

EMPLOYEE INFORMATION FORM

Client Number: _____ Client Name: _____

Check only one: New Employee
 Change of Information on Current Employee
 Rehire of Previous Employee

Employee Number: _____ (if change to current or previous employee)

Employee Name: _____

Address: _____

City, State: _____ Zip Code: _____

*Social Security Number: - - _____ Birth Date: / /

Department /Org Unit: _____ Position: _____

Employee is: Full Time Part Time *Hire Date: ___/___/___

Salary: (per pay period) _____

Rate 1: \$ _____ Description: _____ Shift Differential: _____

Rate 2: \$ _____ Description: _____ Shift Differential: _____

Rate 3: \$ _____ Description: _____ Shift Differential: _____

Standard Hours: _____

This employee is paid: Weekly Bi-weekly Semi-monthly Monthly

Federal Filing Status: Single Married Married @ Higher Single Rate # of allowances _____

What state does this EE WORK in?

_____ STATE NAME

Act 32 EE LIVE LOCAL? _____ RATE: _____%
LOCALITY/COUNTY / PSD

Act 32 EE WORK LOCAL? _____ RATE: _____%
LOCALITY/COUNTY / PSD

Withhold LST Tax? Yes No Annual Amount? \$ _____

Which deductions should this employee have?

Description (401K, Medical, Uniform, Dues, FSA, Dental, etc.)	Amount	Percentage