



Change of Personal Details Form HR 104

Please complete in typed format (not handwritten) and tick appropriate boxes

To be completed by employee when updating personal information

Surname					First Name				
Effective Date					Personnel Number				
Work Location					Location Code				
Grade									

Please indicate what details you wish to be updated then complete the required sections with your **new** details, Sign form and forward to your Line Manager. Please ensure that original supporting documentation is included where applicable

Details to be updated	Please Tick	Section to be Completed	List of documents attached (if Applicable)
Personal Information		1	
Postal & Email Address		2	
Next of Kin		3	
Bank Details		4	
PRSI Classification		5	
Qualifications *		6	
Professional Registration *		7	
Personal IDs *		8	

* Line Managers' signature required.

1. Personal Information

Title	Mr <input type="checkbox"/>	Mrs <input type="checkbox"/>	Ms <input type="checkbox"/>	Miss <input type="checkbox"/>	Dr <input type="checkbox"/>	Sr. <input type="checkbox"/>	Rev. <input type="checkbox"/>	Fr. <input type="checkbox"/>	Prof. <input type="checkbox"/>	Gender Change	M <input type="checkbox"/>	F <input type="checkbox"/>
Surname				First Name								
Marital Status												
Single <input type="checkbox"/> Married <input type="checkbox"/> Civil Partnership <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Co-Habiting <input type="checkbox"/>												
Relevant certificate/s attached					Yes <input type="checkbox"/>	No <input type="checkbox"/>	PPS Number					

2. Postal & Email Address (Please note this address will be used for all HSE correspondence to you)

Street Address											
Town/City						County					
Post Code				Country				Contact Phone No.			
Mobile Phone No						Email Address					

3. Next of Kin (Emergency Contact Details)

Surname				First Name				Initial			
Relationship to you											
Street Address											
Town/City											
County				Post Code				Country			
Contact Phone No:						Mobile Phone No:					



Name _____ Personnel No. _____

4. Bank Details

Note: Any change of Bank Details can only occur on the first day of any pay period. Please contact your payroll section for details of when change may be effective from. **It is your responsibility to ensure the change has been completed on payroll before making any amendments to your Old or New bank account** (e.g. Cancel or set up of standing orders / direct debits, Closing old account etc)

Bank Name		Bank Address	
Bank Sort Code		Account Number	
Bank Identifier Code (BIC)			
International Bank Acc No. (IBAN)			
Payee Name			

5. PRSI Details

New PRSI Class		Note: Attach supporting documentation from Dept Social & Family Affairs (Social Welfare)/ HSE
Start Date		End Date

6. Qualification Details

Note: Copy of Certificates to be attached				Official use only			
Name of Qualification	From	Proficiency/ Grade awarded	Qualification Code (if applicable)	Validated (tick One)			
				Yes <input type="checkbox"/> No <input type="checkbox"/>			
				Yes <input type="checkbox"/> No <input type="checkbox"/>			

7. Professional Registration

Note: only applies to Medical & Dental, Health & Social Care Professionals & Nursing. Please attach supporting documentation

Name on Registration		Issued by	
Date of issue		Expiry Date	
Professional Registration Membership Number			
Application Status (Medical Council)	Trainee Specialist Division <input type="checkbox"/>	Internship Division <input type="checkbox"/>	Specialist Division <input type="checkbox"/>
		General Division <input type="checkbox"/>	Supervised Division <input type="checkbox"/>
			Visiting EEA Practitioners Division <input type="checkbox"/>

8. Personal IDs

Driving Licence <input type="checkbox"/>	Work Permit <input type="checkbox"/>	Visa <input type="checkbox"/>
Start Date		End Date

9. Employee Declaration

I declare that the above information is accurate and correct on the date indicated below. I undertake to notify my employer of any changes to this information by completing the appropriate form.

Signature		Date	
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Name _____ Personnel No. _____

10. Line Managers Declaration

I declare that the above information is accurate and correct on the date indicated below.

Original documents Checked	Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>	Copies attached	Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>
Signature		Date	<input type="text"/>
Name (Capitals)		Grade	<input type="text"/>
Contact Phone No:	<input type="text"/>	Mobile No:	<input type="text"/>
E-mail Address	<input type="text"/>		

11. Payroll Section (SAP phase 1 sites only)

Location Number	<input type="text"/>	<input type="text"/>	<input type="text"/>
Checked by Payroll <input type="checkbox"/>			
Name (Print)	Signature		
Tel No	Date	<input type="text"/>	<input type="text"/>