MONTEREY COUNTY

DEPARTMENT OF CHILD SUPPORT SERVICES

752 La Guardia Street
Post Office Box 2059
Salinas, CA 93902
www.co.monterey.ca.us/mcdcss

Phone: 866/901-3212
Facsimile: 831/796.0232
TDD: 831/769.9306

TO: CHILD SUPPORT OFFICE
DEPARTMENT OF CHILD SUPPORT SERVICES
P.O. BOX 2059
SALINAS, CA 93902-2059

DATE: _____
CASE #: _____
PHONE #: 866/901-3212
EMPLOYEE: _____

FROM: _____

_____

_____

SSN: _____

DOB: _____

TERMINATION OF EMPLOYMENT NOTICE

INSTRUCTIONS: Use this form to report termination of employment of NONCUSTODIAL PARENT for whom you have a requirement to withhold support or enroll the employee's children in a health insurance plan.

DATE OF TERMINATION	REASON OF TERMINATION
SUBJECT TO REHIRE	COBRA HEALTH INSURANCE COVERAGE AVAILABLE
LAST KNOWN HOME ADDRESS (Street address, City, State & Zip Code)	TELEPHONE NUMBER (If known)
NEW EMPLOYER'S NAME (If known)	TELEPHONE NUMBER (If known)
NEW EMPLOYER'S ADDRESS (If known – Street address, City, State & Zip Code)	

CERTIFICATION OF RECORD

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

DATED: _____

_____
Signature

NAME: _____
TITLE: _____