HSC Student Employee's Check Sheet The University of Toledo

AFTER YOU HAVE BEEN HIRED, BUT BEFORE YOU CAN BEGIN WORKING, YOU MUST COMPLETE THE FOLLOWING:

I. These employment forms must be completed and returned to Experiential Learning and Career Services & Student Employment, SU 1533.

- State Tax Form
- OPERS Optional Exemption Request
- Personal Information Form (PIF)
- Fraud Alert
- I-9 Employment Eligibility Verification - 2 IDs required (to be completed by Hiring Department)
- Expected Behavior of Employees
- Ethical Conduct Statement
- Invention Reporting and Assignment Agreement
- ICARE Attestation
- Patient Rights Form
- Recognition of Impaired Licensed Independent Practitioners
- Authorization to Release Information Form (background checks completed by Student Employment)
- HSC Student Employee Health Screening Request Form (green) - return after completion by Family Health Services

2. Online Forms Must Be Completed By the Student Through myUT Portal - Employee Tab

- Federal Tax W-4 Form
- Direct Deposit Form

II. Required health screenings and trainings:

A. FAMILY HEALTH SERVICES: The Hiring Manager should use the following link to begin the health screening process and monitor results. https://medicalscreening.utoledo.edu/login.aspx. Please make an appointment by calling 419-383-5000 for the

- Pre-employment drug screen
- Verification of immunization including: titers for rubella, rubeola, varicella, mumps, hepatitis B, tetanus, diphtheria and pertussis. You must take a copy of these records to Family Health Services
- 2-step PPD (tuberculosis) test

B. SAFETY TRAINING Log In to MyUT portal, student tab, scroll down to "My Other Resources", click on Training Test Bank, log in with your UTAD ID and Password, select "Safety Training for Student Employees #173". Upon completion, please print and bring your test results to Student Employment, SU 1533.

C. CULTURAL DIVERSITY TRAINING: See reverse side of this form for instructions

D. HIPAA TRAINING: Log into MyUT portal, student tab, scroll down to "My Other Resources", check on Training Test bank, log in with your UTAD ID and password, select "HIPAA Training #252". Upon completion, please print and bring your test results to Student Employment, SU 1533

III. Forms to be signed by supervisor and student. Return the three items below to Student Employment within two business days after your first day of work. PLEASE NOTE: You will be activated in the payroll system after ALL steps have been completed

- General Orientation Check Sheet (signatures required)
- Original Work Study Contract (signatures required)
- Job Description (no signatures required)

All paper work must be completed and submitted to Student Employment before student can begin working.
ONLINE DIVERSITY TRAINING INSTRUCTIONS

The Online Diversity Training is located at https://testbank.utoledo.edu/Public/Lo~'ln.aspx. This link will take you to something that looks like a calendar. Above the calendar grid, there are login boxes for UTAD ID and Password. After entering the ID and Password, it will take you to a page with the heading "UT Safety Testing / Training" and a welcome message that should include your name.

Please be sure that any "Pop-up Blocker" on your browser is turned off during this training or the training module will not come up. Also, please be sure your screen resolution does not exceed 100% or you may not be able to access the buttons necessary to advance to the next slide. (If you have difficulty in locating these tools, please call Terrie Kovacs at 419-530-1478)

On the left side of the page, there is a list of links to access the tests. Under "testing/training" the third link is labeled "Select Test." Clicking on the 'select test' link will lead to a drop-down selection menu. Use this drop-down to find the test labeled "Diversity Training (172)". Select that test and click the button beneath it labeled "take selected test". This will open up the training module. If you see a message that reads "This test currently has no media", please disregard as it is referring to any external media such as a policy link or an external PowerPoint.

When you have finished, you may check your results by selecting "Past Results" on the panel on the left side of the home page (where you originally chose "Select Test") If completed correctly, it will show that you have taken Test # 172, your name and the date it was completed. It will also display that you have completed Topic # 273. Do not let this confuse you. It is the same training but identified in a different category within the test bank. If you would like, you may print that page as proof of your completion and present it to your supervisor for your file.

For any additional problems or questions, please contact Terrie Kovacs by email at Terrie.Kovacs@utoledo.edu or by phone at 419-530-1478.
Notice to Employee

1 For state purposes, an individual may claim only natural dependency exemptions. This includes the taxpayer, spouse and each dependent. Dependents are the same as defined in the Internal Revenue Code and as claimed in the taxpayer's federal income tax return for the taxable year for which the taxpayer would have been permitted to claim had the taxpayer filed such a return.

2 You may file a new certificate at any time if the number of your exemptions increases. You must file a new certificate within 10 days if the number of exemptions previously claimed by you decreases because:
   (a) Your spouse for whom you have been claiming exemption is divorced or legally separated, or claims her (or his) own exemption on a separate certificate.
   (b) The support of a dependent for whom you claimed exemption is taken over by someone else.
   (c) You find that a dependent for whom you claimed exemption must be dropped for federal purposes.

The death of a spouse or a dependent does not affect your withholding until the next year but requires the filing of a new certificate. If possible, file a new certificate by Dec 1st of the year in which the death occurs.

For further information, consult the Ohio Department of Taxation, Personal and School District Income Tax Division, or your employer.

3 If you expect to owe more Ohio income tax than will be withheld, you may claim a smaller number of exemptions, or under an agreement with your employer, you may have an additional amount withheld each pay period.

4 A married couple with both spouses working and filing a joint return will, in many cases, be required to file an individual estimated income tax form IT 1040ES even though Ohio income tax is being withheld from their wages. This result may occur because the tax on their combined income will be greater than the sum of the taxes withheld from the husband's wages and the wife's wages. This requirement to file an individual estimated income tax form IT 1040ES may also apply to an individual who has two jobs, both of which are subject to withholding. In lieu of filing the individual estimated income tax form IT 1040ES, the individual may provide for additional withholding with his employer by using line 5.

---

Ohio Department of Taxation

Employee's Withholding Exemption Certificate

Print full name____________________________________ Social Security number________________________

Home address and ZIP code_____________________________ School district no __________________________
(See 71.1050 at tax.oh.gov)

1 Personal exemption for yourself, enter "1" if claimed

2 If married, personal exemption for your spouse if not separately claimed (enter "1" if claimed)

3 Exemptions for dependents

4 Add the exemptions that you have claimed above and enter total

5 Additional withholding per pay period under agreement with employer $____________

Under the penalties of perjury, I certify that the number of exemptions claimed on this certificate does not exceed the number to which I am entitled.

Signature________________________________________ Date________________________
REQUEST FOR:
OPTIONAL EXEMPTION AS A STUDENT

Social Security Number

Daytime Phone Number

Employee ID Number

First Name

Last Name

E-mail Address

Name of School, College or University

I have reviewed this form and I choose an optional exemption from membership in OPERS as a student working at the public school, college or university where I attend. I understand I must become a member of OPERS if my employment does not meet the proper requirements. I have made this election within 30 days of my employment date.

Today's Date
Month
Day
Year

Student Signature

Do not print or type name

STEP 2: Employer Authorization (to be completed by employer contact with signature authority)

I certify this employee is a student enrolled and attending this school. I understand if this request is approved by OPERS, this form will be stamped "APPROVED" and returned to this school. After the school receives the approved exemption, provided the student meets all required criteria, no deductions will be taken from the student's salary. Membership shall be established if this exemption is not approved or if the student does not meet all the requirements of Ohio Revised Code Section 145.03.

Employee Employment Date
Month
Day
Year

Today's Date
Month
Day
Year

Employer Contact Signature

Do not print or type name

DO NOT WRITE BELOW THIS LINE - FOR OPERS OFFICE USE ONLY

Date Rec'd Stamp

"APPROVED" Stamp
## Personal Information Form (PIF)

### The University of Toledo

<table>
<thead>
<tr>
<th>Name</th>
<th>(Last)</th>
<th>(First)</th>
<th>(Middle)</th>
</tr>
</thead>
<tbody>
<tr>
<td>SSN</td>
<td>Address</td>
<td>(Number and Street)</td>
<td></td>
</tr>
<tr>
<td>City</td>
<td>State</td>
<td>Zip</td>
<td>Phone Number</td>
</tr>
</tbody>
</table>

**Marital Status**

- Divorced
- Separated
- Married
- Single
- Widowed
- Domestic Partner

**Gender**

- Female
- Male

**Are you a Citizen of the United States?**

- Yes
- No

### Complete The Following Section If You Are Not A Citizen Of The United States

**Are you a Lawful Permanent Resident Alien?**

- Yes
- No

**VISA Status**

(Complete the following only if a NON-RESIDENT ALIEN)

- Student
- Faculty, Staff

**Country of Legal Residence**

- OPT
- Date of Original Entry To U.S.

### Race/Ethnicity

This information is required for Ohio and United States governmental Affirmative Action statistical purposes. **Check all that apply.**

- African American: (not of Hispanic origin) All persons having origins in any of the Black racial groups of Africa
- Caucasian or White: (not of Hispanic origin) All persons having origins in any of the original peoples of Europe, North Africa, or the Middle East.
- Hispanic: All persons of Mexican, Puerto Rican, Cuban, Central or South American, or other Spanish culture or origin, regardless of race
- American Indian or Alaskan Native: All persons having origins in any of the original peoples of North America, and who maintain cultural identifications through tribal affiliation or community recognition.
- Asian American or Pacific Islander: All persons having origins in any of the original peoples of Far East, Southeast Asia, the Indian Subcontinent, or the Pacific Islands

### Veteran Status: Complete If Applicable

**Dates of Service (mm-dd-yy)**

- (From)
- (To)

**Campaign Ribbon(s) (see page 2/3):**

- Veteran
- Vietnam Veteran
- Disabled Veteran

**Type of Disability**

- (Percent)
### Identification of a Disability

As a new employee, you are given the opportunity to advise the University whether or not you consider yourself to be disabled according to the definition given below. Your response is purely voluntary and you will not be subjected to disciplinary action for failing to respond. Should you decide to change your decision at a later date, please notify the Human Resources Office in writing.

According to Section 504 of the Rehabilitation Act of 1973, a disabled person is any person who: (1) has a physical or mental impairment that substantially limits one or more major life activities (functions such as caring for one's self, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, and working); (2) has a record of such an impairment that substantially limits one or more major life activities; or (3) is regarded as having such an impairment.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th>(Type of Disability)</th>
<th>(Percent)</th>
</tr>
</thead>
<tbody>
<tr>
<td><em>No</em></td>
<td><em>Yes</em></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Religious Accomodation (optional)

As a new employee, you are given the opportunity to advise the University whether or not you will require any religious accommodations. Your response is purely voluntary and you will not be subjected to disciplinary action for failing to respond. Should you decide to change your decision at a later date, please notify your supervisor and the Human Resources Office in writing.

<table>
<thead>
<tr>
<th>(Religion)</th>
<th>Accommodation Requested</th>
</tr>
</thead>
</table>

### Emergency Contact Information

<table>
<thead>
<tr>
<th>Name</th>
<th>Relationship</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address</td>
<td></td>
</tr>
<tr>
<td>Home Phone Number</td>
<td>Cell Phone Number</td>
</tr>
</tbody>
</table>

I understand and agree that providing the information requested on this form is based on the fact that I have accepted employment with the University of Toledo and that the information is required in order to establish my employment record and to place me on the University's payroll system.

<table>
<thead>
<tr>
<th>Signature of Employee</th>
<th>Date (mm-dd-yyyy)</th>
</tr>
</thead>
</table>
**U.S. Office of Personnel Management VetGuide Appendix A:**
Wars, Campaigns and Expeditions of the Armed Forces
Since WWII Quality for Veterans' Preference

**War Service Creditable for Veterans Preference.** In the absence of statutory definition for "war" and "campaign or expedition," OPM considers to be "wars" only those armed conflicts for which a declaration of war was issued by Congress. The title 38, U.S.C., definition of "period of war," which is used in determining benefits administered by the Department of Veterans Affairs, includes the Vietnam Era and other armed conflicts. That title 38 definition is NOT applicable for civil service purposes. Thus the last "war" for which active duty is qualifying for Veterans preference is World War II. The inclusive dates for World War II service are December 7, 1941, through April 28, 1952.

**Non-combat operations that are not qualifying for Veterans preference.** Many medals are awarded for non-combat operations. These medals are not a basis for preference and include the following: Global War on Terrorism Service Medal for service from September 11, 2001, to date to be determined, The Medal of Merit for meritorious service in World War II, The Medal of Freedom for meritorious achievements or meritorious service to the United States on or after December 7, 1941, in the war against an enemy outside the continental limits of the United States, The Antarctica Service Medal for participating in a scientific, direct support, or exploratory operation on the Antarctic Continent, The National Defense Service Medal for honorable service between June 27, 1950 and July 27, 1954 or January 1, 1961 and August 14, 1974; or for the period between August 2, 1990, and November 30, 1995, The Armed Forces Service Medal for participation in a United States military operation deemed to be a significant activity for which there was no threat of encounter of foreign armed opposition or imminent threat of hostile action, The Armed Forces Reserve Medal for 10 years of honorable service in a Reserve component; or active duty service in a Reserve component on or after August 1, 1990; or volunteer service for active duty on or after August 1, 1990.

**Military Operations Since 1937 for Which a Campaign or Expeditionary Medal Has Been Awarded, Except for Operations Occurring During a Declared War**
Military personnel receive many awards and decorations. To help agencies make decisions concerning entitlement to Veterans preference and other benefits, the following list identifies those awards that are campaign and expeditionary medals. Any Armed Forces expeditionary Medal, whether listed here or not, is qualifying for Veterans preference. The Department of Defense, not OPM, determines who is entitled to receive a medal, and under what circumstances. The list below is derived from DoD 1348.33-M, Manual of Military Decorations and Awards. DD 214, Certificate of Discharge or Separation from Active Duty, or other official documents issued by the branch of service are required as verification of eligibility for Veterans preference.

**Note:** Section 572 of Subtitle G of the Defense Authorization Act of Fiscal Year 1998 (Public Law 105-85), signed into law on November 18, 1997, allows the Secretary of the military department concerned to determine whether individual members who participated in Operation Joint Endeavor or Operation Joint Guard in the Republic of Bosnia and Herzegovina and in such other areas in the region as the Secretary of Defense considers appropriate, meet the individual service requirements for award of the Armed Forces Expeditionary Medal (AFEM). Generally, service members will be considered eligible if they: deployed to Bosnia and Herzegovina (or other area that the Secretary of Defense considers appropriate) in direct support of one or both of the operations; served on board a ship in the Adriatic in direct support of one or both of the operations; or operated in airspace above Bosnia, Herzegovina (or other area that the Secretary of Defense considers appropriate) while the operations were in effect.
<table>
<thead>
<tr>
<th>Campaign or Expedition</th>
<th>Inclusive dates</th>
</tr>
</thead>
<tbody>
<tr>
<td>Armed Forces Expeditionary Medal (AFEM)</td>
<td>In October 11, 2001; and present</td>
</tr>
<tr>
<td>Army Occupation of Austria</td>
<td>September 11, 1945, to August 1, 1955</td>
</tr>
<tr>
<td>Army Occupation of Berlin</td>
<td>September 11, 1945, to August 1, 1955</td>
</tr>
<tr>
<td>Army Occupation of Germany (exclusive of Berlin)</td>
<td>September 11, 1945, to August 1, 1955</td>
</tr>
<tr>
<td>Army Occupation of Japan</td>
<td>September 11, 1945, to August 1, 1955</td>
</tr>
<tr>
<td>Chinese Service Medal (Extended)</td>
<td>September 3, 1945, to April 27, 1952</td>
</tr>
<tr>
<td>Korea Defense Service Medal</td>
<td>July 28, 1954 to (date to be determined)</td>
</tr>
<tr>
<td>Kosovo Campaign Medal (KCM) Operation Allied Force</td>
<td>March 24, 1999 to June 10, 1999</td>
</tr>
<tr>
<td>Kosovo Campaign Medal (KCM) Operation Joint Guardian</td>
<td>June 11, 1999 to (date to be determined)</td>
</tr>
<tr>
<td>Kosovo Campaign Medal (KCM) Operation Allied Harbor</td>
<td>April 4, 1999 to September 1, 1999</td>
</tr>
<tr>
<td>Kosovo Campaign Medal (KCM) Operation Noble Anvil</td>
<td>March 24, 1999 to July 22, 2000</td>
</tr>
<tr>
<td>Kosovo Campaign Medal (KCM) Task Force Hawk</td>
<td>April 5, 1999 to June 24, 1999</td>
</tr>
<tr>
<td>Kosovo Campaign Medal (KCM) Task Force Saber</td>
<td>March 31, 1999 to July 8, 1999</td>
</tr>
<tr>
<td>Kosovo Campaign Medal (KCM) Task Force Hunter</td>
<td>June 11, 1999 to (date to be determined)</td>
</tr>
<tr>
<td>Kosovo Campaign Medal (KCM) Operation Uphold Democracy</td>
<td>April 1, 1999 to November 1, 1999</td>
</tr>
<tr>
<td>Navy Occupation of Austria</td>
<td>May 8, 1945 to October 25, 1954</td>
</tr>
<tr>
<td>Navy Occupation of Trieste</td>
<td>May 8, 1945 to October 25, 1954</td>
</tr>
<tr>
<td>Southwest Asia Service Medal (SWASM) (Operations Desert Shield and Desert Storm)</td>
<td>August 2, 1990 to November 30, 1995</td>
</tr>
<tr>
<td>U.S. Army Tours of the Sixth Fleet (Navy)</td>
<td>May 9, 1945 to October 25, 1955</td>
</tr>
<tr>
<td>Rwanda</td>
<td>April 7 - 10, 1994</td>
</tr>
</tbody>
</table>

Navy expeditionary medal and Marine Corps medal for these operations:

<table>
<thead>
<tr>
<th>Campaign or Expedition</th>
<th>Inclusive dates</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cuba</td>
<td>January 3, 1961 to October 23, 1962</td>
</tr>
<tr>
<td>Indian Ocean/Iran</td>
<td>November 21, 1979, to October 20, 1991</td>
</tr>
<tr>
<td>Iranian/Yemen/Indian Ocean</td>
<td>December 9, 1979 to June 8, 1979</td>
</tr>
<tr>
<td>Lebanon</td>
<td>August 20, 1982 to May 31, 1983</td>
</tr>
<tr>
<td>Liberia (Operation Sharp Edge)</td>
<td>August 5, 1990 to February 21, 1991</td>
</tr>
<tr>
<td>Libyan Area</td>
<td>January 20, 1989 to June 27, 1986</td>
</tr>
<tr>
<td>Panama</td>
<td>April 1, 1980 to December 19, 1986 and February 1, 1991 to June 13, 1990</td>
</tr>
<tr>
<td>Persian Gulf</td>
<td>February 1, 1987 to July 23, 1990</td>
</tr>
<tr>
<td>Rwanda (Operation Distant runner)</td>
<td>April 7 - 18, 1994</td>
</tr>
<tr>
<td>Thailand</td>
<td>May 16 - August 10, 1962</td>
</tr>
</tbody>
</table>
START HERE. Read instructions carefully before completing this form. The instructions must be available during completion of this form.

ANTI-DISCRIMINATION NOTICE: It is illegal to discriminate against work-authorized individuals. 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.

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>Address (Street Number and Name)</td>
<td>Apt Number</td>
<td>City or Town</td>
<td>State</td>
</tr>
<tr>
<td>Date of Birth (mm/dd/yyyy)</td>
<td>U.S. Social Security Number</td>
<td>E-mail Address</td>
<td>Telephone Number</td>
</tr>
</tbody>
</table>

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)

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:
   - Foreign Passport Number ________________________________
   - Country of Issuance ________________________________

   Some aliens may write "N/A" in this field. (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)

Last Name (Family Name)                      First Name (Given Name)

Address (Street Number and Name)                      City or Town                      State                      Zip Code

STOP  Employer Completes Next Page  STOP
### 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.)

#### Employee Last Name, First Name and Middle Initial from Section 1:

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

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

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

#### 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 Zip Code</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 |

Form I-9 03/08/13 N
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 OR</th>
<th>LIST B</th>
<th>Documents that Establish Identity 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>
<td>1. A Social Security Account Number card, unless the card includes one of the following restrictions (1) NOT VALID FOR EMPLOYMENT (2) VALID FOR WORK ONLY WITH INS AUTHORIZATION (3) VALID FOR WORK ONLY WITH DHS AUTHORIZATION</td>
<td></td>
<td></td>
<td></td>
</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>2. Certification of Birth Abroad issued by the Department of State (Form FS-545)</td>
<td></td>
<td></td>
<td></td>
</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>3. Certification of Report of Birth issued by the Department of State (Form DS-1350)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Employment Authorization Document that contains a photograph (Form I-766)</td>
<td>4. Voter's registration card</td>
<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>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. For a nonimmigrant alien authorized to work for a specific employer because of his or her status a. Foreign passport, and b. Form I-94 or Form I-94A that has the following (1) The same name as the passport, and (2) An endorsement of the alien's nonimmigrant status as long as that period of endorsement has not yet expired and the proposed employment is not in conflict with any restrictions or limitations identified on the form</td>
<td>5. U.S. Military card or draft record</td>
<td>5. Native American tribal document</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>6. Military dependent's ID card</td>
<td>6. U.S. Citizen ID Card (Form I-197)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>7. U.S. Coast Guard Merchant Mariner Card</td>
<td>7. Identification Card for Use of Resident Citizen in the United States (Form I-179)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>8. Native American tribal document</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>9. Driver's license issued by a Canadian government authority</td>
<td>For persons under age 18 who are unable to present a document listed above:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>10. School record or report card</td>
<td>10. School record or report card</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>11. Clinic, doctor, or hospital record</td>
<td>11. Clinic, doctor, or hospital record</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>12. Day-care or nursery school record</td>
<td>12. Day-care or nursery school record</td>
<td></td>
<td></td>
<td></td>
</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.
Acknowledgement of receipt of Auditor of State fraud reporting system information

Pursuant to Ohio Revised Code 117.103(B)(1), a public office shall provide information about the Ohio fraud-reporting system and the means of reporting fraud to each new employee upon employment with the public office.

Each new employee has thirty days after beginning employment to confirm receipt of this information.

By signing below you are acknowledging The University of Toledo provided you information about the fraud-reporting system as described by Section 117.103(A) of the Revised Code, and that you read and understand the information provided. You are also acknowledging you have received and read the information regarding Section 124.341 of the Revised Code and the protections you are provided employee if you use the before-mentioned fraud reporting system.

I ________________________________, have read the information provided by my employer regarding the fraud-reporting system operated by the Ohio Auditor of State’s office. I further state that the undersigned signature acknowledges receipt of this information.

PRINT NAME, TITLE, AND DEPARTMENT

PLEASE SIGN NAME DATE
General Orientation Check Sheet for Student Employees - Health Science Campus

The supervisor/manager is to explain the material listed below

<table>
<thead>
<tr>
<th>GENERAL ORIENTATION</th>
<th>Supervisor's Initials</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mission, Vision, and Values</td>
<td></td>
</tr>
<tr>
<td>Organization/Department Structure &amp; Key Leaders (department specific)</td>
<td></td>
</tr>
<tr>
<td>External/Internal Customers (department specific)</td>
<td></td>
</tr>
<tr>
<td>The Joint Commission Accreditation Process</td>
<td></td>
</tr>
<tr>
<td>Infection Prevention and Control</td>
<td></td>
</tr>
<tr>
<td>Diversity Training (complete online training)</td>
<td></td>
</tr>
<tr>
<td>Expected Behavior of Employees *</td>
<td></td>
</tr>
<tr>
<td>Ethical Conduct Statement *</td>
<td></td>
</tr>
<tr>
<td>HIPPA Training (complete online or by attendance at training session)</td>
<td></td>
</tr>
<tr>
<td>Safety Training (complete online training)</td>
<td></td>
</tr>
<tr>
<td>Invention Reporting and Assignment Agreement*</td>
<td></td>
</tr>
<tr>
<td>iCARE Learning Program *</td>
<td></td>
</tr>
<tr>
<td>Patient Rights*</td>
<td></td>
</tr>
<tr>
<td>Recognition of Impaired Licensed Independent Practitioner *</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>EMPLOYMENT INFORMATION / POLICIES</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Attendance/Punctuality **</td>
<td></td>
</tr>
<tr>
<td>Lunch/Break Periods **</td>
<td></td>
</tr>
<tr>
<td>Overtime **</td>
<td></td>
</tr>
<tr>
<td>Performance Evaluations</td>
<td></td>
</tr>
<tr>
<td>Identification Badge (05-049)</td>
<td></td>
</tr>
<tr>
<td>Lost and Found</td>
<td></td>
</tr>
<tr>
<td>Smoking Policy (01-006)</td>
<td></td>
</tr>
</tbody>
</table>

* Forms to be signed by student employee and forwarded to Student Employment
** See "Student Employee Supervisor's Guide" on the Center for Experiential Learning and Career Development website http://www.utoledo.edu/success/celcs

Department Name __________________________ Student's Name __________________________ (Print)

Supervisor ______________________ / ______________________ Phone ___________ Date __________ (Print) (Signature)

Student Employee Signature __________________________ Date __________________________

The Orientation Check Sheet and a job description must be forwarded to Student Employment, SU 1533, within two business days of the student's first day of work.

Rev 2/19/14
Pre-Employment Statement

EXPECTED BEHAVIORS OF EMPLOYEES

All applicants are asked to read and sign this statement as part of the application procedure. (If you are unwilling to sign, please indicate such in writing below.)

Employees at the University of Toledo are expected to exhibit certain behaviors in the workplace. These expected behaviors are stated below. I understand that consideration for employment at the University of Toledo is dependent on my willingness to commit to conform to these expectations if hired.

1. I will be honest in all I do.

2. Customer service is the most important work I will do. Everyone I will come into contact with is a customer.

3. I will treat all persons with respect and dignity. The University of Toledo is richer because of its diverse students, faculty, patients, employees and volunteers.

4. Because The University of Toledo is an educational institution, I will continue to learn and teach others.

5. I will be dependable – be at work on time and work my schedule.

6. I will provide a fair day’s work in return for a fair day’s pay.

I agree that, if employed, I will conduct myself as described above, in accordance with all the University of Toledo policies, procedures, rules and in compliance with applicable collective bargaining agreements, and understand that failure to do so may result in discipline up to and including discharge.

Applicant Signature ___________________________ Date ________________
EMPILOYEE CERTIFICATION OF UNDERSTANDING ETHICAL CONDUCT STATEMENT

I understand that I have a continuing obligation to adhere to the expectations of University of Toledo-Health Science Campus and will conduct my business affairs in an ethical manner. I have read and understand the Ethical Conduct Statement and am aware that I have an obligation to be familiar with the sections of the Ohio Revised Code contained in this booklet. I hereby certify that I have received the appropriate sections of the Revised Code as an attachment to this document. Should I become aware of information that indicates a probable violation of the ethical conduct expectations of the University of Toledo-HSC, I further understand my responsibility to report such violation to an appropriate University of Toledo-HSC Vice President.

PLEASE SIGN AND RETURN THIS FORM TO THE HUMAN RESOURCE DEPARTMENT WITHIN 10 (TEN) DAYS OF RECEIPT OF THIS BOOKLET.

_________________________  ____________________________
Signature                                  Date

_________________________
Typed or Printed Name

_________________________
Position

- 3 -
INVENTION REPORTING & ASSIGNMENT OBLIGATIONS

DATE: __________________________

I have read the UT patent policy, a current copy of which is enclosed with this agreement, and agree to abide by the terms and conditions set forth in the policy.

I hereby agree to report to the Vice President for Research Development and any potentially patentable inventions and discoveries arising from any of my university work, including research, investigations, studies, and other scholarly activities. I also agree to assign all my rights in such inventions and discoveries to The University of Toledo in accordance with the UT patient policy and Section 3345.14 of the Ohio Revised Code.

NAME (type or print): ____________________________________________________________

TITLE OR POSITION: ____________________________________________________________

SCHOOL, DEPARTMENT, CENTER, ETC: __________________________________________

SIGNATURE: ___________________________________________________________________

Since this policy, like all UT policies, is revised from time to time, you should always refer to the UT policy website for the most recent revision of the UT patent policy 3364-70-04.

Completed forms must be returned to UT Human Resources Office, HSC, Mail Stop 205, and TC1105 E Campus Mail.
icare Standard of Excellence
Attestation of Commitment
2009

I, __________________________ (print name), have read and fully understand the icare Standards Policy (UT 3364-10-11). I understand that I am bound by the provisions in this policy and will, to the best of my ability, provide patients, families, and colleagues with the highest standards in quality of care, respect, and exemplary patient-centered service.

I understand that extreme patient-centered care reflects the highest standards possible for communication, access, respect, and excellence that I would expect or provide to my own family. Further, I understand that any breach of this or other applicable polices and procedures may result in disciplinary action up to and including termination.

By signing below, I attest that icare!

____________________________
Signature

____________________________
Date

Please check all that apply:

____ Medical Student
____ Nursing Student
____ Resident/ Fellow
____ Other Student
____ Faculty Member
____ Staff Member
____ Medical Staff Member
____ Hospital Administration
University of Toledo Medical Center is dedicated to caring for each person with respect and dignity. We consider the patient to be a partner who wants to understand and make informed decisions about their health care. We also believe the patient and their family (as desired) can participate if they know their rights and responsibilities. Guardians, legal representatives, and parents (for minors) have the same rights and responsibilities. The following summarizes these principles for you.

Patients have a right to:

- Reasonable access to treatment that is available and medically indicated regardless of age, sex, race/color, creed, origin, culture, economic or educational background, sexual orientation, disability, or sources of payment.
- Generate advance medical directives and have them followed.
- Know the names and titles of doctors and other care givers.
- Participate in the development and implementation of the plan of care.
- Complete information about their diagnosis, condition and treatment in terms they can understand. An interpreter will be available when they do not speak or understand English.
- Considerate care that respects culture, values and beliefs.
- Freedom from restraint that is not medically necessary.
- Know the reasons for any limits to visitors, phone calls, mail, or other communications.
- Make or have a representative make informed decisions about care. This includes risks, side effects, and outcomes expected.
- Request a change of provider or second opinion if desired.
- Information about continuing health care needs along with information about resources available.
- Be as comfortable as possible (especially at the end of life) and to make decisions regarding life-sustaining treatment.
- Care is available to meet physical, mental, spiritual and emotional needs.
- Request an Ethics Consult if having difficulty making health care decisions. Do this by calling the hospital operator (0) or (419) 383-4000 and ask for the ethicist on call.
- Information about billed services and cost of care. Assistance shall be provided to apply for financial aid as needed.
- Appropriate assessment and satisfactory management of pain (includes options to manage pain).
- Personal privacy. Permission must be obtained before sharing medical record information with anyone not involved with treatment and care.
• Receive care in a safe environment.
• Refuse treatment (as permitted by law) and to be informed of the possible consequences of this action.
• Consent or refuse to participate in experimental treatment/research.
• Access protective services when needed.
• Voice concerns about your care or service.

Patients have a responsibility to:
• Provide advance medical directives to the hospital/doctor.
• Act in a considerate and cooperative manner and respect the rights and property of others.
• Keep scheduled appointments or cancel them in advance.
• Provide accurate and complete information regarding health history along with insurance and third party payer information.
• Follow medical instructions and discuss changes or concerns about ability to comply.
• Notify the provider of care regarding any changes in condition and ask questions if they do not understand information about their care.
• Accept the consequences of actions if they refuse treatment or do not follow instructions.
• Keep personal belongings and valuables in a safe place.
• Satisfy financial obligations for health care services provided.
• Follow the rules and regulations of the health care facility.
• Express concerns about their care.

Signature: __________________________ Date: __________________________

Print Name: __________________________
Impaired Licensed Independent Practitioners

Medical Staff Standards (MS.4.80 EP-1) requires education of licensed independent practitioners and staff about illness and impairment recognition issues specific to licensed independent practitioners (at-risk criteria).

As an integral part of patient safety, all UTMC physicians and employees have a duty to come forward should they have such concerns about physicians or any other licensed independent practitioners. You will find that policy 3364-87-16 at the University Policy Website addresses the process to be used upon identification of an impaired practitioner.

Signs of impairment that may be observed include physical state and behavior in the hospital. Examples are as follows:

- Deterioration in personal hygiene
- Deterioration in clothing and dressing habits
- Unusual patterns of prescribing and/or taking prescription drugs
- Frequent visits to physicians and dentists
- Accidents
- Emotional crises
- Making rounds late, or displaying inappropriate, abnormal behavior during rounds
- Decreasing quality of performance, e.g., in staff presentations, writing in charts
- Inappropriate orders or over-prescriptions of meds
- Reports of behavioral changes from other personnel
- Involvement in malpractice suits and legal sanctions against hospital
- Unavailability or inappropriate responses to telephone calls
- Hostile, withdrawn, unreasonable behavior to staff and patients
- Complaints by patients to staff about doctor's or practitioner's behavior

If you believe that a licensed independent practitioner is impaired...

Report your concern - Reports regarding suspected impaired licensed independent practitioners may be directed to Medical Staff Services (Dowling Hall 0015, Mail Stop 1108, Telephone 419.383.5322, Fax 419.383.6235) during normal working hours, or the Medical Director on call after normal working hours (page through hospital operator). If there is an immediate need for intervention, please contact your supervisor if on site, or the Administrative Coordinator at any other time. Your report should articulate the nature of the concern and the reasons in support of it. If requested, identity of informants will remain confidential.

Signature: ____________________________ Date: __________________

Name: ________________________________
AUTHORIZATION TO RELEASE INFORMATION

I have accepted a conditional offer of employment with the University of Toledo and hereby specifically authorize and permit the University of Toledo and its principals, employees, agents, servants, and contractors to contact character references, former employers, law enforcement agencies, courts of law, federal, state and local regulatory agencies, and schools to obtain information from such sources about me. I understand that any investigation into my background may include reference to any information which is a matter of public record (for example, criminal convictions, traffic offenses, and lawsuits). I hereby waive any rights of action I may have against the University of Toledo and its employees, agents, servants, and contractors in connection with the obtaining and/or reporting of such information for purposes of determining my eligibility for employment.

I further authorize the University of Toledo to conduct pre-employment drug testing, physical examinations, and/or psychological examinations to determine my suitability for employment, as required.

This release is executed with full knowledge and understanding that the information is for the official use of University of Toledo. I understand that this form may be photocopied and sent to Police Departments, employers, etc., as deemed necessary by Human Resources and the UT Campus Police Department. I further understand that information obtained from any job-related and behavioral tests will also be evaluated when making final hiring decisions.

Consent is also hereby granted to release requested information to the UT Campus Police Department. I hereby release you as the custodian of such records, both individually and collectively, from any and all responsibility or liability for damages of whatever kind, which at any time may result to me, my heirs, family, or associates, because of compliance with this authorization and request to release information or any attempt to comply with it.

I understand that in signing this release I will be authorizing the University of Toledo to make inquiries into my personal, educational and work history. I also understand that a conditional offer of employment may be withdrawn based on the information obtained in such inquiries and tests, and also based upon the results of a pre-employment drug screen, physical examination and/or psychological examination, or driving record, if required.

Print Full Name: ___________________________ SSN: _______ - _______ - _______

First Middle Last

Previous Names Used: ___________________________ Gender: Male ___ Female ___

Date of Birth (MM/DD/YYYY): _______ / _______ / _______ Telephone #: (_____) _______ - _______

Current Street Address (No P.O. Box Please): __________________________________________

City/State/Zip: __________________________________________ County _______

Previous Cities/Towns, State(s) lived in: __________________________________________

Email Address: ___________________________________________ Job Title: ______________

SIGNATURE: ___________________________________________ Date: ______________

To Be Completed By Human Resources

Intelllicorp: ___________________________ Notified UHS ___________________________

Position Offered: ___________________________ Department: ___________________________

Position Extended By: ___________________________ Date: ___________________________

Human Resources; Revised – December, 2013
STUDENT TO TAKE THIS FORM TO APPOINTMENT WITH FAMILY HEALTH SERVICES

Hiring Department: Please complete the top portion of this form and give to your student employee to take to his/her appointment with Family Health Services

Student Employee ______________________________________   R ______________________
(Print Name)   (Rocket Number)

WILL       WILL NOT (Circle one) have direct and/or limited patient contact

Brief description of duties________________________________________________________
____________________________________________________________________________
____________________________________________________________________________

Department Name______________________________________ (Phone No )

Supervisor name ________________________________________ (Print name of person requesting health screening)
(or designee's)

Supervisor signature ____________________________________ (Date)
(or designee's)

Family Health Services: Based on the information above, please provide the appropriate health screening for this student employee. Please complete all information

Based on the position information above, we have provided appropriate health screening for the student employee's position on the Health Science Campus.

Check all that apply

☐ Drug test      ☐ Vaccination review/update   ☐ 2-Step PPD   ☐ Other_____________________________

(Print FHS representative's name)   (Signature)   (Date)

PLEASE RETURN THIS COMPLETED FORM TO THE STUDENT
This form must be returned by the student to his/her Hiring Department which will forward the form to Student Employment, MS 112 / SU 1532.
Acknowledgement of receipt of Auditor of State fraud reporting system information

Pursuant to Ohio Revised Code 117.103(B)(1), a public office shall provide information about the Ohio fraud-reporting system and the means of reporting fraud to each new employee upon employment with the public office.

Each new employee has thirty days after beginning employment to confirm receipt of this information.

By signing below you are acknowledging The University of Toledo provided you information about the fraud-reporting system as described by Section 117.103(A) of the Revised Code, and that you read and understand the information provided. You are also acknowledging you have received and read the information regarding Section 124.341 of the Revised Code and the protections you are provided employee if you use the before-mentioned fraud reporting system.

I ________________________________, have read the information provided by my employer regarding the fraud-reporting system operated by the Ohio Auditor of State’s office. I further state that the undersigned signature acknowledges receipt of this information.

PRINT NAME, TITLE, AND DEPARTMENT

PLEASE SIGN NAME DATE