VENTURA COUNTY COMMUNITY COLLEGE DISTRICT
HUMAN RESOURCES DEPARTMENT

Academic Resignation

I, _____, Employee ID Number _____, do hereby tender my resignation from my position as _____ Department/Discipline: _____ (√ **only one box** ☐ full-time contract / ☐ part-time academic employee) with the Ventura County Community College District, at:

☐ Moorpark College ☐ Oxnard College ☐ Ventura College

This resignation will be effective at the close of business on _____, my last day of work in a paid status. This resignation is executed by me freely and voluntarily and of my own free will for the reason that:

_____.

NOTE:
If this resignation is for the purpose of retirement from STRS (State Teachers' Retirement System) or PERS (Public Employee's Retirement System), please be aware that it is your responsibility to submit the necessary application forms.

☐ **Resignation for purposes of retirement only – intend to continue teaching part-time**

Employee Name (Please Print) _____

Employee ID No. _____

Employee Signature: _____ Date: _____

Submit completed form to the office of your Dean and/or appropriate College Administrator who will forward to the Human Resources Department at the District Administrative Center for processing.

FOR REVIEW / SIGNATURE:

College Dean: _____ Date: _____

Chancellor,
College President
and/or Designee _____ Date: _____

IMPORTANT: ***If you have health, vision and dental benefits at the time of resignation/ retirement, complete the COBRA information on the second page of this form. If you qualify for District-paid retirement benefits, it is NOT necessary to complete the second page.***

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-NOTICE-

FEDERAL HEALTH INSURANCE LAW

Federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), provides eligible employees and certain family members the right to continue health care coverage under our group health plans with the eligible member paying the premium costs.

Please complete the information below so that we may notify you and your spouse of each of your rights to continued coverage as required by COBRA.

Name **Birthdate**

Employee: _____ _____

Address: _____ _____ _____ _____
Street City State Zip

Spouse: _____ _____

Address: _____ _____ _____ _____
Street City State Zip

Children: _____ _____

_____ _____

_____ _____

_____ _____

Signature: _____ Date: _____