Personal Data Form

Augusta University (AU)
Human Resources Division

- ❑ **New Hire**
- ❑ **Rehire**
- ❑ **Personal Data Change**

Primary Name (as it appears on SS Card) Prefix: Doctor Miss Mr. Mrs. Ms.

First _____ Middle _____ Last _____ Suffix _____

Preferred Name (will only update outlook)

First _____ Middle _____ Last _____ Suffix _____

Home Address:

Address _____

City _____ State _____

County _____ Zip Code _____

Mailing Address: (If different from Home Address)

Address _____

City _____ State _____

County _____ Zip Code _____

Telephone Information: (Please check your preferred number)

Home (__ __ __) __ __ __ – __ __ __ __ □ Mobile (__ __ __) __ __ __ – __ __ __ __ □

Pager (__ __ __) __ __ __ – __ __ __ __ □ Other (__ __ __) __ __ __ – __ __ __ __ □

Gender:

- ❑ Male
- ❑ Female
- ❑ I do not wish to provide this information

Marital Status:

- ❑ Single
- ❑ Married*
- ❑ Divorced*
- ❑ Widowed*

*Marital Status Date: ____/____/____

Race:

- ❑ American Indian or Alaskan Native
- ❑ Asian
- ❑ Black or African American
- ❑ Native Hawaiian or Other Pacific Islander
- ❑ White
- ❑ I do not wish to provide this information

Ethnic Group:

- ❑ Hispanic/Latino
- ❑ Not Hispanic Latino
- ❑ I do not wish to provide this information

Date of Birth:
__ __ / __ __ / __ __ __ __

Birth Country: _____

AU/USG Status/History:

I have previously been employed by AU/USG:

- ❑ Yes, employment ended ___/___/___
- ❑ No

I am currently employed by AU or any other USG Institution:

- ❑ Yes, department/institution: _____
- ❑ No

AU Status/History:

I am currently enrolled as a Full-Time AU Student:

- ❑ Yes
- ❑ No

I am related to a current AU Employee:

- ❑ Yes
- ❑ No

Personal Email Address:

_____

Retirement Information:

I am an **active member** or **retiree** of another Georgia State retirement plan:

- ❑ Yes, retirement plan: _____
- ❑ No

Emergency Contact Data:

Primary- Please select only one as Primary

(1) _____ Name _____ Relationship ☐ (__ __ __) __ __ __ – __ __ __ __ Phone Number

(2) _____ Name _____ Relationship ☐ (__ __ __) __ __ __ – __ __ __ __

I understand that any changes to Personal Data indicated on this form, should be reported to Human Resources within **14 days** of the change.

Signature: _____ Date: _____ revised 1/2020

Office of Diversity and Inclusion

Anti-Sexual Harassment Policy

Augusta University (AU) is an equal opportunity/equal access institution. We continuously strive to provide our employees with a professional working environment free of sexual harassment and all forms of sexual intimidation and exploitation. As one of our preventive measures against sexual harassment, you as an AU employee are required to read AU's anti-sexual harassment policy and to not partake in any activity that is or may lead to sexual harassment.

In signing your name below, you are stating that you have received AU's Anti- Sexual Harassment policy and that you will abide by this policy.

Signature	**Date**
Print your name	**Employee ID number**

CONFIDENTIALITY STATEMENT

Augusta University and its affiliated health system (AU Medical Center, Children's Hospital of Georgia, and AU Medical Associates) maintain strict confidentiality and security of paper and electronic records in compliance with the Family Educational Rights and Privacy Act of 1974 (FERPA), the Health Insurance Portability and Accountability Act (HIPAA), and the Georgia Personal Identity Protection Act (GPIPA), in addition to other federal and state laws. These laws pertain to the confidentiality and security of all records that contain directly identifiable information that could reveal private information concerning our students, our customers and patients, our research participants and our employees and volunteers.

Our employees, students, volunteers and authorized others may access such private information to the extent necessary to perform their duties within our university and our health system. As an individual with access to private information at any of our institutions, you are required to protect against unauthorized access and disclosure, to ensure the privacy and security of records, and to report any credible threats or known violations related to this private information. You must be very careful not to release this information to any individuals, including but not limited to unauthorized university or health system employees, who do not have a **work or business related need to know**. If in doubt, you should act to preserve the confidentiality of such private information, until you have verified the work or business related need for access through your supervisor or his/her designee, one of our legal offices, or the Enterprise Privacy Officer.

Augusta University defines **unauthorized** access or disclosure as:

- Access to student, patient, research participant, employee or volunteer information not necessary to carry out your job responsibilities. This includes access to the private records of your family, friends and acquaintances that is not for a legitimate or business use.
- Disclosure of student, patient, research participant, employee or volunteer records to unauthorized internal or external recipients.
- Disclosure of additional or excessive student, patient, research participant, employee, or volunteer information to an authorized individual/agency than is essential to the stated purpose of an approved request.

Information may not be used, disclosed, copied, sold, loaned, reviewed, altered or destroyed except as properly authorized by the appropriate university or health system official within the scope of applicable federal or state laws, including record retention schedules and corresponding policies. No university or health system workforce member or other individuals are permitted to realize any personal gain as a result of disclosing or using confidential information. This obligation of nondisclosure or unauthorized use continues indefinitely, even after your relationship with the university and health system ends.

You must abide by our rules, regulations, policies and procedures as well as federal and state laws applicable to your position at the university or health system. Your failure to comply with any applicable law or procedure may result in the revocation of your access to confidential information; disciplinary action, including termination of employment or student status; criminal and/or civil penalties, depending upon the nature and severity of the breach of confidentiality.

- I will not access my own or family's record in any information system without prior authorization.
- I will not disclose user access and passwords to anyone.
- I acknowledge my accountability for all activity performed under my log-in.

Print Name:	☐ AU ☐ AUMC ☐ AUMA ☐ Contractor ☐ Other
Signature:	☐ Employee ☐ Student ☐ Volunteer ☐ Other
Date:	Define Other:

MEMORANDUM

TO: All Employees of Augusta University

The Employee Manual is intended to provide employees with a general understanding of the Human Resources policies at Augusta University.

Please become familiar with the manual location for your review when needed. As you read through the manual, any questions you may have should be directed to your immediate supervisor, or to the Human Resources Division.

Your signature on the bottom of this page acknowledges that you understand the manual is located in the following location http://www.augusta.edu/hr/employee_manuals.php. This receipt will be placed in your official personnel file.

_____

Employee Print Name

_____

Employee Signature

_____

Date

* The Georgia Department of Corrections' and Department of Juvenile Justice policies and procedures supersede the Augusta University's in matters of safety and security of Georgia Correctional Healthcare and Department of Juvenile Justice employees. Copies of relevant GDC/DJJ policies and procedures are available to you at the site.

Ethics Policy Acknowledgment Form

I will uphold Augusta University Code of Ethics, as listed below, and as described in the Ethics Policy (http://policy.augusta.edu/12-1-1-ethics-policy/), and all related laws, regulations and policies. I understand that failure to do so may result in disciplinary action, including possible termination.

Augusta University Code of Ethics

1. We will carry out our official duties for the benefit of our institution, and the public.
2. We will avoid actual and apparent conflicts of interest between our official obligations and our personal interests.
3. We will disclose conflicts of interest, both actual and apparent, and they must be properly managed.
4. We will not accept improper gifts and favors.
5. We will adhere to the laws, rules, regulations and policies that apply to us.
6. We will maintain the confidentiality of all sensitive information.
7. We will treat everyone with respect and dignity.
8. We will be honest. For instance, we should not record conversations with others without their knowledge.
9. We will uphold this code of ethics.

Questions concerning these matters should be brought to your chain of command. Anonymous concerns may be shared through our hotline at 1-800-576-6623. You may also contact the Office of Legal Affairs (706.721.4018 or http://www.augusta.edu/services/legal/) and the Office of Compliance and Enterprise Risk Management (706.721.0900 or http://www.augusta.edu/admin/oia/services.php).

_____
Printed Name

_____ _____
Signature Date (mm/dd/yyyy)

_____ _____
Title Employee PeopleSoft ID

_____
College or Department Location

AUGUSTA UNIVERSITY

Information Systems Security and Computer Usage Policy
Receipt Acknowledgment Form

Purpose:
The Information Systems Security and Computer Usage Policy is to ensure that information systems resources are used in an appropriate and responsible manner consistent with the mission of the institution, and that the use of these resources is in accordance with AU policy, procedures, federal and state law.

Scope:
This policy applies to all information systems resources with includes all data and hardware regardless of media, the facilities containing them, and the supporting software and hardware including host computer systems, workstations, systems software, application software, datasets and communications networks either direct or remote that are controlled, administered or accessed by AU Students, faculty, employees, visitors or any other person accessing form on-campus as well as off-campus.

Statement of Policy:
The appropriate use and protection of all information systems and associated resources is expected from all users including faculty, students, employees, and visitors throughout the institution. "Appropriate use" of information system resources is defined as use which is for the purpose of furthering the mission of AU.

All users of information systems resources are expected to comply with existing AU Policies and Procedures and those of the University System. In addition, users are expected to honor copyrights and software licenses and comply with all federal and state laws including those prohibiting slander, libel, harassment and obscenity. Users must obey laws prohibiting the private use of state property. Information that is confidential by law, including educational and medical records must be protected.

Users must be aware that information stored or transmitted electronically (or via computer), including e-mail, may be subject to disclosure under open records laws. Users should have no expectation of privacy for information stored or transmitted using AU information resources except for records or other information that is confidential by law (i.e. medical and educational records).

Information systems resources are to be used as expressly authorized by AU administration and management.

The information systems user is responsible for the general protection of resources.

This policy includes additional specific information regarding the following topics:

- General Responsibilities
- Access Controls
- Risk Assessment
- Awareness
- Harassment
- Training
- Auditing
- Breach of Security
- Compliance

Your signature at the bottom of this page acknowledges your receipt and understanding of this policy. This receipt will be placed in your personnel file.

Printed Name	Title	Department
Signature	Empl ID	Date

Right to Know Instructions

1. Go to http://www.usg.edu/facilities/rtk-ghs

2. Click Next and continue through the entire training including the Knowledge Test

3. Click on “Complete the training program”

    Answer/Enter the following information:

    a. Are you faculty, staff or a student at a University System of Georgia Institution? YES

    b. Enter Your Name:

    c. Select your institution Affiliation: Augusta University

    d. Location: Augusta

    e. Enter your Department/Division:

    f. Enter your Building Name of your primary work (or classroom) location: (If known)

    g. Enter your Immediate Supervisors name

    h. Select your status at the institution:

4. Click Submit

5. Print Certificate – Please go to File – Print to ensure it prints correctly.

6. Give copy to Human Resources

AUGUSTA UNIVERSITY

Veterans Self-Identification

Please check one of the answers below:

☐ Yes, I identify as one of more of the classifications of a protected veteran as listed below.

☐ No, I am not a protected veteran.

☐ I don't wish to answer.

This employer is a Government contractor subject to the Vietnam Era Veterans' Readjustment Assistance Act of 1974, as amended by the Jobs for Veterans Act of 2002, 38 U.S.C. § 4212 (VEVRAA), which requires Government contractors to take affirmative action to employ and advance in employment: (1) disabled veterans; (2) recently separated veterans; (3) active duty wartime or campaign badge veterans; and (4) Armed Forces service medal veterans. These classifications are defined below.

If you believe you belong to any of the categories of protected veterans listed above, please indicate by checking the appropriate boxes below. As a Government contractor subject to VEVRAA, we request this information in order to measure the effectiveness of the outreach and positive recruitment efforts we undertake pursuant to VEVRAA.

☐ A "***disabled veteran***" is one of the following: a veteran of the U.S. military, ground, naval or air service who is entitled to compensation (or who but for the receipt of military retired pay would be entitled to compensation) under laws administered by the Secretary of Veterans Affairs; or a person who was discharged or released from active duty because of a service-connected disability.

- ☐ Accommodation Requested
- ☐ Accommodation Declined

☐ A ***"recently separated veteran***" means any veteran during the three-year period beginning on the date of such veteran's discharge or release from active duty in the U.S. military, ground, naval, or air service.

☐ An "***active duty wartime or campaign badge veteran***" means a veteran who served on active duty in the U.S. military, ground, naval or air service during a war, or in a campaign or expedition for which a campaign badge has been authorized under the laws administered by the Department of Defense.

☐ An "***Armed forces service medal veteran***" means a veteran who, while serving on active duty in the U.S. military, ground, naval or air service, participated in a United States military operation for which an Armed Forces service medal was awarded pursuant to Executive Order 12985.

Protected veterans may have additional rights under USERRA—the Uniformed Services Employment and Reemployment Rights Act. In particular, if you were absent from employment in order to perform service in the uniformed service, you may be entitled to be reemployed by your employer in the position you would have obtained with reasonable certainty if not for the absence due to service.

Employee Name: _____ Employee ID: _____

Employee Signature: _____ Date: _____

Voluntary Self-Identification of Disability

Form CC-305
OMB Control Number 1250-0005
Expires 1/31/2020

Why are you being asked to complete this form?

Because we do business with the government, we must reach out to, hire, and provide equal opportunity to qualified people with disabilities.[i] To help us measure how well we are doing, we are asking you to tell us if you have a disability or if you ever had a disability. Completing this form is voluntary, but we hope that you will choose to fill it out. If you are applying for a job, any answer you give will be kept private and will not be used against you in any way.

If you already work for us, your answer will not be used against you in any way. Because a person may become disabled at any time, we are required to ask all of our employees to update their information every five years. You may voluntarily self-identify as having a disability on this form without fear of any punishment because you did not identify as having a disability earlier.

How do I know if I have a disability?

You are considered to have a disability if you have a physical or mental impairment or medical condition that substantially limits a major life activity, or if you have a history or record of such an impairment or medical condition.

Disabilities include, but are not limited to:

- Blindness
- Deafness
- Cancer
- Diabetes
- Epilepsy
- Autism
- Cerebral palsy
- HIV/AIDS
- Schizophrenia
- Muscular dystrophy
- Bipolar disorder
- Major depression
- Multiple sclerosis (MS)
- Missing limbs or partially missing limbs
- Post-traumatic stress disorder (PTSD)
- Obsessive compulsive disorder
- Impairments requiring the use of a wheelchair
- Intellectual disability (previously called mental retardation)

Please check one of the boxes below:

☐ YES, I HAVE A DISABILITY (or previously had a disability)
☐ NO, I DON'T HAVE A DISABILITY
☐ I DON'T WISH TO ANSWER

_____ _____
Your Name Today's Date

Reasonable Accommodation Notice

Federal law requires employers to provide reasonable accommodation to qualified individuals with disabilities. Please tell us if you require a reasonable accommodation to apply for a job or to perform your job. Examples of reasonable accommodation include making a change to the application process or work procedures, providing documents in an alternate format, using a sign language interpreter, or using specialized equipment.

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[i] Section 503 of the Rehabilitation Act of 1973, as amended. For more information about this form or the equal employment obligations of Federal contractors, visit the U.S. Department of Labor's Office of Federal Contract Compliance Programs (OFCCP) website at www.dol.gov/ofccp.

PUBLIC BURDEN STATEMENT: According to the Paperwork Reduction Act of 1995 no persons are required to respond to a collection of information unless such collection displays a valid OMB control number. This survey should take about 5 minutes to complete.

Board of Regents
University System of Georgia

Augusta University
SECURITY QUESTIONNAIRE

NOTICE TO EMPLOYEES: The Sedition and Subversive Activities Act of 1953 (Ga. Laws, 1953), as amended, requires each employee to complete and sign, prior to his/her employment by the State of Georgia, a questionnaire which is designed to establish that there are no reasonable grounds to believe that he/she is a subversive person. A subversive person is defined as one who commits acts, advocates, or teaches the overthrow of the government of the United States or government of the State of Georgia by force or violence or who is a knowing member of a subversive organization.

INSTRUCTIONS: Prepare in original only. Fill in all items. If more space is needed for any item, or explanation, continue under Item 5. Please type or print in ink.

1. Name_____ Social Security No._____

Other Names Used: (Maiden name, names by former marriages, former names changed legally or otherwise: Aliases, nicknames, etc. Specify which, and show dates used.)

_____

_____

2. Address_____
Street and No. City State County Phone No.

3. Are you now or have you been within the last ten (10) years a member of any organization which to your knowledge at the time of membership advocates or has as one of its objectives, the overthrow of the government of the United States or the government of the State of Georgia by force or violence? ☐ Yes ☐ No If "Yes," state the name of the organization and your past and present membership status including any offices held therein. _____

_____

NOTE: If the answer to Question 3 is "yes" and the employing authority deems further inquiry is necessary, you will be notified of such determination. No action adverse to your application will be taken because of an affirmative answer until after such an inquiry, with notice to you and an opportunity for you to present evidence, and only if the results of such inquiry bring your application within the prohibition within the Sedition and Subversive Activities Act of 1953, as amended.

4. (A) Have you ever been convicted or are any charges now pending against you by Federal, State, or other law-enforcement authorities, for any violation of any federal law, state law, county or municipal law, regulation, or ordinance? (Do not include anything that happened before your sixteenth birthday. Do not include minor traffic violations for which a fine of $35.00 or less was imposed. All other convictions must be included even if they were pardoned.)
☐ Yes ☐ No

(B) If the answer to 4 (A) is "yes," state the reason convicted, the date convicted, and the place where convicted.

REASON CONVICTED	DATE	PLACE WHERE CONVICTED

5. SPACE FOR CONTINUING ANSWERS OR EXPLANATIONS: (Show item numbers to which answers or explanations apply. Attach a separate sheet if more space is needed.)

_____

_____

_____

_____

_____

_____

NOTE: Before signing this form, check all answers and explanations to see that you have answered all questions fully and correctly. This form is to be executed under oath subject to the penalties of false swearing as prescribed in Code Section 16-11-14 of the Criminal Code of Georgia.

AFFIDAVIT OF VERIFICATION

State of _____ County _____

Personally appeared before the undersigned attesting officer, duly authorized to administer oaths, (Print your Name)_____ who, after being sworn, deposes and says and declares under penalties of false swearing that he or she is the person who executed the foregoing instrument; that he or she has read and completed the same and knows and understands the contents thereof; that the matters stated therein and the answers and information furnished by him or her in the foregoing questionnaire, including any attachments thereto, are true and correct.

SWORN TO AND SUBSCRIBED BEFORE ME _____
(Signature of Employee)

This_____ day of_____, _____
Month Year

_____
Notary Public

County of_____ My commission expires_____ day of_____, _____
month year

(Affix seal)

INFORMATION TO BE FURNISHED BY EMPLOYING UNIT

INSTRUCTIONS TO UNIT: If this questionnaire is executed by applicant, insert "APPL" in the space for date of appointment, and show date of application. If this questionnaire is executed by an individual who has been offered employment or who is already employed, provide the information requested.

DATE OF APPOINTMENT	TITLE OF POSITION	UNIT AND DEPARTMENT	DUTY STATION
			University System Office

Board of Regents
University System of Georgia
LOYALTY OATH

STATE OF_____ COUNTY OF _____

I, (Print your Name)_____, a citizen of_____
State / Country

and being an employee of the University System of Georgia and the recipient of public funds for services rendered as such employee, do hereby solemnly swear and affirm that I will support the Constitution of the United States and the Constitution of the State of Georgia.

This_____ day of_____, _____ _____
Month Year Signature of Employee

Sworn to and subscribed before me this day and year above set out.

_____
Notary Public

(Affix Seal)

PLEASE NOTE THAT EACH OF THE ABOVE DOCUMENTS, THE SECURITY QUESTIONNAIRE AND THE LOYALTY OATH, MUST BE SIGNED AND NOTARIZED.

AUGUSTA UNIVERSITY

Intellectual Property Agreement

In consideration of my employment by the Board of Regents of the University System of Georgia at Augusta University, I agree to comply with the Augusta University Intellectual Property Policy ("Policy") and any future amendments to it. The current Policy can be found at the following address: https://www.augusta.edu/research/tools-for-researchers/.

When required by the Policy to do so, I agree to promptly disclose in writing to Augusta University ("AU") all Intellectual Property (as that term is defined by the Policy) that I conceive, reduce to practice, invent, author, create, or develop, either alone or jointly with others, during the term of my employment, and to make and maintain adequate and current records thereof.

I agree to assign, and do hereby assign, to AU all of my right, title, and interest in and to all such Intellectual Property conceived, reduced to practice, invented, authored, created, and/or developed in performance of any one or more Sponsor- Supported Efforts and/or AU-Assigned Efforts (as those terms are used in the Policy).

I agree to assist AU in any way it deems necessary to obtain, enforce, defend, and commercialize such Intellectual Property. Assistance may include, but is not limited to, preparation of documents and delivery of written records and materials. During and after the term of my employment, I agree to sign any assignment, affidavit, or other document that AU may require with respect to perfecting, obtaining, maintaining, and defending AU's legal rights in Intellectual Property.

Upon termination of my employment for any reason, I agree to promptly turn over to AU all tangible property in my possession or under my control relating to Intellectual Property. Such tangible property may include but is not limited to biological and chemical materials, models, prototypes, drawings, records, documents, and the like. I acknowledge that I do not personally own any such items.

Discharge of my responsibilities in this Agreement shall be an obligation of my executors, administrators, or other legal representatives or assigns.

I have read the Policy and have carefully considered its terms and this Agreement before signing below. If I have any questions relating to this Agreement or my obligations under it, I understand that it is my responsibility to obtain answers or assistance before signing.

By signing below, I certify that I have read the above information and Intellectual Property (IP) Policy and agree to abide by the IP Policy as a condition of employment.

Signature: _____

Printed Name: _____

Date: _____

Employment Eligibility Verification

Department of Homeland Security
U.S. Citizenship and Immigration Services

USCIS
Form I-9
OMB No. 1615-0047
Expires 10/31/2022

►START HERE: Read instructions carefully before completing this form. The instructions must be available, either in paper or electronically, during completion of this form. Employers are liable for errors in the completion of this form.

ANTI-DISCRIMINATION NOTICE: It is illegal to discriminate against work-authorized individuals. Employers **CANNOT** specify which document(s) an employee may present to establish employment authorization and identity. The refusal to hire or continue to employ an individual because the documentation presented has a future expiration date may also constitute illegal discrimination.

Section 1. Employee Information and Attestation *(Employees must complete and sign Section 1 of Form I-9 no later than the **first day of employment**, but not before accepting a job offer.)*

Last Name *(Family Name)*	First Name *(Given Name)*	Middle Initial	Other Last Names Used *(if any)*

Address *(Street Number and Name)*	Apt. Number	City or Town	State	ZIP Code

Date of Birth *(mm/dd/yyyy)*	U.S. Social Security Number	Employee's E-mail Address	Employee's Telephone Number
	☐☐☐ - ☐☐ - ☐☐☐☐		

I am aware that federal law provides for imprisonment and/or fines for false statements or use of false documents in connection with the completion of this form.

I attest, under penalty of perjury, that I am (check one of the following boxes):

☐ 1. A citizen of the United States

☐ 2. A noncitizen national of the United States *(See instructions)*

☐ 3. A lawful permanent resident (Alien Registration Number/USCIS Number): _____

☐ 4. An alien authorized to work until (expiration date, if applicable, mm/dd/yyyy): _____
Some aliens may write "N/A" in the expiration date field. *(See instructions)*

Aliens authorized to work must provide only one of the following document numbers to complete Form I-9:
An Alien Registration Number/USCIS Number OR Form I-94 Admission Number OR Foreign Passport Number.

1. Alien Registration Number/USCIS Number: _____
OR
2. Form I-94 Admission Number: _____
OR
3. Foreign Passport Number: _____
Country of Issuance: _____

QR Code - Section 1
Do Not Write In This Space

Signature of Employee	Today's Date *(mm/dd/yyyy)*

Preparer and/or Translator Certification (check one):

☐ I did not use a preparer or translator. ☐ A preparer(s) and/or translator(s) assisted the employee in completing Section 1.

(Fields below must be completed and signed when preparers and/or translators assist an employee in completing Section 1.)

I attest, under penalty of perjury, that I have assisted in the completion of Section 1 of this form and that to the best of my knowledge the information is true and correct.

Signature of Preparer or Translator	Today's Date *(mm/dd/yyyy)*

Last Name *(Family Name)*	First Name *(Given Name)*

Address *(Street Number and Name)*	City or Town	State	ZIP Code

STOP *Employer Completes Next Page* STOP

Employment Eligibility Verification

Department of Homeland Security
U.S. Citizenship and Immigration Services

USCIS
Form I-9
OMB No. 1615-0047
Expires 10/31/2022

Section 2. Employer or Authorized Representative Review and Verification

(Employers or their authorized representative must complete and sign Section 2 within 3 business days of the employee's first day of employment. You must physically examine one document from List A OR a combination of one document from List B and one document from List C as listed on the "Lists of Acceptable Documents.")

Employee Info from Section 1	Last Name *(Family Name)*	First Name *(Given Name)*	M.I.	Citizenship/Immigration Status

List A Identity and Employment Authorization	OR	List B Identity	AND	List C Employment Authorization
Document Title		Document Title		Document Title
Issuing Authority		Issuing Authority		Issuing Authority
Document Number		Document Number		Document Number
Expiration Date *(if any) (mm/dd/yyyy)*		Expiration Date *(if any) (mm/dd/yyyy)*		Expiration Date *(if any) (mm/dd/yyyy)*
Document Title				
Issuing Authority				
Document Number				
Expiration Date *(if any) (mm/dd/yyyy)*				
Document Title				
Issuing Authority				
Document Number				
Expiration Date *(if any) (mm/dd/yyyy)*				

Additional Information

QR Code - Sections 2 & 3
Do Not Write In This Space

Certification: I attest, under penalty of perjury, that (1) I have examined the document(s) presented by the above-named employee, (2) the above-listed document(s) appear to be genuine and to relate to the employee named, and (3) to the best of my knowledge the employee is authorized to work in the United States.

The employee's first day of employment *(mm/dd/yyyy)*: _____ ***(See instructions for exemptions)***

Signature of Employer or Authorized Representative	Today's Date *(mm/dd/yyyy)*	Title of Employer or Authorized Representative

Last Name of Employer or Authorized Representative	First Name of Employer or Authorized Representative	Employer's Business or Organization Name

Employer's Business or Organization Address *(Street Number and Name)*	City or Town	State	ZIP Code

Section 3. Reverification and Rehires *(To be completed and signed by employer or authorized representative.)*

A. New Name *(if applicable)*			**B.** Date of Rehire *(if applicable)*
Last Name *(Family Name)*	First Name *(Given Name)*	Middle Initial	Date *(mm/dd/yyyy)*

C. If the employee's previous grant of employment authorization has expired, provide the information for the document or receipt that establishes continuing employment authorization in the space provided below.

Document Title	Document Number	Expiration Date *(if any) (mm/dd/yyyy)*

I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented document(s), the document(s) I have examined appear to be genuine and to relate to the individual.

Signature of Employer or Authorized Representative	Today's Date *(mm/dd/yyyy)*	Name of Employer or Authorized Representative

LISTS OF ACCEPTABLE DOCUMENTS
All documents must be UNEXPIRED

Employees may present one selection from List A
or a combination of one selection from List B and one selection from List C.

LIST A Documents that Establish Both Identity and Employment Authorization	OR	LIST B Documents that Establish Identity	AND	LIST C Documents that Establish Employment Authorization
1. U.S. Passport or U.S. Passport Card		**1.** Driver's license or ID card issued by a State or outlying possession of the United States provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		**1.** A Social Security Account Number card, unless the card includes one of the following restrictions: (1) NOT VALID FOR EMPLOYMENT (2) VALID FOR WORK ONLY WITH INS AUTHORIZATION (3) VALID FOR WORK ONLY WITH DHS AUTHORIZATION
2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551)		**2.** ID card issued by federal, state or local government agencies or entities, provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		**2.** Certification of report of birth issued by the Department of State (Forms DS-1350, FS-545, FS-240)
3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa		**3.** School ID card with a photograph		**3.** Original or certified copy of birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal
4. Employment Authorization Document that contains a photograph (Form I-766)		**4.** Voter's registration card		**4.** Native American tribal document
5. For a nonimmigrant alien authorized to work for a specific employer because of his or her status: **a.** Foreign passport; and **b.** Form I-94 or Form I-94A that has the following: (1) The same name as the passport; and (2) An endorsement of the alien's nonimmigrant status as long as that period of endorsement has not yet expired and the proposed employment is not in conflict with any restrictions or limitations identified on the form.		**5.** U.S. Military card or draft record		**5.** U.S. Citizen ID Card (Form I-197)
		6. Military dependent's ID card		**6.** Identification Card for Use of Resident Citizen in the United States (Form I-179)
		7. U.S. Coast Guard Merchant Mariner Card		**7.** Employment authorization document issued by the Department of Homeland Security
		8. Native American tribal document		
		9. Driver's license issued by a Canadian government authority		
		For persons under age 18 who are unable to present a document listed above:		
		10. School record or report card		
		11. Clinic, doctor, or hospital record		
		12. Day-care or nursery school record		
6. Passport from the Federated States of Micronesia (FSM) or the Republic of the Marshall Islands (RMI) with Form I-94 or Form I-94A indicating nonimmigrant admission under the Compact of Free Association Between the United States and the FSM or RMI				

Examples of many of these documents appear in the Handbook for Employers (M-274).

Refer to the instructions for more information about acceptable receipts.

Form **W-4**

Department of the Treasury
Internal Revenue Service

Employee's Withholding Certificate

► **Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay.**
► **Give Form W-4 to your employer.**
► **Your withholding is subject to review by the IRS.**

OMB No. 1545-0074

2020

Step 1: Enter Personal Information

(a) First name and middle initial	Last name	**(b) Social security number**
Address		► **Does your name match the name on your social security card?** If not, to ensure you get credit for your earnings, contact SSA at 800-772-1213 or go to *www.ssa.gov*.
City or town, state, and ZIP code		

(c) ☐ **Single or Married filing separately**
☐ **Married filing jointly** (or Qualifying widow(er))
☐ **Head of household** (Check only if you're unmarried and pay more than half the costs of keeping up a home for yourself and a qualifying individual.)

Complete Steps 2–4 ONLY if they apply to you; otherwise, skip to Step 5. See page 2 for more information on each step, who can claim exemption from withholding, when to use the online estimator, and privacy.

Step 2: Multiple Jobs or Spouse Works

Complete this step if you (1) hold more than one job at a time, or (2) are married filing jointly and your spouse also works. The correct amount of withholding depends on income earned from all of these jobs.

Do **only one** of the following.

(a) Use the estimator at *www.irs.gov/W4App* for most accurate withholding for this step (and Steps 3–4); **or**

(b) Use the Multiple Jobs Worksheet on page 3 and enter the result in Step 4(c) below for roughly accurate withholding; **or**

(c) If there are only two jobs total, you may check this box. Do the same on Form W-4 for the other job. This option is accurate for jobs with similar pay; otherwise, more tax than necessary may be withheld . . . . . ► ☐

TIP: To be accurate, submit a 2020 Form W-4 for all other jobs. If you (or your spouse) have self-employment income, including as an independent contractor, use the estimator.

Complete Steps 3–4(b) on Form W-4 for only ONE of these jobs. Leave those steps blank for the other jobs. (Your withholding will be most accurate if you complete Steps 3–4(b) on the Form W-4 for the highest paying job.)

Step 3: Claim Dependents

If your income will be $200,000 or less ($400,000 or less if married filing jointly):

Multiply the number of qualifying children under age 17 by $2,000 ► $ _____

Multiply the number of other dependents by $500 . . . . ► $ _____

Add the amounts above and enter the total here . . . . . **3** $

Step 4 (optional): Other Adjustments

(a) Other income (not from jobs). If you want tax withheld for other income you expect this year that won't have withholding, enter the amount of other income here. This may include interest, dividends, and retirement income . . . . . **4(a)** $

(b) Deductions. If you expect to claim deductions other than the standard deduction and want to reduce your withholding, use the Deductions Worksheet on page 3 and enter the result here . . . . . **4(b)** $

(c) Extra withholding. Enter any additional tax you want withheld each **pay period** . **4(c)** $

Step 5: Sign Here

Under penalties of perjury, I declare that this certificate, to the best of my knowledge and belief, is true, correct, and complete.

Employee's signature (This form is not valid unless you sign it.) _____ **Date** _____

Employers Only

Employer's name and address	First date of employment	Employer identification number (EIN)

Form G-4 (Rev. 01/03/19)

1811004012

STATE OF GEORGIA EMPLOYEE'S WITHHOLDING ALLOWANCE CERTIFICATE

1a. YOUR FULL NAME	1b. YOUR SOCIAL SECURITY NUMBER
2a. HOME ADDRESS (Number, Street, or Rural Route)	2b. CITY, STATE AND ZIP CODE

PLEASE READ INSTRUCTIONS ON REVERSE SIDE BEFORE COMPLETING LINES 3 – 8

3. MARITAL STATUS
(If you do not wish to claim an allowance, enter "0" in the brackets beside your marital status.)

A. Single: Enter 0 or 1.....[ ]
B. Married Filing Joint, both spouses working:
Enter 0 or 1 .....[ ]
C. Married Filing Joint, one spouse working:
Enter 0 or 1 or 2 .....[ ]
D. Married Filing Separate:
Enter 0 or 1 .....[ ]
E. Head of Household:
Enter 0 or 1 .....[ ]

4. DEPENDENT ALLOWANCES [ ]

5. ADDITIONAL ALLOWANCES [ ]
(worksheet below must be completed)

6. ADDITIONAL WITHHOLDING $_____

WORKSHEET FOR CALCULATING ADDITIONAL ALLOWANCES
(Must be completed in order to enter an amount on step 5)

1. COMPLETE THIS LINE ONLY IF USING STANDARD DEDUCTION:
Yourself: ☐ Age 65 or over ☐ Blind
Spouse: ☐ Age 65 or over ☐ Blind Number of boxes checked _____ x 1300.....$_____
2. ADDITIONAL ALLOWANCES FOR DEDUCTIONS:
A. Federal Estimated Itemized Deductions (If Itemizing Deductions).....$_____
B. Georgia Standard Deduction (enter one): Single/Head of Household $4,600
Each Spouse $3,000 $_____
C. Subtract Line B from Line A (If zero or less, enter zero).....$_____
D. Allowable Deductions to Federal Adjusted Gross Income .....$_____
E. Add the Amounts on Lines 1, 2C, and 2D .....$_____
F. Estimate of Taxable Income not Subject to Withholding .....$_____
G. Subtract Line F from Line E (if zero or less, stop here).....$_____
H. Divide the Amount on Line G by $3,000. Enter total here and on Line 5 above..... _____
(This is the maximum number of additional allowances you can claim. If the remainder is over $1,500 round up)

7. LETTER USED (Marital Status A, B, C, D, or E) _____ **TOTAL ALLOWANCES** (Total of Lines 3 - 5) _____
(Employer: The letter indicates the tax tables in Employer's Tax Guide)

8. EXEMPT: (Do not complete Lines 3 - 7 if claiming exempt) **Read the Line 8 instructions on page 2 before completing this section.**
a) I claim exemption from withholding because I incurred no Georgia income tax liability last year **and** I do not expect to have a Georgia income tax liability this year. **Check here** ☐
b) I certify that I am not subject to Georgia withholding because I meet the conditions set forth under the Servicemembers Civil Relief Act as amended by the Military Spouses Residency Relief Act as provided on page 2. My state of residence is _____. My spouse's (servicemember) state of residence is _____. The states of residence must be the same to be exempt. **Check here** ☐

I certify under penalty of perjury that I am entitled to the number of withholding allowances or the exemption from withholding status claimed on this Form G-4. Also, I authorize my employer to deduct per pay period the additional amount listed above.

Employee's Signature_____ Date _____

Employer: Complete Line 9 and mail entire form only if the employee claims over 14 allowances or exempt from withholding.
If necessary, mail form to: Georgia Department of Revenue, Withholding Tax Unit, 1800 Century Blvd NE, Suite 8200, Atlanta, GA 30345

9. EMPLOYER'S NAME AND ADDRESS:

EMPLOYER'S FEIN:_____

EMPLOYER'S WH#:_____

Do not accept forms claiming additional allowances unless the worksheet has been completed. Do not accept forms claiming exempt if numbers are written on Lines 3 - 7.

Benefits Enrollment Checklist for Benefits-Eligible (Resident)

You must complete online enrollment in your benefits and submit required supporting documentation **within 30 calendar days** from your hire/eligibility date or status change effective date.

Prepare for online benefits enrollment

This checklist is designed to help you prepare in advance for the online enrollment process. Review your options with your family to ensure that your elections meet the needs of you and your dependents' needs for the remainder of the calendar year.

Important:

- You will have one opportunity to complete the online enrollment process and submit any required supporting documentation during your 30-calendar-day enrollment period.
- While you are online making your elections, more information is provided on each plan option.
- After your enrollment period ends, your next opportunity to enroll or make changes will be during the next annual benefits open enrollment period, unless a qualified life event occurs.

☐ Verify during your in-processing appointment, verify that your home address is current as ID cards and other relevant information will be sent to your home address.

☐ Gather required dependent information and documentation (if enrolling eligible dependents in medical, dental, vision, and/or any other plan(s)).

☐ Compare medical plans and choose one or decline coverage.

➢ If you are on a J-1 Visa, you are not eligible to enroll in the Consumer Choice HSA plan.

☐ Compare dental plans and choose one or decline coverage.

☐ Review vision plan and elect or waive coverage.

☐ Review the healthcare flexible spending account and estimate your calendar year election or waive.

☐ Review health savings account (HSA) (available to Consumer Choice HSA Medical Option plan participants only) and estimate your calendar year election or waive.

➢ Annual Employer Matching:
- Single Coverage – up to $375.00
- Family Coverage – up to $750.00

☐ Review the limited healthcare flexible spending account (available to Consumer Choice HSA Medical Option plan participants only) and estimate your calendar year election or waive.

☐ Review employee basic life insurance plan and designate beneficiaries. You will need the following information to complete your beneficiaries: name, address, date of birth and social security number.

☐ Review employee supplemental life insurance plan, choose coverage amounts or waive, and if applicable designate beneficiaries.

☐ Review employee and/or family accidental death and dismemberment insurance plan, choose coverage amounts or waive, and if applicable designate beneficiaries.

Benefits Enrollment Checklist for Benefits-Eligible (Resident)

- [ ] Review spouse life insurance plan and choose coverage amounts or waive.
- [ ] Review child life insurance plans and choose coverage amounts or waive.
- [ ] Review the child/adult day care flexible spending account and estimate your calendar year election or waive.
- [ ] Review short-term disability plan and elect or waive coverage.
- [ ] Review critical illness plan for employee and elect or waive coverage.
- [ ] Review critical illness plan for spouse (available to enrolled critical illness participants) and elect or waive coverage.
- [ ] Review accident plan and elect or waive coverage.
- [ ] Review hospital indemnity plan and elect or waive coverage.
- [ ] Review legal plan and elect or waive coverage.

Enroll online

Follow this navigation path:

- Sign in to Soft Serv - https://hcm-sso.onehcm.usg.edu
- Click Self Service > Benefits > OneUSG Connect - Benefits
- Click on Augusta University on the picker page
- Sign in when the Augusta University page comes up

Incomplete election edits may not be saved, and you may be required to resubmit all edits and dependent data if you are within your 30-calendar-day enrollment period.

Questions? Contact the OneUSG Connect – Benefits Call Center at 1-844-5-USGBEN (1-844-587-4236) or Benefits & Data Management at 706-721-3770.

Outstanding Wages Beneficiary Designation

Augusta University offers its employees the option of designating a beneficiary (ies) to receive the employee's last check in the event of an employee's death while an employee of Augusta University.

You must name a beneficiary; you must complete the section below, Outstanding Wages Beneficiary Designation Form, at the time of your employment and submit to Human Resources along with all of your new hire paperwork. Should you desire to change your beneficiary at some point in the future, it will be your responsibility to complete and submit to Human Resources another Outstanding Wages Beneficiary Designation Form.

If an employee does not elect to name a beneficiary, AU's payroll office will issue the employee's final paycheck, including any pay for unused annual/vacation leave, to the estate of the deceased employee. If your final check goes to your estate, please be advised that access to the funds by your family may be delayed due to the probate process.

Augusta University
Outstanding Wages Beneficiary Designation Form

Employee's Name: _____ **Employee ID:** _____

Name of Primary Beneficiary for Outstanding Wages: _____

Address: _____
Street City State Zip

Name of Secondary Beneficiary for Outstanding Wages: _____

Address: _____
Street City State Zip

_____
PRINT EMPLOYEE FULL NAME

_____
SIGNATURE OF EMPLOYEE

_____
DATE