

Salt Lake City, UT 84114-3245

### State of Utah Department of Workforce Services

#### **EMPLOYMENT INFORMATION**

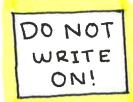
Case Name:	Case #:	
Employed Person:		
For <b>new and returning employment</b> , the entire form must To <b>verify changes to your current employment</b> , the entire form must be completed, and	mployer information and questions	
Please use a black pen to complete form.		
Employer Information:		
Company Name:	Corporate Name (if different):	
Company Address:		
Name of Supervisor or HR contact:	Phone Number:	
Date employment began or returned to work after lea	ave of absence:	
2. Is the employment temporary?  Yes No		
Is the employment considered Educational Work Students	- · · · · · · · · · · · · · · · · · · ·	
4. Hourly wage or Salary: \$	•	/Monthly Yearly
	<u>.</u>	. , ,
Check scheduled work days: Mon Tues		□Sun
Enter work schedule (ex: 9 a.m.to 6 p.m.): From:		
6. Is overtime offered on a regular basis? ☐ Yes ☐ No	o Weekly overtime hours: Ov	vertime rate: \$
7. Will the weekly number of hours worked each week v	vary? ☐ Yes ☐No	
If yes: Minimum hours:	Maximum hours:	
8. How often paid?: Weekly Every Two Weel  Monthly Other (explain):	ks (ex: every other Friday) Twice a Mo	
If paid weekly or every two weeks, list day of the v		
If paid twice a month, list dates:		
Date first paycheck will be (or was) received:		
What will be the estimated gross amount (before to		st check?
10. When does the pay period end (ex: every other Frida	y or 15 <sup>th</sup> & 30 <sup>th</sup> )?	
11. Does employment include Tips, Commission, Health If yes, list amount and frequency:	Savings Account or Shift Differential?	Yes  No
12. Does employment include bonuses (holiday, profit-sh lf yes, list amount and frequency:	naring, performance, etc.)?	∃No
13. Does employer offer Medical, Health, Accident or Co	mprehensive Insurance?	No
14. If terminated, list the termination date:	•	
Employer Signature*		Date
Customer Signature		Date
*Additional verification will be required if employer does not s	sign form.	
Return form to employee or to DWS. If returning to DN Department of Workforce Services Imaging Operations P.O Box 143245	<b>WS, mail, email, or fax to:</b> Salt Lake City Area: 80 Toll free: 1-877-313-47	

**Equal Opportunity Employer Program** 

Email: imagingops@utah.gov



#### State of Utah Department of Workforce Services **EMPLOYMENT INFORMATION**



Case Name:		Case #:	
Employed Person:	Your name here	SSN:	
To verify changes to	ng employment, the entire form muo your current employment, the elemployment must be completed, as	employer information and questions	- Copy exactly
Please use a black p	en to complete form.		your knowledg
Employer Informatio	on:		J
		Corporate Name (if different):	
Company Address:	2024 WSC. Provo. UT	84602	
Name of Supervisor	or HR contact:	Phone Number:	(801) 422-0817
	it began or returned to work after lea		1.0
		If yes, what is the expected end da	ite?
	nt considered Educational Work Stu	•	
4. Hourly wage or S	(	_ /hr. Salary: _\$	/Monthly Yearly
	worked each week:		
	•	Wed ☐Thurs ☐ Fri ☐	
		a.m. / p.m. To:	
		Weekly overtime hours:	Overtime rate: \$
	umber of hours worked each week		
If yes: Minimu		Maximum hours:	No. 41 ( 5th 4 ooth)
8. How often paid?:		ks (ex: every other Friday)	e a Month (ex: 5" and 20")
If paid woolds	☐Monthly ☐Other (explain):		
	or every two weeks, list day of the	week (ex. I lidays). I Fluays	
·	a month, list dates:	0.00.00.00.00.00.00.00.00.00.00.00.00.0	
· •	ck will be (or was) received:	Payers): C Hours poid on	the first shook?
vvnat will be tr	ie estimated gross amount (before t	axes): \$ Hours paid on the same of the sam	the first check?
		Savings Account or Shift Differential	Yes Kino
-	ount and frequency:	haring, performance, etc.)?	es <mark>XNo</mark>
	nt include bonuses (holiday, profit-sl	naring, performance, etc.)?	es No
	ount and frequency:		Mala
	offer Medical, Health, Accident or Co		No
14. If terminated, list	the termination date: N/A	Date of final pay check:	N/A
	Employer Signature*		Date
Your	Signature here		Today's Date
	Customer Signature		Date
*Additional verification	on will be required if employer does not	sign form.	
	ovee or to DWS. If returning to D		

Department of Workforce Services Imaging Operations P.O Box 143245 Salt Lake City, UT 84114-3245

Salt Lake City Area: 801-526-9500

Toll free: 1-877-313-4717

Email: imagingops@utah.gov

Equal Opportunity Employer Program



#### State of Utah Department of Workforce Services EMPLOYMENT INFORMATION



Case Name: Case #: **Employed Person:** SSN: For **new and returning employment**, the entire form must be completed and signed. To verify changes to your current employment, the employer information and questions relating to changes of employment must be completed, and the form signed. Please use a black pen to complete form. **Employer Information:** Company Name: Brigham Young University Corporate Name (if different): Company Address: 2024 Phone Number: 801-422-081 Name of Supervisor or HR contact: 1. Date employment began or returned to work after leave of absence: 2. Is the employment temporary? 
Yes 
No If yes, what is the expected end date? 3. Is the employment considered Educational Work Study? Tyes No. 4. Hourly wage or Salary: \$ Salary: \$ Number of hours worked each week: Check scheduled work days: 
Mon Tues □Wed Thurs Fri Sat Sun Enter work schedule (ex: 9 a.m.to 6 p.m.): From: a.m. / p.m. To: \_\_\_ a.m. / p.m. 6. Is overtime offered on a regular basis? Tyes KNo Weekly overtime hours: Overtime rate: \$ 7. Will the weekly number of hours worked each week vary? 

Yes No If yes: Minimum hours: Maximum hours: 8. How often paid?: ☐ Weekly ADMIN — Monthly Other (explain): If paid weekly or every two weeks, list day of the week (ex: Fridays): If paid twice a month, list dates: 9. Date first paycheck will be (or was) received: What will be the estimated gross amount (before taxes): \$ < Hours paid on the first check? 10. When does the pay period end (ex: every other Friday or 15<sup>th</sup> & 30<sup>th</sup>)? Every other Frida 11. Does employment include Tips, Commission, Health Savings Account or Shift Differential? Yes If yes, list amount and frequency: 12. Does employment include bonuses (holiday, profit-sharing, performance, etc.)? Yes If yes, list amount and frequency: 13. Does employer offer Medical, Health, Accident or Comprehensive Insurance? 14. If terminated, list the termination date: Date of final pay check: Canalley Employer \$ignature\* Date Customer Signature Date \*Additional verification will be required if employer does not sign form. Return form to employee or to DWS. If returning to DWS, mail, email, or fax to: Salt Lake City Area: 801-526-9500 Department of Workforce Services **Imaging Operations** Toll free: 1-877-313-4717

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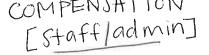


Department of Workforce Services

Salt Lake City, UT 84114-3245

Imaging Operations P.O Box 143245

# State of Utah Department of Workforce Services Employment Termination



Case #: Case Name: Employed Person: Please use a black pen to complete form. **EMPLOYER INFORMATION** Company Name: Bhaham Corporate Name (if different): Company Address: 2024 Phone Number: 801 Name of Supervisor or HR contact: 1. Average hours the employee was working per week: ( ) in 2016 Hourly wage: \$( 2. Date of hire: Last day worked: 3. Date final check available to the employee: 4. Gross amount (before taxes) of final paycheck: ( 5. Total **gross pay** (before taxes) in the month employee received their final check: 6. Did employee receive severance pay or vacation pay separate from their final check? If so, how much? Reason for leaving: Quit (list reason) Laid off (date) \* confirmin JOB DATA -> WORK LOCATION Other (reason) Yes No 8. Is this a temporary termination or furlough? If yes, when is the employee expected to return to work for this company? If yes, please list insurance carrier: Group #: and COBRA amount: \$ Does the employee have any retirement and/or 401K benefits? 

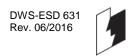
Yes No If yes, how much? \$ 11. Any additional comments: Date **Customer Signature** \*Additional verification will be required if employer does not sign form. Return form to employee or to DWS. If returning to DWS, mail, email, or fax to:

Equal Opportunity Employer Program

Salt Lake City Area: 801-526-9500

Toll free: 1-877-313-4717

Email: imagingops@utah.gov



#### State of Utah Department of Workforce Services

#### **Employment Termination**

Case name:C	Case number:	
Employed person:	SSN:	
Please use a black pen to complete form. This for Insurance eligibility. Employer Information:	m is not used to determine Unemployment	
Company name:		
	Phone number:	
1. Average hours the employee worked per week:	Hourly wage: \$	
2. Date of hire:	Last day worked:	
3. Date final check available to the employee:		
	loyee received their final check:	
6. Did the employee receive severance pay or vaca	ation pay separate from their final check?	
If so, how much?		
	Laid off (date)	
☐ Fired (state reason)	Leave of absence (length)	
Other (state reason)		
8. Is this a temporary termination or furlough?	∕es □ No	
If yes, when is the employee expected to return t	o work for this company?	
If yes, will the employee receive pay during their	leave of absence?	
9. Is there an option for continued medical insurance	ce? 🗌 Yes 🔲 No	
If yes, please list insurance carrier:	Group #:	
Policy number:	and COBRA amount: \$	
10. Does the employee have any retirement and/or 40	1K benefits?  Yes  No If yes, how much?	
11. Any additional comments:		
Employer Signature* *Additional verification will be required if employer does	Date not sign form.	
Customer Signature	Date	

Return form to employee or to Department of Workforce Services:

Mail - Department of Workforce Services, Imaging Operations, P.O. Box 143245, Salt Lake City, UT 84114-3245

Fax - Salt Lake City Area: 801-526-9500 or Toll free: 1-877-313-4717

Questions? Call - Salt Lake City Area: 801- 526-0950 or Toll Free: 866-435-7414 and press option 5



DWS-ESD 631 Rev. 06/2016



### State of Utah Department of Workforce Services

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	Case	number:
mployed person:	CONTRACTOR OF THE PARTY OF THE	SSN:
Please use a black pen to con nsurance eligibility. Employer Information:	nplete form. This form is n	ot used to determine Unemployment
Corporate name (if differen	nt):	
Company address:		
Name of supervisor or HR imployee History:	contact:	Phone number:
1. Average hours the employ	ee worked per week:	Hourly wage: \$
2. Date of hire:	La	st day worked:
3. Date final check available to the employee:		
		received their final check:
		ay separate from their final check?
If so, how much?		
7. Reason for leaving: Qu	it (state reason)	Laid off (date)
☐ Fire	ed (state reason)	Leave of absence (length)
☐ Oth	er (state reason)	
8. Is this a temporary termina	tion or furlough? Yes	No
if yes, when is the employe	e expected to return to work	for this company?
		of absence?
9. Is there an option for conti		\/
If yes, please list insurance	carrier:	Group #:
		d COBRA amount: \$
-		*
10. Does the employee have ar	y retirement and/or 401K be	netits? 🔲 Yes 🔛 No it yes, now much?

Customer Signature

Date

Return form to employee or to Department of Workforce Services:

Mall - Department of Workforce Services, Imaging Operations, P.O. Box 143245, Salt Lake City, UT 84114-3245

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Equal Opportunity Employer Program

Auxillary aids and services are available upon request to individuals with disabilities by calling (801) 526-9240. Individuals with speech and/or hearing impairments may call Relay Utah by dialing 711. Spanish Relay Utah: 1-888-346-3162.



\* DO NOT FILL OUT THIS FORM BUT YOUR OWN \*



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Mon Tues □Wed Thurs Fri Sat Sun Enter work schedule (ex: 9 a.m.to 6 p.m.): From: a.m. / p.m. To: \_\_\_ a.m. / p.m. 6. Is overtime offered on a regular basis? Tyes KNo Weekly overtime hours: Overtime rate: \$ 7. Will the weekly number of hours worked each week vary? 

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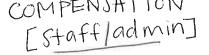


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