Minnesota New Hire Reporting Form

Effective July 1, 1996 Minnesota Statute 256.998 requires all Minnesota Employers, both public and private, to report all newly hired, rehired, or returning to work employees to the State of Minnesota within 20 days of hire or rehire date.

Information about new hire reporting and online reporting is available on our web site: www.mn-newhire.com

Send completed forms to:

PO Box 64212

Minnesota New Hire Reporting Center

To ensure the highest level of accuracy, please print neatly in

capital letters and avoid contact with the edges of the boxes.

The following will serve as an example:

St. Paul, MN 55164-0212 Fax: (651) 227-4991 or toll-free fax (800) 692-4473 A B C 1 2 3	
EMPLOYER INFORMATION Federal Employer ID Number (FEIN) (Please use the same FEIN as the listed employee's quarterly wages will be reported to the same of the sam	nder):
Employer Name:	
Employer Address (Please indicate the address where the Income Withholding Orders should be sent).	
Employer City: Employer State: Zip Code (5 digi	:):
Employer Phone: Extension: Employer Fax:	
Email:	
EMPLOYEE INFORMATION Employee Social Security Number (SSN): Check this box if this is an Independent Contractor (1099)	
Employee Social Security Number (SSN): Check this box if this is an	Initial:
Employee Social Security Number (SSN): Check this box if this is an Independent Contractor (1099)	Initial:
Employee Social Security Number (SSN): Check this box if this is an Independent Contractor (1099)	Initial:
Employee Social Security Number (SSN): Check this box if this is an Independent Contractor (1099) Employee First Name: Middle	Initial:
Employee Social Security Number (SSN): Check this box if this is an Independent Contractor (1099) Employee First Name: Middle	Initial:
Employee Social Security Number (SSN): Check this box if this is an Independent Contractor (1099) Employee First Name: Employee Last Name:	Initial:
Employee Social Security Number (SSN): Check this box if this is an Independent Contractor (1099) Employee First Name: Employee Last Name:	
Employee Social Security Number (SSN): Check this box if this is an Independent Contractor (1099) Employee First Name: Employee Last Name: Employee Address:	it):

REPORTS WILL NOT BE PROCESSED IF REQUIRED INFORMATION IS MISSING