MAK HEALTHCARE INC

NEW EMPLOYEE PAYROLL INFORMATION

NAME ______________________________ DATE OF BIRTH ______________

CURRENT ADDRESS ______________________________

CITY ______________________ STATE __________ ZIP CODE ____________

HOME PHONE ____________________ ALTERNATE PHONE ____________________

SOCIAL SECURITY # ____________________ # OF DEDUCTIONS CLAIMED__________

POSITION INFORMATION

Position Title:______________________ Reports To:______________________

Hire Date:______________ FULL TIME / PART TIME (Circle one) and TEMPORARY / PERMANENT (Circle one)

Schedule (work days and hours) ______________________________

SALARY

- Yearly salary, Exempt ______________ per year.
- Office Staff, Hourly salary, Non-Exempt ____________ per hour.
- Direct Care Staff, Hourly salary, Non-Exempt:

Position	Rate/Hour	Rate/Visit	Rate/Live-In	Rate/Sleep-In
RN				
LPN				
HHA				
PCA				
HMKR				
Other				

OTHER EMPLOYEE COMPENSATION

Mileage Reimbursement: $ _________ per mile

Travel Reimbursement: $__________ per trip

Employee Signature ______________________________ Date ______________

Approved ______________________________ Date ______________

Revised 03/09

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