# Other Employment Questionnaire

**Instructions:** To be completed only if UB contractual employee has additional employment at another state agency or USM institution. Not used for employees whose total state employment is at UB. Employee completes this form and returns to the Office of Human Resources.

Employee Name: _____ Empl ID: _____

Section I: Current UB Employment

Department_____ Title: _____

Department_____ Title: _____

Department_____ Title: _____

Section II: Other State Health Insurance

Are you currently eligible for subsidized health insurance through other state employment?

_____ Yes _____ No _____ Not Sure If yes, skip Section III. Sign at the bottom and return to OHR.

Section III: Other State / USM Employment

State Agency / Institution: _____ Title: _____

Department: _____ Average hours per week: _____

Supervisor's Name: _____

Supervisor's Contact Information: _____

State Agency / Institution: _____ Title: _____

Department: _____ Average hours per week: _____

Supervisor's Name: _____

Supervisor's Contact Information: _____

Printed Name: _____

Signature: _____ Date:_____