☐ DC HEALTH	☐ I-9 TOP PORTION
☐ WAIVED	☐ W-4
☐ DENTAL	☐ STATE WITHHOLDING
☐ VISION	☐ DIRECT DEPOSIT/VOIDEDCHECK
	☐ 2 FORMS OF ID

Employment Information Sheet

Employee Information

Full Name: _____

Address: _____

Home Phone: _____ Cell Phone: _____

Email Address: _____

Social Security Number or Government ID: _____

Birth Date: _____ Marital Status: _____

Spouse's Name: _____

Spouse's Phone: _____

Job Information

Title: _____

E-mail Address: _____

Work Phone: _____ Cell Phone: _____

Start Date: _____

Emergency Contact Information

Full Name: _____

Address: _____

Primary Phone: _____ Cell Phone: _____

Relationship: _____

Dependent Information (For insurance purposes only)

Name(s) of Dependent(s)	Relationship to Employee
_____	_____
_____	_____
_____	_____