



Employee Change in Information Form  
Please return to Human Resources  
Fax- 509-546-2296

Employee Name: \_\_\_\_\_ Dept: \_\_\_\_\_

Contact Information:

Telephone Number: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  cell  home  
Telephone Number: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  cell  home

Emergency Contact Information:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Telephone Number: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  cell  home

Address:

\_\_\_\_\_  
Address  
\_\_\_\_\_  
City State Zip

Name Change\*:

Social Security Number: \_\_\_\_\_  
New Full Name: \_\_\_\_\_  
Last First M  
Prev. Full Name: \_\_\_\_\_  
Last First M

\*All name changes must be accompanied by W-4 form and a current copy of your social security card or social security card application letter with your new name. **Clinical staff:** Change will not be effective until all active credentials you may have match the name on your new social security card. Please see Benefit Specialist if your name change will affect the status on your insurance for adding or deleting dependents.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date