

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 _____
