

PAYROLL ENROLLMENT FORM
SUBSTITUTE
2020-2021

NAME: _____
(Last) (First) (Middle)

SOCIAL SECURITY #: _____ - _____ - _____ DOB: ____/____/____

ADDRESS: _____

CITY/STATE: _____ ZIP _____

HOME PHONE #: (____) _____ - _____ RACE: _____
(optional)

CELL PHONE #: (____) _____ - _____

E-MAIL ADDRESS: _____

WOULD YOU LIKE DIRECT DEPOSIT? N Y-new Y-use same account as last yr

ARE YOU ARIZONA STATE RETIRED? N Y RETIREMENT DATE _____

****PLEASE DO NOT WRITE BELOW THIS LINE****

- CERTIFIED CLASSIFIED NURSE LPN RN
 NEW RETURN FORMER DIST EE

RATE PER DAY \$ _____

DEDUCT FINGERPRINTING FEE (\$22) Y N

PAYROLL ACCNT # _____

STANDARD DEDUCTIONS:

FEDERAL TAX: M S _____ ADD'L AMT \$ _____ EXEMPT _____

STATE TAX _____% ADD'L AMT \$ _____ EXEMPT _____

RETIREMENT Y _____ N _____

COMMENTS: _____
