

**PULASKI COUNTY PUBLIC SCHOOLS  
REQUEST FOR TERMINATION OF EMPLOYMENT**

**INSTRUCTIONS:**

1. This form should be filed by all personnel who wish to be released from their present contract or who do not wish to be re-employed for the next contract year.
2. The channel of procedure is to file the request with the person to whom the employee is directly responsible.
3. Action is required on the request at the appropriate level indicated on this form. Upon final action by the School Board, copies of the form will be returned to all appropriate persons indicating final action taken.

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I, \_\_\_\_\_ wish to resign my position with the Pulaski County  
(NAME)

Public Schools for the following reason: \_\_\_\_\_

If approved, my last day of employment will be (month/day/year) \_\_\_\_\_

Telephone # \_\_\_\_\_ Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

School or Department \_\_\_\_\_ Position \_\_\_\_\_

Signature of Principal/Department Head \_\_\_\_\_ Date \_\_\_\_\_

**IF YOU WISH TO PURCHASE SICK LEAVE, PERSONAL AND/OR VACATION LEAVE, PLEASE COMPLETE THE INFORMATION BELOW:**

1. Sick leave will be purchased only upon approved termination of employment for **RETIREMENT**.
2. **ALL** accumulated sick leave days may be purchased from **RETIRING EMPLOYEES**. Sick leave may be transferred to other school divisions in Virginia for those employees terminating for other reasons.
3. Personal leave that is not used may be purchased at the current sick leave rate.
4. Vacation leave (up to 30 days) that is not used may be purchased at the employee's current per diem rate.

\_\_\_\_ I am retiring, please pay accumulated sick leave.

\_\_\_\_ Please pay me for all unused personal/annual leave. \_\_\_\_ Please apply unused personal/annual leave to extend employment.

**COBRA NOTIFICATION: I understand that under the COBRA law, I have sixty (60) days, beginning on the date that regular coverage ends, to apply for continued coverage of my medical/dental insurance and/or my flexible benefits plan on an after-tax basis. For information regarding coverage during the period, please call the Payroll Department at (540) 643-0200.**

Employee Name (Please Print) \_\_\_\_\_ Social Security # \_\_\_\_\_

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

**TO BE COMPLETED BY THE DEPARTMENT OF HUMAN RESOURCES**

Resignation approved effective at end of workday on \_\_\_\_\_

Personnel Administrator \_\_\_\_\_

Signature

Date

**TO PAYROLL: PLEASE PAY MONIES DUE ON** \_\_\_\_\_

\_\_\_\_ days of sick leave @ \_\_\_\_\_/day = \_\_\_\_\_

\_\_\_\_ days personal/vacation leave @ \_\_\_\_\_/day = \_\_\_\_\_