ouisiana Workforce Commission djudication Support Unit . O. Box 91253 laton Rouge, LA 70821-9253 Fax (225) 346-6068	Separation Notice
1. Applicant Information	
First Name: SSN: Date of Separation: M M D D Y Y	Last Name: Date Last Worked: M M D D Y Y
Please provide detailed explanation for the items complete facts will enable this agency to make an	checked below. Should this individual file a claim for unemployment insurance benefits, equitable decision.
2. Reason for Separation	3. Vacation, Severance, Dismissal, Bonus, Holiday Pay Information
Voluntary Leaving (Quit)	Hourly Rate of Pay \$ Hrs Worked per Week
Discharged (Fired) Lack of Work (Reduction in Force) Leave of Absence	Vacation/Accrued
Not Physically Able to Work	Bonus \$ #Hrs
School Employee Contract Refused Other Suitable Work	Holiday Pay \$ # Hrs
Labor Dispute/Union Strike	Wages in Lieu of \$ # Hrs
Retirement	4. Pension
Work Part Time Explain the reason for separation:	Monthly Lump Sum \$ If lump sum, what would the monthly amount \$ be if that option had been chosen?

I certify that the worker whose name and social security number appear above has been separated from work and that the above information is true and correct. I further certify that the individual has been handed or mailed a copy of this notice.

Employer Name	Employer Acc	ount No.				
Street Address	City	State	Zip			
Telephone Number Fa	x Number					
Signature	Printed Name					
Title	Phone Number					
FILL OUT IN TRIPLICATE. Mail original within 72 hours after sep Give a copy of this form and a copy of the "Instructions to the Wo employee within 72 hours, and retain a copy for your files. File online at: http://www.laworks.net	ion					
·	Fax (225) 346-6068					

Failure to submit this notice within the specified time limits may forfeit your right to appeal. It must be submitted within 72 hours after the worker's separation from employ.



EXIT INTERVIEW QUESTIONNAIRE

Please give this form to Mandy Grey upon completion

Employee's Name	Job Title	Job Title	
Department	Dates of Employment	to	
Reason for leaving			
2. If you are going to another place of employment, what does it offer tha	it West Carroll Health Systems does not?		
3. What were the factors that contributed to your originally accepting a jo	b at West Carroll Health Systems?		
4. Did your job measure up to what you thought it would be when you ac	ccepted it?		
5. Were you paid fairly for the effort you put forth in your position? $__$ Y	⁄es No		
6. How did the benefits package compare to other organizations where yo	ou worked?		
7. Do you feel that your received proper orientation and adequate training	g?YesNo		
8. What is the overall rating of your supervisor in terms of			
Complaint resolution?			
Openness to suggestions?			
Leadership and direction?			
9. Which method of communication worked best? Between member Other (explain)	rs of the department To/from your supervisor _		
10. How do you view opportunities for advancement within West Carroll	Health Systems?		
11. What constructive comments would you have for administration in re	gard to making this a better place to work?		
12. Would you recommend West Carroll Health Systems to a friend as a go	ood place to work? Why or why not?		
13. During the course of you employment, did you become aware of, or d	lid you observe any, conduct or activity that could be o	considered questionable,	
unethical, or illegal at West Carroll Health Systems? YesNo			
14. Please explain and be as specific as possible			
15. If you answered yes to question 13, did you notify your supervisor, the lf yes, please explain, and be as specific as possible when you reference			
TO BE COMPLETED BY SUPERVISOR: Employee eligible for rehire? YES NO			
Why or why not?			

NOTICE OF RESIGNATION AND TERMINATION

Employee:		Effective Date:		
Department:				
Please check box to indicate you have received to Payroll Department once all parties have che		rson. Please return this form		
PayrollAccounts PayablePharma	Health Information	Business Office		
OTICE OF RESIGNATION AND TERMINA	TION			
Employee:		Effective Date:		
Department:				
Please check box to indicate you have received and pass along to the next person. Please return this form to Payroll Department once all parties have checked.				
PayrollAccounts PayablePharmacyHealth InformationBusine Office				
OTICE OF RESIGNATION AND TERMINA	TION			
Employee:		Effective Date:		
Department:				
Please check box to indicate you have received to Payroll Department once all parties have che		erson. Please return this form		
Payroll Accounts Payable Pharma	acv Health Information	Business Office		