



**TOWN OF BERLIN
PERSONNEL ACTION FORM**

Employee #: _____

Employee Name: _____
(Last) (First) (MI) (Phone #)

Address: _____
(Street) (Town) (State) (ZIP) (Personal email)

Social Security No: _____ - _____ - _____ Date of Birth: ____/____/____ (attach school approval if needed)

REASON FOR ACTION:

New Hire: ____ Salary Change: ____ Promotion: ____ Transfer: ____ Change in Hours: ____ Longevity: ____ Stipend: ____
Retro Payment: ____ Accrual Adjustment: ____ COLA: ____ Military Leave: ____ Miscellaneous (Describe in Comments): ____
Termination: ____ Termination Date: ____/____/____ Reason (Describe in Comments): ____
(Please check one) Non-Union Position: ____ Union Position (MCOP Local 264): ____

PAY FREQUENCY: (Please check one) Weekly: ____ Biweekly: ____ Monthly: ____ Other (specify): ____

POSITION/BUDGET INFORMATION FOR ALL POSITIONS:

Date of Hire: ____/____/____ Start Date (If different from date of hire): ____/____/____
Department: _____ Position: _____ Previous Employee: _____
Name of prior employee in position
Exempt: ____ Non-Exempt: ____ F/T: ____ P/T: ____ Intermittent P/T: ____ # Hours per/week: ____ FTE %: ____
Is this position Budgeted: Yes / No Budget Account Number: ____/____
(Org) (Object)
Annual Salary Amount: \$ _____ Step (If applicable): _____ Hourly Rate: \$ _____
Effective Date: ____/____/____ Benefit Eligible: Yes/No Prorated Benefits (Describe in Comments): ____

SEASONAL/TEMPORARY EMPLOYMENT: (This is a seasonal/temporary position at a flat hourly rate with no benefits.)

Program: _____ Position: _____ Hourly Rate: \$ _____ Length of Employment: _____

SALARY CHANGE:

Old Rate: \$ _____ New Rate: \$ _____
If Retro Payment: # of days _____ x Daily Rate \$ _____ = \$ _____ (Please provide detailed calculations)
Step / Merit / Salary / Other: _____ Effective Date: ____/____/____

FOR PROMOTION OR RECLASSIFICATION:

Present Position: _____ Rate: \$ _____ Step: _____
New Position: _____ Rate: \$ _____ Step: _____ Effective Date: ____/____/____

ACCRUAL CHANGE: (Worksheet showing all changes in hours and dollars **MUST** be attached)

Vacation / Sick / Other: _____ Total Amount of Adjustment _____

LONGEVITY (MCOP Local 264 only) or **STIPEND** Amount: \$ _____

Additional Week of Vacation: Yes / No **Number of hours:** _____

COMMENTS: _____

1. Department Head Signature _____ Date ____/____/____

2. Personnel Committee Approval _____ Date ____/____/____

3. Treasurer/Payroll Signature _____ Date ____/____/____

☐ New Hire employment paperwork received

4. Town Administrator (or Select Board) Approval _____ Date ____/____/____

☐ Pre-employment/Personnel/HR requirements met

5. Accountant Signature (Certification of Funds) _____ Date ____/____/____

Form must be returned to Town Administrator for employee's personnel file