



DENTISTRY EMPLOYEE RESIGNATION FORM

College of Dentistry
Office of Administrative Affairs
UKMC D-131
800 Rose Street
Lexington, KY 40536-0297

Phone: (859) 323-5788
Fax: (859) 257-9497
www.mc.uky.edu/Dentistry

Name: _____

Department: _____

HOME ADDRESS: _____

Phone: _____

To whom it may Concern:

I am resigning from my position effective _____.

My last official day at work will be _____.

Reason for Resignation: _____

I certify that this resignation is executed by me voluntarily and of my own free will.

Employee Signature

Date

Management Signature

Date

CC: Supervisor
Dentistry Personnel File
Employee Records

