

DEPARTMENT OF HEALTH AND HOSPITALS

PERSONAL DATA

(Please Print)

Name: _____ Personnel # _____ Gender: Male Female
Last First MI

PERMANENT RESIDENCE: *(Please do not put P. O. Boxes here.)* Privacy Request: Yes No

Address: _____ City: _____ State: _____ Zip: _____
Parish: _____ DOB: _____

MAILING ADDRESS: *(If different from permanent.)* Privacy Request: Yes No

Address: _____ City: _____ State: _____ Zip: _____
(P.O. Boxes allowed here)

PHONE NUMBERS:

Home: _____ Cell: _____ Other: _____
Office: _____ Other: _____ Other: _____

EMERGENCY CONTACT:

Mr. Mrs. Ms. Name: _____ Tel. #: _____
Mr. Mrs. Ms. Name: _____ Tel. #: _____
Mr. Mrs. Ms. Name: _____ Tel. #: _____

Ethnic Origin: Hispanic Non-Hispanic or Non-Latino Declined to state Nationality: _____
(Check all that apply) *(ex. American, Mexican, etc.)*

Race: American Indian/Alaskan Native Asian Black or African American
 Native Hawaiian or Other Pacific Islander White Declined to state

Marital Status: Single Married Divorced NM = Not Married

I certify that the above information is accurate and that it is my personal responsibility to notify Human Resources immediately of any changes to my address. I hereby authorize the above changes.

Employee's Signature: _____ Date: _____