

SOUTHEASTERN COMMUNITY COLLEGE

WORK-STUDY STATUS CHANGE FORM

Student Name: _____

Position Held: _____

Telephone Number: _____

Email: _____

Mailing Address: _____

Department: _____

Office/Rm# _____

Supervisor Name: _____

Email: _____

Telephone Ext: _____

Reason for Resignation/Termination:

Student Signature _____ **Date** _____

Department Supervisor _____ **Date** _____

Office Use Only

Hire Date: _____ Term. Date: _____

Fall: _____ Spring: _____

Date Sent to Human Resources: _____

Financial Aid Staff signature

Date

RETURN THIS FORM TO THE FINANCIAL AID OFFICE