

EMPLOYEE INFORMATION FORM

Employee Name:	<input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Seasonal	
Social Security Number:	<input type="checkbox"/> New Employee <input type="checkbox"/> Returning Employee	
<input type="checkbox"/> Transfer <input type="checkbox"/> Promotion <input type="checkbox"/> Change <input type="checkbox"/> Position <input type="checkbox"/> Addition		
	Current	New
Title		
Department		
Range		
Salary		
Annualized Salary		
Amount of Change from Prior Salary		
Percent Change from Prior Salary		
Effective Date of Change		
Date of Next Review		
Comments: Performance Appraisal Attached		
Supervisor Approval:		Date: