EMPLOYEE RECORD INFORMATION FORM

EMPLOYEE NAME:_____

◯ Change in Mailing Address: _____

Home Phone #: _____ Message Phone #: _____

Driver License #: _____ State Issued: _____ Exp. Date: _____

Email address: _____

EDUCATION & TRAINING

Please circle:

High School				College				Graduate Studies				Skilled Training		Specialization
1	2	3	◯	1	2	3	◯	5	6	7	◯	Yes ◯	No	

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)

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*