**USE THIS TEMPLATE IF YOUR AGENCY IS IMPLEMENTING A LAYOFF, FURLOUGH OR REORGANIZATION. COMPLETE THE BLANKS, REWORD, CUT OUT OR ADD ADDITIONAL INFORMATION AS NEEDED. DELETE THIS PARAGRAPH, BOLDED SENTENCES, AND PARENTHESES. LHP MUST HAVE A MINIMUM OF 30 DAY’S NOTICE TO PROCESS.**

Dear Local Health Personnel Manager:

In accordance with Administrative Regulation 902 KAR 8:080, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**County or District** Health Department has the necessity to submit a Reduction in Workforce Policy and Reorganization Plan for Implementation. The current plan being used was adopted by the Board of Health on \_\_\_\_\_\_\_\_\_\_ (date). This (layoff/reorganization/furlough) plan is being implemented in response to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (reasons for layoff/reorganization/furlough). Based on the analysis of the impact of \_\_\_\_\_\_\_ (could be funding, ending a program, loss of patient census etc.,) it is necessary to implement the following actions effective \_\_\_\_\_\_\_\_\_\_. (COB last Friday of a pay roll if possible)

The following employees will be laid off: (List or bullet point each person)

NAME CLASSIFICATION STATUS MONTHS OF SERVICE

**Under each name, add the following sentence:**

(Name)\_\_\_\_\_\_\_\_\_\_duties will be absorbed by the \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (name and classification of the employee taking the duties) while \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_duties will be abolished.

**LIST THE SAME INFORMATION AS ABOVE FOR ANY REORGANIZATION. INCLUDE TITLE CHANGES WITH RECLASSIFICATIONS, PROMOTIONS OR DEMOTIONS. REORGANIZATIONS ALLOW DEMOTIONS TO OCCUR WITHOUT THE LOSS OF MONEY. STATE IF THE DEMOTION WILL HAVE A CUT IN PAY OR WILL REMAIN THE SAME. ALL RECLASSIFICATIONS AND PROMOTIONS WILL FOLLOW THE REGULATIONS.**

**FOR FURLOUGHS, LIST ALL EMPLOYEE NAMES AFFECTED AND THE TOTAL HOURS THEY WILL BE FURLOUGHED. IF SPECIFIC DATES ARE PART OF THE FURLOUGH, LIST THEM.**

The employee(s) impacted by this plan will be given a written fifteen (15) (some LHDs have a 30-day notice) day notice by Local Health Department Personnel Administrative Regulation 902 KAR 8:080, Section 12.

Please feel free to contact me at \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ if you have questions.

Sincerely,

Director Name