EMPLOYEE RESIGNATION

CLIENT NAME ______________________________ DATE ______________

EMPLOYEE NAME ______________________________ ______________

DEPARTMENT ______________________________ POSITION ______________

RESIGNATION NOTICE

I have decided to resign from my position with the Company and my last day of employment will be ______________________________. I understand that I will be paid all money due to me in accordance with the company policy and the law. Further, I understand that my health insurance benefits, if applicable, will be terminated. Thereafter, continuation of my health insurance benefits coverage is subject to the provision of COBRA.

I have reported all work-related injuries that may have occurred while I have been employed by the Company and to the best of my knowledge I am not currently suffering from any work-related injury or illness. Further, I have provided any complaints that I may have had regarding any supervisors, co-workers or their treatment of me to the Company's attention and any such complaints have been resolved.

I have submitted my resignation and signed this form voluntarily.

EMPLOYEE SIGNATURE ______________________________ **DATE** ______________

PRINTED NAME ______________________________ **SS#** ______________

FOR COMPANY USE ONLY

SUPERVISOR SIGNATURE ______________________________ **DATE** ______________

PRINTED NAME ______________________________