Revised 7/28/2022

SOCORRO INDEPENDENT SCHOOL DISTRICT

Request to Reassign an Employee

Employee Name: _____ Employee Number: _____

Current Campus/Department: _____ Current Position: _____

Receiving Campus/Department: _____ Proposed Position: _____

Reason for Reassignment: _____

Effective Date: _____ Cabinet Member Making the Request:

Supervisor Notified by Cabinet Member: ☐ Yes ☐ No _____

Does the employee qualify/hold required certification for this position? ☐ Yes ☐ No

Approval Signatures

_____ _____

Superintendent Signature Date

_____ _____

Chief Human Resources Officer Date

FOR HUMAN RESOURCES USE ONLY

Director needs to attach this form to the reassignment letter when completed.

	Date	Date Completed
Received: Human Resources		
PAF #1: Campus		
PAF#2: Receiving Campus		
Reassignment Letter Signed		
Reassignment Letter Emailed to Cabinet Member/Principal		