NEW EMPLOYEE PAYROLL FORM

FULL TIME_____ PART TIME_____

EMPLOYEE #_____

STARTING DATE:_____DATE OF BIRTH:_____

STARTING SALARY_____

TITLE:_____

NAME:_____(First, middle and last)

ADDRESS: _____

_____

HOME PHONE#_____

CELL #:_____

SOCIAL SECURITY #:_____

E-MAIL ADDRESS:_____

WEEKLY HEALTH BENEFIT COST: _____

ACCRUED MONTHLY SICK TIME:_____

ACCRUED MONTHLY VACATION TIME:_____

PENSION APPLICATION DATE SENT:_____

PROOF OF HEALTH BENEFIT FOR BUY OUT:_____

IN CASE OF EMERGENCY CONTACT NAME, ADDRESS AND PHONE NUMBER:

_____

_____

EMPLOYEE SIGNATURE:_____ APPROVAL:_____