

NEVADA SYSTEM OF HIGHER EDUCATION PERSONAL DATA FORM

Campus	<input type="checkbox"/> DRI <input type="checkbox"/> GBC <input type="checkbox"/> NSHE <input type="checkbox"/> TMCC <input type="checkbox"/> UNR <input type="checkbox"/> WNC					
Action	<input type="checkbox"/> New Employee <input type="checkbox"/> Address Change* <input type="checkbox"/> Name Change** <input type="checkbox"/> Mail Stop Change <input type="checkbox"/> Other					Effective Date _____
Employee Type	<input type="checkbox"/> Classified <input type="checkbox"/> Faculty <input type="checkbox"/> Letter of Appointment		<input type="checkbox"/> Temporary <input type="checkbox"/> Postdoctoral Scholar <input type="checkbox"/> Medical Resident		<input type="checkbox"/> Technical <input type="checkbox"/> Graduate Assistant <input type="checkbox"/> Volunteer/Adjunct	
	Employee ID # (if assigned) _____					

* This form is for human resources and payroll records only. Additional forms are required for insurance /retirement purposes. Contact your human resources office to obtain those forms.
 **For name changes a copy of a new Social Security Card, W-4, insurance change form, and retirement membership change form must be provided to the respective HR Office/Payroll.

EMPLOYEE PERSONAL CONTACT INFORMATION

Employee Name	Last	First	MI
Nickname	If changing name, indicate former name here		
Mailing Address*	Street	City, State	Zip
Phone and Email	Phone	Email	
Emergency Contact	Name	Relationship	Phone

*Mailing address is confidential with the exception that home address of all new or rehired employees is reported to the State of Nevada Department of Employment, Training and Rehabilitation in accordance with NRS 606.120.

AFFIRMATIVE ACTION INFORMATION

By Federal mandate this institution collects and maintains the data below. Definitions: <http://www.bcn-nshe.org/hr/employment/categories/>

NEW EMPLOYEE ONLY	Gender <input type="checkbox"/> Female <input type="checkbox"/> Male	Disability Status <input type="checkbox"/> Not Disabled (F) <input type="checkbox"/> Disabled Individual (T)
	Date of Birth: (mm/dd/yyyy) ____/____/____	Military Discharge Date: (mm/dd/yyyy) ____/____/____
	Are you Hispanic or Latino? A person of Cuban, Mexican, Puerto Rican, South or Central American or other Spanish culture or origin, regardless of race. <input type="checkbox"/> Yes <input type="checkbox"/> No	Military Status: Check as many as apply or none. <input type="checkbox"/> Disabled Veteran <input type="checkbox"/> Other Protected Veteran (Campaign badge list) See list www.opm.gov/veterans/html/vgmedal2.htm <input type="checkbox"/> Armed Forces Service Medal Veteran
	Racial Category or Categories: Please select the category(ies) with which you most closely identify (check as many as apply or none). <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White	Visa Status: Expiration Date(mm/dd/yyyy) ____/____/____ Type _____ (F-1/J-1/H-1B) Country of Citizenship _____

EDUCATION INFORMATION

Degree	Month/Year	Major	Name of Institution

EMPLOYEE SIGNATURE:

DATE:

WORK INFORMATION TO BE COMPLETED BY THE DEPARTMENT

Department	Mail Stop	Building	
Phone	Fax	Room	
Cell	Email		