



Los Angeles County Office of Education

LOS ANGELES COUNTY OFFICE OF EDUCATION

PERSONNEL SERVICES

PERSONNEL DATA FORM

INSTRUCTIONS: PLEASE RETURN ALL COPIES OF COMPLETED FORM TO PERSONNEL SERVICES FOR DISTRIBUTION.

Please complete this form by printing the appropriate information in the provided spaces. ALL EMPLOYEES are to complete items 1, 3, and 9.

NEW EMPLOYEES are to provide all information in items 4 through 8.

CURRENT EMPLOYEES will enter only information that is to be changed in items 4 through 8.

SOCIAL SECURITY NUMBER (REQUIRED) 1 <input style="width:100%;" type="text"/>	PERSONNEL SERVICES USE ONLY 2 <input type="checkbox"/> Record Sequence Number	CHECK APPLICABLE ITEM(S) (REQUIRED) 3 <input type="checkbox"/> A. Initial Completion at Employment <input type="checkbox"/> B. Change of: <input type="checkbox"/> Address <input type="checkbox"/> Emergency Contact <input type="checkbox"/> Name <input type="checkbox"/> Phone <input type="checkbox"/> Prefix
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LEGAL NAME (Certificated employees please use the name appearing on your California Credential)

Last name (comma, no space) first name (one space) middle initial (two spaces) (Jr., Sr., III, etc.)

PREFIX Enter Appropriate Number **4**
 1 = Dr., 2 = Mr., 3 = Mrs., 4 = Miss, 5 = Ms

OTHER NAMES: (Prior married names, maiden name, other prior names)
 Last name (comma, no space) first name (one space) middle initial (two spaces) (Jr., Sr., III, etc.)

1

2

3

ADDRESS **5**
 (Number and Street)

(City) (State) (Zip Code)

HOME PHONE Area Code Number

Authorization to allow access to home information:
 Indicate in item number 6 and item number 7 below the information you authorize to be printed in an Office Directory and/or to be made available to any applicable exclusive employee organization representative. Unless otherwise indicated only your name and site will be printed.

N - Name Only A - Name and Address
 P - Name and Home Phone B - Name, Address and Home Phone

ENTER APPROPRIATE LETTER: **6** Personnel Directory Authorization **7** Collective Bargaining Directory Authorization

PERSON(S) TO NOTIFY IN CASE OF ACCIDENT OR ILLNESS **8**

NAME A	RELATIONSHIP TO EMPLOYEE (REQUIRED)	TELEPHONE (REQUIRED)
COMPLETE ADDRESS (NUMBER, STREET, CITY, STATE, ZIP CODE) (REQUIRED)		
NAME B	RELATIONSHIP TO EMPLOYEE (REQUIRED)	TELEPHONE (REQUIRED)
COMPLETE ADDRESS (NUMBER, STREET, CITY, STATE, ZIP CODE) (REQUIRED)		

SIGNATURE OF EMPLOYEE (REQUIRED) 9	DATE SIGNED
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DISTRIBUTION:
 1 – Personnel Services
 2 – Payroll
 3 – Division
 4 – Data Control

PERSONNEL SERVICES USE ONLY		
BP 21 2-Address	INITIALS AND DATE	<input type="checkbox"/> CSP <input type="checkbox"/> CSD <input type="checkbox"/> Ins/%
Verified		<input type="checkbox"/> Name Change Pending Credential
Key Entered		INITIALS AND DATE
Data Control		