



New Employee Information Form

Last Name _____ First Name _____ MI _____ Social Security No. _____

Date of Birth _____ Street Address _____ P.O. Box / Apt. No. _____

City _____ State _____ Zip Code _____ Home Phone No. _____

Please circle relevant category:

Gender	Marital Status	Race/Ethnicity	Disability Status	Veteran Status
<input type="checkbox"/> Male	<input type="checkbox"/> Single	<input type="checkbox"/> White	<input type="checkbox"/> Not Disabled	<input type="checkbox"/> No veteran Status
<input type="checkbox"/> Female	<input type="checkbox"/> Married	<input type="checkbox"/> American Indian or Alaskan Native	<input type="checkbox"/> Disabled	<input type="checkbox"/> Vietnam Veteran
	<input type="checkbox"/> Widowed	<input type="checkbox"/> Black or African American		<input type="checkbox"/> Disabled Veteran
	<input type="checkbox"/> Divorced	<input type="checkbox"/> Hispanic or Latino		<input type="checkbox"/> Disabled Vietnam Veteran
		<input type="checkbox"/> Native Hawaiian or other Pacific Islander		<input type="checkbox"/> Military
		<input type="checkbox"/> Asian		
		<input type="checkbox"/> Two or more races		

Primary contact in case of emergency:

Name _____ Relationship _____

Address _____

Home Phone No. _____ Mobile Phone No. _____