Employee Basic Data Form

Name: _____ _____ _____
Last Name First Name Middle Initial

US Social Security #: _____ (Enter 9 digits only don't put dashes(-))

Most Recent Unbroken Other CARE Years of Service: _____

DEMOGRAPHICS

Date of Birth (mm/dd/yyyy): _____

Gender: ◯ Male -or- ◯ Female

Marital Status: ◯ Single -or- ◯ Married

Race or Ethnic Group:

◯ Hispanic or Latino
◯ Asian
◯ American Indian or Alaska Native
◯ Black or African American
◯ Native Hawaiian or Pacific Islander
◯ White
◯ Two or more races (please identify race(s) below):

_____ and _____

Primary Country of Citizenship: _____

Secondary Country of Citizenship: _____

◯ **Check if US Permanent Resident**

***(For US Citizens and Permanent Residents only)* I voluntarily identify myself as:**

☐ An Individual with a Disability
☐ Disabled Veteran
☐ Armed Forces Service Medal Veteran
☐ Recently Separated Veteran
☐ Other Protected Veteran

If you are disabled, it would assist us if you tell us about:

(i) Any special methods, skills and procedures which qualify you for positions that you might not otherwise be able to do because of your disability, so that you will be considered for any positions of that kind.

_____

_____

(ii) Any accommodations which we could make which would enable you to perform the job properly and safely, including special equipment, changes in the physical layout of the job, elimination of certain duties relating to the job, provision of personal assistance services or other accommodations.

_____

_____

PLEASE SEE PAGE 2

CONTACT INFORMATION

Street Address: _____

_____

City: _____ **State:** _____ **Zip Code:** _____

County: _____ **Country:** _____

Phone Number: _____ **Email:** _____

SUPPLEMENTAL CONTACT INFORMATION

Street Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Country: _____ **Phone Number:** _____

HOME OF RECORD
Location you will be returning to upon completion of assignment.

City: _____ **Country:** _____

DEPENDENT INFORMATION

Do you have declared Dependents?
Note: (If Yes, please fill out details below) _____ (Yes/No)

IMPORTANT: It is imperative that you notify Human Resources if your Dependent(s) at Post (DAP) changes. Please note, changing the number of DAP may impact your allowances and/or pay.

Eligible Depedent/s:
*Spouse
*Child(ren) - Dependent children may be covered up to age 26 or a child of any age who becomes disabled according to Social Security Administration guidelines.
*Domestic Partner with provided supporting documents (Please see Domestic Partnership Form for reference)

LAST NAME	FIRST NAME	DATE OF BIRTH (mm/dd/yyyy)	US SOCIAL SECURITY #	RELATIONSHIP (Spouse/Domestic Partner/ Son/Daughter)	AT POST
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No

EMERGENCY CONTACT

Name: _____ _____ _____
Last Name First Name Initial

Relationship: _____ **Email:** _____

Street Address: _____

City: _____ **State:** _____ **Zip Code:** _____

County: _____ **Phone Number:** _____

IMPORTANT: If any information you have declared on this form changes, please let the HR Service Center know by refiling this form with the updated information within 31 days of the effective date of change.