD **WORK STUDY TRANSFER OR SEPARATION NOTICE** Training Services Division, Office of Human Resources	**THIS IS A** ☐ TRANSFER ☐ SEPARATION
EMPLOYEE INFORMATION	
EMPLOYEE NAME (LAST, FIRST, MIDDLE INITIAL)	WORKDAY #:
HOME ADDRESS, CITY, STATE, ZIP	Home Phone #: Office Phone #:
ADMINISTRATION NAME AND MAILING ADDRESS (Spell/No acronym)	Email:

TRANSFER TO NEW MARYLAND DEPARTMENT OF HEALTH ADMINISTRATION	
NEW SUPERVISOR NAME	PHONE NO:
NEW ADMINISTRATION NAME AND MAILING ADDRESS	POSITION START DATE:

SEPARATION FROM MARYLAND DEPARTMENT OF HEALTH STATE SERVICE		
I will be separating from the Maryland Department of Health DATE:		☐ Termination ☐ Separation
I WOULD LIKE THE OPTION TO REDUCE MY OBLIGATED SERVICE/CASH REPAYMENT AMOUNT		☐ Yes ☐ No
CURRENT AMOUNT OF OBLIGATED SERVICE TO BE REPAID		ANNUAL LEAVE BALANCE
TOTAL ANNUAL LEAVE HOURS TO DEDUCT	OBLIGATED SERVICE HOURS	CASH REPAYMENT BALANCE FORWARD $

EMPLOYEE OFFICE APPROVALS		
PRINT APPOINTING AUTHORITY NAME & TITLE	Appointing Authority Signature	Date
PRINT SUPERVISOR NAME & TITLE	Supervisor Signature	Date
PRINT EMPLOYEE NAME & TITLE	Employee Signature	Date

++++++++++++++++++++++++++++ TSD USE ONLY +++++++++++++++++++++++++++++++++		
☐ APPROVED ☐ DENIED	DATE:	
APPROVER/TRAINING SERVICES DIVISION: SIGNATURE:	201 W. Preston Street, Room 106 Baltimore, Maryland 21201	Phone Number 410-767-1605

CHANGING Maryland for the Better