COUNTY OF LOS ANGELES DEPARTMENT OF MENTAL HEALTH

TELECOMMUTING PROGRAM
EMPLOYEE PARTICIPATION TERMINATION FORM

_____ Date

TO: Telecommuting Coordinator
Human Resources Bureau

FROM: _____ Name

_____ Telephone Number

_____ Position

_____ Bureau/Section/Division

SUBJECT: **EMPLOYEE PARTICIPATION TERMINATION**

Remove the employee listed below from participation in the Department of Mental Health Telecommuting Program.

Employee Name _____

Employee Position _____

Date of Termination _____

Reason(s) for Termination _____

_____

_____

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