



PAYROLL  
 WORKERS COMP  
 HUMAN RESOURCES  
 BENEFITS  
 STAFFING

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## Employee - Data Change Form

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Client Company: \_\_\_\_\_

Employee Name: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

\*If this change will affect your state withholding status please contact TEL Staffing & HR Payroll Department at 850.476.9008

Telephone Number: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Name (must provide legal documentation)

Stop Direct Deposit: Financial Institution: \_\_\_\_\_

Account #: \_\_\_\_\_ Routing#: \_\_\_\_\_

Other (explain in detail): \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_

\_\_\_\_\_  
 EMPLOYEE SIGNATURE, (REQUIRED)

\_\_\_\_/\_\_\_\_/\_\_\_\_  
 DATE

\_\_\_\_\_  
 SUPERVISORS SIGNATURE, IF REQUIRED

\_\_\_\_/\_\_\_\_/\_\_\_\_  
 DATE