

EMPLOYEE PERSONAL INFORMATION FORM

<u>Employee Full Name</u> (Last, First, M.I.)		<u>Social Sec Number</u>		<u>Preferred Name</u>	
<u>Primary Address (Mailing)</u>		<u>City</u>	<u>State</u>	<u>County</u>	<u>Zip Code</u>
<u>Supplemental Address</u>		<u>City</u>	<u>State</u>	<u>County</u>	<u>Zip Code</u>
<u>Gender</u> <input type="checkbox"/> Male <input type="checkbox"/> Female	<u>Birth Date</u> ____/____/____ <small>Month Day Year</small>	<u>Marital Status</u> <input type="checkbox"/> Single <input type="checkbox"/> Married	<u>Home / Cell Telephone Number</u> () _____ h () _____ c		
<u>Emergency Contact Information</u>					
Name		_____			
Address		_____			
City		_____			
State / Province		_____			
Postal Code		_____			
Country		_____			
Relationship		_____			
Cell Telephone		(____) _____			
Home Telephone		(____) _____			
Work Telephone		(____) _____			
Employee Signature			Date		EIN

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OPTIONAL INFORMATION

Detach Before Filing

<u>Ethnic Code (Select One Only)</u>	<u>Veteran Status</u>	<u>Disability</u>
<input type="checkbox"/> American Indian / Alaska Native	<input type="checkbox"/> No	<input type="checkbox"/> No
<input type="checkbox"/> Asian / Pacific Islander	<input type="checkbox"/> Veteran	<input type="checkbox"/> Yes
<input type="checkbox"/> African American / Black	<input type="checkbox"/> Disabled Veteran	
<input type="checkbox"/> Hispanic		
<input type="checkbox"/> White		
<input type="checkbox"/> Unspecified		