

**JEFFERSON COMMUNITY HEALTH CARE CENTERS, INC.
POST EMPLOYMENT INFORMATION FORM**

Employee Information

Full Name: _____ Date: _____
 Last First MI

Person to be notified in case of emergency:

Name _____ Telephone Number _____

Address _____ Relationship _____

For Insurance Purpose Only: List All Dependents

Name	Relationship	Birthday	Social Security #

EMPLOYER USE ONLY

Date of employment _____ Job Title _____

Department _____ Location _____

Rate of Pay _____ Full Time Part Time Salaried

Application Signature acknowledging above information _____

Drug Test confirmation number _____

Name of person verifying information _____

Name of person authorization employment _____