Personal Data Form Augusta University (AU) Human Resources Division

New Hire
Rehire
Personal Data Change

Native Hawaiian or Other Pacific Islander   Birth Country:	Primary Name (as it appears on SS Card)			Prefix:	Doctor	Miss	Mr.	Mrs.	Ms.
First Middle Last Suffix  Home Address: Mailing Address: (if different from Home Address)  Address  City State City State  County Zip Code County Zip Code  Telephone Information: (Please check your preferred number) Home (	First Middle				Last		Su	ffix	
Home Address:   Mailing Address: (If different from Home Address)	Preferred Name (will only	update outlook)							
Address  City State City State  County Zip Code County Zip Code  Telephone Information: (Please check your preferred number) Home (	First	Middle		<del> </del>	Last	<del> </del>	Suf	fix	
City   State   City   State   City   State   County   Zip Code	Home Address:		Mailin	g Addres	s: (If differer	nt from H	ome Ad	ddress)	
County   Zip Code   County   Zip Code	Address		Addre	ss					
Telephone Information: (Please check your preferred number) Home (	City	State	City				St	ate	
Home (	County	Zip Code	Count	y			Zip	o Code	
Pager (		Please check your preferred	number)	•					
Gender:	Home ()_		Mobi	le (	)				_ 🗆
Male	Pager ()_		Othe	r (.	)_				_ 🗆
Race:	■ Male				☐ Sing	gle	s:		
Race: American Indian or Alaskan Native Asian Black or African American Native Hawaiian or Other Pacific Islander  Date of Birth:	I do not wish to pro	ovide this information					us Date		/laowea"
American Indian or Alaskan Native	Paga						us Date	, <u>/_</u>	
AU/USG Status/History:    have previously been employed by AU/USG:   Yes, employment ended/_/   No   am currently employed by AU or any other USG Institution:   Yes, department/institution:   No   No   I am related to a current AU Employee:   Yes   No   No   I am related to a current AU Employee:   Yes   No   No   Retirement Information:   I am an active member or retiree of another Georg State retirement plan:   Yes, retirement plan:   No   No   No   Retirement plan:   Yes, retirement plan:   No   No   Retirement plan:   Yes, retirement plan:   No   No   Primary- Please select only one as Primary Phone Number   Name   Relationship   Phone Number	<ul> <li>□ American Indian or Alaskan Native</li> <li>□ Asian</li> <li>□ Black or African American</li> <li>□ Native Hawaiian or Other Pacific</li> <li>□ White</li> <li>□ I do not wish</li> <li>this informat</li> </ul>			to provide				is information	
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  Personal Email Address:  Retirement Information: I am an active member or retiree of another Georg State retirement plan: No    Yes, retirement plan:   No   No   No   Retirement Information:   I am an active member or retiree of another Georg State retirement plan:   No   No   No   Primary- Please select only one as Primary Phone Number   Name   Relationship   Phone Number	Date of Birth:	-			Birth Co	ountry:			
Yes, employment ended//   No				AU Statu	s/History:				
Personal Email Address:    I am an active member or retiree of another George State retirement plan:   Yes, retirement plan:   No	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:			□ Y □ N I am relat □ Y □ N	′es lo ted to a cur ′es lo	rent AU			Student:
Emergency Contact Data:  (1)	Personal Email Address:	:		I am an <b>a</b>	ctive mem	<b>ber</b> or <b>r</b>	etiree	of anotl	her Georgia
Emergency Contact Data:  (1) Name  Relationship  Primary- Please select only one as Primary  (2) Phone Number						ent plar	n:		
Name Relationship Phone Number  (2)	<b>Emergency Contact Data</b>	1:	I I			Please s	elect o	nly one	as Primary
(2)	(1)Nam	 ne Re	elationship	<u> </u>	□ (_	 Ph	.) one Nu	 umber	
\ \ \ \ \ \	(2)		·						
Name Relationship • ()	Nam	ne Re	elationship	)	<b>-</b> (_		.)		

Signature:



### 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 <a href="http://www.augusta.edu/hr/employee\_manuals.php">http://www.augusta.edu/hr/employee\_manuals.php</a>. This receipt will be placed in your official personnel file.

Employee Print Name		
Employee Signature		
 Date		

<sup>\*</sup> 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 (<a href="http://policy.augusta.edu/12-1-1-ethics-policy/">http://policy.augusta.edu/12-1-1-ethics-policy/</a>), 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 <a href="http://www.augusta.edu/services/legal/">http://www.augusta.edu/services/legal/</a>) and the Office of Compliance and Enterprise Risk Management (706.721.0900 or <a href="http://www.augusta.edu/admin/oia/services.php">http://www.augusta.edu/admin/oia/services.php</a>).

Printed Name	
Signature	Date (mm/dd/yyyy)
Title	Employee PeopleSoft ID
College or Department Location	



### 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 <a href="http://www.usg.edu/facilities/rtk-ghs">http://www.usg.edu/facilities/rtk-ghs</a>
- 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



### **Veterans Self-Identification**

Pleas	se check one of the answers below:	
	Yes, I identify as one of more of the classi	fications of a protected veteran as listed below.
	No, I am not a protected veteran.	
	I don't wish to answer.	
amen take a (3) ac	ded by the Jobs for Veterans Act of 2002, 38 ffirmative action to employ and advance in e	to the Vietnam Era Veterans' Readjustment Assistance Act of 1974, as U.S.C. § 4212 (VEVRAA), which requires Government contractors to mployment: (1) disabled veterans; (2) recently separated veterans; as; and (4) Armed Forces service medal veterans. These classifications
appro	priate boxes below. As a Government contra	of protected veterans listed above, please indicate by checking the actor—subject to VEVRAA, we request this information in order to tive recruitment efforts we undertake pursuant to VEVRAA.
	entitled to compensation (or who but for the	ving: a veteran of the U.S. military, ground, naval or air service who is the receipt of military retired pay would be entitled to compensation) of Veterans Affairs; or a person who was discharged or released from disability.
	Accommodation Requested	
	Accommodation Declined	
	· -	veteran during the three-year period beginning on the date of such uty in the U.S. military, ground, naval, or air service.
	• •	<i>lge veteran</i> " means a veteran who served on active duty in the U.S. a war, or in a campaign or expedition for which a campaign badge has d by the Department of Defense.
		means a veteran who, while serving on active duty in the U.S. military a United States military operation for which an Armed Forces service Order 12985.
Right may l	s Act. In particular, if you were absent from	er USERRA—the Uniformed Services Employment and Reemployment employment in order to perform service in the uniformed service, you er in the position you would have obtained with reasonable certainty if
Em	ployee Name:	Employee ID:
Em	plovee 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. 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
- Cancer
- Epilepsy
- - HIV/AIDS
  - Muscular dystrophy
- Bipolar disorder
- Deafness
   Cerebral palsy
   Major depression
  - Multiple sclerosis (MS)
- Diabetes Schizophrenia 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

### **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.

<sup>1</sup> 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 <a href="https://www.dol.gov/ofccp">www.dol.gov/ofccp</a>.

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. Social Security No. 1. Name 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 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? Ves 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. 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 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.)

USO Page 1

**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 O	F VERIFICATION	
State of		County		
who, after being swo foregoing instrument	rn, deposes and sa ; that he or she has	ys and declares under penalt read and completed the san	uthorized to administer oaths, (Print your ies of false swearing that he or she is the ne and knows and understands the content her in the foregoing questionnaire, included	e person who executed the nts thereof; that the matters
SWORN TO AND S	UBSCRIBED BE	FORE ME	(Signature of Employee)	
This	day of	, , , Y	(Signature of Employee)	
		Month Y	ear	
	Notary Public			
County of		My commission expir	esday of	, , , , , , , , , , , , , , , , , , ,
(Affix seal)				month year
	INF	ORMATION TO BE FUR	NISHED BY EMPLOYING UNIT	
	f this questionnaire		oplicant, insert "APPL" in the space for or all who has been offered employment or	
DATE OF APPOINTMEN		ITLE OF POSITION	UNIT AND DEPARTMENT	DUTY STATION
THE CHARMEN				University System Office
		University Sy	of Regents ystem of Georgia LTY OATH	
STATE OF			COUNTY OF	
I, (Print your Name)			, a citizen of	
			e recipient of public funds for services re on of the United States and the Constitut	
This	day of	, Year	Sign	ature of Employee
Sworn to and subscri	bed before me this	day and year above set out.		active of Employee
	Notary Public			
(Affix Seal)				

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

USO



### **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: <a href="https://www.augusta.edu/research/tools-for-researchers/">https://www.augusta.edu/research/tools-for-researchers/</a>.

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:	
Date.	<del></del>



# 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 than the first day of employment, but no	n and Attestation of before accepting a j	l (Employees n ob offer.)	oust complete an	nd sign S	ection 1 d	of Form I-9 no later
ast Name (Family Name) First Name (Given Name) Middle In			Middle Initial	Other	Last Name	s 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 Se	curity Number Emp	loyee's E-mail Ad	ldress	E	mployee's	Telephone Number
I am aware that federal law provides fo connection with the completion of this		or fines for fal	se statements	or use o	f false do	ocuments in
I attest, under penalty of perjury, that I	am (check one of th	e following bo	xes):			
1. A citizen of the United States						
2. A noncitizen national of the United State	es (See instructions)					
3. A lawful permanent resident (Alien Re	egistration Number/USCI	S Number):				
4. An alien authorized to work until (expi		,,,,,		-		
Aliens authorized to work must provide only of An Alien Registration Number/USCIS Number  1. Alien Registration Number/USCIS Number  OR	r OR Form I-94 Admissio	ment numbers to on Number OR Fo	complete Form I-9 preign Passport Nu	: ımber.		R Code - Section 1 ot Write In This Space
2. Form I-94 Admission Number: OR						
3. Foreign Passport Number:						
Country of Issuance:						
Signature of Employee			Today's Date	e (mm/dd	/уууу)	
Preparer and/or Translator Certi I did not use a preparer or translator. (Fields below must be completed and sign	A preparer(s) and/or tra	anslator(s) assiste				
l attest, under penalty of perjury, that l l knowledge the information is true and o	have assisted in the correct.	completion of	Section 1 of thi	is form a	and that	to the best of my
Signature of Preparer or Translator				Today's [	Date (mm/c	dd/yyyy)
Last Name <i>(Family Name)</i>		First Nar	ne (Given Name)			
Address (Street Number and Name)		City or Town			State	ZIP Code



Employer Completes Next Page





### **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 employm

Employee Info from Section 1	iame ( <i>i-ai</i>	mily Name)		First Name (G	iven Nam	e)	M.I.	Citizenship/Immigration Status	
List A Identity and Employment Authorizati	OR ion	₹	Lis Iden		1A	VD		List C Employment Authorization	
Document Title		Document <sup>-</sup>	Title			Docum	ent Titl		
ssuing Authority	Issuing Authority				Issuing Authority				
Document Number	Document Number				Docum	Document Number			
Expiration Date (if any) (mm/dd/yyyy) Expi			xpiration Date (if any) (mm/dd/yyyy) Ex			Expirat	piration Date (if any) (mm/dd/yyyy)		
Document Title									
ssuing Authority		Additiona	I Informatio	n				QR Code - Sections 2 & 3 Do Not Write In This Space	
Occument Number									
expiration Date (if any) (mm/dd/yyyy)									
Occument Title	-								
ssuing Authority									
ocument Number									
expiration Date (if any) (mm/dd/yyyy)									
(	Hill								
ertification: I attest, under penalty o	ar to be	genuine as	have exami	ned the documento the employer	nent(s) p ee name	resente	d by the	he above-named employee, ne best of my knowledge th	
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## 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  AN	۱D	LIST C Documents that Establish Employment Authorization
2.	U.S. Passport or U.S. Passport Card  Permanent Resident Card or Alien Registration Receipt Card (Form I-551)  Foreign passport that contains a	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		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
4.	temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa  Employment Authorization Document that contains a photograph (Form	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,	2.	INS AUTHORIZATION  (3) VALID FOR WORK ONLY WITH DHS AUTHORIZATION  Certification of report of birth issued
5.	For a nonimmigrant alien authorized to work for a specific employer		gender, height, eye color, and address  3. School ID card with a photograph  4. Voter's registration card	3.	by the Department of State (Forms DS-1350, FS-545, FS-240)  Original or certified copy of birth certificate issued by a State,
l	b. Form I-94 or Form I-94A that has	5. 6.	U.S. Military card or draft record Military dependent's ID card	_	county, municipal authority, or territory of the United States bearing an official seal
	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.		U.S. Coast Guard Merchant Mariner Card  Native American tribal document	_	U.S. Citizen ID Card (Form I-197)
		9.	Driver's license issued by a Canadian government authority	6.	Identification Card for Use of Resident Citizen in the United States (Form I-179)
		F	or persons under age 18 who are unable to present a document listed above:	7.	Employment authorization document issued by the Department of Homeland Security
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	11	School record or report card     Clinic, doctor, or hospital record     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.

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

Step 1:	(a) First name and middle initial		Last name		(b) So	cial security number			
Enter Personal Information	Address  City or town, state, and ZIP code				name of	s your name match the on your social security f not, to ensure you get or your earnings, contact			
	City or town, state, and ZIP code	SSA at	SSA at 800-772-1213 or go to www.ssa.gov.						
	(c) Single or Married filing separa	ately							
	Married filing jointly (or Qualify	ing widow(er))							
	Head of household (Check only	if you're unmai	ried and pay more than half the costs	of keeping up a home for yo	urself an	d a qualifying individual.)			
	ps 2–4 ONLY if they apply to your from withholding, when to use			2 for more information	n on e	ach step, who can			
Step 2: Multiple Jobs			ore than one job at a time, on the control of the c						
or Spouse	Do only one of the follow	ing.							
Works	(a) Use the estimator at v	vww.irs.gov/	W4App for most accurate wi	thholding for this step	(and S	Steps 3–4); <b>or</b>			
	<b>(b)</b> Use the Multiple Jobs V	Vorksheet on	page 3 and enter the result in S	step 4(c) below for rough	nlv accu	rate withholding: or			
	<ul> <li>(b) Use the Multiple Jobs Worksheet on page 3 and enter the result in Step 4(c) below for roughly accurate withholding; or</li> <li>(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 ▶ □</li> </ul>								
	<b>TIP:</b> 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.								
	ps 3–4(b) on Form W-4 for only ate if you complete Steps 3–4(b)				bs. (Yo	our withholding will			
Step 3:	If your income will be \$20	0,000 or les	s (\$400,000 or less if married	filing jointly):					
Claim Dependents	Multiply the number of	qualifying ch	nildren under age 17 by \$2,000	<b>\$</b>					
	Multiply the number o	f other depe	endents by \$500	<b>▶</b> <u></u> \$					
	Add the amounts above a	and enter the	e total here		3	\$			
Step 4 (optional): Other		ve withholdir	you want tax withheld for othing, enter the amount of other rement income			\$			
Adjustments			im deductions other than thing, use the Deductions Wor			\$			
	(c) Extra withholding. En	nter any add	itional tax you want withheld	each <b>pay period</b> .	4(c)	\$			
Step 5: Sign Here	Under penalties of perjury, I declare	that this cert	ificate, to the best of my knowled	dge and belief, is true, co	orrect, a	nd complete.			
.1010	Employee's signature (This	ate							
Employers Only	Employer's name and address			1	Employe number	er identification (EIN)			
For Privacy Act	and Paperwork Reduction Act No	tice, see pag	<b>e 3.</b> Cat.	No. 10220Q		Form <b>W-4</b> (2020)			

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



STATE OF GEORGIA EMPLOYEE'S WITHHOLDING ALLOWANCE CERTIFICATE

OTATE OF GEORGIA EIIII EGTEE 5 11	THIOLDING 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 REVER	SE SIDE BEFORE COMPLETING LINES 3 – 8
3. MARITAL STATUS	
(If you do not wish to claim an allowance, enter "0" in the brackets b	
A. Single: Enter 0 or 1	4. DEPENDENT ALLOWANCES [ ]
B. Married Filing Joint, both spouses working:  Enter 0 or 1[ ]	
C. Married Filing Joint, one spouse working:	5. ADDITIONAL ALLOWANCES [ ]
Enter 0 or 1 or 2[ ]	(worksheet below must be completed)
D. Married Filing Separate:	
Enter 0 or 1	C ADDITIONAL WITHIUS DING
E. Head of Household:  Enter 0 or 1	6. ADDITIONAL WITHHOLDING \$
	ING ADDITIONAL ALL OWNERS
	ING ADDITIONAL ALLOWANCES er to enter an amount on step 5)
1. COMPLETE THIS LINE ONLY IF USING STANDARD D	EDUCTION:
Yourself: ☐ Age 65 or over ☐ Blind	
_	of boxes checked x 1300\$
2. ADDITIONAL ALLOWANCES FOR DEDUCTIONS:	7. 20x00 011001100 X 1000
A. Federal Estimated Itemized Deductions (If Itemizing Deductions)	aduations) &
<del>-</del>	d 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	an claim. If the remainder is over \$1,500 round up)
7. LETTER USED (Marital Status A, B, C, D, or E)	
(Employer: The letter indicates the tax tables in Employer's Tax Guid	le)
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 have a Georgia income tax liability this year. <b>Check here</b>	income tax liability last year <b>and</b> I do not expect to
b) I certify that I am not subject to Georgia withholding because I med	et the conditions set forth under the Servicemembers
Civil Relief Act as amended by the Military Spouses Residency Relie	f Act as provided on page 2. My state of residence is
. My spouse's (servicemember) state of residence	ce is The states of residence
must be the same to be exempt. Check here	
l certify under penalty of perjury that I am entitled to the number of wi claimed on this Form G-4. Also, I authorize my employer to deduct pe	thholding allowances or the exemption from withholding status er pay period the additional amount listed above.
Employee's Signature	Date
Employee's Signature  Employer: Complete Line 9 and mail entire form only if the emplete Line 9 and mail entire form only if the emplete Line 9 and mail entire form only if the emplete Line 9 and mail entire form only if the emplete Line 9 and mail entire form only if the emplete Line 9 and mail entire form only if the emplete Line 9 and mail entire form only if the emplete Line 9 and mail entire form only if the emplete Line 9 and mail entire form only if the emplete Line 9 and mail entire form only if the emplete Line 9 and mail entire form only if the emplete Line 9 and mail entire form only if the emplete Line 9 and mail entire form only if the emplete Line 9 and mail entire form only if the emplete Line 9 and mail entire form only if the emplete Line 9 and mail entire form only if the emplete Line 9 and mail entire form only if the emplete Line 9 and mail entire form only if the emplete Line 9 and mail entire form only if the emplete Line 9 and mail entire form only if the emplete Line 9 and mail entire form only if the emplete Line 9 and mail entire form only if the emplete Line 9 and mail entire form only if the emplete Line 9 and mail entire form only if the emplete Line 9 and mail entire form only if the emplete Line 9 and mail entire form only if the emplete Line 9 and mail entire form only if the emplete Line 9 and mail entire form only if the emplete Line 9 and mail entire form only if the emplete Line 9 and mail entire form only if the emplete Line 9 and mail entire form only if the emplete Line 9 and mail entire form only if the emplete	byee claims over 14 allowances or exempt from withholding.
r necessary, mail form to: Georgia Department of Revenue, Withhold	ling Tax Unit, 1800 Century Blvd NE, Suite 8200, Atlanta, GA 30345
9. EMPLOYER'S NAME AND ADDRESS: EMI	PLOYER'S FEIN:
	IDLOVEDIC MUH.
EM	PLOYER'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.



### **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:			E1					
Name of Primary Beneficiary for Outstanding Wages:								
Address:								
Street		City	State	Zip				
Name of Secondary F	-	_						
Address: Street		City	State	Zip				
PRINT EMPLOYEE I	FULL NAME							
SIGNATURE OF EM	PLOYEE							
DATE								



# Benefits Enrollment Checklist for Benefits-Eligible

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 waive 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 purpose 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.

Review spouse life insurance plan and choose coverage amounts or waive.



# **Benefits Enrollment Checklist for Benefits-Eligible**

Review child life insurance plans and choose coverage amounts or waive.

Review the dependent care (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 long-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.

Review identity protection plan and elect or waive coverage.

### Retirement:

- If you are an exempt (salaried) employee, you have one opportunity to enroll in retirement. You can complete this through the online enrollment process. You must enroll in retirement within 60 calendar days from your hire date. This decision is irrevocable.
- If you are a non-exempt (hourly paid) employee, you are required to enroll in the Teachers Retirement System of Georgia plan.

### **Enroll online**

Follow this navigation path:

- > Sign in to: <a href="https://hcm-sso.onehcm.usg.edu/">https://hcm-sso.onehcm.usg.edu/</a>
- 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.

### Well-being

USG cares about your health and well-being. That's why we provide you with a variety of tools that make it easy for you to incorporate healthy habits into your daily life. Complete healthy activities from Jan. 1 to Sept. 30, and you can earn up to a \$100 well-being credit or points. The well-being credit is only available to employees and spouses covered on a USG healthcare plan and will be paid in November.

**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.