

LSU Health Sciences Center – New Orleans
Person to Notify in Case of Emergency

SS#: _____ Appointment Date: _____

Name as on Social Security Card: _____
Last First MI

Birth Date: _____ Birth Place _____ Country _____
Month/Day/Year City, State USA or other citizenship

Marital Status: Single Married Divorced Widowed Sex: Male Female

Ethnic Group: Caucasian African American Hispanic American Indian Asian Other

Home Address: _____

City: _____ State: _____ Zip Code: _____ Home Phone: _____

Highest Education Level (1-16)

Degree: _____ Date Rec'd: _____ University _____ Discipline _____
Month/Year

Degree: _____ Date Rec'd: _____ University _____ Discipline _____
Month/Year

Degree: _____ Date Rec'd: _____ University _____ Discipline _____
Month/Year

Relative employed by LSU: _____
Name or N/A, if none Relationship

Person to notify in case of emergency

Name: _____ Relationship: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____

Are you a member of any professional organization, society, or hold licenses in any area? If so, indicate name or organization or society, license held and certificate number _____
If applicable Exp. Date

*** Have you previously worked for the State of Louisiana?** _____ If yes, provide the following:

Agency Name & Address _____ Dates

Agency Name & Address _____ Dates

Agency Name & Address _____ Dates

Did you work under a different name? _____
Name if different from above

*All annual and sick balances will be transferred or credited in accordance with Chapter 11 of the Civil Service Rules. The information you provide regarding any prior state service will benefit this process. Please allow up to 6 weeks to complete the transaction.