Work Study Placement Procedure

- Career Services signs off on Clearance form and sends student with packet (if required) to Employer for interview

- If hired, “Employer” will complete and sign Clearance Form then send student to Human Resources

- Student MUST provide Human Resources with:
  - the completed Clearance Form
  - Human Resource Packet (if required)

- Student MUST receive official start date from the Human Resource Department before starting work

- Student should notify Employer of start date
W-4 Form

Complete: A – H and 1 – 10
Personal Allowances Worksheet (Keep for your records.)

A
Enter "1" for yourself if no one else can claim you as a dependent.

- You are single and have only one job;
- You are married, have only one job, and your spouse does not work.
- Your wages from a second job or your spouse's wages (or the total of both) are $1,500 or less.

B
Enter "1" if:

- You are married, have only one job, and your spouse does not work;
- Your wages from a second job or your spouse's wages (or the total of both) are $1,500 or less.

C
Enter "1" for your spouse. But you may choose to enter "0-0" if you are married and have either a working spouse or more than one job. (Entering "0-0" may help you avoid having too little withholding.)

D
Enter number of dependents (other than your spouse or yourself) you will claim on your tax return.

E
Enter "1" if you will file as head of household on your tax return (see conditions under Head of Household above).

F
Enter "1" if you have at least $2,000 of child or dependent care expenses for which you plan to claim a credit.

(Note: Do not include child support payments. See Pub. 503, Child and Dependent Care Expenses, for details.)

G
Child Tax Credit (including additional child tax credit). See Pub. 972, Child Tax Credit, for more information.

- If your total income will be less than $70,000 ($100,000 if married), enter "2" for each eligible child; then less "1" if you have two or four eligible children or less "2" if you have five or more eligible children.
- If your total income will be between $70,000 and $84,000 ($100,000 and $119,000 if married), enter "1" for each eligible child.

H
Add lines A through G and enter total here. (Note: This may be different from the number of exemptions you claim on your tax return.)

For accuracy, complete all worksheets that apply.

Separate here and give Form W-4 to your employer. Keep the top part for your records.

Employee's Withholding Allowance Certificate

Whether you are entitled to claim a certain number of allowances or exemption from withholding is subject to review by the IRS. Your employer may be required to send a copy of this form to the IRS.

1 Your first name and middle initial
2 Your social security number

Home address (number and street or rural route)

City or town, state, and ZIP code

Total number of allowances you are claiming (from line H above or from the applicable worksheet on page 2)

Additional amount, if any, you want withheld from each paycheck

Last year I had a right to a refund of all federal income tax withheld because I had no tax liability, and

This year I expect a refund of all federal income tax withheld because I expect to have no tax liability.

If you meet both conditions, write "Exempt" here.

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

Employee's signature

Date

For Privacy Act and Paperwork Reduction Act Notice, see page 2.

Cat. No. 10220Q

Form W-4 (2016)
## Deductions and Adjustments Worksheet

**Note:** Use this worksheet only if you plan to itemize deductions or claim certain credits or adjustments to income.

1. Enter an estimate of your 2016 itemized deductions. These include qualifying home mortgage interest, charitable contributions, state and local taxes, medical expenses in excess of 10% (7.5% if either you or your spouse was born before January 1, 1992) of your income, and miscellaneous deductions. For 2016, you may have to reduce your itemized deductions if your income is over $311,300 and you are married filing jointly or $239,400 if you are single and not head of household or a qualifying widow(er); or $155,650 if you are married filing separately. See Pub. 505 for details.

   \[ \text{Deductions} = \text{marginal tax brackets} \times \text{tax rate} \times (\text{total income} - \text{standard deduction}) \]

   \[ \text{Total Income} = \text{wages} + \text{interest} + \text{dividends} + \text{capital gains} + \text{other income} \]

2. Enter:

   \[ \text{Net Income} = \text{wages} - \text{deductions} \]

3. Subtract line 2 from line 1. If zero or less, enter "0."

4. Enter an estimate of your 2016 adjustments to income and any additional standard deduction (see Pub. 505).

5. Add lines 3 and 4 and enter the total. (Include any amount for credits from the Converting Credits to Withholding Allowances for 2016 Form W-4 worksheet in Pub. 505.)

6. Enter an estimate of your 2016 nonwage income (such as dividends or interest).

7. Subtract line 6 from line 5. If zero or less, enter "0."

8. Divide the amount on line 7 by $4,050 and enter the result here. Drop any fraction.

9. Enter the number from the Personal Allowances Worksheet, line H, page 1.

10. Add lines 8 and 9 and enter the total here. If you plan to use the Two-Earners/Multiple Jobs Worksheet, also enter this total on line 1 below. Otherwise, stop here and enter this total on Form W-4, line 5, page 1.

### Two-Earners/Multiple Jobs Worksheet (See Two earners or multiple jobs on page 1.)

1. Enter the number from line H, page 1 (or from line 10 above if you used the Deductions and Adjustments Worksheet).

2. Find the number in Table 1 below that applies to the LOWEST paying job and enter it here. However, if you are married filing jointly and wages from the highest paying job are $65,000 or less, do not enter more than "$3."

3. If line 1 is more than or equal to line 2, subtract line 2 from line 1. Enter the result here (if zero, enter "0") and on Form W-4, line 5, page 1. Do not use the rest of this worksheet.

4. Enter the number from line 2 of this worksheet.

5. Enter the number from line 1 of this worksheet.

6. Subtract line 5 from line 4.

7. Find the amount in Table 2 below that applies to the HIGHEST paying job and enter it here.

8. Multiply line 7 by line 6 and enter the result here. This is the additional withholding needed.

9. Divide line 8 by the number of pay periods remaining in 2016. For example, divide by 25 if you are paid every two weeks and you complete this form on a date in January when there are 25 pay periods remaining in 2016. Enter the result here and on Form W-4, line 6, page 1. This is the additional amount to be withheld from each paycheck.

### Table 1

<table>
<thead>
<tr>
<th>Married Filing Jointly</th>
<th>All Others</th>
</tr>
</thead>
<tbody>
<tr>
<td>If wages from LOWEST paying job are—</td>
<td>Enter on line 2 above</td>
</tr>
<tr>
<td>$0 - $6,000</td>
<td>0</td>
</tr>
<tr>
<td>6,001 - 14,000</td>
<td>1</td>
</tr>
<tr>
<td>14,001 - 25,000</td>
<td>2</td>
</tr>
<tr>
<td>25,001 - 27,000</td>
<td>2</td>
</tr>
<tr>
<td>27,001 - 35,000</td>
<td>4</td>
</tr>
<tr>
<td>35,001 - 44,000</td>
<td>5</td>
</tr>
<tr>
<td>44,001 - 55,000</td>
<td>6</td>
</tr>
<tr>
<td>55,001 - 65,000</td>
<td>7</td>
</tr>
<tr>
<td>65,001 - 75,000</td>
<td>8</td>
</tr>
<tr>
<td>75,001 - 80,000</td>
<td>9</td>
</tr>
<tr>
<td>80,001 - 100,000</td>
<td>10</td>
</tr>
<tr>
<td>100,001 - 115,000</td>
<td>11</td>
</tr>
<tr>
<td>115,001 - 130,000</td>
<td>12</td>
</tr>
<tr>
<td>130,001 - 140,000</td>
<td>13</td>
</tr>
<tr>
<td>140,001 - 150,000</td>
<td>14</td>
</tr>
<tr>
<td>150,001 and over</td>
<td>15</td>
</tr>
</tbody>
</table>

### Table 2

<table>
<thead>
<tr>
<th>Married Filing Jointly</th>
<th>All Others</th>
</tr>
</thead>
<tbody>
<tr>
<td>If wages from HIGHEST paying job are—</td>
<td>Enter on line 7 above</td>
</tr>
<tr>
<td>$0 - $75,000</td>
<td>$610</td>
</tr>
<tr>
<td>75,001 - 135,000</td>
<td>1,010</td>
</tr>
<tr>
<td>135,001 - 205,000</td>
<td>1,130</td>
</tr>
<tr>
<td>205,001 - 360,000</td>
<td>1,340</td>
</tr>
<tr>
<td>360,001 - 405,000</td>
<td>1,420</td>
</tr>
<tr>
<td>405,001 and over</td>
<td>1,600</td>
</tr>
</tbody>
</table>

**Privacy Act and Paperwork Reduction Act Notice:** We ask for the information on this form to carry out the Internal Revenue laws of the United States. Internal Revenue Code sections 3402(f)(3) and 6109 and their regulations require you to provide this information; your employer uses it to determine your federal income tax withholding. Failure to provide a properly completed form will result in your being treated, as a single person who claims no withholding allowances; providing fraudulent information may subject you to penalties. Routine uses of this information include giving it to the Department of Justice for civil and criminal litigation; to cities, states, the District of Columbia, and U.S. commonwealths and possessions for use in enforcing their tax laws; and to the Department of Health and Human Services for use in the National Directory of New Hires. We may also disclose this information to other countries under a tax treaty, to federal and state agencies to enforce federal non-tax crimes, or to federal law enforcement and intelligence agencies to combat terrorism.

You are not required to provide the information requested on a form that is subject to the Paperwork Reduction Act unless the form displays a valid OMB control number. Books or records relating to a form or its instructions must be retained as long as their contents may become material in the administration of any Internal Revenue law. Generally, tax returns and return information are confidential, as required by Code section 6103.

The average time and appraisal required to complete and file this form will vary depending on individual circumstances. For estimated averages, see the instructions for your income tax return.

If you have suggestions for making this form simpler, we would be happy to hear from you. See the instructions for your income tax return.
Retirement questionnaire

Complete:

1. Personal information
2. Select A, B or C
3. Select
   “I do wish to join”, sign and date or
   “I do not wish to join”, sign and date
SUNY ORANGE
Orange County Community College

ORANGE COUNTY COMMUNITY COLLEGE
Middletown, NY 10940

RETIREMENT QUESTIONNAIRE

NAME: ___________________________ SOCIAL SECURITY NUMBER: ___________________________

ADDRESS: ____________________________________________________________

CITY: ___________________________ STATE: _______ ZIP CODE: ____________

BIRTHDATE: ________________ TELEPHONE: ____________________________

(a) IF YOU RETAIN AN ACTIVE CONTRACT WITH ONE OF THE FOLLOWING NEW YORK STATE RETIREMENT SYSTEMS OR TIAA, YOU MUST INDICATE WHICH RETIREMENT SYSTEM YOU ARE A MEMBER OF AND COMPLETE THE INFORMATION REQUIRED.

☐ NYS TEACHERS' RETIREMENT SYSTEM

REGISTRATION NO: ___________________________ DATE JOINED: ___________________________

TIER NO. __________ CONTRIBUTION? ☐ YES ☐ NO

☐ NYS EMPLOYEES' RETIREMENT SYSTEM

REGISTRATION NO: ___________________________ DATE JOINED: ___________________________

TIER NO. __________ CONTRIBUTION? ☐ YES ☐ NO

☐ TIAA (TEACHERS' INSURANCE ANNUITY ASSOCIATION)

REG. NO. ___________________________ DATE JOINED: ___________________________

TIER NO. __________ CONTRIBUTION? ☐ YES ☐ NO

SUNY CONTRACT: ___________________________ NON-SUNY CONTRACT: ___________________________

DATE OF LAST PREMIUM: ________________ DATE OF LAST PREMIUM: ________________

IF YOU HAVE RETIRED WITH AN INCENTIVE OR BEGUN WITHDRAWING FROM YOUR ACCOUNT, YOU ARE NO LONGER ELIGIBLE FOR TIAA-CREF PARTICIPATION.

HAVE YOU RETIRED WITH AN INCENTIVE OR BEGUN WITHDRAWING FROM YOUR ACCOUNT?

☐ YES ☐ NO

(b) IF YOU ARE A NEW FULL-TIME EMPLOYEE AND DO NOT BELONG TO A RETIREMENT SYSTEM, YOU MUST CHOOSE ONE OF THE FOLLOWING WITHIN 30 DAYS OF EMPLOYMENT:

☐ NYS TEACHERS' RETIREMENT SYSTEM

☐ NYS EMPLOYEES' RETIREMENT SYSTEM

☐ TIAA CREF (TEACHERS' INSURANCE ANNUITY ASSOCIATION)

Signature__________________________________________ Date________________________
IF YOUR EFFECTIVE DATE IN ANY OF THE ABOVE RETIREMENT SYSTEMS IS JULY 1, 1976, OR LATER, YOU WILL BE REQUIRED TO CONTRIBUTE A PERCENTAGE OF YOUR GROSS SALARY TOWARD YOUR RETIREMENT BY PAYROLL DEDUCTION.

(C) PART-TIME EMPLOYEES:

*** IF YOU ARE A MEMBER OF A NYS RETIREMENT SYSTEM, PLEASE COMPLETE THE FRONT OF THIS FORM

***IF YOU ARE NOT A MEMBER OF A NYS RETIREMENT SYSTEM, PLEASE TURN OVER, READ, THEN COMPLETE THE BACK OF THIS FORM

PART-TIME EMPLOYEES ARE ELIGIBLE TO JOIN EITHER NYS TEACHERS' RETIREMENT SYSTEM OR NYS EMPLOYEES' RETIREMENT SYSTEM (DEPENDING ON YOUR JOB TITLE).

IF YOU CHOOSE TO JOIN A RETIREMENT SYSTEM, A PERCENTAGE OF YOUR GROSS SALARY WILL BE DEDUCTED AS YOUR CONTRIBUTION TO THE RETIREMENT SYSTEM.

**IMPORTANT**

THE FOLLOWING ACKNOWLEDGMENT MUST BE READ AND COMPLETED.

I HEREBY ACKNOWLEDGE THAT I HAVE BEEN INFORMED BY ORANGE COUNTY COMMUNITY COLLEGE (EMPLOYER), AND THAT AS AN EMPLOYEE NOT CURRENTLY A MEMBER OF NYS TEACHERS' RETIREMENT SYSTEM OR NYS EMPLOYEES' RETIREMENT SYSTEM AND WHO IS OR WILL BE RENDERING LESS THAN FULL-TIME SERVICE, I MAY, AS A MATTER OF RIGHT, JOIN EITHER NYS TEACHERS' OR EMPLOYEES' RETIREMENT SYSTEM (DEPENDING ON JOB TITLE).

I FURTHER ACKNOWLEDGE THAT I UNDERSTAND UNDER PRESENT LAW, IF I ELECT TO JOIN A RETIREMENT SYSTEM, I MUST COMPLETE A MEMBERSHIP APPLICATION WHICH WILL BE FILED WITH THE RETIREMENT SYSTEM IN ORDER TO BE EFFECTIVE.

AS A RESULT OF JOINING THE RETIREMENT SYSTEM, I WILL BE REQUIRED TO CONTRIBUTE, PURSUANT TO ARTICLE 15 OF THE RSSL, A PERCENTAGE OF MY SALARY TO SAID RETIREMENT SYSTEM.

IF I JOIN A RETIREMENT SYSTEM, MY BENEFICIARY WILL BE PROTECTED BY A DEATH BENEFIT SHOULD I DIE IN SERVICE AFTER I HAVE BEEN CREDITED BY THE SYSTEM WITH ONE YEAR OF SERVICE. UPON MEETING ELIGIBILITY REQUIREMENTS, I WILL BE ENTITLED TO A LIFETIME PENSION AT AGE 55 OR A DISABILITY PENSION AT AN EARLIER AGE IF I BECOME PERMANENTLY AND TOTALLY DISABLED FROM GAINFUL EMPLOYMENT.

I ALSO UNDERSTAND IF I DO NOT ELECT TO JOIN, I MAY BE UNABLE TO OBTAIN CREDIT AT A LATER DATE FOR SERVICE RENDERED DURING THE PERIOD I WAS NOT A MEMBER.

I DO WISH TO JOIN:

☐ TEACHERS' RETIREMENT ☐ EMPLOYEES' RETIREMENT

AND REQUEST THAT YOU SEND ME AN APPLICATION FORM.

SIGNATURE __________________________________________ dated: ____________________________

PRINT NAME __________________________________________________________

I DO NOT WISH TO JOIN

SIGNATURE __________________________________________ dated: ____________________________

PRINT NAME __________________________________________________________
Employee Information & Change Form

Complete:
1. Employee Section
2. Sign and Date
Employee Information & Change Form

Please select one: ☐ New Employee ☐ Change

Full Legal Name: __________________________ Date of Birth ________________

Name Change: (Former Name) ________________________________

*Please note name changes will prompt a change in your email address. Legal documentation is required.*

Street Address: __________________________________________

_____________________________________________________________________

Mailing Address: _____________________________________________

(please complete if different from street address)

Home Phone No. ___________________________ Cell Phone No. _____________

In case of Emergency please contact: ________________________________

Emergency Contact Phone: ________________________________

☐ Spouse ☐ In-law ☐ Parent ☐ Friend ☐ Other __________________________

__________________________ ________________
Signature Date

________________________________________

*Please do not mark below this line - Office Use Only*

Department: ___________________________ Ext & Build/Room __________________________

Start Date: ___________________________ Title: ___________________________ A # __________

☐ PPC/HR ☐ Banner ☐ Access ☐ File ☐ Risk Management

☐ Academic Affairs (Faculty Changes) ☐ Payroll (all Changes)

☐ President's Office (FT Changes)
1. Read pages 1 – 6
2. Complete Page 7
3. Provide Documents from page 9
read all instructions carefully before completing this form.

anti-discrimination notice. it is illegal to discriminate against any work-authorized individual in hiring, discharge, recruitment or referral for a fee, or in the employment eligibility verification (form i-9 and e-verify) process based on that individual's citizenship status, immigration status or national origin. employers cannot specify which document(s) they will accept from an employee. the refusal to hire an individual because the documentation presented has a future expiration date may also constitute illegal discrimination. for more information, call the office of special counsel for immigration-related unfair employment practices (osc) at 1-800-255-7688 (employees), 1-800-255-8155 (employers), or 1-800-237-2515 (tdd), or visit www.justice.gov/crt/about/osc.

what is the purpose of this form?

employers must complete form i-9 to document verification of the identity and employment authorization of each new employee (both citizen and noncitizen) hired after november 6, 1986, to work in the united states. in the commonwealth of the northern mariana islands (cnmi), employers must complete form i-9 to document verification of the identity and employment authorization of each new employee (both citizen and noncitizen) hired after november 27, 2011. employers should have used form i-9 cnmi between november 28, 2009 and november 27, 2011.

general instructions

employers are responsible for completing and retaining form i-9. for the purpose of completing this form, the term "employer" means all employers, including those recruiters and referrers for a fee who are agricultural associations, agricultural employers, or farm labor contractors.

form i-9 is made up of three sections. employers may be fined if the form is not complete. employers are responsible for retaining completed forms. do not mail completed forms to u.s. citizenship and immigration services (uscis) or immigration and customs enforcement (ice).

section 1. employee information and attestation

newly hired employees must complete and sign section 1 of form i-9 no later than the first day of employment. section 1 should never be completed before the employee has accepted a job offer.

provide the following information to complete section 1:

name: provide your full legal last name, first name, and middle initial. your last name is your family name or surname. if you have two last names or a hyphenated last name, include both names in the last name field. your first name is your given name. your middle initial is the first letter of your second given name, or the first letter of your middle name, if any.

other names used: provide all other names used, if any (including maiden name). if you have had no other legal names, write "n/a."

address: provide the address where you currently live, including street number and name, apartment number (if applicable), city, state, and zip code. do not provide a post office box address (p.o. box). only border commuters from canada or mexico may use an international address in this field.

date of birth: provide your date of birth in the mm/dd/yyyy format. for example, january 23, 1950, should be written as 01/23/1950.

u.s. social security number: provide your 9-digit social security number. providing your social security number is voluntary. however, if your employer participates in e-verify, you must provide your social security number.

e-mail address and telephone number (optional): you may provide your e-mail address and telephone number. department of homeland security (dhs) may contact you if dhs learns of a potential mismatch between the information provided and the information in dhs or social security administration (ssa) records. you may write "n/a" if you choose not to provide this information.
All employees must attest in Section 1, under penalty of perjury, to their citizenship or immigration status by checking one of the following four boxes provided on the form:

1. **A citizen of the United States**

2. **A noncitizen national of the United States:** Noncitizen nationals of the United States are persons born in American Samoa, certain former citizens of the former Trust Territory of the Pacific Islands, and certain children of noncitizen nationals born abroad.

3. **A lawful permanent resident:** A lawful permanent resident is any person who is not a U.S. citizen and who resides in the United States under legally recognized and lawfully recorded permanent residence as an immigrant. The term "lawful permanent resident" includes conditional residents. If you check this box, write either your Alien Registration Number (A-Number) or USCIS Number in the field next to your selection. At this time, the USCIS Number is the same as the A-Number without the "A" prefix.

4. **An alien authorized to work:** If you are not a citizen or national of the United States or a lawful permanent resident, but are authorized to work in the United States, check this box.

If you check this box:

a. Record the date that your employment authorization expires, if any. Aliens whose employment authorization does not expire, such as refugees, asylees, and certain citizens of the Federated States of Micronesia, the Republic of the Marshall Islands, or Palau, may write "N/A" on this line.

b. Next, enter your Alien Registration Number (A-Number)/USCIS Number. At this time, the USCIS Number is the same as your A-Number without the "A" prefix. If you have not received an A-Number/USCIS Number, record your Admission Number. You can find your Admission Number on Form I-94, "Arrival-Departure Record," or as directed by USCIS or U.S. Customs and Border Protection (CBP).

   (1) If you obtained your admission number from CBP in connection with your arrival in the United States, then also record information about the foreign passport you used to enter the United States (number and country of issuance).

   (2) If you obtained your admission number from USCIS within the United States, or you entered the United States without a foreign passport, you must write "N/A" in the Foreign Passport Number and Country of Issuance fields.

Sign your name in the "Signature of Employee" block and record the date you completed and signed Section 1. By signing and dating this form, you attest that the citizenship or immigration status you selected is correct and that you are aware that you may be imprisoned and/or fined for making false statements or using false documentation when completing this form. To fully complete this form, you must present to your employer documentation that establishes your identity and employment authorization. Choose which documents to present from the Lists of Acceptable Documents, found on the last page of this form. You must present this documentation no later than the third day after beginning employment, although you may present the required documentation before this date.

**Preparer and/or Translator Certification**

The Preparer and/or Translator Certification must be completed if the employee requires assistance to complete Section 1 (e.g., the employee needs the instructions or responses translated, someone other than the employee fills out the information blocks, or someone with disabilities needs additional assistance). The employee must still sign Section 1.

**Minors and Certain Employees with Disabilities (Special Placement)**

Parents or legal guardians assisting minors (individuals under 18) and certain employees with disabilities should review the guidelines in the *Handbook for Employers: Instructions for Completing Form I-9 (M-274)* on [www.uscis.gov/1-9Central](http://www.uscis.gov/) before completing Section 1. These individuals have special procedures for establishing identity if they cannot present an identity document for Form I-9. The special procedures include (1) the parent or legal guardian filling out Section 1 and writing "minor under age 18" or "special placement," whichever applies, in the employee signature block; and (2) the employer writing "minor under age 18" or "special placement" under List B in Section 2.
Section 2. Employer or Authorized Representative Review and Verification

Before completing Section 2, employers must ensure that Section 1 is completed properly and on time. Employers may not ask an individual to complete Section 1 before he or she has accepted a job offer.

Employers or their authorized representative must complete Section 2 by examining evidence of identity and employment authorization within 3 business days of the employee's first day of employment. For example, if an employee begins employment on Monday, the employer must complete Section 2 by Thursday of that week. However, if an employer hires an individual for less than 3 business days, Section 2 must be completed no later than the first day of employment. An employer may complete Form I-9 before the first day of employment if the employer has offered the individual a job and the individual has accepted.

Employers cannot specify which document(s) employees may present from the Lists of Acceptable Documents, found on the last page of Form I-9, to establish identity and employment authorization. Employees must present one selection from List A OR a combination of one selection from List B and one selection from List C. List A contains documents that show both identity and employment authorization. Some List A documents are combination documents. The employee must present combination documents together to be considered a List A document. For example, a foreign passport and a Form I-94 containing an endorsement of the alien's nonimmigrant status must be presented together to be considered a List A document. List B contains documents that show identity only, and List C contains documents that show employment authorization only. If an employee presents a List A document, he or she should not present a List B and List C document, and vice versa. If an employer participates in E-Verify, the List B document must include a photograph.

In the field below the Section 2 introduction, employers must enter the last name, first name and middle initial, if any, that the employee entered in Section 1. This will help to identify the pages of the form should they get separated.

Employers or their authorized representative must:

1. Physically examine each original document the employee presents to determine if it reasonably appears to be genuine and to relate to the person presenting it. The person who examines the documents must be the same person who signs Section 2. The examiner of the documents and the employee must both be physically present during the examination of the employee's documents.

2. Record the document title shown on the Lists of Acceptable Documents, issuing authority, document number and expiration date (if any) from the original document(s) the employee presents. You may write "N/A" in any unused fields.

   If the employee is a student or exchange visitor who presented a foreign passport with a Form I-94, the employer should also enter in Section 2:
   
   a. The student's Form I-20 or DS-2019 number (Student and Exchange Visitor Information System-SEVIS Number); and the program end date from Form I-20 or DS-2019.

3. Under Certification, enter the employee's first day of employment. Temporary staffing agencies may enter the first day the employee was placed in a job pool. Recruiters and recruiters for a fee do not enter the employee's first day of employment.

4. Provide the name and title of the person completing Section 2 in the Signature of Employer or Authorized Representative field.

5. Sign and date the attestation on the date Section 2 is completed.

6. Record the employer's business name and address.

7. Return the employee's documentation.

Employers may, but are not required to, photocopy the document(s) presented. If photocopies are made, they should be made for ALL new hires or reverifications. Photocopies must be retained and presented with Form I-9 in case of an inspection by DHS or other federal government agency. Employers must always complete Section 2 even if they photocopy an employee's document(s). Making photocopies of an employee's document(s) cannot take the place of completing Form I-9. Employers are still responsible for completing and retaining Form I-9.
**Unexpired Documents**

Generally, only unexpired, original documentation is acceptable. The only exception is that an employee may present a certified copy of a birth certificate. Additionally, in some instances, a document that appears to be expired may be acceptable if the expiration date shown on the face of the document has been extended, such as for individuals with temporary protected status. Refer to the *Handbook for Employers: Instructions for Completing Form I-9 (M-274)* or I-9 Central (www.uscis.gov/I-9Central) for examples.

**Receipts**

If an employee is unable to present a required document (or documents), the employee can present an acceptable receipt in lieu of a document from the Lists of Acceptable Documents on the last page of this form. Receipts showing that a person has applied for an initial grant of employment authorization, or for renewal of employment authorization, are not acceptable. Employers cannot accept receipts if employment will last less than 3 days. Receipts are acceptable when completing Form I-9 for a new hire or when reverification is required.

Employees must present receipts within 3 business days of their first day of employment, or in the case of reverification, by the date that reverification is required, and must present valid replacement documents within the time frames described below.

There are three types of acceptable receipts:

1. A receipt showing that the employee has applied to replace a document that was lost, stolen or damaged. The employee must present the actual document within 90 days from the date of hire.

2. The arrival portion of Form I-94/I-94A with a temporary I-551 stamp and a photograph of the individual. The employee must present the actual Permanent Resident Card (Form I-551) by the expiration date of the temporary I-551 stamp, or, if there is no expiration date, within 1 year from the date of issue.

3. The departure portion of Form I-94/I-94A with a refugee admission stamp. The employee must present an unexpired Employment Authorization Document (Form I-766) or a combination of a List B document and an unrestricted Social Security card within 90 days.

When the employee provides an acceptable receipt, the employer should:

1. Record the document title in Section 2 under the sections titled List A, List B, or List C, as applicable.

2. Write the word "receipt" and its document number in the "Document Number" field. Record the last day that the receipt is valid in the "Expiration Date" field.

By the end of the receipt validity period, the employer should:

1. Cross out the word "receipt" and any accompanying document number and expiration date.

2. Record the number and other required document information from the actual document presented.

3. Initial and date the change.

See the *Handbook for Employers: Instructions for Completing Form I-9 (M-274)* at www.uscis.gov/I-9Central for more information on receipts.

**Section 3. Reverification and Rehires**

Employers or their authorized representatives should complete Section 3 when reverifying that an employee is authorized to work. When rehiring an employee within 3 years of the date Form I-9 was originally completed, employers have the option to complete a new Form I-9 or complete Section 3. When completing Section 3 in either a reverification or rehire situation, if the employee's name has changed, record the name change in Block A.

For employees who provide an employment authorization expiration date in Section 1, employers must reverify employment authorization on or before the date provided.
Some employees may write "N/A" in the space provided for the expiration date in Section 1 if they are aliens whose employment authorization does not expire (e.g., asylees, refugees, certain citizens of the Federated States of Micronesia, the Republic of the Marshall Islands, or Palau). Reverification does not apply for such employees unless they chose to present evidence of employment authorization in Section 2 that contains an expiration date and requires reverification, such as Form I-766, Employment Authorization Document.

Reverification applies if evidence of employment authorization (List A or List C document) presented in Section 2 expires. However, employers should not reverify:

1. U.S. citizens and noncitizen nationals; or
2. Lawful permanent residents who presented a Permanent Resident Card (Form I-551) for Section 2.

Reverification does not apply to List B documents.

If both Section 1 and Section 2 indicate expiration dates triggering the reverification requirement, the employer should reverify by the earlier date.

For reverification, an employee must present unexpired documentation from either List A or List C showing he or she is still authorized to work. Employers CANNOT require the employee to present a particular document from List A or List C. The employee may choose which document to present.

To complete Section 3, employers should follow these instructions:

1. Complete Block A if an employee's name has changed at the time you complete Section 3.
2. Complete Block B with the date of rehire if you rehire an employee within 3 years of the date this form was originally completed, and the employee is still authorized to be employed on the same basis as previously indicated on this form. Also complete the "Signature of Employer or Authorized Representative" block.
3. Complete Block C if:
   a. The employment authorization or employment authorization document of a current employee is about to expire and requires reverification; or
   b. You rehire an employee within 3 years of the date this form was originally completed and his or her employment authorization or employment authorization document has expired. (Complete Block B for this employee as well.)

To complete Block C:
   a. Examine either a List A or List C document the employee presents that shows that the employee is currently authorized to work in the United States; and
   b. Record the document title, document number, and expiration date (if any).

4. After completing block A, B or C, complete the "Signature of Employer or Authorized Representative" block, including the date.

For reverification purposes, employers may either complete Section 3 of a new Form I-9 or Section 3 of the previously completed Form I-9. Any new pages of Form I-9 completed during reverification must be attached to the employee's original Form I-9. If you choose to complete Section 3 of a new Form I-9, you may attach just the page containing Section 3, with the employee's name entered at the top of the page, to the employee's original Form I-9. If there is a more current version of Form I-9 at the time of reverification, you must complete Section 3 of that version of the form.

What Is the Filing Fee?

There is no fee for completing Form I-9. This form is not filed with USCIS or any government agency. Form I-9 must be retained by the employer and made available for inspection by U.S. Government officials as specified in the "USCIS Privacy Act Statement" below.

USCIS Forms and Information

For more detailed information about completing Form I-9, employers and employees should refer to the Handbook for Employers: Instructions for Completing Form I-9 (M-274).
You can also obtain information about Form I-9 from the USCIS Web site at www.uscis.gov/I-9Central, by e-mailing USCIS at I-9Central@dhs.gov, or by calling 1-888-464-4218. For TDD (hearing impaired), call 1-877-875-6028.

To obtain USCIS forms or the Handbook for Employers, you can download them from the USCIS Web site at www.uscis.gov/forms. You may order USCIS forms by calling our toll-free number at 1-800-870-3676. You may also obtain forms and information by contacting the USCIS National Customer Service Center at 1-800-375-5283. For TDD (hearing impaired), call 1-800-767-1833.

Information about E-Verify, a free and voluntary program that allows participating employers to electronically verify the employment eligibility of their newly hired employees, can be obtained from the USCIS Web site at www.dhs.gov/E-Verify, by e-mailing USCIS at E-Verify@dhs.gov or by calling 1-888-464-4218. For TDD (hearing impaired), call 1-877-875-6028.

Employees with questions about Form I-9 and/or E-Verify can reach the USCIS employee hotline by calling 1-888-897-7781. For TDD (hearing impaired), call 1-877-875-6028.

**Photocopying and Retaining Form I-9**

A blank Form I-9 may be reproduced, provided all sides are copied. The instructions and Lists of Acceptable Documents must be available to all employees completing this form. Employers must retain each employee's completed Form I-9 for as long as the individual works for the employer. Employers are required to retain the pages of the form on which the employee and employer enter data. If copies of documentation presented by the employee are made, those copies must also be kept with the form. Once the individual's employment ends, the employer must retain this form for either 3 years after the date of hire or 1 year after the date employment ended, whichever is later.

Form I-9 may be signed and retained electronically, in compliance with Department of Homeland Security regulations at 8 CFR 274a.2.

**USCIS Privacy Act Statement**

**AUTHORITIES:** The authority for collecting this information is the Immigration Reform and Control Act of 1986, Public Law 99-603 (8 USC 1324a).

**PURPOSE:** This information is collected by employers to comply with the requirements of the Immigration Reform and Control Act of 1986. This law requires that employers verify the identity and employment authorization of individuals they hire for employment to preclude the unlawful hiring, or recruiting or referring for a fee, of aliens who are not authorized to work in the United States.

**DISCLOSURE:** Submission of the information required in this form is voluntary. However, failure of the employer to ensure proper completion of this form for each employee may result in the imposition of civil or criminal penalties. In addition, employing individuals knowing that they are unauthorized to work in the United States may subject the employer to civil and/or criminal penalties.

**ROUTINE USES:** This information will be used by employers as a record of their basis for determining eligibility of an employee to work in the United States. The employer will keep this form and make it available for inspection by authorized officials of the Department of Homeland Security, Department of Labor, and Office of Special Counsel for Immigration-Related Unfair Employment Practices.

**Paperwork Reduction Act**

An agency may not conduct or sponsor an information collection and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. The public reporting burden for this collection of information is estimated at 35 minutes per response, including the time for reviewing instructions and completing and retaining the form. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to: U.S. Citizenship and Immigration Services, Regulatory Coordination Division, Office of Policy and Strategy, 20 Massachusetts Avenue NW, Washington, DC 20529-2140; OMB No. 1615-0047. Do not mail your completed Form I-9 to this address.
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.)

<table>
<thead>
<tr>
<th>Last Name (Family Name)</th>
<th>First Name (Given Name)</th>
<th>Middle Initial</th>
<th>Other Names Used (if any)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Address (Street Number and Name)</th>
<th>Apt. Number</th>
<th>City or Town</th>
<th>State</th>
<th>Zip Code</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

**Date of Birth (mm/dd/yyyy)** | **U.S. Social Security Number** | **E-mail Address** | **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):

- [ ] A citizen of the United States
- [ ] A noncitizen national of the United States (See instructions)
- [ ] A lawful permanent resident (Alien Registration Number/USCIS Number): ____________________________

- [ ] An alien authorized to work until (expiration date, if applicable, mm/dd/yyyy) ________________. Some aliens may write "N/A" in this field. (See instructions)

  For aliens authorized to work, provide your Alien Registration Number/USCIS Number OR Form I-94 Admission Number:

  1. Alien Registration Number/USCIS Number: ____________________________
  
  OR
  
  2. Form I-94 Admission Number: ____________________________

If you obtained your admission number from CBP in connection with your arrival in the United States, include the following:

<table>
<thead>
<tr>
<th>Foreign Passport Number:</th>
<th>Country of Issuance:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Some aliens may write "N/A" on the Foreign Passport Number and Country of Issuance fields. (See instructions)

**Signature of Employee:**

**Date (mm/dd/yyyy):**

Preparer and/or Translator Certification (To be completed and signed if Section 1 is prepared by a person other than the employee.)

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

**Signature of Preparer or Translator:**

**Date (mm/dd/yyyy):**

<table>
<thead>
<tr>
<th>Last Name (Family Name)</th>
<th>First Name (Given Name)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Address (Street Number and Name)</th>
<th>City or Town</th>
<th>State</th>
<th>Zip Code</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

STOP Employer Completes Next Page STOP
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 examine a combination of one document from List B and one document from List C as listed on the “Lists of Acceptable Documents” on the next page of this form. For each document you review, record the following information: document title, issuing authority, document number, and expiration date, if any.)

<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>Identity and Employment Authorization</td>
<td>Document Title:</td>
<td>Document Title:</td>
<td>Document Title:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Issuing Authority:</td>
<td>Issuing Authority:</td>
<td>Issuing Authority:</td>
<td></td>
</tr>
<tr>
<td></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></td>
<td></td>
</tr>
</tbody>
</table>

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>Date (mm/dd/yyyy)</th>
<th>Title of Employer or Authorized Representative</th>
</tr>
</thead>
<tbody>
<tr>
<td>Last Name (Family Name)</td>
<td>First Name (Given Name)</td>
<td>Employer’s Business or Organization Name</td>
</tr>
<tr>
<td>Employer’s Business or Organization Address (Street Number and Name)</td>
<td>City or Town</td>
<td>State</td>
</tr>
</tbody>
</table>

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

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

C. If employee’s previous grant of employment authorization has expired, provide the information for the document from List A or List C the employee presented that establishes current employment authorization in the space provided below.

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

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

Signature of Employer or Authorized Representative:  
Date (mm/dd/yyyy):  
Print Name of Employer or Authorized Representative:
# LISTS OF ACCEPTABLE DOCUMENTS

All documents must be UNEXPIRED

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

<table>
<thead>
<tr>
<th>LIST A</th>
<th>Documents that Establish Both Identity and Employment Authorization</th>
<th>LIST B</th>
<th>Documents that Establish Identity</th>
<th>AND</th>
<th>LIST C</th>
<th>Documents that Establish Employment Authorization</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. U.S. Passport or U.S. Passport Card</td>
<td>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</td>
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<td></td>
<td></td>
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</tr>
<tr>
<td>2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551)</td>
<td>2. ID card issued by federal, state or local government agencies or entities, provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address</td>
<td></td>
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</tr>
<tr>
<td>3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa</td>
<td>3. School ID card with a photograph</td>
<td></td>
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<tr>
<td>4. Employment Authorization Document that contains a photograph (Form I-766)</td>
<td>4. Voter's registration card</td>
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<tr>
<td>5. For a nonimmigrant alien authorized to work for a specific employer because of his or her status:</td>
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<tr>
<td>a. Foreign passport; and</td>
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<tr>
<td>b. Form I-94 or Form I-94A that has the following:</td>
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<tr>
<td>(1) The same name as the passport; and</td>
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</tr>
<tr>
<td>(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.</td>
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</tr>
<tr>
<td>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</td>
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<tr>
<td>For persons under age 18 who are unable to present a document listed above:</td>
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<tr>
<td>7. Native American tribal document</td>
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<tr>
<td>8. Driver's license issued by a Canadian government authority</td>
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<tr>
<td>9. Native American tribal document</td>
<td></td>
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<td></td>
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<tr>
<td>10. School record or report card</td>
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<tr>
<td>11. Clinic, doctor, or hospital record</td>
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<tr>
<td>12. Day-care or nursery school record</td>
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<tr>
<td>1. A Social Security Account Number card, unless the card includes one of the following restrictions:</td>
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</tr>
<tr>
<td>(1) NOT VALID FOR EMPLOYMENT</td>
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<tr>
<td>(2) VALID FOR WORK ONLY WITH INS AUTHORIZATION</td>
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<tr>
<td>(3) VALID FOR WORK ONLY WITH DHS AUTHORIZATION</td>
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<tr>
<td>2. Certification of Birth Abroad issued by the Department of State (Form FS-545)</td>
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<tr>
<td>3. Certification of Report of Birth issued by the Department of State (Form DS-1350)</td>
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<tr>
<td>4. Original or certified copy of birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal</td>
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<tr>
<td>5. Native American tribal document</td>
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<tr>
<td>6. U.S. Citizen ID Card (Form I-197)</td>
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<tr>
<td>7. Identification Card for Use of Resident Citizen in the United States (Form I-179)</td>
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<tr>
<td>8. Employment authorization document issued by the Department of Homeland Security</td>
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</tr>
</tbody>
</table>

Illustrations of many of these documents appear in Part 8 of the Handbook for Employers (M-274).

Refer to Section 2 of the instructions, titled "Employer or Authorized Representative Review and Verification," for more information about acceptable receipts.
HIPPA Policy

and

Confidentiality Agreement

1. Read Policy
2. Sign and Date Agreement
Inter-Office Memorandum
Office of the Vice-President of Administration

To: The College Community
From: Vice President for Administration & Finance
Subject: SUNY Orange HIPAA Policy

In accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and with Federal Privacy Rule 45C.F.R., Section 164.520, the College must maintain the privacy of all protected health information (PHI) and give you this notice that describes our legal duties and privacy practices concerning your PHI, as well as the PHI of our students.

Attached you will find a copy of the College’s policy and procedures regarding the privacy of individual healthcare information, and also the workforce confidentiality agreement, which has been approved by the Board of Trustees. We must follow the privacy practices described in this policy. However, we reserve the right to change the privacy practices described in this notice, in accordance with the law. Changes would apply to all protected health information we maintain.

The Policy also describes how medical information may be disclosed, and how you may get access to your health information maintained by the College. It should be noted that the College, as your employer, does not have access to protected health information maintained by your health insurance plan.

Please review the Policy carefully, then sign and date the workforce confidentiality agreement, and return it to the Human Resources office.

Questions regarding this Policy should be directed to the VP of Administration & Finance / HIPAA Compliance Officer at 845-341-4905.

Questions on protected health information should be directed to the Director of Wellness at 845-341-4870.

ORANGE COUNTY COMMUNITY COLLEGE
Policy and Procedure

Subject: Confidentiality of Health Information

Statement of Policy:
Orange County Community College is committed to protecting the privacy and confidentiality of health information for the population it serves. Health information is strictly confidential and should never be disclosed, or confirmed to anyone who is not specifically authorized under college policy or applicable law to receive the information. Failure to adhere to state and federal law or Orange County Community College policies and procedures regarding the confidentiality of protected health information, will be considered a breach of confidentiality and will result in the imposition of appropriate sanctions.

Definition of Protected Health Information:
For the purpose of this policy, the term “protected health information" means any information, including very basic information such as an individual’s name and address, that relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present or future payment for the provision of health care to an individual, and identifies or contains information that could be reasonably used to identify the individual. This policy applies to protected health information obtained in any form, including verbal, written and electronic forms.

Uses and Disclosures of Protected Health Information:
Federal law limits the use and disclosure of protected health information without authorization from that individual. This authorization must be obtained in writing. Appropriate “Disclosure of Protected Health Information” forms will be available and utilized in any authorized campus health provider’s office including Health Services, the Dental Hygiene Clinic and Human Resources. Permitted disclosures are limited to the individual, to those persons authorized by the individual to receive their health information for purposes of treatment, payment or healthcare operations, and those persons otherwise authorized by law. For example, employees and students may be required to meet statutory public health requirements prior to employment and/or enrollment. Protected health information disclosures without the individual’s authorization are limited to emergencies, to avert a serious threat to health or safety, and to those disclosures required by law which include disclosures about victims of abuse, neglect, or domestic violence, disclosures for judicial proceedings, and disclosures for law enforcement purposes. Healthcare professionals may share information necessary to provide care to patients, but safeguards should be taken to avoid unintentional disclosure. Conversation about patients in public areas should be limited; files and charts should be properly secured.
Confidential information containing personal health information should be hand delivered and not placed in interoffice mail, unless sealed, addressed to a specific recipient, and stamped confidential. Copies of documents containing personal health information should be shredded and never placed in a regular trash bin. Individual consent or authorization is not required by law for releases of protected health information that is required by worker’s compensation laws. This information is excluded from the general rule against disclosure of protected health information.

Scope:
This policy applies to all members of the Orange County Community College workforce, whether directly employed by the college or serving under an alternative arrangement. It shall include, but not be limited to:

- Employees
- Volunteers
- Student Aides
- All students participating in a health related program
- Agency and contracted staff (including temporary staff)
- Consultants
- Contractors and subcontractors
- Faculty and credentialed staff

Education and Training:
Orange County Community College is responsible for providing job appropriate training to its workforce regarding, the need for confidentiality; types of information that are considered confidential; sanctions associated with a breach of confidentiality; and Orange County Community College’s confidentiality agreement.

Confidentiality Agreement:
Each member of Orange County Community College’s affected workforce will be expected to review Orange County Community College’s “Confidentiality of Health Information” policy and sign the college’s “Workforce Confidentiality Agreement”. For all current employees this agreement should be reviewed and returned to Human Resources as soon as possible, but not later than December 1, 2003. For new hires, this should occur at the time of hire. This signed statement will be maintained in the appropriate employee personnel file Students in the Health Professions shall sign the “Student Confidentiality Statement”, which shall be maintained in the appropriate department chair’s student files.

Suspected Breach:
Anyone who knows of, or has reason to believe that another person has violated this policy, should report the matter immediately to their department supervisor or department chair, or the college’s Privacy Officer. The Privacy Officer shall investigate all reports of breach of this policy. Failure to report a breach will be considered a violation of this policy.

Sanctions:
Upon a finding of a breach of confidentiality by an employee in a collective bargaining unit, the college shall initiate action pursuant to the applicable collective bargaining agreement to implement an appropriate disciplinary penalty. Such penalty may include, but is not limited to the following:

- Letter of reprimand
- Suspension
- Fine
- Loss of accrued leave credits
- Demotion
- Termination

For employees not represented by a collective bargaining unit, sanctions may include actions up to and including termination of employment. For students, violations of this policy shall be considered a serious offense and appropriate disciplinary action will be taken as outlined in the Student Code of Conduct. Penalties may include, but are not limited to the following:

- failure of the course in which violation occurred
- suspension
- expulsion from the program

Effective Date: November, 2003

Rev 1/29/15
ORANGE COUNTY COMMUNITY COLLEGE
Workforce Confidentiality Agreement

IMPORTANT: Please read all sections. If you have any questions, please seek clarification before signing.

1. Confidentiality of Protected Health Information:
   I understand and acknowledge that:
   a. All health services that provided to students, faculty, staff and/or visitors are private and confidential.
   b. Students, faculty and staff provide personal health information to the college with the expectation that it will be kept confidential and only be used by authorized persons as necessary;
   c. All personally identifiable information provided by individuals regarding health or medical services provided to them in whatever form such information exists, including oral, written, printed, photographic and electronic (collectively the “Protected Health Information”) is strictly confidential and is protected by federal and state laws and regulations that prohibit its unauthorized use or disclosure; and
   d. In the course of my employment/affiliation with Orange County Community College, I may be given access to certain Confidential and Protected Health Information.

2. Disclosure, Use and Access
   I agree that, except as authorized in connection with my assigned duties, I will not at any time use, access or disclose any Confidential Information to any person (including, but not limited to co-workers, friends and family members), without appropriate authorization. I understand that this obligation remains in full force during the entire term of my employment/affiliation and continues in affect after such employment/affiliation terminates.

3. Confidentiality Policy
   I agree that I will comply with confidentiality policies that apply to me as a result of my employment/affiliation with Orange County Community College.

4. Return of Confidential Information
   Upon termination of my employment/affiliation for any reason, or at any other time upon request, I agree to promptly return to Orange County Community College any copies of Confidential Information then in my possession or control (including all printed and electronic copies), unless such retention is specifically required by law or regulation.

I have read and understand the above policy of the Orange County Community College Board of Trustees.

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<tr>
<th>Printed Name</th>
<th>Department/Job Title</th>
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<tr>
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<td>Work Study</td>
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</table>
Optional Forms

1. If you wish to join the Employee’s Retirement System:
   - Complete - Membership Registration (RS 5420)
     Designation of Beneficiary (R5127)

2. Invitation to Self-Identify for Veterans
3. Voluntary Self-Identification of Disability
4. SUNY Orange Voluntary Disclosure Form
Employees’ Retirement System
Membership Registration
RS 5420
(Rev. 10/15)

If your employment is on a part-time, temporary or provisional basis, or less than 12 months per year, membership is optional.

IF YOUR MEMBERSHIP IS OPTIONAL, DO NOT COMPLETE OR SUBMIT THIS FORM UNLESS YOU DESIRE TO BECOME A MEMBER.

Instructions: Please print clearly in ink or type. Application must be signed and notarized on last page.
Employee: Complete Items 1–3, 10–13 on page 2 and other applicable sections. Employer: Complete Items 4–9a.
FOR A REGISTRATION NUMBER: Call 1-866-805-0990 or (518) 474-3081. Or fax the application to (518) 466-4382.
This completed membership application must be mailed to the Retirement System for the membership to be effective.

IMPORTANT INFORMATION: Has this person been registered to membership by means of the telephone or fax registration system? ☐ Yes ☐ No (If yes, enter the information given to you in the boxes below.)

In order to complete the registration process this membership registration form must be received by the Retirement System.

<table>
<thead>
<tr>
<th>Location Code</th>
<th>Report Code</th>
<th>Plan Code</th>
<th>Group Code</th>
<th>Date of Membership</th>
<th>Age Years Code</th>
<th>Registration Number</th>
<th>Rate</th>
</tr>
</thead>
</table>

Employee’s Name

Last
First
Middle Initial

Employee’s Address
Street and/or PO Box #
City
State
Zip Code + 4

Date of Birth
Month
Day
Year
Sex
M F

*Social Security Number

Maiden or Other Name Used

Employer Name (Indicate State, or, if not, name of public entity by which employed and Department, Division, or Institution)

Employer’s Address
Street
City
County
State
Zip Code + 4
Employer Telephone Number

Payroll Title:

Indicate Length of Work Year
☐ 10 Months ☐ 12 Months ☐ Seasonal

Employer Fax Number
( )

Check If Either Applies
☐ Appointed Official ☐ Elected Official

*If accountant, auditor, physician, attorney, engineer or architect please submit documentation as indicated at www.osc.state.ny.us/retire/employers/classify_an_employee.htm

Enter the Date or Dates Relating to Employee’s Present Position:

Part-Time Employment
Date of First Appointment
Month
Day
Year
Date of Permanent Appointment
Month
Day
Year

Full-Time Employment
Date of Temporary or Provisional Appointment
Month
Day
Year
Date of Permanent or Probationary Appointment
Month
Day
Year

Frequency of Payment:

☐ Annually ☐ Semi-Annually ☐ Quarterly ☐ Monthly
☐ Semi-Monthly ☐ Bi-weekly ☐ Weekly ☐ Other – Please Specify

Basis of Compensation and Rate (Tier 1, 2, 3, 4 and 5 ONLY):

Annual $________ Daily $________ Hourly $________

Units of Work Performed $________ per ________

(Example: $50 per meeting or $10 per examination, etc.)

Basis of Compensation and Rate (Tier 6 ONLY):

Annual Wage $________

Tier 6 requires employers to determine the Annual Wage for individuals who work Part Time, Seasonal or on an Hourly, Daily or Unit of Work Basis. See the Chart on Page Two for instructions.
Examples of Tier 6 annual wage for individuals paid at an Hourly, Daily or Unit of Work basis of compensation:

<table>
<thead>
<tr>
<th>Hourly Employees</th>
<th>Daily Employees</th>
</tr>
</thead>
<tbody>
<tr>
<td>12 month Employee: $ ____________ x _____ Standard Workday x 260 = $ 0.00</td>
<td></td>
</tr>
<tr>
<td>10 month Employee: $ ____________ x _____ Standard Workday x 180 = $ 0.00</td>
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Hours x Standard Workday = Days Worked x Annual Wage

*Standard Workday (Hrs/day) (Applies to all Tiers): The minimum number of hours that can be established for a standard workday is six, while the maximum is eight. A standard workday is the denominator to be used for the days worked calculation; it is not necessarily the number of hours the person actually worked. For example, if a bus driver works four hours a day, you must still establish a standard workday between six and eight hours as the denominator for their days worked calculation.

<table>
<thead>
<tr>
<th>Unit of Work Employees</th>
<th>Example: Paid $50 per Meeting</th>
</tr>
</thead>
<tbody>
<tr>
<td>$ ____________ x _____ # of Events = $ 0.00</td>
<td></td>
</tr>
</tbody>
</table>

**Estimated or Actual

Universe 

**An estimate of the number of events is acceptable

Note: Any questions regarding annual wage, please contact the Retirement System.

Are you currently an active or vested member of any other public retirement system in New York State?  

If yes, what is the name of the system?  

10 

WARNING: If you are now an active or vested member of any other public retirement system in New York State, you should contact that system concerning the advantages of transferring your membership to this System. Failure to contact that system could cause loss of the privilege of transferring membership and may affect contribution cessation dates.

Are you currently receiving or are you about to begin receiving a RETIREMENT BENEFIT from any retirement system on THE BASIS OF EMPLOYMENT with New York State or any public entity in the State?  

11 

Have you ever been a member of the New York State Employees’ Retirement System?  

12 

List below all previous periods of employment with New York State or any New York State public entity (County, City, Town, Village, School District, Public Authority or Special District). Include any military service. Attach additional sheets as required.

13 Name of Employer | Name of Dept. or Agency | Title of Position | From | To | Indicate if Permanent or Temporary, and Full or Part Time |
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<td>Mo.</td>
<td>Day</td>
<td>Year</td>
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<td>Mo.</td>
<td>Day</td>
<td>Year</td>
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</table>

NOTE: In accordance with the Personal Privacy Protection Law you are hereby advised that pursuant to the Retirement and Social Security Law, the Retirement System is required to maintain records. The records are necessary to determine eligibility for and to calculate benefits. Failure to provide information may result in the failure to pay benefits. The System may provide certain information to participating employers. The official responsible for maintaining these records is the Director of Member Services, New York State and Local Retirement System, Albany, NY 12244-0145; telephone number (518) 474-3524.
Reinstatement to a former membership in accordance with Section 645 (Tiers 3, 4, 5 and 6).

Note: Completion of this form does not constitute an application for reinstatement.

Section 645 of the Retirement and Social Security Law allows members of a New York State public retirement system, whose original membership was terminated or withdrawn, to return to their former Tier or date of membership.

Members with a former Tier 3, 4, 5 or 6 membership in the New York State and Local Employees' Retirement System will be automatically provided with the cost, if any, and procedures for reinstatement at a later date.

Former Tier 3, 4, 5 or 6 members of any NYS public retirement system, other than the NYS Employees' Retirement System, please complete the section below. We will provide you with the cost, if any, and procedures for reinstatement at a later date.

Reinstatement to a former membership in accordance with Section 645 (Tiers 1 and 2).

Members with a former Tier 1 or 2 membership in any New York public retirement system may apply for reinstatement by completing the section below.

Important Information:

If you are not sure of your employer’s current Tier 1 or 2 retirement plan, or if you are a member of the Police and Fire Retirement System or if you have any questions regarding reinstatement you should contact the Retirement System before completing the section below.

If you are given Tier 1 or 2 status, your Tier 3, 4, 5 or 6 contributions are not refundable and you will not be able to take a loan against these contributions.

If your date of membership will be before April 1, 1960, you may owe contributions for services rendered prior to April 1, 1960. Any deficit in contributions for service before the date noted will result in a reduction of your retirement benefit.

---

**FORMER MEMBERSHIP INFORMATION:**

PLEASE CHECK THE FIRST FORMER RETIREMENT SYSTEM YOU WERE A MEMBER OF:

- [ ] New York State Teachers' Retirement System
- [ ] New York State and Local Employees' Retirement System
- [ ] New York State and Local Police and Fire Retirement System
- [ ] New York City Employees' Retirement System
- [ ] New York City Board of Education Retirement System
- [ ] New York City Teachers' Retirement System
- [ ] New York City Police Pension Fund
- [ ] New York City Fire Pension Fund

PLEASE COMPLETE THE FOLLOWING (if known):

Former Registration Number: ___________________________ Date of Membership: ________________

Former Name (if applicable):

Have you received credit for this former membership in any other retirement system? Yes [ ] No [ ]

If Yes, what retirement system? ________________________________

Are you receiving or eligible to receive a retirement benefit based on this service? Yes [ ] No [ ]

Signature ____________________________________________ Date ________________

---

If you are eligible for a refund of contributions, the Retirement System is required to withhold 10% of the taxable amount of the refund for federal taxes unless you instruct us not to take the withholding.

If you do not want the Retirement System to withhold federal income tax from your payment, sign and date this election.

**I DO NOT WANT TO HAVE FEDERAL INCOME TAX WITHHELD FROM MY PAYMENT.**

Signed: ___________________________ Date: ___________________________
If you have not already done so, please complete an RS5127 Designation of Beneficiary With Contingent Beneficiaries form to designate beneficiary(ies) to receive an Ordinary Death Benefit. If there is no RS5127 Designation of Beneficiary With Contingent Beneficiaries form on file with this System, your Ordinary Death Benefit will become payable to your estate.

WARNING: If you are receiving a pension from a public retirement system in New York State, contact the system providing your pension BEFORE signing this form. Failure to do so could result in the suspension of payment of your pension benefit.

IMPORTANT: You must sign and enter date below to affirm Retirement System membership.
I acknowledge that my membership in the New York State and Local Employees’ Retirement System is governed by the provisions of Article 15 of the Retirement and Social Security Law and that I am entitled to all the benefits thereof. I understand that, as required by law, a deduction will be made from my salary or compensation for retirement contributions.

Signature

Date

Employee Telephone Number*

Employee E-Mail Address*

ACKNOWLEDGEMENT TO BE COMPLETED BY A NOTARY PUBLIC

State of __________________________ County of __________________________

On the ___ day of __________ in the year ___ before me, the undersigned, personally appeared __________________________, personally known to me or proved to me on the basis of satisfactory evidence to be the individual(s) whose name(s) is (are) subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their capacity(ies), and that by his/her/their signature(s) on the instrument, the individual(s), or the person upon behalf of which the individual(s) acted, executed the instrument.

NOTARY PUBLIC (Please sign and affix stamp)

Notary Stamp

*Not Required

FOR OFFICE USE ONLY

Reviewed

Examined
Designation of Beneficiary
With Contingent Beneficiaries

Please PRINT clearly, using only blue or black ink.

Member/Pensioner Information

Registration/Retirement Number: ____________________________

Last 4 Digits of Social Security Number* ______________________

Name: ____________________________

Former Name: ______________________________

Home Address: ____________________________

Date of Birth: ____________________________

City, State, Zip Code: ____________________________

Telephone Number: ____________________________

Email Address: ________________________________

Employed By: ____________________________

Employer Address: ____________________________

IMPORTANT INFORMATION REGARDING THIS FORM

• If you find this form is not suited to the type of designation you prefer please advise the Retirement System. In the meantime, for your protection and the protection of your beneficiary(ies), you should make an interim designation using this form. If you wish to designate more beneficiaries than this form allows or to designate a Trust, Guardianship or payment under the Uniform Transfers to Minors Act please contact the Retirement System for the appropriate form.

• Attachments to your beneficiary form are unacceptable.

• New beneficiary forms filed will supersede any previous designation. Therefore, if you want to add or delete a beneficiary, for example a new child, you must include on the new form all beneficiaries you wish to designate.

• The same person or persons cannot be designated as both primary and contingent beneficiaries. We make payment to a contingent beneficiary(ies) only if all primary beneficiary(ies) die before you do.

• If you wish to have these benefits distributed through your estate, you should name “my estate” as beneficiary. Your estate can be named as either primary or contingent beneficiary. However, if you name your estate as primary beneficiary, you may not name any contingent beneficiary.

• This form is for designating beneficiaries to receive your ordinary death or post retirement death benefit. You may not designate beneficiaries to receive accidental death benefits. The beneficiaries entitled to receive accidental death benefits are mandated by statute.

Make sure that you:

• Complete all requested information.

• Sign and date the form.

• Have the form notarized, making sure the notary has entered the date his or her commission expires.

• Mail your completed form to:
  New York State and Local Retirement System
  Member & Employer Services
  Registration — Mail Drop 5-6
  110 State Street
  Albany, NY 12244-0001

PERSONAL PRIVACY PROTECTION LAW
In accordance with the Personal Privacy Protection Law you are hereby advised that pursuant to the Retirement and Social Security Law, the Retirement System is required to maintain records. The records are necessary to determine eligibility for and to calculate benefits. Failure to provide information may result in the System’s inability to pay benefits the way you prefer. The System may provide certain information to participating employers. The official responsible for maintaining these records is the Director of Member & Employer Services, New York State and Local Retirement Systems, Albany, NY 12244. For questions concerning this form, please call 1-866-805-0990 or 518-474-7796.

SOCIAL SECURITY DISCLOSURE REQUIREMENT
In accordance with the Federal Privacy Act of 1974, you are hereby advised that disclosure of the Social Security Account Number is mandatory pursuant to sections 11, 31, 34 and 334 of the Retirement and Social Security Law. The number will be used in identifying retirement records and in the administration of the Retirement System.

Please go to the reverse side of this form to designate beneficiaries, sign and date the form, and have the form notarized.

RS 5127 (front)
Do not alter this form or make stipulations. The use of correction fluid or other alterations on this form will render the designation invalid.

To the Comptroller of the State of New York.

Designation of Primary Beneficiary(ies). I hereby name the following beneficiary(ies) to receive any ordinary death or post retirement death benefit, payable on my behalf. If I have named more than one beneficiary, it is my intention that those living at the time of my death should share equally any benefit payable. I reserve the right to change this designation at any time.

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<th>Name</th>
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<th>Female</th>
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<td>Address</td>
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<td>Relationship</td>
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<td>Telephone Number</td>
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Designation of Contingent Beneficiary(ies). If all of the designated primary beneficiaries die before I do, any ordinary death or post retirement death benefit payable on my behalf shall be paid to the following. If I have named more than one beneficiary, it is my intention that those living at the time of my death should share equally any benefit payable. If I out-live all of these contingent beneficiaries, any benefit payable should be paid to my estate. I reserve the right to change this designation at any time.

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This form must be signed, dated and notarized in order to be valid

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<tr>
<th>Member/Pensioner Signature</th>
<th>Date</th>
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Acknowledgement To Be Completed by a Notary Public

State of ____________________________ County of ____________________________

On the ______ day of ______ in the year ______ before me, the undersigned, personally appeared ____________________________, personally known to me or proved to me on the basis of satisfactory evidence to be the individual(s) whose name(s) is (are) subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their capacity(ies), and that by his/her/their signature(s) on the instrument, the individual(s), or the person upon behalf of which the individual(s) acted, executed the instrument.

Notary Public Stamp

NOTARY PUBLIC (Please sign and affix stamp)
Invitation to Self-Identify for Veterans

Why are you being asked to complete this form?
Because we do business with the government; we must reach out to current employees, new hires and applicants, and take affirmative action to employ and advance in employment: (1) disabled veterans; (2) recently separated veterans; (3) active duty wartime or campaign badge veterans; and (4) Armed Forces service medal veterans. These classifications are defined as follows:

Definitions:

- A "disabled veteran" is one of the following:
  (1) a veteran of the U.S. military, ground, naval or air service who is entitled to compensation (or who but for the receipt of military retired pay would be entitled to compensation) under laws administered by the Secretary of Veterans Affairs; or
  (2) a person who was discharged or released from active duty because of a service-connected disability.
- A "recently separated veteran" means any veteran during the three-year period beginning on the date of such veteran's discharge or release from active duty in the U.S. military, ground, naval, or air service.
- An "active duty wartime or campaign badge veteran" means a veteran who served on active duty in the U.S. military, ground, naval or air service during a war, or in a campaign or expedition for which a campaign badge has been authorized under the laws administered by the Department of Defense.
- An "Armed forces service medal veteran" means a veteran who, while serving on active duty in the U.S. military, ground, naval or air service, participated in a United States military operation for which an Armed Forces service medal was awarded pursuant to Executive Order 12985.

Protected veterans may have additional rights under USERRA - the Uniformed Services Employment and Reemployment Rights Act. In particular, if you were absent from employment in order to perform service in the uniformed service, you may be entitled to be re-employed by your employer in the position you would have obtained with reasonable certainty if not for the absence due to service. For more information, call the U.S. Department of Labor's Veterans Employment and Training Service (VETS), toll-free at 1-866-4-USA-DOL.

To help us measure how well we are doing, we are asking you to tell us if you are an individual as defined above. 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.

APPLICANT

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

☐ I IDENTIFY AS ONE OR MORE OF THE CLASSIFICATIONS OF PROTECTED VETERAN LISTED ABOVE

☐ I AM NOT A PROTECTED VETERAN

Rev 1/2015
NEW HIRE/CURRENT EMPLOYEE

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 based on your circumstances at this time, regardless of whether you identified as having a disability earlier.

If you believe you belong to any of the categories of protected veterans listed above, please indicate by checking the appropriate box below.

I BELONG TO THE FOLLOWING CLASSIFICATIONS OF PROTECTED VETERANS (CHOOSE ALL THAT APPLY):

☐ DISABLED VETERAN
☐ RECENTLY SEPARATED VETERAN   DATE SEPARATED FROM MILITARY SERVICE: _______________________
☐ ACTIVE WARTIME OR CAMPAIGN BADGE VETERAN
☐ ARMED FORCES SERVICE MEDAL VETERAN

☐ I am a protected veteran, but I choose not to self-identify the classifications to which I belong.
☐ I am NOT a protected veteran.

If you are a disabled veteran it would assist us if you tell us whether there are accommodations we could make that would enable you to perform the essential functions of the job, including special equipment, changes in the physical layout of the job, changes in the way the job is customarily performed, provision of personal assistance services or other accommodations. This information will assist us in making reasonable accommodations for your disability.

Submission of this information is voluntary and refusal to provide it will not subject you to any adverse treatment. The information provided will be used only in ways that are not inconsistent with the Vietnam Era Veterans' Reemployment Assistance Act of 1974, as amended.

The information you submit will be kept confidential, except that (1) supervisors and managers may be informed regarding restrictions on the work or duties of disabled veterans, and regarding necessary accommodations; (ii) first aid and safety personnel may be informed, when and to the extent appropriate, if you have a condition that might require emergency treatment; and (iii) Government officials engaged in enforcing laws administered by the Office of Federal Contract Compliance Programs, or enforcing the Americans with Disabilities Act, may be informed.

__________________________________________  ________________________________________
Your Name (Print legibly)                     Today's Date (Month/Day/Year)

SUNY IDENTIFIERS:
☐ I AM A CURRENT EMPLOYEE
Title of position: ____________________________

☐ I AM APPLYING FOR A POSITION
Title of position: ____________________________

Rev 1/2015
Voluntary Self-Identification of Disability

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.

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

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

SUNY IDENTIFIERS:

☐ I AM A CURRENT EMPLOYEE
  Title of Position: __________________________

☐ I AM APPLYING FOR A POSITION
  Title of Position: __________________________
Voluntary Self-Identification of Disability

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

Please check one of the boxes below:

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

__________________________________________
Your Name

__________________________________________
Today's Date

Rev 1/2015
SUNY Orange Voluntary Disclosure Form

Pursuant to College policy, the College is committed to fostering a diverse community of outstanding faculty, staff, and students, as well as ensuring equal educational opportunity, employment, and access to services, programs, and activities, without regard to an individual's race, color, national origin, religion, creed, age, disability, sex, gender identity, sexual orientation, familial status, pregnancy, predisposing genetic characteristics, military status, domestic violence victim status, or criminal conviction. Employees, students, applicants or other members of the College community (including but not limited to vendors, visitors, and guests) may not be subjected to harassment that is prohibited by law, or treated adversely or retaliated against based upon a protected characteristic.

The College’s policy is in accordance with federal and state laws and regulations prohibiting discrimination and harassment. These laws include the Americans with Disabilities Act (ADA), Section 504 of the Rehabilitation Act of 1973, Title IX of the Education Amendments of 1972, Title VII of the Civil Rights Act of 1964 as Amended by the Equal Employment Opportunity Act of 1972, and the New York State Human Rights Law. These laws prohibit discrimination and harassment, including sexual harassment and sexual violence.

Inquiries regarding the application of Title IX and other laws, regulations and policies prohibiting discrimination may be directed to the Title IX Coordinator. Inquiries may also be directed to the United States Department of Education's Office for Civil Rights, 32 Old Slip 26th Floor, New York, NY 10005-2500; Tel. (646) 428-3800; email OCR.NewYork@ed.gov.

PLEASE PRINT
NAME: ____________________________ DATE: ____________________________

POSITION APPLIED FOR: ____________________________

WHAT IS YOUR ETHNICITY/RACE?
Ethnicity
Are you Hispanic/Latino? (A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race)

☐ No, not Hispanic or Latino   ☐ Yes, Hispanic or Latino

If Hispanic/Latino, is your background (select one):
☐ Central American ☐ Dominican ☐ Mexican ☐ Other Hispanic/Latino ☐ Puerto Rican
☐ South American ☐ Cuban

Race
Is your Race (check all that apply)
☐ American Indian or Alaska Native (Persons having origins in any of the original peoples of North, Central or South America, and who maintains tribal affiliation or community attachment)

☐ Asian (Person having origins in any of the original peoples of the Far East, Southeast Asia, or Indian subcontinent)

☐ Black or African American (Person having origins in any of the black racial groups of Africa)

☐ Native Hawaiian/Other Pacific Islander (Person having origins in any of the original peoples of Hawaii, Guam, Samoa or other Pacific Islands)

☐ White (Person having origins in any of the indigenous peoples of Europe, North Africa, or Middle East)

Gender: ☐ Female ☐ Male

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