

South Central Louisiana Human Services Authority  
Human Resources Division

**PERSONAL DATA**

(Please Print)

Name: \_\_\_\_\_ Personnel # \_\_\_\_\_ Gender:  Male  Female  
Last First MI

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

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Parish: \_\_\_\_\_ DOB: \_\_\_\_\_

**MAILING ADDRESS:**(If different from Permanent.) Request Private:  Yes  No

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
(P.O. Boxes here)

**PHONE NUMBERS:**

Home: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Cell: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Other: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Office: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Other: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Other: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

**EMERGENCY CONTACT:**

Name: \_\_\_\_\_ Tel.# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Gender:  Male  Female

Name: \_\_\_\_\_ Tel.# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Gender:  Male  Female

Name: \_\_\_\_\_ Tel.# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Gender:  Male  Female

Ethnic Origin:  Hispanic  Non-Hispanic or Non-Latino  Decline to state

(Check all that apply)

Race:  American Indian/ Alaskan Native  Asian  Black or African American

Native Hawaiian or Other Pacific Islander  Other  White  Decline to state

Marital Status:  Single  Married  Widowed Disabled:  Yes  No

Date of Marriage: \_\_\_\_\_ Date Disability Started: \_\_\_\_\_

Military Status:  N/A  Inactive  Active  Reserve  Vietnam Veteran  Disabled Veteran

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 or contact information.

Employee's Signature: \_\_\_\_\_

Date: \_\_\_\_\_