Name of Client Company	
Processor:	Date Processed

Data

Name and Address

Employee #	SSN	Email Address	
Last Name	First Name		MI
Address		DOB	
CITY	STATE ZIP	Phone	
County		PC Clock Number	
Gender ☐ Male ☐ Female		US Citizen ☐ Yes ☐ No	

This Area To Be Completed By Supervisor/Employer

Job Title	Work State	Base Rate $	
Work Status ☐ Reg Full-Time ☐ Part-Time With Benefits ☐ Temporary Part-Time ☐ Temporary Full-Time ☐ Part-Time NO Benefits ☐ On Call ☐ Seasonal			
☐ Hourly ☐ Salary ☐ Commission		Wage/Hr Exempt ☐ Yes ☐ No	
Division	Department	System Hire Date:	Original Date:
Work Comp Code		Job Code	
Pay Frequency ☐ Weekly ☐ Bi-Weekly ☐ Semi-Monthly ☐ Monthly			

Manager's Signature _____ Date _____

ACKNOWLEDGEMENT OF THE DRUG-FREE WORKPLACE PROGRAM

I understand that the employer maintains a drug-free workplace policy requiring all employees to report to work in a substance free condition. I also understand that a condition of my initial/continued employment, random, and where reasonable suspicion of drug use exists, the Company may require me to undergo substance screening urinalysis, blood (for alcohol), hair follicle, or other testing procedures, and I hereby agree to submit to such tests, including follow-up to rehabilitation testing and the required post-accident testing. I further consent to the results of any such drug screen being released to the Company's authorized representative by the testing facility. I further release all Company officials from liability arising from the release or use of the test results. I understand that if I am injured on the job and either refuse to be tested or test positive for drugs or alcohol, medical and Workers' Compensation benefits can be denied. I agree to enter into an employment relationship with the employer under the terms of the Drug-Free Workplace Program. Policies and benefits may be changed at the discretion of the employer. Material changes will be relayed to the employee through the usual means of communication.

Signature _____ Date _____