EMPLOYEE PERSONAL DATA FORM

Eden_____Admin____

Address change will be updated for: City of Ceres employee file, Medical, Dental, Vision and StanCera. Employee is responsible for contacting voluntary benefit plans to change address, ie; deferred comp, voluntary life, etc.

NAME (FIRST, MIDDLE, LAST):	TODAY'S DATE:	LAST FOUR DIGITS OF SOCIAL SECURITY #:
DATE OF BIRTH:	ADDRESS:	CITY/STATE/ZIP:
HOME PHONE:	CELL PHONE:	OTHER:

PERSONAL PHYSICIAN INFORMATION

HOSPITAL:	PHYSICIAN:	PHONE:
ADDRESS:	CITY/STATE/ZIP:	FAX (OTHER):

EMERGENCY CONTACT INFORMATION

Contacted in the order given in case of an emergency

1. NAME:	ADDRESS:	CITY/STATE/ZIP:
WORK PHONE:	HOME PHONE:	CELL PHONE:
RELATIONSHIP:		

2. NAME:	ADDRESS:	CITY/STATE/ZIP:
WORK PHONE:	HOME PHONE:	CELL PHONE:
RELATIONSHIP:		

3. NAME:	ADDRESS:	CITY/STATE/ZIP:
WORK PHONE:	HOME PHONE:	CELL PHONE:
RELATIONSHIP:		

PERSONAL MEDICAL INFORMATION (Optional)

This information is for Emergency Responders Only. (Ex. Allergic to bee stings, Epi-pen, Located in Desk drawer, purse, etc.)

ALLERGIES:	MEDICATION/LOCATION:
OTHER CONDITIONS:	MEDICATION/LOCATION:

It is incumbent upon the employee to notify HR immediately if you change your address, contact information, or any information affecting notification in the event of an emergency. By signing this document, you state that all information identified is true and correct as of the date above and you agree to comply with the requirements of maintaining and updating HR accordingly, should any information change.

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EMPLOYEE SIGNATURE

Rev 06/03/2019