

ACKNOWLEDGEMENT OF UNCLASSIFIED POSITION

I hereby acknowledge that the position I have accepted, _____ ,
with the _____ County Board of Health, is in the unclassified service.

I understand that as an employee in the unclassified service, my employment is “at-will”
and I may be separated at any time without notice or statement of reasons.*

I Further understand that in accepting this unclassified position, any employment rights I
may have had in a position in the classified service no longer exist.

Employee Name (Please Print): _____

Employee Signature: _____

Date: _____

* Employees who first established membership in the Employees’ Retirement System prior to April 1, 1972, and who have a minimum of eighteen (18) years of State employment, may have involuntary separation rights under the Georgia Retirement System Law. See CBH County Board of Health Personnel Policy #1904 -*Involuntary Separation - Retirement Benefits* for specific information.