



Employee Information & Change Form

Employee Name: _____ Employee #: _____
(as listed on Social Security Card)

Please Check:

- | | | |
|-----------------------------------|---|---|
| <input type="checkbox"/> New Hire | <input type="checkbox"/> Full-time (works 40 or more) | <input type="checkbox"/> Part-time (less than 40 hours) |
| <input type="checkbox"/> Rehire | <input type="checkbox"/> Full-time (works 40 or more) | <input type="checkbox"/> Part-time (less than 40 hours) |

OR

Change (complete only changed data) Proposed Date of Change: _____

EMPLOYEE INFORMATION

Address: _____

City: _____ State: _____ Zip: _____

Phone Number: _____ Social Security #: _____

Foundation Cell: _____ Date of Birth: _____

Gender: _____ Race: Caucasian Black American Indian Asian

Emergency Contact Name: _____ Phone: _____

Approved by: _____ Date: _____

Comments:

Office Use Only

HR Manager: _____ Date: _____ Effective Date of Change: _____