

**SANTA MONICA-MALIBU UNIFIED SCHOOL DISTRICT
EMPLOYEE CHANGE & DIRECTORY INFORMATION SHEET**

SOCIAL SECURITY #: _____

CERTIFICATED

CLASSIFIED

CHANGE TO EXISTING DATA: NAME ADDRESS TELEPHONE EMERGENCY CONTACT

DIRECTORY INFORMATION

TITLE: DR MR MRS MS NICKNAME: _____

NAME: _____
(PLEASE FILL IN YOUR FULL LEGAL NAME)

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

TELEPHONE: (_____) _____ CELL PHONE: (_____) _____

POSITION/GRADE(S) _____
SCHOOL / WORK SITE: _____ SUBJECT(S) TAUGHT _____

WHAT DO YOU WISH TO HAVE PRINTED IN THE DIRECTORY? ALL INFORMATION(B) _____ NAME ONLY(N) _____

NAME & ADDRESS ONLY (A) _____ NAME & PHONE ONLY (P) _____

EMERGENCY INFORMATION

WHOM SHOULD WE CONTACT IN CASE OF AN EMERGENCY:

NAME: _____ RELATIONSHIP: _____

ADDRESS: _____ PHONE: (_____) _____

WHOM SHOULD WE CONTACT IF THE ABOVE PERSON CANNOT BE REACHED:

NAME: _____ RELATIONSHIP: _____

ADDRESS: _____ PHONE: (_____) _____

IF NECESSARY, MAY WE TAKE YOU TO A PHYSICIAN? YES NO

FAMILY PHYSICIAN _____

DO YOU HAVE ANY PHYSICAL PROBLEMS THAT WE SHOULD BE AWARE OF AT PRESENT?

IF SO, EXPLAIN: _____

DO YOU CARRY MEDICATION WITH YOU THAT YOU SHOULD TAKE? _____

IF SO, EXPLAIN: _____

DO YOU CARRY MEDICATION WITH YOU THAT YOU SHOULD TAKE? _____

WHERE DO YOU KEEP THIS MEDICATION? _____

ARE YOU UNDER TREATMENT AT THE PRESENT TIME FOR ANY PHYSICAL PROBLEM? _____

DATE: _____ SIGNATURE: _____