

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:		Mailing Address: (If different from Home Address)	
Address _____		Address _____	
City _____	State _____	City _____	State _____
County _____	Zip Code _____	County _____	Zip Code _____
Telephone Information: (Please check your preferred number)			
Home (____) ____ - ____	<input type="checkbox"/>	Mobile (____) ____ - ____	<input type="checkbox"/>
Pager (____) ____ - ____	<input type="checkbox"/>	Other (____) ____ - ____	<input type="checkbox"/>
Gender:		Marital Status:	
<input type="checkbox"/> Male		<input type="checkbox"/> Single	
<input type="checkbox"/> Female		<input type="checkbox"/> Divorced*	
<input type="checkbox"/> I do not wish to provide this information		<input type="checkbox"/> Married*	
		<input type="checkbox"/> Widowed*	
		*Marital Status Date: ____/____/____	
Race:		Ethnic Group:	
<input type="checkbox"/> American Indian or Alaskan Native		<input type="checkbox"/> Hispanic/Latino	
<input type="checkbox"/> Asian		<input type="checkbox"/> Not Hispanic Latino	
<input type="checkbox"/> Black or African American		<input type="checkbox"/> I do not wish to provide this information	
<input type="checkbox"/> Native Hawaiian or Other Pacific Islander			
<input type="checkbox"/> White			
<input type="checkbox"/> I do not wish to provide this information			
Date of Birth:		Birth Country:	
____/____/____		_____	
AU/USG Status/History:		AU Status/History:	
I have previously been employed by AU/USG:		I am currently enrolled as a Full-Time AU Student:	
<input type="checkbox"/> Yes, employment ended ____/____/____		<input type="checkbox"/> Yes	
<input type="checkbox"/> No		<input type="checkbox"/> No	
I am currently employed by AU or any other USG Institution:		I am related to a current AU Employee:	
<input type="checkbox"/> Yes, department/institution: _____		<input type="checkbox"/> Yes	
<input type="checkbox"/> No		<input type="checkbox"/> No	
Personal Email Address:		Retirement Information:	
_____		I am an active member or retiree of another Georgia State retirement plan:	
		<input type="checkbox"/> Yes, retirement plan: _____	
		<input type="checkbox"/> No	
Emergency Contact Data:		Primary- Please select only one as Primary	
(1) _____	_____	<input type="checkbox"/> (____) ____ - ____	
Name	Relationship	Phone Number	
(2) _____	_____	<input type="checkbox"/> (____) ____ - ____	
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



AUGUSTA UNIVERSITY

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:	<input type="checkbox"/> AU <input type="checkbox"/> AUMC <input type="checkbox"/> AUMA <input type="checkbox"/> Contractor <input type="checkbox"/> Other
Signature:	<input type="checkbox"/> Employee <input type="checkbox"/> Student <input type="checkbox"/> Volunteer <input type="checkbox"/> Other
Date:	Define Other:



AUGUSTA
UNIVERSITY

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.



AUGUSTA
UNIVERSITY

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
Page 1 of 2

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.¹ 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
- Autism
- Bipolar disorder
- Post-traumatic stress disorder (PTSD)
- Deafness
- Cerebral palsy
- Major depression
- Obsessive compulsive disorder
- Cancer
- HIV/AIDS
- Multiple sclerosis (MS)
- Impairments requiring the use of a wheelchair
- Diabetes
- Schizophrenia
- Missing limbs or partially missing limbs
- Intellectual disability (previously called mental retardation)
- Epilepsy
- Muscular dystrophy

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

Voluntary Self-Identification of Disability

Form CC-305
OMB Control Number 1250-0005
Expires 1/31/2020
Page 2 of 2

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.

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: _____

Statement Concerning Your Employment in a Job Not Covered by Social Security

Employee Name _____ Employee ID# _____

Employer Name _____ Employer ID# _____

Your earnings from this job are not covered under Social Security. When you retire, or if you become disabled, you may receive a pension based on earnings from this job. If you do, and you are also entitled to a benefit from Social Security based on either your own work or the work of your husband or wife, or former husband or wife, your pension may affect the amount of the Social Security benefit you receive. Your Medicare benefits, however, will not be affected. Under the Social Security law, there are two ways your Social Security benefit amount may be affected.

Windfall Elimination Provision

Under the Windfall Elimination Provision, your Social Security retirement or disability benefit is figured using a modified formula when you are also entitled to a pension from a job where you did not pay Social Security tax. As a result, you will receive a lower Social Security benefit than if you were not entitled to a pension from this job. For example, if you are age 62 in 2013, the maximum monthly reduction in your Social Security benefit as a result of this provision is \$395.50. This amount is updated annually. This provision reduces, but does not totally eliminate, your Social Security benefit. For additional information, please refer to Social Security Publication, "Windfall Elimination Provision."

Government Pension Offset Provision

Under the Government Pension Offset Provision, any Social Security spouse or widow(er) benefit to which you become entitled will be offset if you also receive a Federal, State or local government pension based on work where you did not pay Social Security tax. The offset reduces the amount of your Social Security spouse or widow(er) benefit by two-thirds of the amount of your pension.

For example, if you get a monthly pension of \$600 based on earnings that are not covered under Social Security, two-thirds of that amount, \$400, is used to offset your Social Security spouse or widow(er) benefit. If you are eligible for a \$500 widow(er) benefit, you will receive \$100 per month from Social Security (\$500 - \$400=\$100). Even if your pension is high enough to totally offset your spouse or widow(er) Social Security benefit, you are still eligible for Medicare at age 65. For additional information, please refer to Social Security Publication, "Government Pension Offset."

For More Information

Social Security publications and additional information, including information about exceptions to each provision, are available at www.socialsecurity.gov. You may also call toll free 1-800-772-1213, or for the deaf or hard of hearing call the TTY number 1-800-325-0778, or contact your local Social Security office.

I certify that I have received Form SSA-1945 that contains information about the possible effects of the Windfall Elimination Provision and the Government Pension Offset Provision on my potential future Social Security Benefits.

Signature of Employee _____ Date _____

Information about Social Security Form SSA-1945 Statement Concerning Your Employment in a Job Not Covered by Social Security

New legislation [Section 419(c) of Public Law 108-203, the Social Security Protection Act of 2004] requires State and local government employers to provide a statement to employees hired January 1, 2005 or later in a job not covered under Social Security. The statement explains how a pension from that job could affect future Social Security benefits to which they may become entitled.

Form SSA-1945, **Statement Concerning Your Employment in a Job Not Covered by Social Security**, is the document that employers should use to meet the requirements of the law. The SSA-1945 explains the potential effects of two provisions in the Social Security law for workers who also receive a pension based on their work in a job not covered by Social Security. The Windfall Elimination Provision can affect the amount of a worker's Social Security retirement or disability benefit. The Government Pension Offset Provision can affect a Social Security benefit received as a spouse, surviving spouse, or an ex-spouse.

Employers must:

- Give the statement to the employee prior to the start of employment;
- Get the employee's signature on the form; and
- Submit a copy of the signed form to the pension paying agency.

Social Security will not be setting any additional guidelines for the use of this form.

Copies of the SSA-1945 are available online at the Social Security website, www.socialsecurity.gov/online/ssa-1945.pdf. Paper copies can be requested by email at ofsm.oswm.rqct.orders@ssa.gov or by fax at 410-965-2037. The request must include the name, complete address and telephone number of the employer. Forms will not be sent to a post office box. Also, if appropriate, include the name of the person to whom the forms are to be delivered. The forms are available in packages of 25. Please refer to Inventory Control Number (ICN) 276950 when ordering.



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):

<input type="checkbox"/> 1. A citizen of the United States	
<input type="checkbox"/> 2. A noncitizen national of the United States <i>(See instructions)</i>	
<input type="checkbox"/> 3. A lawful permanent resident (Alien Registration Number/USCIS Number): _____	
<input type="checkbox"/> 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. <i>(See instructions)</i>	
<p><i>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.</i></p> <p>1. Alien Registration Number/USCIS Number: _____ OR 2. Form I-94 Admission Number: _____ OR 3. Foreign Passport Number: _____ Country of Issuance: _____</p>	
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		Additional Information		QR Code - Sections 2 & 3 Do Not Write In This Space
Issuing Authority				
Document Number				
Expiration Date (if any) (mm/dd/yyyy)				
Document Title				
Issuing Authority				
Document Number				
Expiration Date (if any) (mm/dd/yyyy)				

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		
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		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			

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

Refer to the instructions for more information about acceptable receipts.

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.**

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) <input type="checkbox"/> Single or Married filing separately <input type="checkbox"/> Married filing jointly (or Qualifying widow(er)) <input type="checkbox"/> 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)



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.

Augusta University

Student Employment Statement of Acknowledgement

As a student employee I fully understand the following conditions of employment as outlined:

1. I am not eligible for benefits through my student employment with AU.
2. I will not accrue Annual or Sick Leave.
3. As a student employee I may not work more than the total number of weekly hours approved for my student position by the Human Resources Department at the time of my hire. I will only be scheduled for hours required to meet the needs of the department. I will not necessarily be guaranteed a specific schedule or specific number of hours. The department may decide not to schedule me for any hours during any given pay period.
4. To obtain regular employment with Augusta University, I understand that I must apply for regular positions posted on the AU employment web page and must be selected for that position through the regular recruitment process.

I accept this position with full understanding and acknowledgement of the conditions outlined.

Employee

HR Assistant

Date

Date



AUGUSTA UNIVERSITY

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