Augusta University

Service Agreement Request (SAR) and
Employer/Independent Contractor Classification Checklist
For Professional Service Contract Payments

The information provided below will assist Augusta University (AU) in determining whether the provider performing the services will be classified for federal, state, and FICA tax purposes as an employee of AU or as an independent contractor. Complete Section I, Section II, Section III, and Section IV as part of the Service Contract.

I. Vendor/ Provider Information

Provider's Name _____ Social Security #, Tax ID #, or Federal ID # _____

Provider's Address, City, State, Country, & Zip _____

Is the provider a USA citizen? Yes ☐ No ☐ If No: ☐ Resident Alien ☐ Nonresident Alien

If Nonresident Alien: Country of Residence & Visa Type _____

W9 Form Attached: No W8-BEN Form Attached: No 8233 Form Attached: No

If the Provider is a Nonresident Alien, notify the Tax Specialist, at 706-721-4364.

II. Multiple Relationships with the University System of Georgia

A. Is the Provider currently employed by the University System of Georgia (USG)? Yes ☐ No ☐
B. During the past 12 months prior to this contract, did the Provider have a USG position (including temporary) that performed the same or similar services? Yes ☐ No ☐
C. Is the Provider receiving Retirement Benefits from past employment with USG? Yes ☐ No ☐
D. Is it currently expected that USG will hire the Provider as an employee immediately following the termination of the Service Contract? Yes ☐ No ☐
E. Is any member of the Provider's immediate family (i.e. spouse, child, or dependent) employed by USG? Yes ☐ No ☐

If the answer is "No" to all questions, proceed to Section III.
If the answer is "Yes" to any of the 5 questions, the provider should be classified as an employee and processed through Human Resources.

Provider's Initials: _____ Date: _____ Requestor's Initials: _____ Date: _____

III. **Classification Guidelines**

A. Does the Provider provide the same services to other entities or to the general public as part of a trade or business? Yes ☐ No ☐

If the answer is "Yes" continue answering the questions below.
If the answer is "No" the Provider should be classified as an employee and processed through Human Resources.

B. Will the department provide the Provider with specific instructions regarding performance of the required work rather than rely on the Provider's expertise? Yes ☐ No ☐

C. Will the department set the number of hours and/or days of the week that the Provider is required to work, as opposed to allowing the Provider to set their own work schedule? Yes ☐ No ☐

D. Will AU conduct any training for the Provider in order for the Provider to perform the contracted task? Yes ☐ No ☐

E. Will the Provider be performing more than one task or project than what is outlined in the attached contract? Yes ☐ No ☐

F. Will the Provider be working on AU premises and will AU provide use of equipment, supplies, utilities, or space to perform the contracted work? Yes ☐ No ☐

If the answer is "Yes" to ANY questions B-F, the Provider must provide detailed clarification and attach to this form. Depending on the requested service, a determination will be made by the Controller's Division as to whether the Provider will be classified as an independent contractor or an employee.

IV. **Provider's Signature**

By signing below, I certify that the information and answers, to the best of my knowledge, are accurate and complete. I understand that the information will be used to determine whether the services requested will be processed under a contractual agreement or will be processed through Human Resources as an employee/employer agreement.

Provider's Name	Provider's Signature	Date

V. **Funding Information**

Dates of Service: From _____ To _____

Reimbursements: Services $ 0.00 Expenses $ 0.00

Total $ 0.00 (Meals reimbursed only at Per Diem Rates)

Provider's Initials: _____ Date: _____ Requestor's Initials: _____ Date: _____

Expense Chartfield:

Fund	Dept ID	Program	Class	Project

Purpose/ Scope of Work: _____

Yes ☐ No ☐ Mail check to above address

Yes ☐ No ☐ Check to be picked up by: _____
Employee name

VI. **Approvals**

Approvers confirm the following:

a. These services are essential and cannot be provided by AU personnel.
b. The individual selected is the most qualified available considering the nature of the services required and time constraints.
c. The fee is appropriate considering the qualifications of the individual and his/her normal charges.
d. The individual is responsible for all federal, state, FICA, income taxes, and liability insurance.
e. The individual has been made aware that they are not considered an employee of or an agent for AU.

Requestor's Name	Requestor's Signature	Date
Budget Manager's Name	Budget Manager's Signature	Date
Dept. Head/Chairman's Name	Dept. Head/Chairman's Signature	Date

If required:

Dean/Director's Name	Dean/Director's Signature	Date
Sponsored Accountant's Name	Sponsored Accountant's Signature	Date
Additional Approver's Name	Additional Approver's Signature	Date