VENTURA COUNTY COMMUNITY COLLEGE DISTRICT

HUMAN RESOURCES DEPARTMENT

Part – Time Academic Resignation / Retirement Notice

I, _____, Employee ID Number _____, do hereby tender my notice to ☐**Retire from CalSTRS and return to teach part – time, or** ☐**Resign:**_____

My position was Instructor, Discipline:_____; with the Ventura County Community College District, at:

☐Moorpark College ☐Oxnard College ☐Ventura College

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

NOTE: Please be aware that it is your responsibility to submit the necessary retirement application forms to the California State Teachers' Retirement System (CalSTRS). When you resign to retire, your resignation date cannot be the same or past the retirement date with CalSTRS.

Resignation to teach Part-Time: Faculty who retire are eligible to return to teach part- time after completion of the 180-calendar day waiting period. Longevity held in a discipline will remain unchanged, should the faculty not receive assignments for eight (8) consecutive semesters, longevity will be lost and employment terminated.

Employee Signature: _____ **Date:** _____
Submit the completed form to the office of your Dean and/or appropriate College Administrator who will forward it to the Human Resources Department 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

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: _____