

# MONTEREY COUNTY



## DEPARTMENT OF CHILD SUPPORT SERVICES

752 La Guardia Street  
Post Office Box 2059  
Salinas, CA 93902  
[www.co.monterey.ca.us/mcdcsc](http://www.co.monterey.ca.us/mcdcsc)

Phone: 831/755.3200  
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 #: 831.755.3200  
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: \_\_\_\_\_