

# Success on the Job: Writing at Work

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# To the Teacher

The writing challenges of today's work environment are many and can seem overwhelming to those new to the workplace. An employee needs to be able to communicate thoughts, information, and messages in writing. He or she must be able to record information completely and correctly, and write documents such as letters and reports.

*Success on the Job: Writing at Work* is designed to help students increase their proficiency in the basic writing skills necessary for entry-level positions. Wherever possible, we have tried to incorporate cooperative learning activities to reflect the emphasis placed on teamwork in the workplace. The book consists of activities and forms the student may encounter on the job site. The forms used are a representative sampling; some are actual forms and some have been modified to fit the scope of the book. More and more forms are computer-generated rather than handwritten, but the skills necessary to fill out these forms are the same.

The activities are not meant to be sequential, although the ones at the beginning of *Writing at Work* tend to be simpler than those at the end. Activities with more complex forms require the student to review a filled-out form before completing one. Each exercise includes teacher notes and reproducible student pages. The teacher notes include brief objectives, vocabulary terms, possible discussion topics, an extension activity, and suggested answers. Since many of the activities focus on the visual learning style, we have tried to accommodate the other learning styles in the extension activities wherever possible.

We have provided two appendices, a Good Writing Checklist and a Proofreading Symbols Chart, and suggest you copy these for student use before beginning the writing activities. Students are often asked to proofread each other's work in this book, and both appendices will be helpful.

We have addressed the standards for written communications as outlined in the National Standards for Business Education for performance expectations in the first three levels. The Secretary's Commission on Achieving Necessary Skills (SCANS) Report was used as a guideline for determining the skills students need to succeed in today's workplace.

We hope that you find *Writing at Work* beneficial and that it gives your students practical skills to enhance their employability.

Name \_\_\_\_\_ Date \_\_\_\_\_

UNIT 1. FORMS FOR YOUR EMPLOYER

## Emergency Contact Form

This is a form that an employee would fill out upon beginning employment. It is used only by the Human Resources Department in case of emergency.

*Imagine that you have just started a new job. This is one of the forms the Human Resources representative has given you to complete. Fill it out, making up names and phone numbers rather than using your own. Then answer the questions that follow.*

**Emergency Contact Form**

Please complete for emergency contact purposes. Emergency contact information will be used only by Human Resources in the event of an emergency. The information you provide will be kept confidential.

PLEASE KEEP THIS INFORMATION UP TO DATE SO WE MAY BEST SERVE YOU.

Your Name: \_\_\_\_\_

Your Home Phone Number: \_\_\_\_\_

Please notify the following person/people in case of an emergency.

Name: \_\_\_\_\_ Relation: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Relation: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Relation: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Preferred Hospital: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_



Name \_\_\_\_\_ Date \_\_\_\_\_

## Emergency Contact Form

### ***Looking Deeper***

Answer the following questions based on what you have learned about the Emergency Contact Form.

1. Why is it important to keep the information on this form up to date?

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2. Why do you think you must list three people for the company to notify?

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3. Why write the phone numbers of the contact people and not their addresses?

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4. Why is it important to list someone who is close to you?

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5. Why does the company need to know the name of your primary care physician and preferred hospital?

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6. Why do you think this information is considered confidential?

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Name \_\_\_\_\_ Date \_\_\_\_\_

UNIT 1. FORMS FOR YOUR EMPLOYER

## Direct Deposit Authorization

This form authorizes your employer to deposit all or part of your paycheck in the bank or credit union that you designate. You usually fill it out when you start working for the company, but it also can be used at any point during your employment.

*Imagine that you have just started a new job and this is one of the forms the Human Resources person has given you to complete. Fill it out, using your own name and today's date. Your ID number is 462 and your Social Security number is 031-56-8732. You bank at Bayside Bank's Intown Branch at 850 Main Street, and your account number is 498213.*

<b>Direct Deposit Authorization</b>	
Name:	_____
Employee ID No.:	_____
Social Security No.:	_____
Bank Name and Branch:	_____
Address:	_____
Account No.:	_____
Please check appropriate box:	
<input type="checkbox"/> Direct deposit	
The undersigned hereby requests and authorizes the entire amount of my paycheck each pay period to be deposited directly into the bank account named above.	
<input type="checkbox"/> Direct payroll deduction deposit	
The undersigned hereby requests and authorizes the sum of _____ dollars (\$_____ ) to be deducted from my paycheck each pay period and to be deposited directly into the bank account named above.	
<input type="checkbox"/> I would like to cancel my deposit authorization.	
The undersigned hereby cancels the authorization for direct deposit or payroll deduction deposit previously submitted.	
Employee Signature _____	Date _____
Please attach a copy of deposit slip.	



Name \_\_\_\_\_ Date \_\_\_\_\_

UNIT 1. FORMS FOR YOUR EMPLOYER

## Direct Deposit Authorization

### *Looking Deeper*

Answer the following questions based on what you have learned about the Direct Deposit Authorization form.

1. What is the purpose of the Direct Deposit Authorization form?

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2. Give three instances in which this form would be used.

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3. Why is it important for the employee to sign this form?

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4. Why do you need to write your bank's name and account number?

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5. What is the difference between direct deposit and direct payroll deduction deposit?

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6. What would you do if you wanted to stop having your check deposited each week?

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Name \_\_\_\_\_ Date \_\_\_\_\_

UNIT 1. FORMS FOR YOUR EMPLOYER

## Application for Insurance

If you are employed by a company that offers insurance to its employees, you will be required to fill out an Application for Insurance Enrollment. Some applications for insurance are quite long and involved. The following form is an adaptation of an insurance application. Read it carefully.

### Application for Insurance Enrollment

Please print.

**1. EMPLOYER: Complete all that applies.**

Company and Department Name Custom Drywall, Inc.  
 Mailing Address 42 Jefferson Road, Binghamton, NY 13902  
 Payroll Number 52 Group Number 33934  
 Date Hired 8/2/98 Date Eligible 9/2/98 # of Hours Worked/Week 40

**2. APPLICANT AND MEMBER INFORMATION: Each member must select a Primary Care Physician.**

You may apply to cover your spouse and unmarried children and stepchildren under 19 years of age. You may also apply to cover your children and stepchildren ages 19–25 if they are unmarried and more than 50% dependent on you (unless your group has special rules that apply).

\*Other Insurance—Please indicate Yes (Y) or No (N) under the OI column if the member will be covered by more than one health care plan.

Name of Person(s) to be Covered			Sex M F	Birth- date	Social Secur- ity #	*OI Y N	Primary Care Physician (Each member must choose a primary care physician.)	Office Use Only				
								SC	AE	MT	WV	RN
Applicant	M.I. ·X	Last Name Schmidt	M	7/7/72	N	005-12- 3545	Andrew Hyde	N			Y	00
Spouse	M.I. ·H	Last Name Prine	F	11/4/73	N	006-82- 3385	Louise Baker	N			Y	00
Dependent	M.I. ·	Last Name						N			Y	00
Dependent	M.I. ·	Last Name						N			Y	00

**3. APPLICANT NAME, MAILING ADDRESS AND TELEPHONE NUMBER**

Boris X. Schmidt 607-517-7961  
 607-517-1713  
 19 Bolton Street, Apt. C  
 Binghamton, NY 13904

**4. AUTHORIZATION AND SIGNATURE**

I request insurance under the group coverages issued to my employer and authorize deductions from my earnings of any required contributions for any such insurance for which I am, or may later become, eligible. I certify that statements and answers I am submitting on this application are entirely true and complete and no information has been withheld or omitted.

**To All Physicians, Hospitals, Other Providers of Medical Care, Third Party Payors and the Medical Information Bureau:**  
 By signing below, I give consent for you to furnish the Companies or their agents all requested information and reports for review and keeping, medical history records, including dates of treatment, nature of accident or illness, and records of surgery for anyone listed on this application.

Applicant Signature X Boris X. Schmidt Date 8/3/98

**5. ELECTION NOT TO ENROLL**

I do not wish to enroll in a plan at this time.

Applicant Signature X \_\_\_\_\_ Date \_\_\_\_\_



Name \_\_\_\_\_ Date \_\_\_\_\_

UNIT 1. FORMS FOR YOUR EMPLOYER

## Application for Insurance

### **Looking Deeper**

Answer the following questions based on the insurance application filled out for Custom Drywall, Inc.

1. Who fills out Section 1 of the the application form?

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2. Which sections of the form are you, the employee, responsible for?

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3. Is it important for you to check the sections filled out by your employer? Why or why not?

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4. In your own words, what does Section 4 say?

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5. If you decide not to be covered by the company's insurance plan, what should you do?

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Name \_\_\_\_\_ Date \_\_\_\_\_

UNIT 1. FORMS FOR YOUR EMPLOYER

# Application for Insurance

*Imagine yourself in the year 2010. Where are you working? Are you married? Do you have children? Using this picture of yourself, fill out the following insurance application.*

## Application for Insurance Enrollment

**Please print.**

**1. EMPLOYER: Complete all that applies.**

Company and Department Name \_\_\_\_\_

Mailing Address \_\_\_\_\_

Payroll Number \_\_\_\_\_ Group Number \_\_\_\_\_

Date Hired \_\_\_\_\_ Date Eligible \_\_\_\_\_ # of Hours Worked/Week \_\_\_\_\_

**2. APPLICANT AND MEMBER INFORMATION: Each member must select a Primary Care Physician.**

You may apply to cover your spouse and unmarried children and stepchildren under 19 years of age. You may also apply to cover your children and stepchildren ages 19–25 if they are unmarried and more than 50% dependent on you (unless your group has special rules that apply).

\*Other Insurance—Please indicate Yes (Y) or No (N) under the OI column if the member will be covered by more than one health care plan.

Name of Person(s) to be Covered			Sex M F	Birth- date	Social Secur- ity #	*OI Y N	Primary Care Physician (Each member must choose a primary care physician.)	Office Use Only									
	M.I. .	Last Name						S	C	A	E	M	T	W	V	R	N
Applicant	.	Last Name						N						Y			00
Spouse	.	Last Name						N						Y			00
Dependent	.	Last Name						N						Y			00
Dependent	.	Last Name						N						Y			00

**3. APPLICANT NAME, MAILING ADDRESS AND TELEPHONE NUMBER**

First Name	M.I.	Last Name	Telephone Number
Street			Home
City/State/Zip Code			Office

**4. AUTHORIZATION AND SIGNATURE**

I request insurance under the group coverages issued to my employer and authorize deductions from my earnings of any required contributions for any such insurance for which I am, or may later become, eligible. I certify that statements and answers I am submitting on this application are entirely true and complete and no information has been withheld or omitted.

**To All Physicians, Hospitals, Other Providers of Medical Care, Third Party Payors and the Medical Information Bureau:**

By signing below, I give consent for you to furnish the Companies or their agents all requested information and reports for review and keeping, medical history records, including dates of treatment, nature of accident or illness, and records of surgery for anyone listed on this application.

Applicant Signature X \_\_\_\_\_ Date \_\_\_\_\_

**5. ELECTION NOT TO ENROLL**

I do not wish to enroll in a plan at this time.

Applicant Signature X \_\_\_\_\_ Date \_\_\_\_\_

