EMPLOYEE CHANGE FORM (Please Print Clearly)

Internal Use Only
Sent To: ( ) Payroll ( ) Benefits

Employee ID# ________________________ Date Received: ________________ Initials: _______________

Employee Name: _________________________________ Social Security: __________________________________

Employer: ____

Employer Initiated Change (This section to be completed by the workplace employer)

EFFECTIVE DATE OF CHANGE: ______________________________

Current		New	
Pay: $ _________________	per: ____________________	Pay: $ _________________	per: ____________________
Job Title:		Job Title:	
Status: Part Time / Full Time	Exempt / Non-Exempt	Status: Part Time / Full Time	Exempt / Non-Exempt
Dept:		Dept.	
Authorized Signature:		Date:	

Has Workers' Compensation Code Changed? Yes / No If yes, what is the new code?

Employee Initiated Change (This section to be completed by employee)

Name:		
Address /Apt# /P.O. Box	County:	
City:	State:	Zip:
Home Phone:	Alternate Number:	
Emergency Contact Name /Relationship:	Phone Number:	
Authorized Signature:	Date:	

Miscellaneous Changes /Directions

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Signature: ____ **Date:** ______________________________