

Employee Information & Change Form

Employee Name: (as listed on Social Security Card)			_ Employee #:	
Please Check:	(ac notou on oocial oo	ourity ouruj		
		o (works 40 or more)	Dort time (less than 40 hours)	
_	_	e (works 40 or more)	<u> </u>	
Rel	nire Full-time	e (works 40 or more)	Part-time (less than 40 hours)	
OR				
Change (complete only changed data)		lata) Proposed	Proposed Date of Change:	
EMPLOYEE INFORM	ATION			
Address:				
City:		State:	Zip:	
Phone Number:		Social So	ecurity #:	
Foundation Cell:		Date of I	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:	

Phone: (870) 572-9655 2428 HWY 49, West Helena, AR 72390