

NOTICE OF EMPLOYMENT (DEFENDANT)

DATE: _____

DEFENDANT NAME: _____

ADDRESS: _____

Please Check One: New Address _____ Address on File _____

SOCIAL SECURITY #: _____

PHONE #: _____

CASE ID # (If known) : _____

CURRENT EMPLOYER: _____

EMPLOYER ADDRESS: _____

EMPLOYER PHONE #: _____

DATE EMPLOYMENT BEGAN: _____

RATE OF PAY: _____

MEDICAL INSURANCE PROVIDER: _____

POLICY #: _____

NAMES(S) OF DEPENDENTS(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)