



Employment Information Sheet

Employee Information			
Full Name:			
Address:	City:	State:	Zip:
Mailing Address:	City:	State:	Zip:
<input type="checkbox"/> Same as above			
Home Phone:	Cell Phone:		
Birth Date:	Email Address		
SS # or Govt ID:	DL #/State		
Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Widowed <input type="checkbox"/> Single <input type="checkbox"/> Decline to state			
Spouse's Name:	Phone #:		

Emergency Contact Information			
Full Name:	Relationship:		
Address:	City:	State:	Zip:
<input type="checkbox"/> Same as above			
Home Phone:	Cell Phone:		

Provider / Massage Therapist only License Information-		
License #:	Type of License:	Exp:
Did you provide a copy for the clinic? <input type="checkbox"/> YES <input type="checkbox"/> NO, need to provide a copy for the clinic.		

HR ONLY - Job Information			
Title:	Supervisor:		
Start Date:	<input type="checkbox"/> Hourly <input type="checkbox"/> Provider <input type="checkbox"/> LMT <input type="checkbox"/> Intern	Clinic: T K W	
Notes:			