

LOUISIANA DEPARTMENT OF HEALTH

PERSONAL DATA

(Please Print)

Name: _____ **Personnel #** _____ **Gender:** Male Female
Last First MI

PERMANENT RESIDENCE: *(Please do not put P. O. Boxes here.)* **Privacy Request:** Yes No

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Parish: _____ **DOB:** _____

MAILING ADDRESS: *(If different from permanent.)* **Privacy Request:** Yes No

Address: _____ **City:** _____ **State:** _____ **Zip:** _____
(P.O. Boxes allowed here)

PHONE NUMBERS:

Home: ___-___-____ **Cell:** ___-___-____ **Other:** ___-___-____

Office: ___-___-____ **Other:** ___-___-____ **Other:** ___-___-____

EMERGENCY CONTACT:

Mr. Mrs. Ms. **Name:** _____ **Tel. #:** ___-___-____

Mr. Mrs. Ms. **Name:** _____ **Tel. #:** ___-___-____

Mr. Mrs. Ms. **Name:** _____ **Tel. #:** ___-___-____

Ethnic Origin: Hispanic Non-Hispanic or Non-Latino Declined to state **Nationality:** _____
(ex. American, Mexican, etc.)

(Check all that apply)

Race: American Indian/Alaskan Native Asian Black or African American
 Native Hawaiian or Other Pacific Islander White Declined to state

Marital Status: Single Married Divorced NM = Not Married

I certify that the above information is accurate and that it is my personal responsibility to notify Human Resources immediately of any changes to my address. I hereby authorize the above changes.

Employee's Signature: _____

Date: _____