



Notice of Personnel Action – NPA



Use the NPA to notify SSAI of all actions related to Enrollment Changes and Authorized Requests.
(Fill in boxes 1,2 and 11 each time an NPA is submitted. Please print legibly)

1 IDENTIFICATION:

Enrollee: _____ SSN: ___/___/___ Date Submitted: ___/___/___
Worksite: _____ Email: _____
Home Address: _____
X Male Female DOB: ___/___/___ Home Phone: ___/___/___ Work Phone: _____

2 TYPE OF ACTION: Enrollment Change Request Effective Date: ___/___/___ (1,2,3,5,11)

3 ENROLLMENT: New Re-Enrollment

Division/Branch: _____
Phone: ___/___/___ Fax: ___/___/___ Mail Code: _____ Room: _____
Position: _____ (Same as title appearing on approved Position Description)
(Attach approved PD, signed and dated by Monitor and Enrollee. Retain copy)
Level: 1 2 3 4 Hourly Pay Rate \$ _____ Hours Per Week: _____
Funding Source/Program: _____ Grant No.: _____
 Medical Monitoring Required *(If this is a change, please attach revised description)*
 Safety Equipment Required *(If this is a change, please attach revised description)*
 Travel Required Health Insurance Eligibility *(If this is a change, please attach supporting documentation)*

4 TERMINATION:

Resignation Laid Off *(Attach supporting documentation)* Discharged *(Attach supporting documentation)*
Notification Date: ___/___/___ Last Work Day: ___/___/___ ID Badge/EPA Property Returned: ___/___/___
Forwarding Address (for final paycheck, W-2): _____
Other: _____

5 MONITOR: *(Complete each time the monitor and alternate monitor is changed)*

Name: _____ Title: _____
Phone: ___/___/___ FAX: ___/___/___ Mail Code: _____ Room: _____
Alternate Monitor: _____ Phone: ___/___/___

6 PERSONAL DATA CHANGES:

Name: _____ Phone: ___/___/___
Home Address: _____
Other: _____

7 LEAVE REQUEST:

Last Work Day

Return Date

Extended Sick Leave (5 or more consecutive days)
(Attach doctor's signed and dated statement)

___/___/___

___/___/___

Leave Without Pay (5 or more consecutive days)

___/___/___

___/___/___

Medical Leave *(Attach doctor's statement)*

___/___/___

___/___/___

Family Medical Leave *(Attach doctor's statement)*

___/___/___

___/___/___

8 SAFETY EQUIPMENT REQUEST:

Cost: \$ _____

(Attach supporting documentation)

Item(s): _____

Purpose: _____

Payment Method: Advance Check *(Attach cost documents)* Reimburse Enrollee *(Attach receipts)*

9 TRAINING REQUEST:

Cost: \$ _____

Dates: _____

Type of Training: _____

Purpose/Benefit to the Agency: _____

Payment Method: Advance Check *(Attach cost documents)* Reimburse Enrollee *(Attach receipts)*
 Pay Vendor *(Attach invoice)*

Note: If travel to training is required, submit a Travel Authorization Form **two weeks** or more prior to trip.
Once training is completed, submit the Travel Expense Report form.

10 OTHER CHANGES OR TRANSACTIONS:

11 AUTHORIZATION SIGNATURE(S) ~ as applicable

Note: The following required signatures for SSAI do not take the place of additional authorizations that may be required by EPA.

Enrollee: _____

Date: ___/___/___

Monitor: _____

Date: ___/___/___

EPA/SEEP Coordinator: _____

Date: ___/___/___

SSAI USE ONLY

Director, SEE Program: _____

Date: ___/___/___

Comments: _____

Route To: Records Payroll Accounting Other: _____