Reset Form

Print Form

DHR-ESB3009
11/03

DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF HUMAN RESOURCES

Direct Care/Critical Care Request Form

Division/Institution Name _____

Date _____

Requested Classification Type:
- ☐ Direct Care Classification Title
- ☐ Critical Care Classification Title

Request Type:
- ☐ Add
- ☐ Remove

Official Class Title: _____

Agency Justification: (Briefly state the reason(s) to support adding the position to the list. Use additional sheets if needed.) _____

_____

_____

_____

_____

_____

_____

_____

_____

Human Resource Director _____
Signature/Date

Division/Institution Director _____
Signature/Date

Note: Use one (1) form for each classification.

Send completed copy to:

Employee Safety and Benefits Section or
fax to 919-715-0991

Revised 9/30/03