NOTICE OF EMPLOYMENT (DEFENDANT)

DATE:_____
YOUR NAME:_____
ADDRESS:_____
_____
please check one: new address____ address on file____
SOCIAL SECURITY #_____
PHONE #_____
CASE ID#(if known)_____

CURRENT EMPLOYER_____
COMPLETE ADDRESS_____
OF EMPLOYER _____
_____
EMPLOYER PHONE #_____
DATE EMPLOYMENT BEGAN_____
RATE OF PAY:_____
MEDICAL INSURANCE PROVIDER_____
POLICY #_____
NAME(S) OF DEPENDENT(S) COVERED_____
_____
EFFECTIVE DATE OF COVERAGE_____
COST OF DEPENDENT COVERAGE_____
IF NOT ELIGIBLE FOR INSURANCE NOW, WHEN WILL INSURANCE COVERAGE BE AVAILABLE?_____

I CERTIFY THE ABOVE INFORMATION IS CORRECT AND I UNDERSTAND IT IS MY RESPONSIBILITY TO MAKE PAYMENTS ON MY OWN PENDING IMPLEMENTATION OF A WAGE ATTACHMENT. FAILURE TO DO SO MAY RESULT IN CONTEMPT CHARGES BEING BROUGHT AGAINST ME.

_____
SIGNATURE

_____
(OFFICE USE ONLY)

PAYMENT PROCEDURES GIVEN TO CLIENT:_____(WRKR INITIALS)