**AGENCY LETTERHEAD**

Date

Employee Name

Employee Address

City, State Zip-Code

Dear Employee Name:

This is to confirm your voluntary demotion to a a / an job classification, in position number Position #, within Agency Name. This appointment is effective Effective Date. In accordance with WAC 357-19-030, you will OR will not be required to serve a six-month trial service period. **If no trial service period, remove this sentence:** Permanent status in this classification will be achieved upon successful completion of the trial service period, which may be extended not to exceed 12 months.

Pertinent details are noted below:

|  |  |
| --- | --- |
|  |  |
| ***Salary:*** | Range Range, Step Step; $Monthly Wage/month |
| ***Periodic Increment Date:*** | Periodic Increment Date |
| ***Insurance Eligibility:*** | Insurance Eligible OR Insurance Ineligible |
| ***Retirement Eligibility:*** | Retirement Eligible OR Retirement Ineligible |
| ***Overtime Eligibility Designation:*** | Overtime Eligible OR Overtime Exempt |
| ***Work Shift/Schedule:*** | Workdays, hours of work |
| ***Bargaining Unit:*** | Non-Represented |
| ***Supervisor:*** | Supervisor Name |
| ***Official Workstation:*** | Address City, State Zip |

In the event you have questions concerning your appointment, please feel free to contact Name at Phone # or Email Address.

Best wishes in your new appointment.

Sincerely,

Supervisor/Appointing Authority/HR Liaison

Title

cc: Supervisor Name, Supervisor

 saa@des.wa.gov

 Personnel File