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:**

_____ _____