SHIPPENSBURG UNIVERSITY
EMPLOYEE INFORMATION SHEET

Employee Name:________________________________________________________

Address: ___________________________________________ Phone #______________
__________________________________________
__________________________________________

(Completion of this section is voluntary)
Please place a check on the line which best describes your race/ethnicity:

___ 1. White/Not Hispanic Origin                    ____ 5. American Indian/Alaskan
___ 2. Black/Not Hispanic Origin                    ____ 6. Native Hawaiian
____ 3. Hispanic                                                ____ 7. Hispanic/White Only
____ 4. Asian or Pacific Islander                       ____ 8. Hispanic/All Other

Veteran ________ Yes   _______ No

Name & Address of Emergency Contact:
____________________________________________
____________________________________________
____________________________________________

Relationship to Employee ____________________________

Day Time Phone #   _________________________________
Night/Evening Phone #  ______________________________

Signature               Date
Shippensburg University
Veteran Status Information Request Form

The US Department of Labor Veteran’s Employment and Training Service requires federal contractors to submit an annual report on the number of employees who have identified themselves as veterans. If you are a veteran, your assistance in providing this information is requested.

Please note that completing this form is completely voluntary and all information is maintained confidentially. Veteran Status Information Request Forms are available from the Human Resources Office and are available on the HR web page. Completed forms should be returned to the Human Resources Department, 109 Old Main, 1871 Old Main Drive, Shippensburg, PA 17257. Questions regarding this form should be addressed to Human Resources at (717) 477-1124.

I am a

☐ Special Disabled Veteran

   (i) 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 Department of Veterans’ Affairs for a disability (A) rated at 30 percent or more, or (B) rated at 10 or 20 percent in the case of a veteran who has been determined under Section 38 U.S.C. 3106 to have a serious employment handicap or (ii) a person who was discharged or released from active duty because of a service-connected disability.

☐ Vietnam Era Veteran

   A person who (i) served on active duty in the U.S. military, ground, naval or air service for a period of more than 180 days, and who was discharged or released there from with other than a dishonorable discharge, if any part of such active duty was performed: (A) in the Republic of Vietnam between February 28, 1961 and May 7, 1975, or (B) between August 5, 1964 and May 7, 1975, in all other cases; or (ii) was discharged or released from active duty in the U.S. military, ground, naval or air service for a service-connected disability if any part of such active duty was performed (A) in the Republic of Vietnam between February 28, 1961 and May 7, 1975, or (B) between August 5, 1964 and May 7, 1975, in any other location.

☐ Newly Separated Veteran

   Any veteran who served on active duty in the U.S. military, ground, naval or air service during the one-year period beginning on the date of such veteran’s discharge or release from active duty.

☐ Other Protected Veteran

   Veterans 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. For a list of relevant campaigns and expeditions, see www.opm.gov/veterans/html/vgmedal2.asp

Name: ________________________________________________

Department: ________________________________________________

Work Number: ________________________________________________
## Form W-4 2021

**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.

### Step 1: Enter Personal Information

<table>
<thead>
<tr>
<th>(a) First name and middle initial</th>
<th>Last name</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Address</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>City or town, state, and ZIP code</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>(c) Single or Married filing separately</th>
</tr>
</thead>
<tbody>
<tr>
<td>Married filing jointly or Qualifying widow(er)</td>
</tr>
<tr>
<td>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.)</td>
</tr>
</tbody>
</table>

### 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 estimator at www.irs.gov/W4App, 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 2021 Form W-4 for all other jobs. If you (or your spouse) have self-employment income, including as an independent contractor, use the estimator.

### Step 3: Claim Dependents

If your total 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

<table>
<thead>
<tr>
<th>Step 4</th>
<th>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</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>▶ 4(a) $</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Step 4</th>
<th>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</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>▶ 4(b) $</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Step 4</th>
<th>Extra withholding. Enter any additional tax you want withheld each pay period</th>
</tr>
</thead>
</table>
|        | ▶ 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.)

<table>
<thead>
<tr>
<th>Employers Only</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employer’s name and address</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Date</th>
</tr>
</thead>
</table>

For Privacy Act and Paperwork Reduction Act Notice, see page 3.

Cat. No. 10220Q

Form W-4 (2021)
General Instructions

Future Developments
For the latest information about developments related to Form W-4, such as legislation enacted after it was published, go to www.irs.gov/FormW4.

Purpose of Form
Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay. If too little is withheld, you will generally owe tax when you file your tax return and may owe a penalty. If too much is withheld, you will generally be due a refund. Complete a new Form W-4 when changes to your personal or financial situation would change the entries on the form. For more information on withholding and when you must furnish a new Form W-4, see Pub. 505, Tax Withholding and Estimated Tax.

Exemption from withholding. You may claim exemption from withholding for 2021 if you meet both of the following conditions: you had no federal income tax liability in 2020 and you expect to have no federal income tax liability in 2021. You had no federal income tax liability in 2020 if (1) your total tax on line 24 on your 2020 Form 1040 or 1040-SR is zero (or less than the sum of lines 27, 28, 29, and 30), or (2) you were not required to file a return because your income was below the filing threshold for your correct filing status. If you claim exemption, you will have no income tax withheld from your paycheck and may owe taxes and penalties when you file your 2021 tax return. To claim exemption from withholding, certify that you meet both of the conditions above by writing “Exempt” on Form W-4 in the space below Step 4(c). Then, complete Steps 1(a), 1(b), and 5. Do not complete any other steps. You will need to submit a new Form W-4 by February 15, 2022.

Your privacy. If you prefer to limit information provided in Steps 2 through 4, use the online estimator, which will also increase accuracy.

As an alternative to the estimator: if you have concerns with Step 2(c), you may choose Step 2(b); if you have concerns with Step 4(a), you may enter an additional amount you want withheld per pay period in Step 4(c). If this is the only job in your household, you may instead check the box in Step 2(c), which will increase your withholding and significantly reduce your paycheck (often by thousands of dollars over the year).

When to use the estimator. Consider using the estimator at www.irs.gov/W4App if you:
1. Expect to work only part of the year;
2. Have dividend or capital gain income, or are subject to additional taxes, such as Additional Medicare Tax;
3. Have self-employment income (see below); or
4. Prefer the most accurate withholding for multiple job situations.

Self-employment. Generally, you will owe both income and self-employment taxes on any self-employment income you receive separate from the wages you receive as an employee. If you want to pay these taxes through withholding from your wages, use the estimator at www.irs.gov/W4App to figure the amount to have withheld.

Nonresident alien. If you’re a nonresident alien, see Notice 1392, Supplemental Form W-4 Instructions for Nonresident Aliens, before completing this form.

Specific Instructions

Step 1(c). Check your anticipated filing status. This will determine the standard deduction and tax rates used to compute your withholding.

Step 2. Use this step if you (1) have more than one job at the same time, or (2) are married filing jointly and you and your spouse both work.

Option (a) most accurately calculates the additional tax you need to have withheld, while option (b) does so with a little less accuracy.

If you (and your spouse) have a total of only two jobs, you may instead check the box in option (c). The box must also be checked on the Form W-4 for the other job. If the box is checked, the standard deduction and tax brackets will be cut in half for each job to calculate withholding. This option is roughly accurate for jobs with similar pay; otherwise, more tax than necessary may be withheld, and this extra amount will be larger the greater the difference in pay is between the two jobs.

Multiple jobs. Complete Steps 3 through 4(b) on only one Form W-4. Withholding will be most accurate if you do this on the Form W-4 for the highest paying job.

Step 3. This step provides instructions for determining the amount of the child tax credit and the credit for other dependents that you may be able to claim when you file your tax return. To qualify for the child tax credit, the child must be under age 17 as of December 31, must be your dependent who generally lives with you for more than half the year, and must have the required social security number. You may be able to claim a credit for other dependents for whom a child tax credit can’t be claimed, such as an older child or a qualifying relative. For additional eligibility requirements for these credits, see Pub. 972, Child Tax Credit and Credit for Other Dependents. You can also include other tax credits in this step, such as education tax credits and the foreign tax credit. To do so, add an estimate of the amount for the year to your credits for dependents and enter the total amount in Step 3. Including these credits will increase your paycheck and reduce the amount of any refund you may receive when you file your tax return.

Step 4 (optional).

Step 4(a). Enter in this step the total of your other estimated income for the year, if any. You shouldn’t include income from any jobs or self-employment. If you complete Step 4(a), you likely won’t have to make estimated tax payments for that income. If you prefer to pay estimated tax rather than having tax on other income withheld from your paycheck, see Form 1040-ES, Estimated Tax for Individuals.

Step 4(b). Enter in this step the amount from the Deductions Worksheet, line 5, if you expect to claim deductions other than the basic standard deduction on your 2021 tax return and want to reduce your withholding to account for these deductions. This includes both itemized deductions and other deductions such as for student loan interest and IRAs.

Step 4(c). Enter in this step any additional tax you want withheld from your pay each pay period, including any amounts from the Multiple Jobs Worksheet, line 4. Entering an amount here will reduce your paycheck and will either increase your refund or reduce any amount of tax that you owe.
Step 2(b)—Multiple Jobs Worksheet 

(Keep for your records.)

If you choose the option in Step 2(b) on Form W-4, complete this worksheet (which calculates the total extra tax for all jobs) on only ONE Form W-4. Withholding will be most accurate if you complete the worksheet and enter the result on the Form W-4 for the highest paying job.

Note: If more than one job has annual wages of more than $120,000 or there are more than three jobs, see Pub. 505 for additional tables; or, you can use the online withholding estimator at www.irs.gov/W4App.

1 Two jobs. If you have two jobs or you’re married filing jointly and you and your spouse each have one job, find the amount from the appropriate table on page 4. Using the “Higher Paying Job” row and the “Lower Paying Job” column, find the value at the intersection of the two household salaries and enter that value on line 1. Then, skip to line 3.

\[1 \text{ \$} \]

2 Three jobs. If you and/or your spouse have three jobs at the same time, complete lines 2a, 2b, and 2c below. Otherwise, skip to line 3.

- a Find the amount from the appropriate table on page 4 using the annual wages from the highest paying job in the “Higher Paying Job” row and the annual wages for your next highest paying job in the “Lower Paying Job” column. Find the value at the intersection of the two household salaries and enter that value on line 2a.

\[2a \text{ \$} \]

- b Add the annual wages of the two highest paying jobs from line 2a together and use the total as the wages in the “Higher Paying Job” row and use the annual wages for your third job in the “Lower Paying Job” column to find the amount from the appropriate table on page 4 and enter this amount on line 2b.

\[2b \text{ \$} \]

- c Add the amounts from lines 2a and 2b and enter the result on line 2c.

\[2c \text{ \$} \]

3 Enter the number of pay periods per year for the highest paying job. For example, if that job pays weekly, enter 52; if it pays every other week, enter 26; if it pays monthly, enter 12, etc.

\[3 \]

4 Divide the annual amount on line 1 or line 2c by the number of pay periods on line 3. Enter this amount here and in Step 4(c) of Form W-4 for the highest paying job (along with any other additional amount you want withheld).

\[4 \text{ \$} \]

Step 4(b)—Deductions Worksheet 

(Keep for your records.)

1 Enter an estimate of your 2021 itemized deductions (from Schedule A (Form 1040)). Such deductions may include qualifying home mortgage interest, charitable contributions, state and local taxes (up to $10,000), and medical expenses in excess of 7.5% of your income.

\[1 \text{ \$} \]

2 Enter:

- If your annual income is:
  - \$25,100 if you’re married filing jointly or qualifying widow(er)
  - \$18,800 if you’re head of household
  - \$12,550 if you’re single or married filing separately

\[2 \text{ \$} \]

3 If line 1 is greater than line 2, subtract line 2 from line 1 and enter the result here. If line 2 is greater than line 1, enter “-0-”.

\[3 \text{ \$} \]

4 Enter an estimate of your student loan interest, deductible IRA contributions, and certain other adjustments (from Part II of Schedule 1 (Form 1040)). See Pub. 505 for more information.

\[4 \text{ \$} \]

5 Add lines 3 and 4. Enter the result here and in Step 4(b) of Form W-4.

\[5 \text{ \$} \]
### Married Filing Jointly or Qualifying Widow(er)

<table>
<thead>
<tr>
<th>Higher Paying Job Annual Taxable Wage &amp; Salary</th>
<th>Lower Paying Job Annual Taxable Wage &amp; Salary</th>
</tr>
</thead>
<tbody>
<tr>
<td>$0 - 9,999</td>
<td>$0 - 9,999</td>
</tr>
<tr>
<td>$10,000 - 19,999</td>
<td>$10,000 - 19,999</td>
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<tr>
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<td>$20,000 - 29,999</td>
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<td>$30,000 - 39,999</td>
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<td>$50,000 - 59,999</td>
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<td>$60,000 - 69,999</td>
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<tr>
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<td>$100,000 - 99,999</td>
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</tr>
<tr>
<td>$110,000 - 120,000</td>
<td>$110,000 - 120,000</td>
</tr>
</tbody>
</table>

### Single or Married Filing Separately

<table>
<thead>
<tr>
<th>Higher Paying Job Annual Taxable Wage &amp; Salary</th>
<th>Lower Paying Job Annual Taxable Wage &amp; Salary</th>
</tr>
</thead>
<tbody>
<tr>
<td>$0 - 9,999</td>
<td>$0 - 9,999</td>
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<tr>
<td>$10,000 - 19,999</td>
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<td>$100,000 - 99,999</td>
</tr>
<tr>
<td>$110,000 - 120,000</td>
<td>$110,000 - 120,000</td>
</tr>
</tbody>
</table>

### Head of Household

<table>
<thead>
<tr>
<th>Higher Paying Job Annual Taxable Wage &amp; Salary</th>
<th>Lower Paying Job Annual Taxable Wage &amp; Salary</th>
</tr>
</thead>
<tbody>
<tr>
<td>$0 - 9,999</td>
<td>$0 - 9,999</td>
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<tr>
<td>$10,000 - 19,999</td>
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</tr>
<tr>
<td>$110,000 - 120,000</td>
<td>$110,000 - 120,000</td>
</tr>
</tbody>
</table>
LOCAL SERVICES TAX – EXEMPTION CERTIFICATE

APPLICATION FOR EXEMPTION FROM LOCAL SERVICES TAX

➢ A copy of this application for exemption from the Local Services Tax (LST), and all necessary supporting documents, must be completed and presented to your employer AND to the political subdivision levying the Local Services Tax where you are principally employed.
➢ This application for exemption from the Local Services Tax must be signed and dated.
➢ No exemption will be approved until proper documentation has been received.

Name: _____________________________________ Soc Sec #: _____________________________________
Address: ___________________________________ Phone #: _____________________________________
City/State: _________________________________ Zip: _________________________________________

REASON FOR EXEMPTION

1. __________ MULTIPLE EMPLOYERS: Attach a copy of a current pay statement from your principal employer that shows the name of the employer, the length of the payroll period and the amount of Local Services Tax withheld. List all employers on the reverse side of this form. You must notify your other employers of a change in principal place of employment within two weeks of the change.

2. __________ EXPECTED TOTAL EARNED INCOME AND NET PROFITS FROM ALL SOURCES WITHIN _____________________ (municipality or school district) WILL BE LESS THAN $___________: Attach copies of your last pay statements or your W-2 for the year prior.

If you are self-employed, please attach a copy of your PA Schedule C, F, or RK-1 for the prior year.

3. __________ ACTIVE DUTY MILITARY EXEMPTION: Please attach a copy of your orders directing you to active duty status. Annual training is not eligible for exemption. You are required to advise the tax office when you are discharged from active duty status.

4. __________ MILITARY DISABILITY EXEMPTION: Please attach copy of your discharge orders and a statement from the United States Veterans Administrator documenting your disability. Only 100% permanent disabilities are recognized for this exemption.

EMPLOYER: Once you receive this Exemption Certificate, you shall not withhold the Local Services Tax for the portion of the calendar year for which this certificate applies, unless you are otherwise notified or instructed by the tax collector to withhold the tax.

Tax Office: _________________________________
Address: ___________________________________ Phone #: _____________________________________
City/State: _________________________________ Zip: _________________________________________

IMPORTANT NOTE TO EMPLOYERS

1. The municipality is required by law to exempt from the LST employees whose earned income from all sources (employers and self-employment) in their municipality is less than $12,000 when the levied rate exceeds $10.00.
2. The school district for the municipality in which your worksite(s) is located may or may not levy an LST. If it does, the income exemption provided may differ from the municipality and can be anywhere from $0 to $11,999.
3. Contact the tax office where your business worksites are located to obtain this information.

LST Exemption 10-07
Employment Information: List all places of employment for the applicable tax year. Please list your PRIMARY EMPLOYER under #1 below and your secondary employers under the other columns. If self employed, write SELF under Employer Name column.

<table>
<thead>
<tr>
<th></th>
<th>1. PRIMARY EMPLOYER</th>
<th>2.</th>
<th>3.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Employer Name</td>
<td></td>
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</tr>
<tr>
<td></td>
<td>Address</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Address 2</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>City, State Zip</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Municipality</td>
<td></td>
<td></td>
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<td></td>
<td>Phone</td>
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<td>Start Date</td>
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<td></td>
<td>End Date</td>
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<tr>
<td></td>
<td>Status (FT or PT)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Gross Earnings</td>
<td></td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>4.</th>
<th>5.</th>
<th>6.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Employer Name</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Address</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>Address 2</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>City, State Zip</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Municipality</td>
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<td></td>
<td>Phone</td>
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<td>Start Date</td>
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<td>End Date</td>
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<td>Status (FT or PT)</td>
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<td></td>
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<tr>
<td></td>
<td>Gross Earnings</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

PLEASE NOTE:

All information received by the Tax Collector is considered to be CONFIDENTIAL and is only used for official purposes relating to the collection, administration and enforcement of the LOCAL SERVICES TAX.

I DECLARE UNDER PENALTY OF LAW THAT THE INFORMATION STATED ON AND ATTACHED TO THIS FORM IS TRUE AND CORRECT:

SIGNATURE: ___________________________________________ DATE: ____________________
Form I-9 10/21/2019

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

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

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

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

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

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

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

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

☐ 1. A citizen of the United States
☐ 2. A noncitizen national of the United States (See instructions)
☐ 3. A lawful permanent resident (Alien Registration Number/USCIS Number):

☐ 4. An alien authorized to work until (expiration date, if applicable, mm/dd/yyyy):

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

☐ 1. Alien Registration Number/USCIS Number:

☐ 2. Form I-94 Admission Number:

☐ 3. Foreign Passport Number:

Country of Issuance: ____________________________

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
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.")

<table>
<thead>
<tr>
<th>Employee Info from Section 1</th>
<th>Last Name (Family Name)</th>
<th>First Name (Given Name)</th>
<th>M.I.</th>
<th>Citizenship/Immigration Status</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>List A</th>
<th>OR</th>
<th>List B</th>
<th>AND</th>
<th>List C</th>
</tr>
</thead>
<tbody>
<tr>
<td>Document Title and Employment Authorization</td>
<td>Document Title</td>
<td>Document Title</td>
<td>Document Title</td>
<td></td>
</tr>
<tr>
<td>Issuing Authority</td>
<td>Issuing Authority</td>
<td>Issuing Authority</td>
<td>Issuing Authority</td>
<td></td>
</tr>
<tr>
<td>Document Number</td>
<td>Document Number</td>
<td>Document Number</td>
<td>Document Number</td>
<td></td>
</tr>
<tr>
<td>Expiration Date (if any) (mm/dd/yyyy)</td>
<td>Expiration Date (if any) (mm/dd/yyyy)</td>
<td>Expiration Date (if any) (mm/dd/yyyy)</td>
<td>Expiration Date (if any) (mm/dd/yyyy)</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Document Title</th>
<th>Issuing Authority</th>
<th>Document Number</th>
<th>Expiration Date (if any) (mm/dd/yyyy)</th>
</tr>
</thead>
</table>

Additional Information

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)

<table>
<thead>
<tr>
<th>Signature of Employer or Authorized Representative</th>
<th>Today's Date (mm/dd/yyyy)</th>
<th>Title of Employer or Authorized Representative</th>
</tr>
</thead>
</table>

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)

<table>
<thead>
<tr>
<th>Last Name (Family Name)</th>
<th>First Name (Given Name)</th>
<th>Middle Initial</th>
</tr>
</thead>
</table>

B. Date of Rehire (if applicable)

<table>
<thead>
<tr>
<th>Date (mm/dd/yyyy)</th>
</tr>
</thead>
</table>

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.

<table>
<thead>
<tr>
<th>Document Title</th>
<th>Document Number</th>
<th>Expiration Date (if any) (mm/dd/yyyy)</th>
</tr>
</thead>
</table>

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.

<table>
<thead>
<tr>
<th>Signature of Employer or Authorized Representative</th>
<th>Today's Date (mm/dd/yyyy)</th>
<th>Name of Employer or Authorized Representative</th>
</tr>
</thead>
</table>
# 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

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>U.S. Passport or U.S. Passport Card</td>
</tr>
<tr>
<td>2.</td>
<td>Permanent Resident Card or Alien Registration Receipt Card (Form I-551)</td>
</tr>
<tr>
<td>3.</td>
<td>Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa</td>
</tr>
<tr>
<td>4.</td>
<td>Employment Authorization Document that contains a photograph (Form I-766)</td>
</tr>
</tbody>
</table>
| 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. 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 |

## List B

Documents that Establish Identity

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>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</td>
</tr>
<tr>
<td>2.</td>
<td>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</td>
</tr>
<tr>
<td>3.</td>
<td>School ID card with a photograph</td>
</tr>
<tr>
<td>4.</td>
<td>Voter's registration card</td>
</tr>
<tr>
<td>5.</td>
<td>U.S. Military card or draft record</td>
</tr>
<tr>
<td>6.</td>
<td>Military dependent's ID card</td>
</tr>
<tr>
<td>7.</td>
<td>U.S. Coast Guard Merchant Mariner Card</td>
</tr>
<tr>
<td>8.</td>
<td>Native American tribal document</td>
</tr>
<tr>
<td>9.</td>
<td>Driver's license issued by a Canadian government authority</td>
</tr>
</tbody>
</table>

For persons under age 18 who are unable to present a document listed above:

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>10.</td>
<td>School record or report card</td>
</tr>
<tr>
<td>11.</td>
<td>Clinic, doctor, or hospital record</td>
</tr>
<tr>
<td>12.</td>
<td>Day-care or nursery school record</td>
</tr>
</tbody>
</table>

## List C

Documents that Establish Employment Authorization

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
</table>
| 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. | Certification of report of birth issued by the Department of State (Forms DS-1350, FS-545, FS-240) |
| 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. | Native American tribal document |
| 5. | U.S. Citizen ID Card (Form I-197) |
| 6. | Identification Card for Use of Resident Citizen in the United States (Form I-179) |
| 7. | Employment authorization document issued by the Department of Homeland Security |

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

Refer to the instructions for more information about acceptable receipts.
RESIDENCY CERTIFICATION FORM
Local Earned Income Tax Withholding

TO EMPLOYERS/TAXPAYERS:

This form is to be used by employers and/or taxpayers to report essential information for the collection and distribution of Local Earned Income Taxes to the local EIT collector. This form must be utilized by employers when a new employee is hired or when a current employee notifies employer of a name and/or address change. Use the Address Search Application at www.newPA.com/Act32 to determine PSD codes, EIT rates and tax collector contact information.

### EMPLOYEE INFORMATION – RESIDENCE LOCATION

| NAME (Last Name, First Name, Middle Initial) | SOCIAL SECURITY NUMBER |
| STREET ADDRESS (No PO Box, RD or RR) |
| ADDRESS LINE 2 |
| CITY | STATE | ZIP CODE | DAYTIME PHONE NUMBER |
| MUNICIPALITY (City, Borough or Township) |
| COUNTY | RESIDENT PSD CODE | TOTAL RESIDENT EIT RATE |

### EMPLOYER INFORMATION – EMPLOYMENT LOCATION

| EMPLOYER BUSINESS NAME (Use Federal ID Name) | EMPLOYER FEIN |
| STREET ADDRESS WHERE ABOVE EMPLOYEE REPORTS TO WORK (No PO Box, RD or RR) |
| ADDRESS LINE 2 |
| CITY | STATE | ZIP CODE | PHONE NUMBER |
| MUNICIPALITY (City, Borough or Township) |
| COUNTY | WORK LOCATION PSD CODE | WORK LOCATION NON-RESIDENT EIT RATE |

### CERTIFICATION

Under penalties of perjury, I (we) declare that I (we) have examined this information, including all accompanying schedules and statements and to the best of my (our) belief, they are true, correct and complete.

| SIGNATURE OF EMPLOYEE | DATE (MM/DD/YYYY) |
| PHONE NUMBER | EMAIL ADDRESS |

For information on obtaining the appropriate MUNICIPALITY (City, Borough, Township), PSD CODES and EIT (Earned Income Tax) RATES, please refer to the Pennsylvania Department of Community & Economic Development website:

www.newPA.com/Act32
SERVICE WITH OTHER STATE AGENCIES

(Print) Last Name    First Name    Middle Initial

Are you currently an active employee in a Pennsylvania state agency or public school district and contributing to a state retirement plan?

YES □               NO □

If yes, please indicate which retirement plan:
(If you are not sure which plan, please check with the agency so that your contribution rate is correct)

☐ PSERS Class T-C (6.25%)   ☐ SERS Class A (5%)
☐ PSERS Class T-D (7.5%)   ☐ SERS Class AA (6.25%)
☐ PSERS Class T-E (7.5%)   ☐ SERS Class A-3 (6.25%)
☐ PSERS Class T-F (10.3%)   ☐ SERS Class A-4 (9.3%)

Have you had a previous periods of service with any Pennsylvania state agency for which you are collecting a retirement benefit?

YES □               NO □

If so, please indicate which retirement plan:

PSERS □               SERS □
## Previous Periods of Service with Other State Agencies

<table>
<thead>
<tr>
<th>Name of Agency or Branch of State Government</th>
<th>From (Month, Day, Year)</th>
<th>To (Month, Day, Year)</th>
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<tbody>
<tr>
<td>1.</td>
<td></td>
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<td>2.</td>
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<td>9.</td>
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<tr>
<td>10.</td>
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</tbody>
</table>

**Note:** All married female employees. If you have worked in another agency under your maiden name, place your maiden name beside the name of the appropriate agency.

**Signature**

**Date**
PAY OPTION SELECTION

FULL TIME / FULL YEAR FACULTY ONLY

I hereby elect to receive my salary while serving as a faculty member at Shippensburg University in the following manner:

☐ Twenty-six pay periods

☐ Twenty pay periods

_______________________________            _____/_____/_____
Signature        Date

_______________________________
Printed name

/____/____
Date
DIRECT DEPOSIT AUTHORIZATION FORM

How Direct Deposit works –

The Pennsylvania State System of Higher Education notifies your financial institution electronically of the funds to be deposited on your behalf. Your financial institution records this transaction into an account of your choice, creating immediate access on the day of deposit. You receive an earnings statement documenting this payment. If you desire to make a direct deposit into more than one institution, you must complete a form for each institution. Only one deposit can be made to one account at each institution.

✓ It’s convenient – saves you a trip to the bank.
✓ It’s faster – most banks post the funds to your account at the beginning of the day’s business on payday allowing immediate access.
✓ It’s safer – Direct Deposit eliminates the worry of a lost or stolen paycheck.
✓ It’s confidential – funds are automatically processed and you can instruct your bank to apply them to your savings or checking account.

Name ____________________________________________________ Personnel Number _________________

I hereby authorize the Pennsylvania State System of Higher Education to (circle one) Start / Change / Stop total biweekly payroll deduction to the Financial Institution shown below. You may designate any bank, savings and loan association, or credit union in the U.S. that (1) is a member of the Federal Reserve System and (2) accepts electronic funds transfer. Payroll will notify you if the institution you choose does not qualify.

Financial Institution Name _________________________________________________________________
Transit Routing Number _________________________________________________________________
Account Number _________________________________________________________________
Account Type (Savings/Checking) _________________________________________________________________
Deduction Amount ($ Amount) _________________________________________________________________
Effective with pay date of __________________________________________________________________

I have an established account at the Financial Institution indicated above and authorize the Pennsylvania State System of Higher Education to initiate credit entries and to initiate debit entries and adjustments for any credit entries in error to my (our) account(s) listed above. I have provided a copy of a voided check (see attached) solely for the purpose of verifying my account number and the Financial Institution’s routing number. My authorization will remain in effect until revoked by me in writing or until I terminate my employment with the Pennsylvania State System of Higher Education.

Signature ______________________________________________________________ Date _______________________________

Co-Signature (Required if Joint Account) __________________________________________________________________
Confidentiality Statement

As an employee/student employee/graduate assistant/volunteer/contractor of Shippensburg University of Pennsylvania, I understand that I may have access to confidential, personal data and/or records of University employees, students, customers and other related constituents. I agree that I will access, use, discuss, release and/or divulge only the data that is needed to perform my job. I understand that I am prohibited from accessing, using, discussing, releasing and/or divulging this data unless doing so is a requirement of my job.

I further understand that unauthorized disclosure of confidential information and records applies to all information on the University computing/networking systems, all printed information, as well as formal and informal verbal conversations.

I understand that any release of this information will be done only through authorized protocols. Breaches in confidentiality of such data may result in disciplinary action up to and including separation from employment and in the case of student employees and graduate assistants, possible University judicial action. A violation of this agreement also may result in legal action if it is determined that any local, state, or federal laws have been violated.

I have reviewed this statement and understand that if I have questions, or would like to discuss this responsibility with a representative of the University I can make that request by contacting the Human Resources office at 717-477-1124 or hr@ship.edu.

By my signature below, I certify that I have read, understand, and agree to abide by the provisions of this statement.

Name (print) _____________________________

__________________________________________  _____________________________
Signature                                      Date

9/2017
Shippensburg University
Workers’ Compensation Employee Notification

The Workers’ Compensation Act is designed to provide reimbursement for reasonable medical care for someone who suffers an injury arising in the course of his employment and causally related thereto. Pursuant to the Act, your employer will provide payment for reasonable surgical and medical services, services rendered by physicians or other health care providers, medicines and supplies, as and when needed.

If you require emergency medical treatment, you may seek it from any provider however, any subsequent non-emergency treatment shall be obtained from one of the designated health care providers whose names appear on the list posted on your employer’s premises. You must obtain treatment from one of these providers for ninety (90) days from the date of your first visit to that provider; otherwise, your employer shall not be responsible for payment of your non-emergency medical bills for that first ninety (90) days.

During the initial ninety (90) days from the date of your first visit, you have the right to switch from one health care provider on the list to another and that treatment will be paid for by your employer.

If a designated health care provider refers you for treatment to another health care provider whose name is not on the list, your employer will pay for treatment rendered by the provider whom you were referred.

Naturally, you have the right to seek treatment or medical consultation from a non-designated health care provider during the initial ninety (90) day period following the first visit, but you are personally responsible for payment for those services.

You have the right to seek treatment from any health care provider at the expiration of the ninety (90) days period from the date of first visit. This treatment will be paid for by your employer unless the treatment is found to be unreasonable or unnecessary by a utilization review organization pursuant to the utilization review process contained in the Pennsylvania Workers’ Compensation Act.

Your employer will be responsible for the cost of that treatment after the initial ninety (90) day period has ended but only if you notify the employer that you are receiving treatment from a non-designated health care provider and only if that notice is provided to your employer within five (5) days after the first visit to that provider. If you provide notice to your employer of treatment by a non-designated provider more than five (5) days after the first visit to that provider, the employer will not be responsible to pay for treatment rendered by that non-designated provider until it receives notification from our that you are receiving such treatment.

Should invasive surgery be prescribed by a designated health care provider, your employer will pay for an additional opinion from a health care provider of your choice. If the additional opinion differs from the opinion of the designated health care provider and if the additional opinion provides a specific and detailed course of treatment, you will then determine which course of treatment to follow. If you choose to follow the procedures recommended in the additional opinion, your employer will pay to have such procedures performed by one of its designated health care providers and will not be responsible for payment for treatment provided by a non-designated provider for a period of ninety (90) days from the date of your visit to the health care provider from whom you obtained the additional opinion.

I HEREBY ACKNOWLEDGE THAT I HAVE BEEN INFORMED OF AND UNDERSTAND MY RIGHTS AND DUTIES UNDER THE WORKERS’ COMPENSATION ACT AS SET FORTH HEREIN.

DATE ________________________   ______________________________
Employee Signature
Workers’ Compensation Information

The following information is being provided to you in compliance with 34 Pa.Code § 121.3b.

1) The workers’ compensation law provides wage loss and medical benefits to employees who cannot work, or who need medical care, because of a work-related injury.

2) Benefits are required to be paid by your employer when self-insured, or through insurance provided by your employer. Your employer is required to post the name of the company responsible for paying workers’ compensation benefits at its primary place of business and at its sites of employment in a prominent and easily accessible place, including, without limitation, areas used for the treatment of injured employees or for the administration of first aid.

3) You should report immediately any injury or work-related illness to your employer.

4) Your benefits could be delayed or denied if you do not notify your employer immediately.

5) If your claim is denied by your employer, you have the right to request a hearing before a workers’ compensation judge.

6) The Bureau of Workers’ Compensation cannot provide legal advice. However, you may contact the Bureau of Workers’ Compensation for additional general information at: Bureau of Workers’ Compensation, 1171 South Cameron Street, Room 103, Harrisburg, Pennsylvania 17104-2501; telephone number within Pennsylvania (800) 482-2383; telephone number outside of this Commonwealth (717) 772-4447; TTY (800) 362-4228 (for hearing and speech impaired only);[www.state.pa.us](http://www.state.pa.us), PA Keyword: workers comp.

Employee’s Signature: ________________________________

Date: ________________________________
SHIPPENSBURG UNIVERSITY
Work-related Injury Procedures

⇒ What is a job related injury?
   An injury that occurs while working or performing work related activities.

⇒ What to do in the event of being injured on the job:

1. If a life-threatening injury, immediately inform your supervisor of the injury.
   An accident report must be filed with the safety director (Ext. 1446) within seven days. When completing
   the report you will need to know the date and time of injury as well as names of witnesses.

2. If medical treatment is necessary report to a panel physician informing that office
   that Shippensburg University is your employer, that your injury occurred at work
   and that they should send bills for treatment to INSERVCO.

3. If your injury requires lost time from work, you should contact the Human
   Resources Office to discuss your options for using paid leave or leave without pay
   and how payments are processed by INSERVCO if your claim is approved.

Under the Pennsylvania Workers’ Compensation Act employees have the
following rights and duties:

   The employee has the duty to obtain treatment for work-related injuries
   and illnesses from one or more of the above providers for 90 days from the date of
   the first visit. During that 90-day period the employee has the right to receive all
   reasonable medical supplies and treatment related to the injury and/or switch from
   one provider on the list to another on the list. The employee also has the right to
   seek treatment from another practitioner if referred to him by a designated
   provider.

   Emergency medical treatment can be sought from any provider, but that
   subsequent non-emergency treatment must be by a designated provider for the
   remainder of the 90-day period. The employee has the right to seek treatment or
   medical treatment from any provider during the 90-day period, but these services
   shall be at their own expense. After the 90-day period, the employee has the right
   to seek treatment from any health care provider, which will be paid for by the
   employer if it is reasonable and necessary. The employee has the duty to notify
   the employer of treatment by a non-designated provider within 5 days of the first
   visit to that provider. The employer may not be required to pay for treatment
   rendered by a non-designated provider prior to receiving this notification.

⇒ Any Questions?
   Please contact the University Safety Coordinator, ext. 1446 or the Human
   Resources Department, ext 1124.
NOTICE TO EMPLOYEES IN CASE OF WORK-RELATED INJURIES

If you suffer a work-related injury, immediately report the injury to your supervisor. Failure to do so may delay your benefits or may cause you to lose your rights to benefits. For necessary medical treatment and supplies to be paid by your employer:

- All treatment must be obtained from one of the healthcare providers listed below.
- You must continue to visit one of the healthcare providers listed below if you need treatment for 90 days from the date of your first visit. If one of the providers listed below refers you to another licensed specialist, those services will be paid.
- After this 90-day period, if you still need treatment, you may go to another healthcare provider for treatment as long as you notify your claims adjuster within five (5) days of your visit to a new provider.
- If a listed physician prescribes invasive surgery, you have the right to obtain a second opinion from a physician of your choice. If a second opinion differs from that of the listed physician’s opinion, you may determine which course of treatment to follow; however, the second opinion must contain a detailed treatment plan. If you choose the treatment prescribed in the second opinion, you must receive the treatment from a listed provider for a period of 90 days after the date of your visit to the provider of the second opinion.

If you are faced with a medical emergency, you may secure initial emergency treatment from any emergency facility. However, when the emergency is resolved, follow-up treatment must be obtained from one of the following healthcare providers. If you choose to treat with an out-of-state provider, you may be subject to balance billing.

<table>
<thead>
<tr>
<th>NAME OF PROVIDER</th>
<th>STREET</th>
<th>CITY, STATE, ZIP</th>
<th>PHONE</th>
<th>SPECIALTY</th>
</tr>
</thead>
<tbody>
<tr>
<td>AllBetterCare</td>
<td>1175 Walnut Bottom Rd.</td>
<td>Carlisle, PA 17015</td>
<td>717.258.9355</td>
<td>Urgent Care</td>
</tr>
<tr>
<td>MedExpress</td>
<td>1048 Lincoln Way East, Ste. 101</td>
<td>Chambersburg, PA 17201</td>
<td>717.267.2273</td>
<td>Urgent Care</td>
</tr>
<tr>
<td>WellSpan Urgent Care</td>
<td>46 Walnut Bottom Road, Ste. 100</td>
<td>Shippensburg, PA 17257</td>
<td>717.477.2764</td>
<td>Urgent Care</td>
</tr>
<tr>
<td>US Healthworks Medical Group</td>
<td>1124 Harrisburg Pike</td>
<td>Carlisle, PA 17013</td>
<td>717.245.2411</td>
<td>Occ. Medicine</td>
</tr>
<tr>
<td>Summit Occupational Health</td>
<td>1610 Orchard Drive</td>
<td>Chambersburg, PA 17201</td>
<td>717.261.0929</td>
<td>Occ. Medicine</td>
</tr>
<tr>
<td>Orthopedic Institute of PA</td>
<td>1 Dunwoody Drive</td>
<td>Carlisle, PA 17015</td>
<td>717.761.5530</td>
<td>Orthopedics</td>
</tr>
<tr>
<td>Richards Orthopaedic Center/ Sports Med.</td>
<td>144 South Eighth Street</td>
<td>Chambersburg, PA 17201</td>
<td>717.414.7798</td>
<td>Orthopedics</td>
</tr>
<tr>
<td>Robert E. Sheep, MD</td>
<td>120 N. 7th St., Ste. 206</td>
<td>Chambersburg, PA 17201</td>
<td>717.263.1211</td>
<td>General Surgery</td>
</tr>
<tr>
<td>Drayer Physical Therapy</td>
<td>97 Progress Blvd., Ste. 2</td>
<td>Shippensburg, PA 17257</td>
<td>866.446.2848</td>
<td>Physical Therapy</td>
</tr>
<tr>
<td>Pivot Physical Therapy</td>
<td>580 Walker Road</td>
<td>Chambersburg, PA 17201</td>
<td>866.446.2848</td>
<td>Physical Therapy</td>
</tr>
<tr>
<td>Chambersburg Chiropractic</td>
<td>1461 Lincoln Way East</td>
<td>Chambersburg, PA 17202</td>
<td>866.446.2848</td>
<td>Chiropractic</td>
</tr>
</tbody>
</table>

FOR PRESCRIPTION MEDICATIONS AND DURABLE MEDICAL EQUIPMENT OR TO SCHEDULE PHYSICAL THERAPY, CHIROPRACTIC AND DIAGNOSTIC IMAGING APPOINTMENTS, AND LOCATIONS CLOSE TO YOU, PLEASE CALL KEYSRIPTS AT 1.866.446.2848.

All of your healthcare provider bills and reports need to be sent to the following address for review and payment in accordance with the Pennsylvania Workers’ Compensation Act:

Inservco Insurance Services, Inc. P.O. Box 3899, Harrisburg, PA 17105-3899
Phone: 1.800.356.0438 - Fax: 1.866.356.0438
Shippensburg University Background Check Information for Employees & Independent Contractors

As part of your employment relationship with Shippensburg University you must give the University authorization to investigate your background. Here are the steps in the process:

1. There are two forms you should complete: the **Information Release Authorization** and the **Background Clearance Certification for Provisional Employment or Volunteering**.
2. Both should be sent to the Human Resources Office (109 Old Main) or the Provost’s Office (309 Old Main). *Remember to safeguard your confidential information by returning forms in a sealed envelope or hand delivering.*
3. A representative from one of those offices will order the appropriate background checks (see information below).
4. You will receive information via the e-mail address you included on your release regarding how to proceed with the PA Child Abuse Search and the FBI Criminal Search with Fingerprints.
5. A copy of the PA Child Abuse Search and the FBI Criminal Search with Fingerprints results must be returned to the Human Resources Office or the Provost’s Office upon completion.
6. If results are not returned within 90 days you will be unable to work until they are provided.

We utilize the services of CBY Systems, Inc. as our background check provider.

The searches that the University will complete are as follows:

**PA State Police Criminal Search**: This search is a criminal history record check from the Pennsylvania State Police (PSP).

**PA Child Abuse Search**: This search requests certification from the Department of Human Services as to whether an individual is named in the statewide database as a perpetrator in a pending child abuse investigation or in a founded or indicated report of child abuse in the last five years.

**FBI Criminal Search with Fingerprints**: This is a federal criminal history record check and individuals must submit a full set of fingerprints to the Pennsylvania State Police to obtain this report. The PSP will submit the fingerprints to the Federal Bureau of Investigation for the purpose of verifying the identity of the individual and obtaining a current record of any criminal arrests and convictions.

*these searches will be conducted prior to your assignment with Shippensburg University and then every three years thereafter.*

All information will be safeguarded per University policy.

Rev 01/26/2015
I, ______________________________________, hereby authorize any educational institution, any past or present employer (including any branch of the armed services), any local, state, or federal government agency (including any laws enforcement or security agencies) to release to Shippensburg University through its authorized representative(s) bearing this authorization, all information concerning me.

I voluntarily agree to this investigation of my background with the knowledge and understanding that whatever information is obtained is for the official use of Shippensburg University and will not be released to any other parties.

I further understand any information obtained during such investigation may only be used to determine my fitness, competence, and ability for the purpose of working at Shippensburg University.

I release Shippensburg University from any liability which may result from making this investigation. Furthermore, I hereby forever release anyone who has knowledge or information concerning my employment history and criminal history from any claims or demands from liability or damages for disclosure of true and accurate information provided by this investigation. This authorization shall supersede and countermand any prior request or authorizations to the contrary.

I further authorize the use of photocopies of this authorization and agree to provide copies of search results if they are sent directly to me.

Name:  Last ___________________________  First ___________________________  M.I. ______

Please print clearly

Home/Cell/Work Phone: _________________  Email Address: ______________________

Current Address: ____________________________________________________________

City/State/Zip Code: __________________________________________________________

*Department/Assignment: ______________________________________________________

Signature: ___________________________  Date: ________________________________

DO NOT WRITE BELOW THIS LINE: FOR UNIVERSITY USE ONLY

Date of Birth: _________________________  SS#: ________________________________
Shippensburg University
Background Clearance Certification
for Provisional Employment or Volunteering
(Under the Child Protective Services Law)

Please read this entire form carefully before completing it. This form is to be used by prospective employees/volunteers to meet the written certification requirement to be considered as a provisional hire or volunteer assignment. In certain limited circumstances, current employees/volunteers may need to complete this form.

Section 1. Personal Information

Full Legal Name: ____________________________________________________________

Any former names or aliases by which you have been identified: ____________________________

Section 2. Instructions

Please submit this form to Human Resources Department, Shippensburg University.

If you have any question about whether to report an offense, you should report it. Failure to report may result in disqualification for employment.

List of Reportable Offenses

A Reportable Offense enumerated under Pennsylvania’s Child Protective Services Law, 23 Pa.C.S. §6344(c), consists of one or more of the following:

1. Provisions of Title 18 of the Pennsylvania Consolidated Statutes (relating to crimes and offenses) or an equivalent crime under the laws or former laws of the United States or one of its territories or possessions, another state, the District of Columbia, the Commonwealth of Puerto Rico or a foreign nation, or under a former law of the Commonwealth of Pennsylvania:
   - Chapter 25 relating to criminal homicide
   - Section 2702 relating to aggravated assault
   - Section 2709.1 relating to stalking
   - Section 2901 relating to kidnapping
   - Section 2902 relating to unlawful restraint
   - Section 3121 relating to rape
   - Section 3122.1 relating to statutory sexual assault
   - Section 3123 relating to involuntary deviate sexual intercourse
   - Section 3124.1 relating to sexual assault
   - Section 3125 relating to aggravated indecent assault
   - Section 3126 relating to indecent assault
   - Section 3127 relating to indecent exposure
   - Section 4302 relating to incest
   - Section 4303 relating to concealing death of a child
   - Section 4304 relating to endangering welfare of children
   - Section 4305 relating to dealing in infant children
   - A felony offense under Section 5902(b) relating to prostitution and related offenses
   - Section 5903(c) or (d) relating to obscene and other sexual materials and performances
   - Section 6301 relating to corruption of minors
   - Section 6312 relating to sexual abuse of children

2. An offense designated as a felony under the act of April 14, 1972 (P.L. 233, No. 64), known as “The Controlled Substance, Drug, Device and Cosmetic Act,” committed within the preceding five-year period.

3. A founded report of child abuse within the preceding five-year period in the statewide database maintained by the Department of Human Services.
Section 3. No Conviction

☐ By checking this box, I certify that I have not been convicted of any Reportable Offense or an offense similar in nature to a Reportable Offense under the laws or former laws of the United States or one of its territories or possessions, another state, the District of Columbia, the Commonwealth of Puerto Rico or a foreign nation, or under a former law of the Commonwealth of Pennsylvania. (See Section 2 for a list of Reportable Offenses.)

Section 4. Application for Background Checks

I certify that I have applied or will apply for the following required background clearance checks:

☐ A report of criminal history record from the Pennsylvania State Police (PSP) or statement from the PSP that no criminal record exists.

☐ Certification from the Pennsylvania Department of Human Services as to whether I am named in the statewide database as a perpetrator in a pending child abuse investigation or in a founded report or indicated report of child abuse.

☐ A report of federal criminal history record information. I understand that I must submit a full set of fingerprints to the PSP to obtain this report if I have not been a resident of Pennsylvania for the entirety of at least the last 10 consecutive years prior to the date of this application.

☐ I further certify that I have provided or will provide copies of the completed request forms and results for these background clearance checks to Shippensburg University. (Appropriate forms may be attached to this Certification Form.)

Section 5. Certification

By signing this form, I swear and affirm under penalty of law that the statements made in this form are true, correct, and complete. I understand that false statements herein, including, without limitation, any failure to accurately report any arrest or conviction for a Reportable Offense, shall subject me to criminal prosecution under 18 Pa.C.S. §4904, relating to unsworn falsification to authorities.

________________________________________  __________________________
Signature                                      Date
Shippensburg University

Applicant Information for Act 114 FBI Criminal Search With Fingerprint

Name:  Last ______________________________ First __________________________ M.I. _____

Please print clearly

Alias/Maiden Name: _____________________________________________________________

Home/Cell/Work Phone: __________________________ Email Address: __________________

Current Address: __________________________________________________________________

City/State/Zip Code: ____________________________________________________________

*Department/Assignment: __________________________________________________________________

Place of Birth (city and state): ___________________________________________________

Country of Citizenship: __________________________________________________________________

Sex: __________________________ Race: __________________________

Eye Color: __________________________ Hair Color: __________________________

Height: __________________________ Weight: __________________________

Signature: __________________________ Date: __________________________

April 28, 2015