



RESIGNATION

TO: Superintendent of Schools
Charlotte County, Florida

I, \_\_\_\_\_, \_\_\_\_\_
Name Personal ID or Social Security #

do hereby resign from the following position:

\_\_\_\_\_
Position/Subject Area School or Department

Now held by me as an employee of Charlotte County Public Schools, Florida, to take effect at the close of day

\_\_\_\_\_
Month/Day/Year

I understand that my insurance coverage will remain in effect only until the last day of the month in which my resignation takes effect as long as I work or am on compensable leave for at least one day in the month of resignation/retirement. Any overpayment of premiums will be refunded. I understand I may continue insurance coverage under COBRA if I resign. I understand that my FSA will remain in effect only until the end of the day of resignation. (Retirees will be given information about their options.)

Check all applicable:

- Accepted another teaching position:
at a nonpublic school within the district
within another district in Florida (County)
outside the State of Florida (State)
Accepted another position in the field of education:
within the same district
within another district in Florida (County)
outside the State of Florida (State)
Accepted a position outside the field of education:
within Charlotte county
within another county in Florida
outside the State of Florida
I decline to disclose future plans
I have not accepted employment elsewhere

Personal Reasons:

- Inadequate salary
Lack of opportunity for advancement
Dissatisfaction with supervisor
Dislike/unsuitability for assigned duties
Resignation in lieu of involuntary termination
Other family/personal reasons
Returning to continuing education
Relocation
Retirement
End of temporary assignment
Inadequate benefits
Stress on job
Other
Spousal relocation
Raising a family
Entrepreneurship
Health problems
Not applicable

Remarks \_\_\_\_\_

Respectfully submitted,

\_\_\_\_\_  
Signature of Employee Date

\_\_\_\_\_  
Name - Printed

\_\_\_\_\_  
Signature of Principal/Department Head Date

\_\_\_\_\_  
Signature of Human Resources Designee Date

FORWARDING ADDRESS FOR MAILING OF W-2 FORM

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_  
Date Approved by Board

Copies to: Human Resources Employee School/Department Payroll Benefits