EMPLOYEE RECORD INFORMATION FORM

EMPLOYEE NAME: _____

☐ Change in Mailing Address: _____

Home Phone #: _____ Cell #: _____ Mssg#: _____

Driver License #: _____ State: _____ Expires: _____

BENEFIT INFORMATION *(If applicable) Shaded area pertains to* ***regular*** *employees*

Primary Care Physician: _____

Retirement Beneficiary(s) & Relationship(s): _____

_____

Life Insurance Beneficiary(s): _____

_____

PAYCHECK BENEFICIARY: ***(Applies To All Employees)***

Name, Address & Phone #: _____

Relationship: _____

IN CASE OF EMERGENCY – CONTACTS

1. Name, Address & Phone #: _____
2. Name, Address & Phone #: _____

Emergency Medical Information (Allergies, Medications, Etc.) _____

_____

_____

Emergency Physician Name, Address & Phone: _____

_____

Please explain if you ever received Worker's Compensation: _____

_____

Describe any major illness or injury you may have had in the past six years: _____

_____

_____ _____

Employee Signature *Date Completed/Updated*