



INTEGRATED BUSINESS SERVICES

Employee Change Form

Worksite Employer Name: _____

Name Change:

First Name: _____ Last: _____ MI: _____

Social Security Number: _____

Address Change:

New Address: _____ Apt # _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Pay Rate or Position Change:

Effective Date: _____ Full Time Part Time - # of Hours _____ Leave

Pay Rate: _____ Hourly Weekly Salary Biweekly Semi-monthly
 Monthly Yearly

Job Title: _____ Description: _____

Location: _____ Dept: _____ Benefit Group: _____

Accruals:

Vacation: Stop Initiate (seniority date: _____ Initial balance: _____)

Sick: Stop Initiate (seniority date: _____ Initial balance: _____)

PTO: Stop Initiate (seniority date: _____ Initial balance: _____)

Will this new position require Driving for your Company? Yes No
(If yes, please provide a current copy of the employees Drivers License)

Supervisor's Signature _____

Please fax to Innovative at (727) 323-7999

2836 5th Ave N - Suite 101, St. Petersburg, FL 33713
(727) 323-7979 (727) 323-7999 Fax