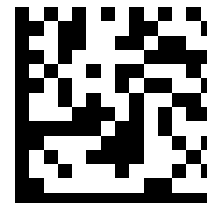




State of Utah
Department of Workforce Services
EMPLOYMENT INFORMATION



Case name: _____ Case number: _____
Employed person: _____ SSN: _____

For **new, changes, and returning employment**, the entire form must be completed and signed by the employer. **Please use a black pen to complete form.**

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Employer Information:

Company name: _____
Corporate name (if different): _____
Payroll company (if different): _____
Company address: _____
Name of supervisor or HR contact: _____ Phone number: _____

Employee Information:

1. Date employment began, changed, or returned to work after leave of absence: _____
2. Is the employment temporary? Yes No If yes, what is the expected end date? _____
3. Is the employment considered Educational Work Study? Yes No
4. Hourly wage: \$ _____ /hr. or Salary: \$ _____ /Monthly /Yearly
5. Will the number of hours worked each week vary? Yes No
If yes, minimum hours: _____ Maximum hours: _____
If no, list the number of hours worked each week: _____
6. Are there months where this employee works more or less than the hours reported in question 5?
(e.g., a teacher who does not work during the summer) Yes No If yes, which months and how many
hours will the employee work each week? _____
7. Is overtime offered on a regular basis? Yes No Weekly overtime hours: _____
Overtime rate: \$ _____
8. How often paid?: Every two weeks (e.g., every other Friday) List day of the week paid: _____
 Twice per month (e.g., 5th and 20th) List dates: _____
 Weekly Monthly Other: _____
9. Date first paycheck will be (or was) received: _____
What is the estimated gross amount (before taxes)? \$ _____ Hours paid on the first check? _____
10. When does the pay period end (e.g., every other Friday or 15th and 30th)? _____
11. Does employment include tips, commission, health savings account or shift differential? Yes No
If yes, list amount and frequency: _____
12. Does employment include bonuses (e.g., holiday, profit-sharing, performance, etc.)? Yes No
If yes, list amount and frequency: _____
13. Does the employer offer health insurance? Yes No
Is the employee eligible to enroll? Yes No If no why: _____
14. If terminated, list the termination date: _____ Date of final pay check: _____

Employer Signature* _____ Date

*Additional verification will be required if employer does not sign form.

Customer Signature _____ Date

Return form to employee or the Department of Workforce Services:

Mail - Department of Workforce Services, Imaging Operations, P.O. Box 143245, Salt Lake City, UT 84114-3245

Fax - Salt Lake City Area: 801-526-9500 or Toll free: 1-877-313-4717

Equal Opportunity Employer/Program

Auxiliary aids and services are available upon request to individuals with disabilities by calling 801-526-9240. Individuals who are deaf, hard of hearing, or have speech impairments may call Relay Utah by dialing 711. Spanish Relay Utah: 1-888-346-3162.