GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT ON DISABILITY SERVICES

Change of Employment Status Form

Today's Date: ____/_____/_____

Name of Provider: _____

Please submit this form *MONTHLY*

The following employee(s) has undergone an employment change within the past month.

Employee Name (PRINT)	Job Title	Add to Roster	Remove from Roster

The above information is being submitted by _____ _____.
(Print Name) (Position Title)

Agency Training Coordinator email address: _____
(Print Please)

Please email the form to the DDS Training Institute
dds.providertraining@dc.gov
Or fax to (202)730-1515.