

NAME CHANGE FORM

Date _____ Location _____
SCHOOL/DEPARTMENT

Previous Name – As currently on file with the District

LAST

FIRST

MIDDLE INITIAL

NEW NAME – Must have new Social Security Card in new name

LAST

FIRST

MIDDLE INITIAL

Last 4 digits of Social Security Number ### - ## - _____

Employee Type Current Former Retired
 Licensed Classified

Please note: This form must be in the Human Resource Department on or before the TENTH (10th) day of the month in order for it to be processed for that month's payroll.

For changes to your address or phone number, log in to Skyward Employee Access. If you need assistance with your login information, please call the Information Systems Helpdesk at (801) 567-8737.

For changes to your W4 or Direct Deposit information, contact the Payroll Department.

For changes to your insurance including Beneficiary information, contact the Insurance Department.

Employee Signature

Date

For Use by Human Resources Only

New SS Card received

I-9 Re-verification

Name change processed _____

Insurance copy