**Faculty Retirement Resignation and Retirement Notification Form**

Use this form for faculty that are retiring to initiate changes to Faculty Appointments, Medical Appointments and Affiliate Staff Clinical Appointments during retirement.

**Resignation of:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Department:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Division:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Retirement Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Last Working Day:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does the above-named faculty member have a clinical appointment: Yes No

If yes, practitioner is resigning from which entity(ies) listed below: (Please mark multiple locations if necessary)

**Entity:** JHBMC JHH JHCP

 **I want to resign my medical staff appointment**

 **I want to resign my faculty appointment**

 **I want to resign my employment from JHU**

**I am requesting a Teaching Appointment when retired (requires Department Director approval)**

Letter of resignation attached: Yes No

**Reason for Resignation:**

 Retirement (please mark which plan enrolled in)

 Standard Retirement PRP Plan ERIP Plan

 Relocation No Longer wants/needs JHH privileges

 Other (please be specific in the space below) Personal illness of family obligations

**Contact Information After Retirement**

**Mailing Address:**  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Email Contact:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Alternative Email Contact:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**After form is completed/signed, please forward to your Department Credentialing contact or Administrator**

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Faculty Member Signature Printed Name Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_

Department Director Signature Printed Name Date