a. Employer ID: _[pre-filled]__ b. Case Number: _[pre-filled]__

Employee Record Review Form

c. Employee Name: : _[pre-filled]_____ d. Employee SSN: _[pre-filled]_____

e. Employee Address on I-9:

_____

_____

_____

f. Alternate Address (if different from address on I-9):

_____

_____

_____

g. Employee Phone: _____

h. Employee file contains: (check all that apply.)

___ Form I-9

___ Copy of system response --> number of responses _____

___ TNC notice

___ Referral letter to SSA

___ Referral letter to DHS

___ Copies of documents used for verification (Please specify, e.g., driver's license, current passport, permanent resident card, etc.)

_____

___ Other (Please specify) _____

i. Current work authorization status: _[pre-filled]__

If there is a reason to believe this is incorrect, please explain:

j. Reviewer: _____ k. Review Date: _____

Employee Record Review Form ([prefilled name]/[prefilled SS#])

Case #: _____[CASE_NBR]___

[1.] Items To Be Reviewed	[2.] Information from Transaction Database	[3.] Does (2) match the employee's record file?	[4.] Information from Employee's Record	[5.] Comments
[6.] Name (I-9) Last First Middle Initial	[prefilled]	 __yes __no __yes __no __yes __no		
[7.] Date of birth (I-9)	[prefilled]	__yes __no		
[8.] SSN (I-9)	[prefilled]	__yes __no		
[9.] Alien/Admission # (I-9)	[prefilled]	__yes __no		
[10.] Citizenship (I-9)	[prefilled]	__yes __no		
[11.] Hire date (I-9)	[prefilled]	__yes __no		
[12.] Verification initiated date (system print-out)	[prefilled]	__yes __no		
[13.] Date of employee signature on I-9				
[14.] Date of employer signature on I-9			`	
[15.] Tentative nonconfirmation issued (system print-out/TNC notice)	[prefilled]	__yes __no		
[16.] Date of employee signature on TNC				
[17.] Date of employer signature on TNC				
[18.] Contested with SSA (TNC notice)?	[prefilled]	__yes __no		
[19.] Contested with DHS (TNC notice)?	[prefilled]	__yes __no		
[20.] Date referred to SSA (Referral letter)	[prefilled]	__yes __no		
[21.] Date SSA signed referral letter (Employee went to SSA)				
[22.] Date resubmitted to SSA	[prefilled]	__yes __no		
[23.] Date referred to DHS (DHS referral letter)	[prefilled]	__yes __no		
[24.] Employee contacted DHS?	[[prefilled]	__yes __no		
[25.] Closure reason (system printout)	[prefilled]	__yes __no		
[26.] Closure date	[prefilled]	__yes __no		

Monthly Absence Record for Exempt (Monthly Paid) Employees

Name: _____

BUID Number: _____

Department: _____

Reporting Period: Month: _____ Year: _____

Legend: (Policy linked)
V – Vacation Hours **C** – Court Leave Hours **S** – Sick Hours
P – Personal Hours **N** – Non-Paid Hours

SUMMARY OF ABSENCES							
TYPE:	V	P	C	N	S		TOTAL HOURS ABSENT
TOTAL HOURS						=	

	SUN	MON	TUES	WED	THUR	FRI	SAT	HRS ABSENT
1ST WEEK								
REASON CODE								
2ND WEEK								
REASON CODE								
3RD WEEK								
REASON CODE								
4TH WEEK								
REASON CODE								
5TH WEEK								
REASON CODE								
							TOTAL HOURS ABSENT:	

INSTRUCTIONS:

1. Report hours requested.
2. Determine the total net hours absent each day and enter the total net hours and type of absence in the appropriate week day column, rounded to the nearest quarter hour.
3. Total the hours by type of absence and record the total in the appropriate columns in the Summary of Absences table.
4. Complete the application for sick time payment when recording use of sick time.
5. Form must be signed by the employee and supervisor.
6. Forms should be maintained in the departmental files.

APPLICATION FOR SICK TIME PAYMENT

Employee is requesting the use of their sick time for:

Illness/Injury of: ☐ Employee ☐ Spouse ☐ Parent ☐ Dependent Child
Date(s): _____

Note: A statement from the attending physician is required of staff applying for more than 3 consecutive days of sick time for themselves or any other eligible family member.

Medical/Dental Appt. for: ☐ Employee ☐ Spouse ☐ Parent ☐ Dependent Child
Date(s): _____

Funeral for: Name: _____ City: _____
Relationship: _____ Date: _____

Please visit the HR website for information on Family Medical Leave. If currently on FML, please also complete the FMLA tracking form.

I hereby certify this report to be a true and accurate record of my absences during this month.

_____ _____
Employee Signature Date

_____ _____
Supervisor Signature Date

Gregory Delivering winners | Kay Delivering winners | Hayton Coulthard Delivering winners

EMPLOYEE RECORD UPDATE

Please send the completed form to the HR & PAYROLL DEPT

*** Please PRINT all details ***

TITLE:	FULL NAME:	EMP NO:
PASSPORT NO:		
DEPARTMENT:	DEPOT:	

NEW ADDRESS:
POST CODE:
NEW TEL No (inc exchange):
MOBILE No:

*** Please note that the Emergency Contact section MUST be completed when your address has changed ***

NEXT OF KIN DETAILS	
NAME:	RELATIONSHIP TO YOU:
ADDRESS:	
	DATE OF BIRTH:
HOME TEL NO:	MOBILE NO:

EMERGENCY CONTACT DETAILS	
NAME:	
RELATIONSHIP TO YOU:	HOME TEL NO:
MOBILE NO:	WORK TEL NO:

BANK / BUILDING SOCIETY DETAILS
NAME OF BANK / BUILDING SOCIETY:
ADDRESS:
SORT CODE:
ACCOUNT IN THE NAME OF:
ACCOUNT NUMBER:
BUILDING SOCIETY REFERENCE NUMBER:

Do you receive income from a Pension? ***YES / NO*** (Please circle)

Date from which new information becomes effective: _____

Employee's Signature: _____

Date: _____

Date received	
Payroll / HR Copied?	

ADAM H. PUTNAM
COMMISSIONER

Florida Department of Agriculture and Consumer Services
Division of Consumer Services/Bureau of Fair Rides Inspection

EMPLOYEE TRAINING RECORD

Section 616.242(16), Florida Statutes,
Rule 5J-18.0012, Florida Administrative Code

Phone: 1-800-435-7352; Fax: (850) 410-3797
FairRides@FreshFromFlorida.com

Amusement Ride Company _____

Employee Name _____ (print) Trainer Name _____ (print)

Name of Amusement Ride and Serial Number _____

OPERATION TRAINING	DATE	SIGNATURE OF EMPLOYEE	SIGNATURE OF TRAINER
1. Operating Procedures			
2. Specific Duties			
3. General Safety Procedures			
4. Emergency Procedures			
5. Demonstration of the physical ride operation			
6. Supervised observation of the physical operation			
7. Additional instructions from owner			
MAINTENANCE TRAINING	DATE	SIGNATURE OF EMPLOYEE	SIGNATURE OF TRAINER
1. Inspection/Preventive maintenance procedures			
2. Specific duties			
3. General safety			
4. Demonstration of performance of assigned duties and inspections			
5. Supervised observation of performance			

I certify that the employee identified above has successfully completed all necessary training required for compliance with ASTM-F24 Committee Standards, as indicated by the date of completion and trainer's signature in the appropriate column. The trainers who conduct the training also meet the requirements of ASTM-F24 Committee Standards and are certified by the company to conduct training, supervise, and observe the inspections and operations of the rides listed hereon. The owner or manager executing this personnel training record certifies that the employee identified hereon is trained in all operation and inspection procedures for each amusement ride listed hereon as required by Section 616.242(16), Florida Statutes and Rule Chapter 5J-18, Florida Administrative Code. Training requirements listed on this table are minimum requirements. A ride owner or manager may attach a ride specific training sheet to this Employee Training Record instead of recording training information on this form by writing "see attached" in the training results for that date. Note that the administrative information on this form: company name, ride name, USAID/SN and trainers signature must be completed.

_____ _____
Signature of Owner/Manager Date

EMPLOYEE RECORD CHANGE

This form is used to change employee name, address, phone, or emergency contact information.
Please fill out/submit changes via email to: HResources@KCSouthern.com
Mail: Human Resources, Kansas City Southern, P.O. Box 219335, KCMO 64121-9335 Fax: 816-983-1108

PLEASE PRINT *(Required Fields)*

EFFECTIVE DATE OF CHANGE(S)	NAME	EMPLOYEE IDENTIFICATION NUMBER (or SS#)

FILL OUT APPLICABLE FIELDS ONLY

NAME CHANGE

NEW NAME _____
(*Include proof of change such as copy of social security card)*

RESIDENCE/PHYSICAL ADDRESS (NO POST OFFICE BOXES)

ADDRESS _____

_____

CITY _____

STATE _____ ZIP _____

PERSONAL EMAIL

(If you are changing your state of residence,
please complete new W-4 for correct payroll deductions to be kept.)

PHONE CHANGE

HOME AREA CODE _____ NUMBER _____

CELL _____ _____

OTHER _____ _____

EMERGENCY CONTACT CHANGE:

NAME _____

RELATIONSHIP _____

ADDRESS _____

_____

CITY _____

STATE _____ ZIP _____

PHONE: HOME AREA CODE _____ NUMBER _____

WORK _____ _____

CELL _____ _____

This form will update employee records in SAP

EMPLOYEE SIGNATURE _____ DATE _____