Ability Care Partners, Inc.
PCA Choice Provider

5701 Kentucky Ave. N., Suite #119 - Minneapolis, MN 55428
Voice: 612-868-3270 Fax: 612-395-5593
Email: info@abilitycare.com
Web Site: www.abilitycare.com

PCA Employment Resignation or Termination Notice

This form is to be completed and returned in the event of employee resignation or termination; it will serve as a formal notification. For resignations, the employee shall complete and sign the form. For terminations of a PCA, the Client or Responsible Party will complete and sign the form. Once complete, please mail or fax to Ability Care Partners, Inc.

Client Name: _____

Employee Name: _____

PCA ID #: _____

____ Employee Resigned. ____ Employee Terminated.

Date of last shift worked: _____

Comments (Optional): _____

_____

_____

As stated in the PCA Choice Service Agreement: *"Employee's may resign their employment with the Consumer and Ability Care Partners, as joint employers, at any time for any or no reason, and the Consumer and Ability Care Partners reserve the same right regarding discontinuation of an individual's employment."*

Employee's will be paid for hours worked as submitted on Time Sheet and verified/signed by the Consumer or Responsible Party. Final Time sheet must be signed and submitted according to our Company Policies & Procedures. Any Time Sheet submitted 30 days after date of termination will not be accepted nor paid.

_____

Signature of person completing this form Date

Office Use Only:
_____ Initials _____ Date Received _____ Date of final payroll