NEW EMPLOYEE DATA

The information collected in this form is treated as highly confidential. It is used for statistical purposes and/or for obtaining services in a medical emergency. Your cooperation in completing the data is appreciated.

NAME: _____ _____
(First) (Middle) (Last) (Suffix) (Maiden)

ADDRESS: _____ **PHONE:** _____

CITY: _____ **STATE:** _____ **ZIP CODE:** _____

SSN: _____ **DEPARTMENT:** _____ **DEPT. PHONE:** _____

EMAIL: _____

Ethnic Background (Select ONE)
___ 1. White (non-Hispanic)
___ 2. Black (non-Hispanic)
___ 3. Hispanic
___ 4. Asian/Pacific Islander
___ 5. American Indian or Alaskan Native

Marital Status: ☐ Married ☐ Single

Gender: ☐ Male ☐ Female

Birthdate: _____

DO YOU HAVE A DISABILITY? ☐ Yes ☐ No
If **Yes**, please state the disability, and any accommodations that may be necessary for you to perform the essential duties of your position: _____
_____

EMERGENCY NOTIFICATION

In the event of a medical emergency I authorize the following contacts:

Name: _____

Address: _____ City/State/Zip: _____

Phone Number: _____ Relationship: _____

Physician's Name: _____

Dr.'s Office Phone: _____ Dr.'s Emergency Phone: _____

PREVIOUS EMPLOYMENT

- List previous employers

Employer Name	Dates of Employment	Position

This Section to be filled out by Employer

POSITION: _____ **TITLE:** _____

ANNUAL SALARY or HOURLY RATE:_____ ☐ per year ☐ per hour

HIRE DATE:_____ **SUPERVISOR:**_____

WORKERS COMP CLASSIFICATION: _____ **UNION:** _____ **UNION DATE:** _____

I9 Verified: ☐ Yes ☐ No Collect Union Dues: ☐ Yes ☐ No
Visa Type:
Expiration: _____
Citizenship: _____

- Is Employee participating in 401(K)**?** ☐ Yes ☐ No; If **Yes**, Date of Eligibility: ___/___/____
- Is Employee eligible for health insurance**?** ☐ Yes ☐ No; If **Yes**, Date of Eligibility: ___/___/____

I affirm that to the best of my knowledge, the information provided on this form is true and correct. I am aware that at any time during my employment I may change my emergency notification designees, my Open Records Selection, and I may request reasonable accommodation for any disability that may arise.

_____ _____
Signature of Employee Date

_____ _____
Signature of Human Resources Representative Date