

**ADWS EMPLOYEE  
INDUCTION/ORIENTATION FORM**

**TO:** COST CENTER MANAGER  
**FROM:** PERSONNEL ADMINISTRATION  
**DATE:**  
**SUBJECT:** INDUCTION PACKET

DWS-ARK-803, Recommendation for Personnel Action, has been approved for the:

\_\_\_\_\_ appointment of  
\_\_\_\_\_ as a/an  
\_\_\_\_\_.

You should discuss in detail with each new employee, during his/her first day orientation session, each item listed on the enclosed Form DWS-ARK-828.

After discussion with the employee, Form DWS-ARK-828 signed by the two of you, should be attached to the induction packet and returned to Personnel Administration. **NOTE: PLEASE DO NOT START SUBJECT EMPLOYEE UNTIL RECEIPT OF PERSONNEL NUMBER. THEN FORWARD A MEMORANDUM INDICATING THE DATE AND TIME EMPLOYEE REPORTED TO WORK.**

**Enclosure**

## EMPLOYEE INDUCTION/ORIENTATION

**TO:** Personnel Administration

**FROM:** Cost Center Manager

**SUBJECT:** Certification of Induction Orientation for \_\_\_\_\_

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***This is to certify that I have furnished and discussed in detail, the following items with the above subject employee during his/her first day orientation session. I further certify that, where applicable, the required certification documents are returned herewith.***

- YES  NO  N/A    1. State of Arkansas Employment Application to be placed in employee's personnel file. **If applicable, attached is completed application.**
- YES  NO  N/A    2. Form W-4, Employee's Withholding Allowance Certificate and Form AR-4EC, State of Arkansas, Employee's Withholding Exemption Certificate. **Completed forms are attached.**
- YES  NO  N/A    3. Letter of Acceptance.
- YES  NO  N/A    4. DWS Payroll Direct Deposit Forms.
- YES  NO  N/A    5. Employee Assistance Program.
- YES  NO  N/A    6. Statement of Selective Service Status. **Attached is completed form.**
- YES  NO  N/A    7. DWS-ARK-808, Personal Data Sheet. **Completed form is attached.**
- YES  NO  N/A    8. Equal Opportunity Policy Statement.
- YES  NO  N/A    9. Equal Opportunity Is The Law Notice. **Attached is signed certificate.**
- YES  NO  N/A    10. ADWS Grievance Procedure.
- YES  NO  N/A    11. Drug Free Workplace Policy. **Attached is signed certificate.**
- YES  NO  N/A    12. Sexual Harrassment Policy.
- YES  NO  N/A    13. Request For Reasonable Accommodation Form.
- YES  NO  N/A    14. Authorization to Conduct a Background Check Form. **If applicable, attached, is completed form.**
- YES  NO  N/A    15. Professional Service Standards For Telephone Communications.
- YES  NO  N/A    16. Information regarding State Employees Insurance Plan, including information booklet and the completion and return of the following, if probational employee:  
Application/Change form. ....  YES  NO

- YES  NO  N/A    17. Policy regarding employee photograph.  
Photograph forwarded? .....  YES  NO  
If no, date to be forwarded: \_\_\_\_\_
- YES  NO  N/A    18. DWS-ARK-802, Health Record Form. **This form will be retained in cost center to be used in the event of an emergency.**
- YES  NO  N/A    19. PERS-2, Arkansas Public Retirement System Membership Data Form. **Attached is completed form.**
- YES  NO  N/A    20. ESD-ARK-850, Conditions Regarding Intermittent Appointment. **If applicable, attached is signed certificate.** (Disciplinary Procedure, Page 68).
- YES  NO  N/A    21. ADWS Disciplinary Rules and Procedures (Full-Time/Intermittent Employees). **If applicable, attached is signed certificate** (Page 69).
- YES  NO  N/A    22. DWS-ARK-852, Conditions Applicable to Special Project/Temporary Program Positions. **If applicable, attached is signed certificate.**
- YES  NO  N/A    23. DWS-ARK-854, Conditions Regarding Temporary Appointment. **If applicable, attached is signed certificate.**
- YES  NO  N/A    24. DWS-ARK-856, Conditions Regarding Emergency Appointment. **If applicable, attached is signed certificate.**
- YES  NO  N/A    25. DWS-ARK-857, Conditions Preliminary to Permanent Appointment. **If applicable, attached is signed certificate.**
- YES  NO  N/A    26. DWS-ARK-861, Request for Determination of Conflict of Interest. **If applicable, attached is completed form.**
- YES  NO  N/A    27. DWS-ARK-870, Arkansas State Vehicle Safety Program Employment Conditions. **If applicable, attached is completed form.**
- YES  NO  N/A    30. INS Form I-9, Employment Eligibility Verification Immigration Reform and Control Act. **Attached is completed form.**

<b><i>I Certify That I Have Discussed in Detail All Materials Enumerated Herein, As Applicable To This Employee Appointment.</i></b>	Cost Center Manager:
	Date:

<b><i>I Certify That I Have Received A Full Explanation Of All Applicable Materials As Enumerated Above.</i></b>	Employee:
	Date:



For additional information consult your employer or:

Arkansas Individual Income Tax Section  
Withholding Branch  
P. O. Box 8055  
Little Rock, Arkansas 72203-8055

AR4EC

# STATE OF ARKANSAS Employee's Withholding Exemption Certificate

Print Full Name \_\_\_\_\_ Social Security Number \_\_\_\_\_  
Print Home Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

<b>How to Claim Your Withholding</b> <i>Instructions on the Reverse Side</i>		Number of Exemptions Claimed
<p><b>Employee:</b> File this form with your employer. Otherwise, your employer must withhold state income tax from your wages without exemptions or dependents.</p> <p><b>Employer:</b> Keep this certificate with your records.</p>	1. CHECK ONE OF THE FOLLOWING FOR EXEMPTIONS CLAIMED (a) You claim yourself. <i>(Enter one exemption)</i> ..... (b) You claim yourself and your spouse. <i>(Enter two exemptions)</i> ..... (c) Head of Household, and you claim yourself. <i>(Enter two exemptions)</i> .....	_____
	2. NUMBER OF CHILDREN or DEPENDENTS. <i>(Enter one exemption per dependent)</i> .....	_____
	3. TOTAL EXEMPTIONS. <i>(Add Lines 1a, b, c and 2)</i> If no exemptions or dependents are claimed, enter zero .....	_____
	4. Additional amount, if any you want deducted from each paycheck. <i>(Enter dollar amount)</i> .....	_____
	5. I qualify for the low income tax rates. <i>(See reverse for details)</i> ..... Please check filing status: <input type="checkbox"/> Single <input type="checkbox"/> Married Filing Jointly <input type="checkbox"/> Head of Household	<input type="checkbox"/> Yes <input type="checkbox"/> No

I certify that the number of exemptions and dependents claimed on this certificate does not exceed the number to which I am entitled.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## Instructions for completing the Employee's Withholding Exemption Certificate

**1. NUMBER OF EXEMPTIONS** – (Husband and/or Wife) Do not claim more than the correct number of exemptions. However, if you expect to owe more income tax for the year, you may increase your withholding by claiming a smaller number of exemptions and/or dependents, or you may enter into an agreement with your employer to have additional amounts withheld. This is especially important if you have more than one employer, or if both husband and wife are employed.

**2. DEPENDENTS** – To qualify as your dependent (line 1 on the reverse side), a person must (a) receive more than 1/2 of their support from you for the year, (b) not be claimed as a dependent by such person's spouse, (c) be a citizen or resident of the United States, and (d) have your home as their principle residence and be a member of your household for the entire year or be related to you as follows: son, daughter, grandchild, stepson, stepdaughter, son-in-law or daughter-in-law; Your father, mother, grandparent, stepfather, stepmother, father-in-law or mother-in-law; Your brother, sister, stepbrother, stepsister, half brother, half sister, brother-in-law or sister-in-law; Your uncle, aunt, nephew or niece (but only if related by blood).

**3. CHANGES IN EXEMPTIONS OR DEPENDENTS** – You may file a new certificate at any time if the number of exemptions or dependents INCREASES. You must file a new certificate within 10 days if the number of exemptions or dependents previously claimed by you DECREASES for any of the following reasons:

- (a) Your spouse for whom you have been claiming an exemption is divorced or legally separated, or claims his or her own exemption on a separate certificate, or
- (b) The support of a dependent for whom you claimed an exemption is expected to be less than half of the total support for the year.

OTHER DECREASES in exemptions or dependents, such as the death of a spouse or a dependent, do not affect your withholding until next year, but require the filing of a new certificate by December 1, of the year in which they occur.

**4.** Claim additional amounts of withholding tax if desired. This will apply most often when you have income other than wages.

**5.** You qualify for the low income tax rates if your total income from all sources are as shown below:

- (a) Single                                 \$7,800 to \$11,400
- (b) Married filing jointly     \$15,500 to \$16,200
- (c) Head of Household     \$12,100 to \$16,200



EMPLOYMENT SECURITY DEPARTMENT  
JOB SERVICE-UI-WIA-LMI  
Post Office Box 2981  
Little Rock, Arkansas

ADMINISTRATIVE MEMORANDUM NUMBER 3-05

Artee Williams, Director

January 03, 2005

**TO:** All Assistant Directors, Central Office Section Heads, Area Operations  
Chiefs, Local  
Office Managers and Satellite Office Supervisors

**SUBJECT:** Employee Assistance Program

1. **Purpose:** To inform employees of the changes to the Employee Assistance Program (EAP) and how time is to be charged when making EAP visits.
2. **General Information:** An Employee Assistance Program is a worksite-based program designed to help identify and resolve employees' personal problems that may interfere with their performance on the job. Implemented as a result of the commitment to the well being of valued employees, I am pledging my full support and cooperation for the EAP.

In compliance with the State of Arkansas Employee Assistance Program Policy, employees are not required to use annual or sick leave when making EAP visits. Visits to the EAP by an employee may be made during working hours while the employee is on Agency time but must be coordinated through the employee's supervisor.

3. **Action Required:** Please make sure all employees are made aware of this change.
4. **Inquiries:** Direct questions to Freddy Jacobs, 682-3106.
5. **Attachment:** Employment Assistance Program Policy.
6. **Expiration Date:** Continuing.

## EMPLOYEE ASSISTANCE PROGRAM POLICY

### Purpose

The purpose of this policy is to define the Arkansas Employee Assistance Program (EAP) for the Employment Security Department (ESD) and to notify employees of the procedures to be followed in accessing the services of the program. The EAP is a worksite based program designed to assist in the identification and resolution of personal problems of employees including, but not limited to depression and anxiety, eldercare and children issues, family alcohol and chemical dependency problems, financial and credit problems, parenting teenagers, marital and divorce issues, family or work problems, which may adversely affect employee job performance.

### Policy

Regular, full-time employees are eligible to participate in the EAP. On occasion members of employees' families may participate in the program when activities are related to employee problems. Participation in the EAP is voluntary. Choosing to participate, or not to participate, will neither adversely affect an employee's job security and promotional opportunities, nor excuse an employee from adherence to ESD policies and procedures concerning job performance and basic code of conduct. Contact with the EAP shall be confidential, except through written authorization by the employee, or in cases of an abused person, an unexplained unusual or suspicious death, or a threat to one's own life or that of another, as prescribed by state and federal law. EAP records will be retained within the offices of the EAP, and will not become part of, or referenced to in any employee's personnel file, medical file, or other file that may be accessed by any other department or organization. Visits to the EAP by an employee may be made during work hours while the employees is on agency time, but must be coordinated through the employee's supervisor.

1. The specific core activities of the Employee Assistance Program (EAP) include:
  - A. Expert consultation and training of appropriate persons in the identification and resolution of job performance issues related to the personal concerns identified above;
  - B. Confidential, appropriate and timely problem assessment and resolution services including referrals for appropriate diagnosis,

treatment and assistance, establishment of linkages between the workplace and community resources that provide such services, and follow-up assistance to employees who use those services.

2. Referrals to the Employee Assistance Program may be made by the employees themselves on a voluntary basis, or by the employee's supervisor when an employee's work performance has declined or basic code of conduct of an employee has not met acceptable standards as defined in the agency's Employee Handbook. However, the decision to accept a supervisor referral to the EAP and subsequent referrals for treatment are voluntary, and are the personal responsibility of the employee.
3. ESD employees or members of their families requesting an appointment with the EAP should contact the EAP Office at 1-866-378-1645. Normal appointments will be scheduled within 72 hours. Response to emergency situations will be scheduled within 24 hours, if possible. Employees seeking assistance from the EAP are encouraged to do so before job performance is impaired. Problems treated early are usually simpler to resolve.
4. Access to the EAP is available 24 hours a day, 7 days a week. The EAP office is located at West Lake Office Park (across the street from the Heart Hospital) in Little Rock. The address is 1701 Centerview Drive, Suite 101, Little Rock, Arkansas 72211.
5. For state employees and insured public school employees, the EAP provides clinical assessment and short-term problem resolution for up to eight sessions at no cost to the member participating in the State of Arkansas Health Plan.

Treatment by psychiatrists and facility-based care are specifically not included in the EAP, and EAP counselors do not provide ongoing therapy for patients needing longer-term care. Serious and/or chronic mental illness or substance abuse problems will require immediate referral to a mental health provider under terms of the behavioral health benefit and involve co-payment and coinsurance.

6. All agency supervisors are asked to make this information available to their employees.

STATE OF ARKANSAS  
STATEMENT OF SELECTIVE SERVICE STATUS  
IN COMPLIANCE WHT ACT 228 OF THE 1997 ACTS OF THE  
ARKANSAS  
GENERAL ASSEMBLY

I understand that to be eligible for employment with the State of Arkansas I must register, or be exempt from registration, with the Selective Service System in accordance with the Military Selective Service Act, 50 U.S.C. Appx §451 et seq., as specified in Act 228 of the 1997 Acts of the Arkansas General Assembly. I therefore swear or affirm under penalty of perjury that I have registered with the Selective Service System, or I am exempted from such registration because of the following provision(s) of the Military Selective Service Act or Act 228 of the 1997 Acts of the Arkansas General Assembly.  I am a female,  I am a current member of the armed forces on active duty,  I am under 18 years of age,  I am 26 years of age or over,  I am an exempted resident alien,  other, specify below.

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\_\_\_\_\_  
Name (Please Print)

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

## PERSONAL DATA SHEET

NAME: (FIRST): (M.I.): (LAST): (SOCIAL SECURITY NUMBER):

MARITAL STATUS:  Single  Married  Widowed  Divorced  Separated

PRESENT ADDRESS: (STREET ADDRESS OR RFD) (CITY) (STATE) (ZIP CODE)

HOME TELEPHONE NO.:

PLACE OF BIRTH: (CITY) (COUNTY) (STATE)

DATE OF BIRTH:

EDUCATION:

Grade (Highest Grade Completed): \_\_\_\_\_ College (Semester Hours): \_\_\_\_\_

Graduated or GED?  Yes  No Degree: \_\_\_\_\_

ETHNIC BACKGROUND:

White  Black  Hispanic  
 American Indian or Alaskan Native  Asian or Pacific Island

NAME OF SPOUSE:

SPOUSE'S EMPLOYMENT:

BUSINESS ADDRESS:

BUSINESS TELEPHONE:

HANDICAPPED:  Yes  No

VETERAN:  Yes  No

10 Point Veteran:  Yes  No

Vietnam Veteran:  Yes  No  
(Service Between 8-4-64 and 5-8-75)

Are you a retired member of the Armed Forces?  Yes  No

DATE:

EMPLOYEE'S SIGNATURE:

EMPLOYMENT SECURITY DEPARTMENT  
JOB SERVICE-UI-WIA-LMI  
Post Office Box 2981  
Little Rock, Arkansas

ADMINISTRATIVE MEMORANDUM NUMBER 2-05

Artee Williams, Director

January 03, 2005

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**TO:** All Assistant Directors, Central Office Section Heads, Area Operations Chiefs,  
Local Office Area Managers and Satellite Office Supervisors

**SUBJECT:** Equal Opportunity Policy Statement

1. **Purpose:** To transmit my statement of goals and objectives concerning Equal Employment Opportunity. This Policy is effective immediately.
2. **General Information:** The Arkansas Employment Security Department's Equal Opportunity Policy Statement is designed to strengthen and reaffirm the agency's commitment to employ and utilize employees in all job classifications in accordance with their abilities.

The agency's position is unmistakably clear with respect to affirmative action for minorities, females, disabled veterans, veterans of Vietnam-Era and people with disabilities.

To ensure the effective communication and implementation of the Policy, the following procedure will prevail:

Upon request, employees and community at large will be given a copy of this Policy Statement. Copies of this syllabus will be conspicuously posted on appropriate bulletin boards.

It shall be the responsibility of the Assistant Directors to ensure that all managers and supervisors understand and are committed to this Policy, and it will be an integral part of orientation, management and supervisory training. It will be publicized in agency publications and in other training sessions.

3. **Action Required:** All administrative and supervisory employees are charged with the responsibility of implementing the attached Equal Opportunity Policy.
4. **Inquiries:** Inquiries should be directed to the Equal Opportunity Office, 682-3106.
5. **Attachment:** Equal Opportunity Policy Statement.
6. **Rescission:** Administrative Memorandum Number 19-95.
7. **Expiration Date:** Continuing.

## EQUAL OPPORTUNITY POLICY STATEMENT

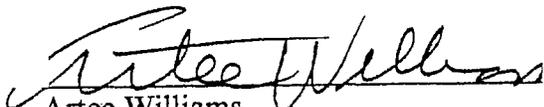
The Arkansas Employment Security Department shall hire, upgrade, train, and promote in all job classifications without regard to race, religion, national origin, color, sex, age, or disability, political affiliation or belief. This Policy applies to all employees of the Arkansas Employment Security Department and to all persons seeking employment with the agency.

The Policy provides for equality of employment opportunity and treatment in internal staffing. Personnel actions will be directed toward encouraging equitable ethnic and female representation in recruitment, selection, and placement efforts, as well as expanding promotional opportunities for applicants and employees. This commitment will affect all employment practices including (but not limited to) hiring, placement, selection, training, transfer, promotion, layoff/termination, re-employment, compensation, benefits, terms, privileges, and conditions of employment.

All Arkansas Employment Security Department employees are to be governed by the intent of the Policy, and it is the responsibility of supervisors at all levels of operations to carry out and assure compliance with the Policy.

This Policy applies to all persons or organizations seeking contracts, agreements, grants and subgrants, programs and projects funded through it, and to all persons, organizations, or employers (both public and private) seeking services from it.

The Policy further provides for equality of access to services under all federally-assisted programs including employment services such as testing and counseling, job referrals, placement services, and unemployment compensation.

  
Artee Williams  
Director

## EQUAL OPPORTUNITY IS THE LAW

It is against the law for this recipient of Federal financial assistance to discriminate on the following basis:

Against any individual in the United States, on the basis of race, color, religion, sex, national origin, age, disability, political affiliation or belief, and

Against any beneficiary of programs financially assisted under Title I of the Workforce Investment Act of 1998 (WIA), on the basis of the beneficiary's citizenship/status as a lawfully admitted immigrant authorized to work in the United States, or his/her participation in any WIA Title I-financially assisted program or activity.

The recipient must not discriminate in any of the following areas:

Deciding who will be admitted, or have access, to any WIA Title I-financially assisted program or activity;

Providing opportunities in, or treating any person with regard to, such a program or activity; or

Making employment decisions in the administration of, or in connection with, such a program or activity.

### **What To Do If You Believe You Have Experienced Discrimination**

**If you think you have been subjected to discrimination under a WIA Title I-financially assisted program or activity, you may file a complaint within 180 days from the date of the alleged violation with either:**

The recipient's Equal Opportunity Officer (or the person whom the recipient has designated for this purpose); or

The Director, Civil Rights Center (CRC), U.S. Department of Labor, 200 Constitution Avenue NW, Room N-4123, Washington, D.C. 20210.

If you file your complaint with the recipient, you must wait either until the recipient issues a written Notice of Final Action, or until 90 days have passed (whichever is sooner), before filing with the Civil Rights Center (see address above).

If the recipient does not give you a written Notice of Final Action within 90 days of the day on which you filed your complaint, you do not have to wait for the recipient to issue that Notice before filing a complaint with CRC. However, you must file your CRC complaint within 30 days of the 90-day deadline (in other words, within 120 days after the day on which you filed your complaint with the recipient).

If the recipient does give you a written Notice of Final Action on your complaint, but you are dissatisfied with the decision or resolution, you may file a complaint with CRC. You must file your CRC complaint within 30 days of the date on which you received the Notice of Final Action.

***I certify that I have been furnished a copy of the Equal Opportunity Is The Law Notice, and that the Notice has been discussed in detail with me.***

\_\_\_\_\_  
APPLICANT/PARTICIPANT/EMPLOYEE SIGNATURE

\_\_\_\_\_  
DATE

## DRUG FREE WORKPLACE POLICY

Drug abuse and use at the workplace are subjects of immediate concern in our society. These problems are extremely complex and ones for which there are no easy solutions. From a safety perspective, the users of drugs may impair the well-being of all employees, the public at large, and result in damage to state property. Therefore, it is the policy of the State of Arkansas that the unlawful manufacture, distribution, dispensation, possession or use of a controlled substance in a state agency's workplace is prohibited. Any employee violating this policy will be subject to discipline up to and including termination. The specifics of this policy are as follows:

1. State agencies will not differentiate between drug users and drug pushers or sellers. Any employee who gives or in any way transfers a controlled substance to another person or sells or manufactures a controlled substance while on the job or on agency premises will be subject to discipline up to and including termination.
2. The term "controlled substance" means any drug listed in 21 U.S.C. Section 812 and other federal regulations. Generally, these are drugs, which have a high potential for abuse. Such drugs include, but are not limited to Heroin, Marijuana, Cocaine, PCP, and "Crack." They also include "legal drugs" which are not prescribed by a licensed physician.
3. Each employee is required by law to inform the agency within five (5) days after he or she is convicted for violation of any federal or state criminal drug statute where such violation occurred on the agency's premises. Conviction means a finding of guilt (including a plea of nolo contendere) or the imposition of a sentence by a judge or jury in any federal court, state court or other court of competent jurisdiction.
4. Arkansas Employment Security Department must notify the U.S. government agency with which the contract was made within ten (10) days after receiving notice from the employee or otherwise receives actual notice of such a conviction.
5. If an employee is convicted of violating any criminal drug statute while in the workplace, he or she will be subject to discipline up to and including termination. Alternatively, the agency may require the employee to successfully finish a drug abuse program sponsored by an approved private or governmental institution.
6. As a condition of further employment on any federal government contract, the law requires all employees to abide by this policy.

Below is a facsimile of the Drug Free Workplace Acknowledgement made by all ESD employees. Your signed copy will be placed in your personnel file as a part of your permanent employment record with this Agency.

## **DRUG FREE WORKPLACE POLICY**

### **ACKNOWLEDGEMENT**

I, \_\_\_\_\_, an employee of Arkansas Employment Security Department hereby certify that I have received a copy of this agency's policy regarding the maintenance of a drug free workplace. I realize that the unlawful manufacture, distribution, dispensation, possession or use of a controlled substance is prohibited on this agency's premises and violation of this policy can subject me to discipline, up to and including termination. I realize that as a condition of employment on such federal contract, I must abide by the terms of this policy and will notify my employer of any criminal drug conviction for a violation occurring in the workplace no later than five (5) days after such conviction. I further realize that federal law mandates that my employer communicates this conviction to the federal agency, and I hereby waive any and all claims that may arise for conveying this information to the federal agency.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

#### **REFERENCES**

**Part V, Personnel Manual, Section 3513.05.**

**Administrative Memorandum Number 31-93, August 26, 1993, Drug-Free Workplace, 29 CFR Part 98.**

**Disciplinary Policy Rules and Procedures – Class A Infraction, 5 (b) and Class B Infraction, 3 (a).**

**Executive Order 89-2.**

**Governor's Policy Directive – 5.**

EMPLOYMENT SECURITY DEPARTMENT  
JOB SERVICE-UI-WIA-LMI  
Post Office Box 2981  
Little Rock, Arkansas

ADMINISTRATIVE MEMORANDUM NUMBER AM 1-05

Artee Williams, Director

January 03, 2005

**TO:** All Assistant Directors, Central Office Section Heads, Area Operations Chiefs,  
Office Area Managers and Satellite Office Supervisors

**SUBJECT:** Request for Reasonable Accommodation

1. **Purpose:** To inform Employment Security Department employees with disabilities of the Request for Reasonable Accommodation.
2. **General Information:** It is the policy of the Employment Security Department (ESD) to provide reasonable accommodations to persons with disabilities who are otherwise qualified for positions for which they are applying or in which they are employed. The policy is based on federal legislation and State mandates including Sections 503 and 504 of the Rehabilitation Act of 1973 as amended, and the Americans with Disabilities Act (ADA) of 1990.

In order to ensure compliance with the Agency's Self-Evaluation Plan for individual's with disabilities, we invite your voluntary participation to submit a Request for Reasonable Accommodation.

As an equal opportunity employer, ESD's Self-Evaluation Plan ensures that programs and services are accessible to "qualified individuals with a disability," and prohibits discrimination in regard to job applications, hiring, advancement, discharge, compensation, training, or other terms, conditions, or privileges of employment. The Request for Reasonable Accommodation for employees and prospective employees will serve to identify those qualified individuals who believe themselves to be covered by the Rehabilitation Act of 1973, as amended and the ADA of 1990. To quote from the ADA, a disabled individual is "any person who (1) has a physical or mental impairment that substantially limits one or more of the major life activities; (2) a record of such an impairment; or (3) being regarded as having such an impairment."

Please note that the information provided on the Request for Reasonable Accommodation form will be kept confidential, and if the need should arise, disclosure would be made after receiving the permission of the employee. Return all completed requests to the Equal Opportunity Office. The Equal Opportunity Office will be responsible for receipt and analysis of the request.

Thank you for your cooperation in assisting with the Agency's effort to conform to the Americans with Disabilities Act.

3. **Action Required:** Please post and/or circulate to all employees.

## REQUEST FOR REASONABLE ACCOMMODATION

Initial application may be made to the Supervisor or Equal Opportunity Office. All information received by agency personnel pertaining to your request for a reasonable accommodation is kept confidential. This information is maintained separate from personnel records and may only be used in connection with the Agency's equal opportunity efforts.

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### Section A Personal Information

(To be completed by all Applicants)

Name \_\_\_\_\_ Title \_\_\_\_\_

Department/Office \_\_\_\_\_ Telephone # (Work) \_\_\_\_\_

### Section B Application for Reasonable Accommodation

(To be completed by Applicant and returned to Supervisor)

I am requesting the following reasonable accommodation(s) \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_  
(Employee)

### Section C Supervisor's Response to Request for an Accommodation

(To be completed by Supervisor)

I have received your application for an accommodation.

Approved

Comments \_\_\_\_\_  
\_\_\_\_\_

No decision has been made at this time. We will continue to assess your request. The EO Office will contact you within the next five business days.

Comments \_\_\_\_\_  
\_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_  
(Supervisor)

*(Applicant should return the original of this form to his/her supervisor within two business days for forwarding to the EO Office)*

**Section D**

**Notification of Need for Additional Information**

(To be completed by the EO Office and returned to Applicant)

Your supervisor has forwarded your application for a reasonable accommodation to the EO Office. We are continuing to assess your request. To make an Agency determination, we need the following information:

\_\_\_ Medical Documentation

Please inform your doctor of your application for an accommodation and have your doctor send us medical documentation, including the limitations placed on your life functions and activities. Information should be sent to the EO Office by \_\_\_\_\_.

\_\_\_ Other

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_ We require no additional information from you at this time.

The agency review process will include an evaluation of all relevant information. This may include an interview with you and/or your supervisor. After completion of the review, you will be informed in writing by the Agency Director regarding the Agency's decision. We anticipate that the decision will be made by \_\_\_\_\_. If you have questions, please call me at \_\_\_\_\_.

Signature \_\_\_\_\_ Date \_\_\_\_\_  
(EO Manager)

*(Applicant should return the original of this form to the EO Office within two business days.)*

**Section E**

**Notification that Agency will provide Reasonable Accommodation**

(To be completed by the EO Office and returned to Applicant)

We are pleased to inform you that based on additional information and with the approval of your supervisor; the Agency is able to provide you the reasonable accommodation that you requested on \_\_\_\_\_. Please discuss this with your supervisor. If you have any questions, please call me at \_\_\_\_\_. A letter from the Agency Director confirming this decision will be sent to you within the next five days.

Signature \_\_\_\_\_ Date \_\_\_\_\_  
(EO Manager)

*(Applicants should return the original of this form to the EO Office with two business days.)*

**Section F**  
**Notification of Denial of Request for Accommodation)**  
(To be completed by the EO Office and returned to the Applicant)

We regret to inform you that the Agency has denied your request for an accommodation that you made on \_\_\_\_\_. We are denying the request for the following reason(s).

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A letter from the Agency Director confirming the decision will be sent to you within the next five business days.

You have the following options:

1. You may choose to accept the Agency's decision and end the process.
2. You may choose to use the external review process and ask the State Grievance Review Committee (SGRC) for a review of the request.

OR

You may file a discrimination complaint if you feel the Agency's denial is based on discrimination. If you choose this option you cannot use the external review process. A charge of discrimination must be filed within 180 days of the alleged discrimination.

3. In addition to the options stated above, other alternatives may also be available. These include but are not limited to filing a complaint with any compliance agency designated under Sections 503/504 of the Rehabilitation Act of 1973, filing a complaint with the Department of Labor, filing a complaint under the Americans with Disabilities Act (ADA) with the Equal Employment Opportunity Commission (EEOC) and/or initiating a private right of action to challenge an alleged discriminatory act.

**Section G**

**Authorization for External Review by State Grievance Review Committee**

If you wish to use the external review process, please complete the information below and return it to the Equal Opportunity Office with five business days.

All information received by the Internal Reasonable Accommodation Committee pertaining to your request for a reasonable accommodation is kept confidential.

I authorize the Agency to release all information pertaining to my request for an accommodation to the State Grievance Review Committee. This information will be used by the State Grievance Review Committee to assess my request for an accommodation.

Signature \_\_\_\_\_ Date \_\_\_\_\_

*(The Equal Opportunity Office will return the original of this form within five business days to the State Grievance Review Committee)*

## BACKGROUND CHECK REQUIREMENTS

The Security Clearance Procedures is predicated upon conducting a criminal record background check to ascertain whether or not an employee or prospective employee has a job-related criminal felony conviction and whether or not such information affects that individual's suitability for continued employment or for employment in the position for which he/she applied.

**The outcome of a criminal record background check may result in termination of employment, transfer to a non-security sensitive position or in a job applicant not being considered for a position opening.**

An employee's refusal to sign or supplying false information on the Authorization to Conduct a Background Check form will be addressed through the Agency's Disciplinary Rules and Procedures.

Since the background record check is being conducted after an individual has been hired, promoted, etc., it will not delay the hiring/promotion process. However, hiring, promotion, etc. will be conditional until the results of the background check are known.

All information on background checks will be kept confidential. However, felony convictions are public records and, therefore, this information may be subject to release under the Freedom of Information Act. Internal Audit and Security will maintain the original document files. Information in the files will be made available to the employee or applicant upon written request to Internal Audit and Security.

Only actual job-related felony convictions, not arrests, will be considered as a factor relating to the applicant's suitability for employment in a security sensitive position. The following felony conviction categories will be considered job related in determining suitability for continued employment or consideration for a job opening:

- (1) Theft
- (2) Robbery
- (3) Burglary
- (4) Fraud
- (5) Forgery
- (6) Embezzlement
- (7) Computer Crime
- (8) Other White Collar or Government Operations Crime convictions



# ARKANSAS STATE POLICE

ASP-122  
(Rev. 04/00)

## Identification Bureau Individual Record Check Form

### Procedure For Criminal History Check

1. The ASP form 122, Individual Record Check Form, must be completed in its entirety.
2. A check or money order in the amount of \$23.00, made payable to the Arkansas State Police, must be included.
3. If the request is presented in person, the person requesting must present a photo I.D. issued by a government agency.
4. If the request is made by mail, the signature on the ASP form 122 must be notarized.
5. If the request is made by mail, a self-addressed envelope with sufficient return postage must be included.
6. If the request is made in person at our office by a third party, such as an employment agency or employer, the ASP form 122 must be notarized.
7. If the request is required by a particular licensing entity as mandated by state law, such as teachers, health care or police, please contact the appropriate licensing entity to obtain the proper forms and be advised of the correct procedure to obtain a criminal history.

Send requests to:

Arkansas State Police  
Identification Bureau  
#1 State Police Plaza Dr.  
Little Rock, AR 72209

To contact the Identification Bureau, you may call 501-618-8500.

SEE OTHER SIDE FOR APPLICATION



# PROFESSIONAL SERVICE STANDARDS FOR TELEPHONE COMMUNICATIONS

## HOW YOU SHOULD ANSWER THE PHONE

You should answer all external calls with the following greeting:

“Department of Workforce Services” and your first and last name.

You should answer all internal calls with the following greeting:

Either stating your first and last name, or “Department of Workforce Services” and your first and last name.

If you cannot distinguish between internal and external calls, you should always answer as if it were an external call. (Internal and external calls on the Nortel System are distinguishable by the number of rings –internal calls are a single ring and external calls are a double ring.)

## SCREENING CALLS

DWS professional service standard is that you will make every effort to accept phone calls at all times unless you are (1) out of the office, (2) on the phone already, or (3) in a meeting.

## OWNERSHIP OF CALLS

DWS professional service standard is that all calls should be “owned” by the person receiving the call. This means that you are responsible for making sure that the customer receives the most courteous and attentive treatment that can be provided. This policy of ownership means that you will never transfer a call without first making sure that you understand what the customer needs. In addition, no call should be transferred to another party without first asking the caller’s permission. For all functions within the agency, you must make sure you are transferring the call to someone who can help the caller before the call is transferred. You should also provide this service for functions outside the agency if you have the knowledge of other agency functions that would permit you to do so. The attitude of “ownership” of the customer should be displayed at all times.

## USE OF SPEAKER PHONES

DWS professional service standard is that speaker phones should not be used by agency employees unless and until the caller is informed that he/she is on the speaker phone and the identity of all persons present in the room; also until the caller has given permission. Administrative approval for an exception to this policy may be given to specific work areas where use of the speaker phone for one-on-one conversation is necessary.

## WHAT TO DO ABOUT YOUR PHONE WHEN YOU ARE AWAY FROM YOUR DESK

You are responsible for insuring that your phone is being answered even if you are away from the office. When you leave your desk, you should either transfer your calls to a central point established by your supervisor, or make specific arrangements for one of your co-workers to answer the phone for you. You should always tell the person who will be answering the phone where you are going and when you will return.

# ATTENTION

Please note the Arkansas Public Employees Retirement System Designation of Beneficiary Form must be notarized and returned to the payroll department along with a copy of your Social Security Card.

If your social security card is lost or misplaced you may order a replacement from your local Social Security office. Ask them for a letter showing you requested a replacement Social Security Card. In lieu of a copy of your Social Security Card you may send a copy of the letter showing your Social Security Card is on order. However, once you receive your replacement Social Security Card you must forward a copy to the payroll department.

**It is mandatory we have a copy of your Social Security Card and that the Designation of Beneficiary Form is notarized.**

**REQUEST FOR APPROVAL OF  
OUTSIDE EMPLOYMENT OR ACTIVITY**

It is necessary that **Form DWS-ARK-861** be completed any time outside employment or related activity is contemplated. Approval is required prior to Employment/Activity. A new **Form DWS-ARK-861** must be completed at any time conditions of the outside employment change. Approval may be withdrawn should a conflict with Agency interests become evident.

NAME:	OFFICE OR SECTION:
<b>I. REQUEST FOR APPROVAL:</b> <input type="checkbox"/> INITIAL <input type="checkbox"/> RENEWAL	
1. I request approval to engage in outside Employment or Activity as follows:	
NAME OF ORGANIZATION:	TYPE OF BUSINESS OR ORGANIZATION:
ADDRESS OF BUSINESS:	
NATURE OF WORK OR ACTIVITY TO BE PERFORMED:	NUMBER OF HOURS OF EMPLOYMENT/ ACTIVITY PER WEEK:
DURATION OF POSITION OR ACTIVITY:                      FROM                      TO	<input type="checkbox"/> PERMANENT
<input type="checkbox"/> TEMPORARY	
2. Brief reason outside Employment or Activity is desired: _____	
_____	
<b>II. REFERRED TO OUTSIDE EMPLOYMENT BY (If Applicable):</b>	
<input type="checkbox"/> Friend <input type="checkbox"/> Relative <input type="checkbox"/> Newspaper <input type="checkbox"/> DWS <input type="checkbox"/> Private Employment Agency <input type="checkbox"/> Other (Specify) _____	
<b>III. CERTIFICATION:</b>	
<i>I certify that the information submitted in support of this request for approval of outside Employment/Activity is true and correct, that such outside Employment/Activity was not gained or solicited in violation of published Agency Policy, and does not to my knowledge constitute a conflict with the interest of the Agency or of the State.</i>	
SIGNATURE:	DATE:
<b>IV. RECOMMENDATION OF MANAGER/SECTION HEAD:</b>	
<input type="checkbox"/> Recommend Approval <input type="checkbox"/> Recommend Disapproval for the following reason(s): _____ _____	
SIGNATURE:	DATE:
<b>V. ACTION BY ADMINISTRATOR:</b>	
<input type="checkbox"/> Approved; inclusive dates _____ To _____ <input type="checkbox"/> Disapproved; for the following reason(s): _____ _____	
SIGNATURE:	DATE:

**ARKANSAS STATE VEHICLE SAFETY  
PROGRAM EMPLOYMENT CONDITIONS**

Due to rapidly increasing insurance rates compounded by a very unfavorable loss experience, the State Insurance Commissioner, through the Risk Management Division of the Arkansas Insurance Department, has implemented a comprehensive vehicle safety program. The safety program consists of several related efforts designed to reduce accidents and injuries and, thus reduce insurance risk and related costs.

Listed below are conditions which must be met prior to operating a State Vehicle or private vehicle on State business.

**PART A**

EMPLOYEE NAME:	SOCIAL SECURITY NUMBER:
CLASSIFICATION:	COST CENTER NAME / COST CENTER NUMBER:

**Acceptance of Privilege To Operate A Vehicle While On Agency Business**

I, \_\_\_\_\_ do hereby accept all responsibilities placed on me under the Vehicle Safety Program in exchange for the privilege of operating a State Vehicle or private vehicle on State business. I do understand that driving in connection with the conduct of Agency of State business is a privilege that can be denied me if I fail at any time to meet the vehicle operator requirements and / or the safe driver responsibilities of the State Vehicle Safety Program and that such forfeiture of driving privileges could possibly result in termination of employment.

\_\_\_\_\_  
SIGNATURE

\_\_\_\_\_  
DATE

**PART B**

**Proof of Liability Insurance and Driver's License**

Please provide the following information:

Year: 20 \_\_\_\_\_

Liability Insurance:  Yes  No

*(Attach a copy of either a Certificate of Insurance or Insurance Card on all privately owned vehicle(s) subject to your use on State business which reflects liability coverage, vehicle identification and policy period.)*

Valid Driver's License:  Yes  No

*(Attach a photocopy of your license)*

Approximate annual mileage traveled on official Agency business \_\_\_\_\_

**PART C**

**Driver's Consent For Release of Traffic Violations Record**

AGENCY: DEPARTMENT OF WORKFORCE SERVICES	DATE:
ADDRESS: POST OFFICE BOX 2981, LITTLE ROCK, AR 72203	AGENCY NO.: 810
EMPLOYEE NAME:	COST CENTER NAME:
<p><i>As an operator of a State or private vehicle on State business, your traffic violations record will be obtained from the Office of Driver's Services for driver risk evaluation purposes as authorized by the Arkansas Statute 75-1057 and 75-1058, including speeding offenses normally excluded by 75-1013.1. Your signature below shall constitute your consent for the release of such records to this Agency.</i></p>	
DRIVER'S SIGNATURE:	DATE OF BIRTH:
	DRIVER'S LICENSE NO.:



ARKANSAS PUBLIC EMPLOYEES RETIREMENT SYSTEM

DESIGNATION OF BENEFICIARY

In accordance with the provisions of ACT 177 of 1957 as amended, creating the Public Employees Retirement System, I \_\_\_\_\_, a member of the Arkansas  
(Print Full Name)

Public Employees Retirement System, enrolled under Social Security Number \_\_\_\_\_, designate \_\_\_\_\_,  
(Print Full Name) (Date of Birth)

\_\_\_\_\_ whose relationship to me is \_\_\_\_\_ as the  
(Address)

beneficiary to whom I request the Board of Trustees of the Arkansas Public Employees Retirement System to pay, in the event of my death, if there are no death-in-service benefits payable, the total amount of the accumulated contributions standing to my credit in the Retirement System.

I hereby authorize the Board of Trustees of the Arkansas Public Employees Retirement System to make payment to the beneficiary whom I have above nominated and agree on behalf of myself and heirs and assigns, that payment so made shall be a complete discharge of the claims and shall constitute a release of the system from any further obligations on account of the benefit. I hereby direct that should I survive the before-mentioned beneficiary, the amount which otherwise would have been payable to the beneficiary shall be paid according to the provisions of the retirement act or to such other beneficiary as I shall hereafter nominate, by written designation filed with the Arkansas Public Employees Retirement System, in accordance with the rules and regulations prescribed by the Board of Trustees.

Signature: \_\_\_\_\_

Address: \_\_\_\_\_

State of \_\_\_\_\_ County of \_\_\_\_\_

On this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_, before me appeared \_\_\_\_\_, to me personally known, who, being by me duly sworn, did say that he/she executed the foregoing instrument and acknowledged said instrument to be his/her free act and deed.

In testimony whereof, I have hereunto set my and affixed my official seal in the County and State aforesaid, the day and the year first above written.

Signature of Notary Public: \_\_\_\_\_

My Commission Expires: \_\_\_\_\_

SEAL

# Employment Eligibility Verification

## INSTRUCTIONS

PLEASE READ ALL INSTRUCTIONS CAREFULLY BEFORE COMPLETING THIS FORM.

**Anti-Discrimination Notice.** It is illegal to discriminate against any individual (other than an alien not authorized to work in the U.S.) in hiring, discharging, or recruiting or referring for a fee because of that individual's national origin or citizenship status. It is illegal to discriminate against work eligible individuals. Employers **CANNOT** specify which document(s) they will accept from an employee. The refusal to hire an individual because of a future expiration date may also constitute illegal discrimination.

**Section 1 - Employee.** All employees, citizens and noncitizens, hired after November 6, 1986, must complete Section 1 of this form at the time of hire, which is the actual beginning of employment. The employer is responsible for ensuring that Section 1 is timely and properly completed.

**Preparer/Translator Certification.** The Preparer/Translator Certification must be completed if Section 1 is prepared by a person other than the employee. A preparer/translator may be used only when the employee is unable to complete Section 1 on his/her own. However, the employee must still sign Section 1 personally.

**Section 2 - Employer.** For the purpose of completing this form, the term "employer" includes those recruiters and referrers for a fee who are agricultural associations, agricultural employers or farm labor contractors.

Employers must complete Section 2 by examining evidence of identity and employment eligibility within three (3) business days of the date employment begins. If employees are authorized to work, but are unable to present the required document(s) within three business days, they must present a receipt for the application of the document(s) within three business days and the actual document(s) within ninety (90) days. However, if employers hire individuals for a duration of less than three business days, Section 2 must be completed at the time employment begins. Employers must record: 1) document title; 2) issuing authority; 3) document number, 4) expiration date, if any; and 5) the date employment begins. Employers must sign and date the certification. Employees must present original documents. Employers may, but are not required to, photocopy the document(s) presented. These photocopies may only be used for the verification process and must be retained with the I-9. However, employers are still responsible for completing the I-9.

**Section 3 - Updating and Reverification.** Employers must complete Section 3 when updating and/or reverifying the I-9. Employers must reverify employment eligibility of their employees on or before the expiration date recorded in Section 1. Employers **CANNOT** specify which document(s) they will accept from an employee.

- If an employee's name has changed at the time this form is being updated/reverified, complete Block A.
- If an employee is rehired within three (3) years of the date this form was originally completed and the employee is still eligible to be employed on the same basis as previously indicated on this form (updating), complete Block B and the signature block.
- If an employee is rehired within three (3) years of the date this form was originally completed and the employee's work authorization has expired or if a current employee's work authorization is about to expire (reverification), complete Block B and:

- examine any document that reflects that the employee is authorized to work in the U.S. (see List A or C),
- record the document title, document number and expiration date (if any) in Block C, and
- complete the signature block.

**Photocopying and Retaining Form I-9.** A blank I-9 may be reproduced, provided both sides are copied. The Instructions must be available to all employees completing this form. Employers must retain completed I-9s for three (3) years after the date of hire or one (1) year after the date employment ends, whichever is later.

For more detailed information, you may refer to the Department of Homeland Security (DHS) Handbook for Employers, (Form M-274). You may obtain the handbook at your local U.S. Citizenship and Immigration Services (USCIS) office.

**Privacy Act Notice.** The authority for collecting this information is the Immigration Reform and Control Act of 1986, Pub. L. 99-603 (8 USC 1324a).

This information is for employers to verify the eligibility of individuals 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.

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 form will be kept by the employer and made available for inspection by officials of the U.S. Immigration and Customs Enforcement, Department of Labor and Office of Special Counsel for Immigration Related Unfair Employment Practices.

Submission of the information required in this form is voluntary. However, an individual may not begin employment unless this form is completed, since employers are subject to civil or criminal penalties if they do not comply with the Immigration Reform and Control Act of 1986.

**Reporting Burden.** We try to create forms and instructions that are accurate, can be easily understood and which impose the least possible burden on you to provide us with information. Often this is difficult because some immigration laws are very complex. Accordingly, the reporting burden for this collection of information is computed as follows: 1) learning about this form, 5 minutes; 2) completing the form, 5 minutes; and 3) assembling and filing (recordkeeping) the form, 5 minutes, for an average of 15 minutes per response. If you have comments regarding the accuracy of this burden estimate, or suggestions for making this form simpler, you can write to U.S. Citizenship and Immigration Services, Regulatory Management Division, 111 Massachusetts Avenue, N.W., Washington, DC 20529. OMB No. 1615-0047.

**NOTE:** This is the 1991 edition of the Form I-9 that has been rebranded with a current printing date to reflect the recent transition from the INS to DHS and its components.

**EMPLOYERS MUST RETAIN COMPLETED FORM I-9  
PLEASE DO NOT MAIL COMPLETED FORM I-9 TO ICE OR USCIS**

# Employment Eligibility Verification

Please 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 eligible individuals. Employers **CANNOT** specify which document(s) they will accept from an employee. The refusal to hire an individual because of a future expiration date may also constitute illegal discrimination.

**Section 1. Employee Information and Verification.** To be completed and signed by employee at the time employment begins.

Print Name: Last	First	Middle Initial	Maiden Name
Address (Street Name and Number)		Apt. #	Date of Birth (month/day/year)
City	State	Zip Code	Social Security #

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 or national of the United States

A Lawful Permanent Resident (Alien #) A \_\_\_\_\_

An alien authorized to work until \_\_\_\_\_

(Alien # or Admission #) \_\_\_\_\_

Employee's Signature	Date (month/day/year)
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**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.

Preparer's/Translator's Signature	Print Name
Address (Street Name and Number, City, State, Zip Code)	
Date (month/day/year)	

**Section 2. Employer Review and Verification.** To be completed and signed by employer. Examine one document from List A OR examine one document from List B and one from List C, as listed on the reverse of this form, and record the title, number and expiration date, if any, of the document(s).

List A	OR	List B	AND	List C
Document title: _____		_____		_____
Issuing authority: _____		_____		_____
Document #: _____		_____		_____
Expiration Date (if any): _____		_____		_____
Document #: _____		_____		_____
Expiration Date (if any): _____		_____		_____

**CERTIFICATION -** I attest, under penalty of perjury, that I have examined the document(s) presented by the above-named employee, that the above-listed document(s) appear to be genuine and to relate to the employee named, that the employee began employment on (month/day/year) \_\_\_\_\_ and that to the best of my knowledge the employee is eligible to work in the United States. (State employment agencies may omit the date the employee began employment.)

Signature of Employer or Authorized Representative	Print Name	Title
Business or Organization Name		Date (month/day/year)
Address (Street Name and Number, City, State, Zip Code)		

**Section 3. Updating and Reverification.** To be completed and signed by employer.

A. New Name (if applicable)	B. Date of rehire (month/day/year) (if applicable)
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C. If employee's previous grant of work authorization has expired, provide the information below for the document that establishes current employment eligibility.

Document Title: \_\_\_\_\_ Document #: \_\_\_\_\_ Expiration Date (if any): \_\_\_\_\_

I attest, under penalty of perjury, that to the best of my knowledge, this employee is eligible 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 (month/day/year)
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## LISTS OF ACCEPTABLE DOCUMENTS

LIST A	LIST B	LIST C
Documents that Establish Both Identity and Employment Eligibility	Documents that Establish Identity	Documents that Establish Employment Eligibility
<ol style="list-style-type: none"> <li>1. U.S. Passport (unexpired or expired)</li> <li>2. Certificate of U.S. Citizenship (Form N-560 or N-561)</li> <li>3. Certificate of Naturalization (Form N-550 or N-570)</li> <li>4. Unexpired foreign passport, with I-551 stamp or attached Form I-94 indicating unexpired employment authorization</li> <li>5. Permanent Resident Card or Alien Registration Receipt Card with photograph (Form I-151 or I-551)</li> <li>6. Unexpired Temporary Resident Card (Form I-688)</li> <li>7. Unexpired Employment Authorization Card (Form I-688A)</li> <li>8. Unexpired Reentry Permit (Form I-327)</li> <li>9. Unexpired Refugee Travel Document (Form I-571)</li> <li>10. Unexpired Employment Authorization Document issued by DHS that contains a photograph (Form I-688B)</li> </ol>	<p style="font-weight: bold; margin: 0;">OR</p> <ol style="list-style-type: none"> <li>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</li> <li>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</li> <li>3. School ID card with a photograph</li> <li>4. Voter's registration card</li> <li>5. U.S. Military card or draft record</li> <li>6. Military dependent's ID card</li> <li>7. U.S. Coast Guard Merchant Mariner Card</li> <li>8. Native American tribal document</li> <li>9. Driver's license issued by a Canadian government authority</li> </ol> <p style="text-align: center; font-weight: bold; margin: 0;">For persons under age 18 who are unable to present a document listed above:</p> <ol style="list-style-type: none"> <li>10. School record or report card</li> <li>11. Clinic, doctor or hospital record</li> <li>12. Day-care or nursery school record</li> </ol>	<p style="text-align: center; font-weight: bold; margin: 0;">AND</p> <ol style="list-style-type: none"> <li>1. U.S. social security card issued by the Social Security Administration (<i>other than a card stating it is not valid for employment</i>)</li> <li>2. Certification of Birth Abroad issued by the Department of State (Form FS-545 or Form DS-1350)</li> <li>3. Original or certified copy of a birth certificate issued by a state, county, municipal authority or outlying possession of the United States bearing an official seal</li> <li>4. Native American tribal document</li> <li>5. U.S. Citizen ID Card (Form I-197)</li> <li>6. ID Card for use of Resident Citizen in the United States (Form I-179)</li> <li>7. Unexpired employment authorization document issued by DHS (<i>other than those listed under List A</i>)</li> </ol>

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

# HEALTH RECORD

NAME:

DATE OF BIRTH:

Person(s) to be notified in case of emergency:

NAME:	CITY:	PHONE:
NAME:	CITY:	PHONE:
NAME:	CITY:	PHONE:
DOCTOR TO BE NOTIFIED:		PHONE:
HOSPITALIZATION INSURANCE:	<input type="checkbox"/> GROUP	<input type="checkbox"/> INDIVIDUAL
NAME OF COMPANY:		POLICY NO.:
HOSPITAL PREFERRED:		PHONE:

List any illness that should be taken into consideration before medical or first aid treatment should be applied:

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