Absence Request for the year:

EMPLOYEE NAME	DATE (MM-DD-YYYY)
SOC. SEC. NO.	DEPARTMENT

DAY	DATE (MM-DD)		TYPE	TOTAL DAYS
		☐ 1/2 DAY ☐ FULL DAY		
		☐ 1/2 DAY ☐ FULL DAY		
		☐ 1/2 DAY ☐ FULL DAY		
		☐ 1/2 DAY ☐ FULL DAY		
		☐ 1/2 DAY ☐ FULL DAY		
		☐ 1/2 DAY ☐ FULL DAY		
		☐ 1/2 DAY ☐ FULL DAY		
		☐ 1/2 DAY ☐ FULL DAY		
		☐ 1/2 DAY ☐ FULL DAY		
TYPE: V = VACATION, PD = PERSONAL DAY, B = BEREAVEMENT, C = COMP, FH = FLOATING HOLIDAY, JD = JURY DUTY, S = SICK DAY, O = OTHER				

EMPLOYEE SIGNATURE

SUPERVISOR: SIGN AND DATE BELOW INDICATING APPROVAL GRANTED OR DENIED FOR THIS ABSENCE REQUEST.
SUBMIT COMPLETED FORM TO PAYROLL DEPARTMENT.

SUPERVISOR SIGNATURE	☐ APPROVED ☐ DENIED
REASON FOR DENIAL (IF APPLICABLE)	

DATE REC'D BY PAYROLL	DATE PAYROLL RECORDS UPDATED	BY

Accident Report

EMPLOYEE

EMPLOYEE NAME	POSITION
SOC. SEC. NO. (XXX-XX-XXXX)	DEPARTMENT
EMPLOYEE ID NO.	SUPERVISOR

ACCIDENT INFORMATION

DATE OF OCCURRENCE (MM/DD/YY)	TIME AM PM	LOCATION
DESCRIBE ACTIVITY PRIOR TO ACCIDENT		
WHAT HAPPENED (DESCRIBE CAUSE AND OBJECT OF INJURY)		

I CERTIFY BY MY SIGNATURE THAT THE INFORMATION PROVIDED ABOVE IS TRUE AND COMPLETE.

EMPLOYEE SIGNATURE	DATE

SUPERVISOR SECTION

WHEN DID YOU FIRST LEARN OF THE ACCIDENT
BASED ON YOUR INVESTIGATION, WHAT WAS THE CAUSE OF THE ACIDENT
HOW COULD THIS ACCIDENT HAVE BEEN PREVENTED?
WHAT ACTIONS HAVE BEEN TAKE TO AVOID FUTURE ACCIDENTS OF THIS TYPE?
WITNESSES: (NAME, ADDRESS, PHONE)

SUPERVISOR SIGNATURE	DATE

Authorization for Direct Deposit

☐ NEW DIRECT DEPOSIT AUTHORIZATION ☐ CHANGE ACCOUNT INFORMATION ☐ STOP DIRECT DEPOSIT

EMPLOYEE INFORMATION

LAST NAME	FIRST NAME	SOCIAL SECURITY NUMBER (XXX-XX-XXXX)

ADDRESS	CITY	STATE	ZIP

ACCOUNT INFORMATION (CHOOSE UP TO FIVE ACCOUNTS, THE LAST ONE MUST BE FOR THE REMAINING AMOUNT OWED TO YOU)

NAME OF FINANCIAL INSTITUTION | CITY | STATE

TYPE OF ACCOUNT ☐ CHECKING ☐ SAVINGS | ROUTING NUMBER | ACCOUNT NUMBER

DEPOSIT AMOUNT ☐ I WISH TO DEPOSIT $ ____________________ ☐ ENTIRE AMOUNT

NAME OF FINANCIAL INSTITUTION | CITY | STATE

TYPE OF ACCOUNT ☐ CHECKING ☐ SAVINGS | ROUTING NUMBER | ACCOUNT NUMBER

DEPOSIT AMOUNT ☐ I WISH TO DEPOSIT $ ____________________ ☐ ENTIRE AMOUNT

NAME OF FINANCIAL INSTITUTION | CITY | STATE

TYPE OF ACCOUNT ☐ CHECKING ☐ SAVINGS | ROUTING NUMBER | ACCOUNT NUMBER

DEPOSIT AMOUNT ☐ I WISH TO DEPOSIT $ ____________________ ☐ ENTIRE AMOUNT

NAME OF FINANCIAL INSTITUTION | CITY | STATE

TYPE OF ACCOUNT ☐ CHECKING ☐ SAVINGS | ROUTING NUMBER | ACCOUNT NUMBER

DEPOSIT AMOUNT ☐ I WISH TO DEPOSIT $ ____________________ ☐ ENTIRE AMOUNT

NAME OF FINANCIAL INSTITUTION | CITY | STATE

TYPE OF ACCOUNT ☐ CHECKING ☐ SAVINGS | ROUTING NUMBER | ACCOUNT NUMBER

DEPOSIT AMOUNT ☐ I WISH TO DEPOSIT $ ____________________ ☐ ENTIRE AMOUNT

It is strongly recommended that you attach a voided copy of a personal check for all checking accounts and a copy of any savings deposit slips to this authorization form. These will verify the routing and account numbers necessary to establish direct deposit.

I hereby authorize my employer to initiate credit entries to my account(s) as indicated above for payments owed to me, and further authorize the financial institution(s) named above to credit such to stated account(s). This authority is to remain in full force and effect until my employer or the financial institution(s) receive written notification from me to terminate such direct deposit authorization. I further understand that I must provide my employer a reasonable time to act on any changes that are initiated by me. I recognize that I must provide my employer of any change in bank or account information to insure proper and timely deposits into my account(s).

_______________________________ _______________________________
EMPLOYEE SIGNATURE DATE

Conflict of Interest Statement

I have read and understand the Company guidelines and policies and acknowledge that I am required to comply with them. I further acknowledge my responsibility to disclose to the Company all actual or perceived conflicts of interest which may exist while employed by the Company.

I declare that:

- ☐ I do not have a conflict of interest.
- ☐ I have a conflict of interest or a perceived conflict of interest.

In the space below is a comprehensive written submission of the complete nature of this actual or perceived conflict of interest. (additional sheets attached, if necessary)

SIGNATURE | DATE | PRINTED NAME

Employee Information Update

EMPLOYEE INFORMATION		
NAME	EMPLOYEE I.D. NUMBER	EFFECTIVE DATE / /
DEPARTMENT	LOCATION	

CHANGES		
TYPE OF ACTION	CURRENT	NEW
☐ CHANGE OF NAME		
☐ CHANGE OF ADDRESS		
☐ CHANGE IN MARITAL STATUS		
☐ CHANGE IN PHONE		
☐ CHANGE IN EMERGENCY CONTACT		
☐ _____		
☐ _____		
☐ _____		
☐ _____		

_____ _____

EMPLOYEE SIGNATURE DATE

EMPLOYEE PERFORMANCE EVALUATION

EMPLOYEE		TITLE
DEPARTMENT		EMPLOYEE NO.
DATE OF PRESENT POSITION / /	DATE OF LAST EVALUATION / /	NEXT SCHEDULED EVALUATION / /

REASON FOR EVALUATION

☐ ANNUAL ☐ MERIT ☐ PERFORMANCE
☐ END OF PROBATION ☐ PROMOTION ☐ OTHER _____

INSTRUCTIONS: Evaluate employee's work performance as it pertains to the job requirements. Circle the letter that best describes the employee's performance since the last evaluation. Add comments if necessary. (N/A if Not Applicable)

E - Excellent A - Above Average S - Satisfactory D - Decreased Performance U - Unsatisfactory

FACTORS	SINCE LAST EVALUATION	COMMENTS
AVAILABILITY The degree to which an employee is prompt, follows rules concerning break and meal periods and overall attendance.	E A S D U	
ADHERENCE TO POLICY The degree to which an employee follows safety rules and other regulations.	E A S D U	
BEHAVIOR PATTERN The stability, politeness, and judgement shown on the job.	E A S D U	
CREATIVITY The degree to which an employee suggests ideas, discovers new and better ways of accomplishing goals.	E A S D U	
DEPENDABILITY The degree to which an employee can be relied upon to complete a job.	E A S D U	
INDEPENDENCE The degree of work accomplished with little or no supervision.	E A S D U	
INITIATIVE The degree to which an employee searches out new tasks and expands abilities professionally and personally.	E A S D U	

CONTINUED ON REVERSE SIDE

FACTORS	SINCE LAST EVALUATION	COMMENTS
INTERPERSONAL RELATIONSHIPS The willingness and ability to communicate, cooperate, and work with co-workers, supervisors, and customers.	E A S D U	
KNOWLEDGE OF JOB Useful technical skills and information used at work.	E A S D U	
PRODUCTIVITY The accuracy of work finished in a specific amount of time.	E A S D U	
QUALITY The accuracy, detail, and acceptability of work accomplished.	E A S D U	

E - Excellent A - Above Average S - Satisfactory D - Decreased Performance U - Unsatisfactory

New Accomplishments or Abilities Since Last Evaluation:

Areas Which Need Improvement:

Recommendations for Career Development - Schooling, Seminars, Etc.:

Rate employee's performance overall in comparison to the job requirements involved with his/her position.

☐ EXCELLENT ☐ AVERAGE ☐ UNSATISFACTORY
☐ ABOVE AVERAGE ☐ BELOW AVERAGE ☐ NOT RATED

Comments

Individual was evaluated on _____ / _____ / _____ Employee's Signature _____

Follow up evaluation requested ☐ Yes ☐ No Follow Up Date _____ / _____ / _____

Evaluator _____ Date _____

Evaluator's Supervisor _____ Date _____

Incident Report

EMPLOYEE

EMPLOYEE NAME	POSITION
SOC. SEC. NO. (000-00-0000)	DEPARTMENT
EMPLOYEE ID NO.	SUPERVISOR

INCIDENT INFORMATION

DATE OF OCCURRENCE (MM/DD/YY)	TIME AM PM	LOCATION

WHAT HAPPENED (DESCRIBE EVENTS LEADING UP TO AND INCLUDING INCIDENT)

I CERTIFY BY MY SIGNATURE THAT THE INFORMATION PROVIDED ABOVE IS TRUE AND COMPLETE.

EMPLOYEE SIGNATURE	DATE

SUPERVISOR SECTION

WHEN DID YOU FIRST LEARN OF THE INCIDENT?

DO YOU HAVE KNOWLEDGE OF PRIOR INCIDENTS INVOLVING THESE SAME PERSONS? IF YES, EXPLAIN.

WHAT ACTIONS HAVE PREVIOUSLY BEEN TAKEN TO ADDRESS THE PRIOR INCIDENTS?

WERE PRIOR INCIDENTS REPORTED TO HUMAN RESOURCES? IF YES, STATE DATE OF REPORT(S).

WITNESSES: (NAME, ADDRESS, PHONE)

SUPERVISOR SIGNATURE	DATE

Injury Report

EMPLOYEE

EMPLOYEE NAME	POSITION
SOC. SEC. NO. (000-00-0000)	DEPARTMENT
EMPLOYEE ID NO.	SUPERVISOR

INJURY INFORMATION

DATE OF OCCURRENCE (MM/DD/YY)	TIME AM PM	LOCATION

DESCRIBE ACTIVITY PRIOR TO INJURY

WHAT HAPPENED (DESCRIBE CAUSE AND OBJECT OF INJURY)

I CERTIFY BY MY SIGNATURE THAT THE INFORMATION PROVIDED ABOVE IS TRUE AND COMPLETE.

EMPLOYEE SIGNATURE	DATE

SUPERVISOR SECTION

WHEN DID YOU FIRST LEARN OF THE INJURY?

BASED ON YOUR INVESTIGATION, WHAT WAS THE CAUSE OF THE INJURY?

HOW COULD THIS INJURY HAVE BEEN PREVENTED?

WHAT ACTIONS HAVE BEEN TAKE TO AVOID FUTURE INJURIES OF THIS TYPE?

WITNESSES: (NAME, ADDRESS, PHONE)

SUPERVISOR SIGNATURE	DATE

Leave of Absence Request

DATE / /

EMPLOYEE	EMPLOYEE NO.	POSITION

REASON FOR LEAVE

- ☐ PERSONAL DISABILITY
- ☐ MILITARY
- ☐ TRAINING CONFERENCE
- ☐ COMPENSATORY TIME OFF
- ☐ JURY DUTY
- ☐ FAMILY ILLNESS
- ☐ FAMILY DEATH
- ☐ OTHER

DETAILS

LEAVE REQUESTED

	DATE	TIME
FROM	/ /	AM PM
TO	/ /	AM PM
	TOTAL DAYS	TOTAL HOURS

REGULAR WORK SCHEDULE:

REQUIRED SIGNATURES

HUMAN RESOURCES _____ DATE _____

SUPERVISOR/MANAGER _____ DATE _____

OTHER APPROVING AUTHORITY _____ DATE _____

Vacation Request for the year:

EMPLOYEE NAME	DATE (MM-DD-YYYY)
SOC. SEC. NO.	DEPARTMENT

DAY	DATE (MM-DD)		TYPE	TOTAL DAYS
		☐ 1/2 DAY ☐ FULL DAY		
		☐ 1/2 DAY ☐ FULL DAY		
		☐ 1/2 DAY ☐ FULL DAY		
		☐ 1/2 DAY ☐ FULL DAY		
		☐ 1/2 DAY ☐ FULL DAY		
		☐ 1/2 DAY ☐ FULL DAY		
		☐ 1/2 DAY ☐ FULL DAY		
TYPE: V = VACATION, FH = FLOATING HOLIDAY, OTHER = O				

VACATION REQUEST FORM MUST BE SUBMITTED TWO WEEKS PRIOR TO VACATION.

ONLY ONE WEEK MAY BE REQUESTED PER FORM. IF ADDITIONAL VACATION IS REQUESTED BEYOND ONE WEEK, USE A SECOND FORM.

EMPLOYEE SIGNATURE

SUPERVISOR: SIGN AND DATE BELOW INDICATING APPROVAL GRANTED OR DENIED FOR THIS VACATION REQUEST.
SUBMIT COMPLETED FORM TO PAYROLL DEPARTMENT.

SUPERVISOR SIGNATURE	☐ APPROVED ☐ DENIED
REASON FOR DENIAL (IF APPLICABLE)	

DATE REC'D BY PAYROLL	DATE PAYROLL RECORDS UPDATED	BY