

New Employee Information

Form/ Status Change Form

* Updated June 2024



*If filling out for Status Change, please complete all appropriate sections

The Basics

Department:				Hire Date:		
Job Title:				Rehire?	Yes	No
Job Description:	Please attach a current copy of employees job description			When? Dates/Years		
Employee Name:				FMLA Start Date:		
Address:				Marital Status <i>Optional</i> (circle one):	Married	Single
Phone:					Divorced	Widowed
Work Email:				Optional Gender: _____ Race: _____		
Preferred PayStub Email*:						
Social Security #:	Date of Birth:					

*Your Preferred PayStub Email will be public information and can be released upon FOIA request

Payroll Information

Status: <i>(circle one)</i>	FT	PT	Temp	Time Accrual: <i>(circle all that apply)</i>	Personal	Vacation	Sick	
	Seasonal	Intern	PRN		Comp	Overtime	Paid Leave	
Union: <i>(circle one)</i>	AFSCME Courthouse	AFSCME Circuit Clerk	AFSCME Ambulance	FOP	Laborers' Local (Health Dept)	N/A		
Pay Type: (circle one)	Hourly	Salary		EEOC: <i>(circle one)</i>	Officials & Administrators	Professionals	Technicians	Protective Service
Rate:	\$	\$			Para-Professional	Administrative Support	Skilled Craft	Service & Maintenance
Hourly/Salary GL#:					General Control	Streets & Highways	Public Welfare	Police Protection
Fund	Dept	Line Item			Natural Resources	Parks & Recreation	Hospitals & Sanitoriums	Health
Overtime GL #:					Employment Security	Sanitation & Sewage	Utilities & Transportation	Corrections
Fund	Dept	Line Item			Community Development	Housing	Other	

*If multiple GL#'s are required, please attach a separate piece of paper

Status Change

Status Change: <i>(circle one)</i>	PT to FT	Other (please describe):		
	FT to PT	N/A	Effective Date of Change:	

*If status change is to FT, please fill in the health insurance section below

Health Insurance

Has Health Insurance been offered?				Has Dental/Vision Insurance been offered?			
Yes	No	Decline*	Not Eligible	Yes	No	Decline	Not Eligible
<i>*If declining Health Insurance, please sign the HOPE form A noting the decline</i>							
Plan Chosen: (circle one)				Flex Account? Yes No Not eligible			
HOPE 4000 w/HSA				HSA Account? Yes No Not eligible			

*Insurance will take effect the 1st day of the month following the hire date (if employee is eligible).

Final Forms

IMRF/SLEP Complete?	IMRF	SLEP	n/a	Federal I-9 Complete with copies of documents provided?	Yes	No	
Direct Deposit Complete?	Yes	No		Employee Handbook?	Yes	No	Other Department
Federal/State W-4 Complete?	Yes	No		Union Card?	Yes	No	n/a
Employee Emergency Contact?	Yes	No		Voluntary Self-Identification of Disability?	Yes	No	

Department Head Signature:

Date:

*Please return a fully completed copy of this form along with ALL completed new hire forms to the County Board Office

Office Use Only			
1095-C information updated in HR	Yes	No	
Paperwork emailed to Payroll Office	Yes	No	
Employee added to NeoGov Training	Yes	No	