Optional – This is in addition to the required Memorandum of Agreement

Month #, 2020

Assignee Name

Address

City, State ZIP

Dear Assignee:

This letter confirms your participation in the COVID-19 Temporary Reassignment Program.  We are pleased to assign you to the position of **Working Title/Role Title,** effective [Start D=Month Day, Year at **the Department of XYZ.** This assignment is temporary in efforts to deploy state workforce members whose roles have been impacted due to COVID-19 global pandemic.

Your pay and benefits will remain the same as they are at your current agency.  We appreciate your agility and willingness to support the Commonwealth during this difficult time.  Without individuals like you, dedicated to public service, we could not serve the citizens of the Commonwealth as effectively.

Please sign below to indicate that you have read and agree to the conditions set forth in this letter and return the letter to me prior to       Date       .

Please feel free to contact me at <(804)555 – 5555> and email address  if you have questions or need further information regarding your temporary reassignment.

Sincerely,

HRM/Agency Designated Person

I accept the offer of temporary employment set forth above.

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Print Name Employee ID

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Signature Date