

Job Title:			Dept Account #		
Social Security Number	Male _____ Female _____	Married _____ Single _____	Veteran Yes or No	Handicap: (please specify)	
Full Legal Name (Last, First, Middle) Mr. ____ Mrs. ____ Ms. ____ Dr. ____			Date of Birth: Month/Day/Year	Citizenship: USA _____ Other _____ Visa Exp: _____	
Employee Present Address:			Employee Permanent Address:		
City, State, Zip			City, State, Zip		
Residence Phone:	Emergency Contact:	Phone No.	Relationship:		
Current PERS Retiree? Yes or No					

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

Ethnic Background: Compliance with the request is consistent with U.S. Dept. of Labor regulations mandated by Federal Executive Orders 11246 and 11375.

This confidential information is not used in making Personnel decisions. Enter most appropriate letter in space:

<b>Black.....</b> F	Laotian..... Y	<b>Hispanic:</b>	<b>Pacific Island:</b>	<b>American Indian:</b>
<b>Asian:</b>	Other..... S	Mex, Mex/Ame	Hawaiian..... P	Amer Indian..... H
Japanese..... I		Chicano..... A	Samoan..... Q	Aleut..... O
Chinese..... J	Other Non-	Puerto	Guamanian/	Eskimo..... N
Korean..... K	White..... X	Rican..... B	Chamorro..... R	Filipio..... G
Vietnamese.. L	White..... E	Cuban..... C	Other..... T	Other..... T
Asian Indian.. M		Other..... D		
Cambodian... U				

**DESIGNATION OF PERSON AUTHORIZED TO RECEIVE COMPENSATIONS (GOV. C., SEC 12479)**

Pursant to Section 12479 of the Government Code, I hereby designate the following person who, notwithstanding any other provision of the law, shall be entitled upon my death, incapacitation, or inability to act on my own behalf, to receive paychecks and other compensation or benefits due me.

IMPORTANT: This is not a designation for payment of death benefits and refund of employee retirement contributions.

**DESIGNEE (Must be 18 years of age or older)**

Designee Name (First, MI, Last)	Age:	Relationship:
Address:	City, State, Zip	Phone:

I hereby revoke any previous designations filed by me. If the above-named designee does not file a written request with the Human Resource Office of my employing agency for such payments within sixty (60) days after the date of my death, this designation shall be and become null and void. I affirm that all the answers and statements on this form are complete and true to the best of my knowledge and belief.

Employee Signature (Please sign in ink)	Date Signed:	Signature of Human Resources:
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The information Practices Act of 1977 and the Federal Privacy Act require that this notice be provided when collecting personal information from individuals. Information requested on this form is used by the employing Human Resource Office for the sole purpose of identifying the designee authorized to receive payments payable to the employee had he/she survived. Legal references authorizing maintenance of this information include the Government Code Section 12479 and the State Administrative Manual Section 8477.1-8477.27. This form and all personal information contained therein is maintained by the employing Human Resource Office. Employees have the right of access to copies of their Designation of Person Authorized to Receive Payments Form upon request.

Do you have any allergies we should be aware of? If so, please list them below:

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