



Employee Information Change/Update Form

This information is requested to ensure that current records are maintained for each employee.

Today's Date: _____

Personal Information

Full Name: _____
Last *First* *M.I.*

Address: _____
Street Address *Apartment/Unit #*

City *State* *ZIP Code*

Home Phone: () _____ Alternate Phone: () _____

E-mail Address: _____

Social Security No.: _____ Drivers License No./State: _____

Birth Date: _____ Marital Status: _____

Spouse's Name: _____

Spouse's Contact
Phone: _____

Job Information

Title: _____

Supervisor: _____ Department: _____

Status: Full-time Part-time Volunteer

Emergency Contact Information

Full Name: _____
Last *First*

Address: _____
Street Address *Apartment/Unit #*

City *State* *ZIP Code*

Primary Phone: () _____ Alternate Phone: () _____

Relationship: _____

For Office Use Only- Update employee information with the following:

<input type="checkbox"/> Medical	<input type="checkbox"/> Dental	<input type="checkbox"/> Vision	<input type="checkbox"/> Life
<input type="checkbox"/> AFLAC	<input type="checkbox"/> ICMA-RC	<input type="checkbox"/> Payroll	<input type="checkbox"/> Personnel File