



University of Pittsburgh Johnstown

Campus Employment Student,

450 Schoolhouse Road
Johnstown, Pennsylvania 15904
Telephone: 814-269-7000

Please follow the attached instructions for completing an electronic I-9 form and also complete the attached paperwork. You should print a confirmation of your electronic I-9 form and bring it with your other completed paperwork and I-9 identification documents to Human Resources, 261 Blackington Hall on or before your first day of work. You may not begin working until you do so.

Direct Deposit of your paycheck is now mandatory for all new employees. A direct deposit form is enclosed in this packet. After completing the form, you have 2 options:

1. You can submit the direct deposit form **along with a voided check** to our office.

OR

2. You may simply list your banking institution, account number, and routing number on the direct deposit form. **We strongly recommend that you utilize the voided check option. By submitting a voided check to our office, you are decreasing the possibility of paycheck errors and ensuring that your money is deposited into the correct account.**

The Payroll Department introduced a new feature which will allow you to access, view, and print your paystub on-line. The instructions are listed below.

Directions for viewing your pay statement on-line

1. **Navigate to the University portal, My Pitt, at my.pitt.edu.**
2. **Enter your University Computing Account username and password.**
3. **Click on the "Log In" button.**
4. **Click on the "PRISM Login" link.**
5. **Select "PHR Employee Self-Service" responsibility.**
6. **Select "Pay Statement".**

*If you forget your username or password, contact the Technology Help Desk at 412- 624-HELP (4357) for assistance.

***Never leave your computer logged on while unattended and always lock your PC when you are going to be away from your desk.** Just press the CTRL, ALT, and DELETE keys simultaneously. Then choose the "Lock this Computer" option.

If you have any questions, please stop in to speak to us.

Pam, Kathy, and Karla
Human Resources
261 Blackington Hall

University of Pittsburgh

Electronic Form I-9 Completion Instructions

As a part of the hiring process, all new employees are required to complete a Form I-9, which is the Employment Eligibility Verification form required by the federal government.

Prior to your first day of employment, we would like you to complete section 1 of the Form I-9 by using an electronic I-9 service called I-9 Express. This confidential and secure service allows you to quickly and conveniently complete section 1 of your Form I-9 online.

Please follow the simplified version of the completion instructions below to begin the form.

On or prior to your first day of work, please bring the identification documents listed in the I-9 confirmation section of the online I-9 form, so that section 2 of the form may be completed by an authorized University representative.

To complete your Form I-9 online:

1. Go to www.newi9.com
2. Enter the Employer Code: **14726**
3. Enter the text in the picture. For a new picture, click 'New Picture.'
4. Complete the I-9 form.
5. Electronically sign the I-9:
 - a. Review the information.
 - b. Click the checkbox to agree to the perjury statement.
 - c. Click Continue to complete your electronic signature.
6. Print the "Thank You" page to remind you to bring your documents on or prior to your first day of employment to Human Resources, 261 Blackington Hall.
7. Close your browser to clear your activity from the browser's memory.

WARNING: You must complete Section 1 of the Form I-9 by no later than your first day of employment, and you must present the documentation required for the University's completion of Section 2 of the Form I-9 on or before the date when your employment begins. If you fail to meet these deadlines, you will not be paid. If you do not satisfy the Form I-9 requirements, your employment/offer of employment may be terminated.

Please contact the Office of Human Resources with any questions at 814-269-7030.



RESIDENCY CERTIFICATION FORM / ADDRESS CHANGE

ADDRESS INFORMATION - PERMANENT RESIDENCE LOCATION		Effective Date: _____
Please check one: <input type="checkbox"/> U.S. Citizen/Permanent Resident <input type="checkbox"/> Visa holder		
NAME (Last, First, Middle Initial)		
EMPLOYEE ID OR LAST 4 DIGITS OF SOCIAL SECURITY NUMBER		
FIRST LINE OF ADDRESS (P.O. BOX not accepted)		
SECOND LINE OF ADDRESS		
CITY	STATE	ZIP CODE
COUNTY	SCHOOL DISTRICT	
MUNICIPALITY		

THE INFORMATION ON THIS FORM IS REQUIRED BY THE COMMONWEALTH OF PENNSYLVANIA.

This form must be completed by all newly hired individuals for entry into the University of Pittsburgh's HR/Payroll system, those returning to the University from a terminated status, and in the event of an address change.

The address provided on this form will be used to calculate applicable state and local tax withholding for employees subject to these taxes.

Student: Use the street address of your permanent residence. For most students, this will be the address where you permanently resided before you went to college. College dormitories, fraternity houses, sorority houses, and off-campus rentals by enrolled college students generally do not qualify as permanent addresses.

Visa Holder: Use your current U.S. mailing address when completing the RCF. To provide or change your home country address, use the International Address Form @ <http://www.cfo.pitt.edu/payroll/documents/InternationalAddressForm.pdf>

Non-Pennsylvania Resident: Do not complete the County, Municipality, and School District fields.

Former Employee: Use this form to submit an address change to the University.

CERTIFICATION

SIGNATURE OF EMPLOYEE		DATE
PHONE NUMBER	EMAIL ADDRESS	

To obtain the appropriate MUNICIPALITY (City, Borough, Township) and SCHOOL DISTRICT please visit www.newPA.com @ <http://munstatspa.dced.state.pa.us/FindLocalTax.aspx?T=1> and type in your address.

For a list of Frequently Asked Questions and Answers regarding the RCF, please visit the University's Payroll Department web site @ <http://www.cfo.pitt.edu/payroll/documents/FrequentlyAskedQuestionsv5.pdf>

Entered by: Date:

Payroll Review: Date:



University of Pittsburgh

Payroll Department

AUTHORIZATION AGREEMENT FOR DIRECT DEPOSIT OF NET EARNINGS, EXPENSE REIMBURSEMENTS AND OTHER PAYMENTS

YOUR NAME **LAST 4 DIGITS ONLY OF SOCIAL SECURITY NUMBER**

DEPARTMENT PHONE

EFFECTIVE DATE PAYCHECK FREQUENCY MONTHLY BIWEEKLY

I authorize and request the University of Pittsburgh to:

BEGIN CHANGE DISCONTINUE

DIRECT DEPOSIT of any amounts owed to me for net earnings, expense reimbursements or any other payments to ONE account in the bank or institution ("BANKING INSTITUTION") named below; and I authorize and request the BANKING INSTITUTION to accept the direct deposit authorization (and/or corrections to previously deposited amounts) as certified correct by the University for my account.

SELECT THE TYPE OF ACCOUNT TO BE CREDITED. ONLY **ONE** CAN BE SELECTED. CHECKING SAVINGS

PROVIDE YOUR ACCOUNT AND ROUTING INFORMATION USING **ONE** OF THE FOLLOWING OPTIONS:

OPTION 1. ATTACH A COPY OF A VOIDED CHECK OR OTHER OFFICIAL BANKING INSTITUTION CONFIRMATION OF YOUR ROUTING AND ACCOUNT INFORMATION.

OPTION 2. TYPE OR LEGIBLY PRINT YOUR ACCOUNT NUMBER, ROUTING NUMBER, AND BANKING INSTITUTION BELOW.

ACCOUNT NUMBER ROUTING NUMBER **(must be 9 digits)**

BANKING INSTITUTION

TERMS AND CONDITIONS

Deposits can be made in one banking institution only and in one account within the banking institution. Deposits are limited to either checking or savings accounts. Partial deposits will not be permitted; total net payment must be deposited. Monthly direct deposit authorization forms received in Payroll after the 15th of the month are not guaranteed for processing until the following month. **Exception: November 30 is the deadline for the December MONTHLY payroll.** The deadline for biweekly direct deposit authorization forms is 8 days before each biweekly payday.

Pay statements are provided online or via paper copy depending on job classification. Visit the payroll web site for more information. In the event this agreement is incomplete, incorrectly prepared, or unsigned, the employee will be notified and required to complete and execute a new agreement.

My signature attests to my agreement with the terms and conditions stated above.

SIGNATURE _____

DATE _____

WORKERS' COMPENSATION PROCEDURES TO FOLLOW

Injuries that occur at work are considered workers' compensation injuries.

I would like to take this opportunity to explain a few key points about Workers' Compensation.

If you are injured at work, you need to follow these procedures:

- **First, call the toll free number on the Workers' Compensation panel to report your injury. Injuries should be reported during the first 24 hours after occurring.**
- **Second, report the injury to your supervisor.**
- **Third, inform Human Resources of your injury.**
- **Fourth, injured workers MUST seek medical treatment from facilities listed on the panel for the first 90 days. Please note that Medwell and Corporate Care are NOT listed on our panel; therefore, injured employees are not able to seek treatment from these facilities.**
- **Fifth, in case of a true emergency, emergent care may be sought from the closest emergency department.**

If you have any questions, please feel free to contact me at (814) 269-7030.

**Kathy Patterson
Human Resources Specialist**

IN CASE OF A WORK-RELATED INJURY:

1. **Immediately report the work-related injury/illness:**
 - **Call WorkPartners at 1-800-633-1197 (24 hours/day, 7 days/week)**
 - **AND Notify your supervisor**
2. Medical care must be provided by one of the designated providers listed below for 90 days.
3. If you require emergency medical care, you may seek treatment at the closest Emergency Department for your initial care, but any additional medical treatment must be obtained by one of the providers below.

<u>Practice/Physician Name</u>	<u>Address</u>	<u>Scheduling</u>	<u>Area of Specialty</u>
WorkPlace Health Mark VanDyke, DO	338 Bloomfield St, Ste 101 Johnstown, PA 15904	814-361-2307	Occupational Medicine ALL work-related injuries
Charles W. Stotler, MD	334 Bloomfield St, Ste 205 Johnstown, PA 15904	814-266-8686	Occupational Medicine ALL work-related injuries
MedExpress Johnstown	1221 Scalp Ave Johnstown, PA 15904	814-266-1138	Urgent Care Initial injury care ONLY
Conemaugh Physicians Group Surgery William Carney, MD	1086 Franklin St, Ground Fl Good Samaritan Johnstown, PA 15905	814-535-1543	General Surgery
Zafar Chowdhry, MD	1111 Franklin St, Ste 130 Johnstown, PA 15905	814-534-5724	Neurosurgery
CP Group Plastic Surgery Drs. Rollins & Shayesteh	1 Tech Park Dr, Ste 1200 Johnstown, PA 15901	814-534-6750	Plastic Surgery
Western Pennsylvania Orthopedics Drs. Lowry, Schroeder, Katz, Vena, Donaldson, & Budny	2 Celeste Dr Johnstown, PA 15905	814-255-6781	Orthopedics
Ophthalmic Associates of Johnstown Joseph Polito, MD	120 Main St Johnstown, PA 15904 Multiple locations available	814-536-5343	Ophthalmology (Eye)
Robert Rundorff, MD	16 Rose St Johnstown, PA 15905	814-539-0257	Physical Medicine & Rehabilitation
One Call Physical Therapy Network	Multiple locations available	844-284-2525	Physical Therapy
Hilltop Chiropractic Drs. Bosserman, Hartlind, & Smith	1837 Goucher St Johnstown, PA 15905 Location: 814-255-7292	844-284-2525	Chiropractic Care
One Call MRI Network	Multiple locations available Identify that WorkPartners/University of Pittsburgh is the payer. Call WorkPartners at 1-800-633-1197 to notify of the date and time of the test.	800-453-0574	Diagnostic Imaging
Conemaugh Advanced Imaging	1450 Scalp Ave Johnstown, PA 15904	814-262-7290	Diagnostic Imaging
Express Scripts Inc.	Multiple retail pharmacy locations Help desk: 800-824-0898 Bring University of Pittsburgh employee ID No out-of-pocket expense	866-759-6146	Pharmacy BIN# 003858 Group# KYSA



UNIVERSITY OF PITTSBURGH

WORKERS' COMPENSATION INFORMATION

To All Employees:

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

Benefits are required to be paid by your employer if self-insured, or through insurance provided by your employer. Your employer is required to post the name of the company responsible for paying workers' compensation benefits at its primary place of business and at its sites of employment in a prominent and easily accessible place. It is also required to be posted in any areas used for treatment of injured employees or for the administration of first aid.

You should report immediately any injury or work-related illness to your employer. Your benefits could be delayed or denied if you do not notify your employer immediately.

If your claim is denied by your employer, you have the right to request a hearing before a Workers' Compensation Judge.

The Bureau of Workers' Compensation cannot provide legal advice. However, you may contact the Bureau of Workers' Compensation for additional general information:

Bureau of Workers' Compensation
1171 South Cameron Street, Room 103
Harrisburg, Pennsylvania 17104-2501
Telephone No. within Pennsylvania: 1-800-482-2383
Telephone No. outside of this Commonwealth: 717-772-4447
TTY: 1-800-362-4228 (for hearing and speech impaired only)
www.dli.state.pa.us, PA keyword: workers' comp

For a complete list of panel physicians, please refer to [http: www.cfo.pitt.edu/wc](http://www.cfo.pitt.edu/wc) . Please contact UPMC Work Partners-Claims Management Services at 1-800-633-1197 or the Workers' Compensation office at 412-624-1198 with any additional questions.

I, _____, employee of the University of Pittsburgh, hereby certify that I have been provided with, read, and understood the information set forth above consistent with the requirements of the Pennsylvania Workers' Compensation Act.

Employee Signature: _____ Date: _____

Revised: 1/1/12

Form – B



UNIVERSITY OF PITTSBURGH

PENNSYLVANIA WORKERS' COMPENSATION ACT

EMPLOYEE ACKNOWLEDGMENT

OF RIGHTS & DUTIES

My employer has provided a list of at least six (6) designated healthcare providers for evaluation and treatment of work-related injuries and illnesses, which include at least three (3) physicians and no more than four (4) coordinated care organizations. I acknowledge that I have received and reviewed this list of designated health care providers and have been presented with this written notice of my rights and duties under Section 306(f.1)(1)(i) of the Pennsylvania Workers' Compensation Act. My rights and duties include:

1. I have the duty to obtain treatment for work-related injuries and illnesses from one or more of the designated health care providers for ninety (90) days from the date of first visit to a designated provider;
2. As long as treatment is obtained from a designated provider during the ninety (90) day period, all reasonable medical supplies and treatment related to the injury will be paid by my employer;
3. I have the right to switch from one designated health care provider on the list to another during the ninety (90) day period and my employer must pay for this treatment;
4. If a designated provider refers me to a non-designated provider, my employer shall pay for the treatment rendered by the referral provider;
5. I have the right to seek emergency medical treatment from any provider, but I understand that subsequent non-emergency treatment must be rendered by a designated provider for the remainder of the ninety (90) day period;
6. I have the right during the ninety (90) day period to seek medical treatment from a non-designated provider, but I understand that my employer is not responsible to pay for these services;
7. After the expiration of the ninety (90) day period, I have the right to seek treatment from any health care provider and my employer must pay for such treatment if it is reasonable and necessary;
8. If I treat with a non-designated health care provider after the expiration of the ninety (90) day period, I understand that I must provide my employer with notice within five (5) days of my first treatment with the non-designated provider. If I fail to do so, my employer may not be responsible to pay for treatment rendered by the non-designated provider prior to notification.
9. Should a physician prescribe invasive surgery or other health care provider so designated by the employer, I shall be permitted to receive an additional opinion from any health care provider of my own choice. If the additional opinion differs from the opinion provided by the physician or health care provider designated by the employer, I shall determine the course of treatment. If I choose to follow the procedures designated in the second opinion, such procedures shall be performed by one of the physicians or health care providers so designated by the employer for a period of ninety (90) days from the date of visit to the physician or health care provider of my own choice. Should I not comply with the foregoing, my employer will be relieved from liability for the payment of services rendered during such applicable period. Any health care provider of my choice may provide subsequent treatment.

My employer has informed me of my rights and duties and my signature acknowledges that I have been so informed and understand my rights and duties.

Date

Employee's Printed Name

Witness Signature

Employee's Signature

Revised: 1/1/12

Form – D

Form W-4 (2018)

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

Purpose. Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay. Consider completing a new Form W-4 each year and when your personal or financial situation changes.

Exemption from withholding. You may claim exemption from withholding for 2018 if **both** of the following apply.

- For 2017 you had a right to a refund of **all** federal income tax withheld because you had **no** tax liability, **and**
- For 2018 you expect a refund of **all** federal income tax withheld because you expect to have **no** tax liability.

If you're exempt, complete **only** lines 1, 2, 3, 4, and 7 and sign the form to validate it. Your exemption for 2018 expires February 15, 2019. See Pub. 505, Tax Withholding and Estimated Tax, to learn more about whether you qualify for exemption from withholding.

General Instructions

If you aren't exempt, follow the rest of these instructions to determine the number of withholding allowances you should claim for withholding for 2018 and any additional amount of tax to have withheld. For regular wages, withholding must be based on allowances you claimed and may not be a flat amount or percentage of wages.

You can also use the calculator at www.irs.gov/W4App to determine your tax withholding more accurately. Consider

using this calculator if you have a more complicated tax situation, such as if you have a working spouse, more than one job, or a large amount of nonwage income outside of your job. After your Form W-4 takes effect, you can also use this calculator to see how the amount of tax you're having withheld compares to your projected total tax for 2018. If you use the calculator, you don't need to complete any of the worksheets for Form W-4.

Note that if you have too much tax withheld, you will receive a refund when you file your tax return. If you have too little tax withheld, you will owe tax when you file your tax return, and you might owe a penalty.

Filers with multiple jobs or working spouses. If you have more than one job at a time, or if you're married and your spouse is also working, read all of the instructions including the instructions for the Two-Earners/Multiple Jobs Worksheet before beginning.

Nonwage income. If you have a large amount of nonwage income, such as interest or dividends, consider making estimated tax payments using Form 1040-ES, Estimated Tax for Individuals. Otherwise, you might owe additional tax. Or, you can use the Deductions, Adjustments, and Other Income Worksheet on page 3 or the calculator at www.irs.gov/W4App to make sure you have enough tax withheld from your paycheck. If you have pension or annuity income, see Pub. 505 or use the calculator at www.irs.gov/W4App to find out if you should adjust your withholding on Form W-4 or W-4P.

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

Specific Instructions

Personal Allowances Worksheet

Complete this worksheet on page 3 first to determine the number of withholding allowances to claim.

Line C. Head of household please note: Generally, you can claim head of household filing status on your tax return only if you're unmarried and pay more than 50% of the costs of keeping up a home for yourself and a qualifying individual. See Pub. 501 for more information about filing status.

Line E. Child tax credit. When you file your tax return, you might be eligible to claim a credit for each of your qualifying children. To qualify, the child must be under age 17 as of December 31 and must be your dependent who lives with you for more than half the year. To learn more about this credit, see Pub. 972, Child Tax Credit. To reduce the tax withheld from your pay by taking this credit into account, follow the instructions on line E of the worksheet. On the worksheet you will be asked about your total income. For this purpose, total income includes all of your wages and other income, including income earned by a spouse, during the year.

Line F. Credit for other dependents. When you file your tax return, you might be eligible to claim a credit for each of your dependents that don't qualify for the child tax credit, such as any dependent children age 17 and older. To learn more about this credit, see Pub. 505. To reduce the tax withheld from your pay by taking this credit into account, follow the instructions on line F of the worksheet. On the worksheet, you will be asked about your total income. For this purpose, total income includes all of

----- Separate here and give Form W-4 to your employer. Keep the worksheet(s) for your records. -----

Form W-4 Department of the Treasury Internal Revenue Service		Employee's Withholding Allowance Certificate		OMB No. 1545-0074 2018	
▶ Whether you're entitled to claim a certain number of allowances or exemption from withholding is subject to review by the IRS. Your employer may be required to send a copy of this form to the IRS.					
1 Your first name and middle initial		Last name		2 Your social security number	
Home address (number and street or rural route)			3 <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Married, but withhold at higher Single rate. Note: If married filing separately, check "Married, but withhold at higher Single rate."		
City or town, state, and ZIP code			4 If your last name differs from that shown on your social security card, check here. You must call 800-772-1213 for a replacement card. <input type="checkbox"/>		
5 Total number of allowances you're claiming (from the applicable worksheet on the following pages)				5	
6 Additional amount, if any, you want withheld from each paycheck				6 \$	
7 I claim exemption from withholding for 2018, and I certify that I meet both of the following conditions for exemption.					
<ul style="list-style-type: none"> • Last year I had a right to a refund of all federal income tax withheld because I had no tax liability, and • This year I expect a refund of all federal income tax withheld because I expect to have no tax liability. If you meet both conditions, write "Exempt" here ▶					
Under penalties of perjury, I declare that I have examined this certificate and, to the best of my knowledge and belief, it is true, correct, and complete.					
Employee's signature (This form is not valid unless you sign it.) ▶				Date ▶	
8 Employer's name and address (Employer: Complete boxes 8 and 10 if sending to IRS and complete boxes 8, 9, and 10 if sending to State Directory of New Hires.)			9 First date of employment		10 Employer identification number (EIN)

your wages and other income, including income earned by a spouse, during the year.

Line G. Other credits. You might be able to reduce the tax withheld from your paycheck if you expect to claim other tax credits, such as the earned income tax credit and tax credits for education and child care expenses. If you do so, your paycheck will be larger but the amount of any refund that you receive when you file your tax return will be smaller. Follow the instructions for Worksheet 1-6 in Pub. 505 if you want to reduce your withholding to take these credits into account.

Deductions, Adjustments, and Additional Income Worksheet

Complete this worksheet to determine if you're able to reduce the tax withheld from your paycheck to account for your itemized deductions and other adjustments to income such as IRA contributions. If you do so, your refund at the end of the year will be smaller, but your paycheck will be larger. You're not required to complete this worksheet or reduce your withholding if you don't wish to do so.

You can also use this worksheet to figure out how much to increase the tax withheld from your paycheck if you have a large amount of nonwage income, such as interest or dividends.

Another option is to take these items into account and make your withholding more accurate by using the calculator at www.irs.gov/W4App. If you use the calculator, you don't need to complete any of the worksheets for Form W-4.

Two-Earners/Multiple Jobs Worksheet

Complete this worksheet if you have more

than one job at a time or are married filing jointly and have a working spouse. If you don't complete this worksheet, you might have too little tax withheld. If so, you will owe tax when you file your tax return and might be subject to a penalty.

Figure the total number of allowances you're entitled to claim and any additional amount of tax to withhold on all jobs using worksheets from only one Form W-4. Claim all allowances on the W-4 that you or your spouse file for the highest paying job in your family and claim zero allowances on Forms W-4 filed for all other jobs. For example, if you earn \$60,000 per year and your spouse earns \$20,000, you should complete the worksheets to determine what to enter on lines 5 and 6 of your Form W-4, and your spouse should enter zero ("-0-") on lines 5 and 6 of his or her Form W-4. See Pub. 505 for details.

Another option is to use the calculator at www.irs.gov/W4App to make your withholding more accurate.

Tip: If you have a working spouse and your incomes are similar, you can check the "Married, but withhold at higher Single rate" box instead of using this worksheet. If you choose this option, then each spouse should fill out the Personal Allowances Worksheet and check the "Married, but withhold at higher Single rate" box on Form W-4, but only one spouse should claim any allowances for credits or fill out the Deductions, Adjustments, and Additional Income Worksheet.

Instructions for Employer

Employees, do not complete box 8, 9, or 10. Your employer will complete these boxes if necessary.

New hire reporting. Employers are

required by law to report new employees to a designated State Directory of New Hires. Employers may use Form W-4, boxes 8, 9, and 10 to comply with the new hire reporting requirement for a newly hired employee. A newly hired employee is an employee who hasn't previously been employed by the employer, or who was previously employed by the employer but has been separated from such prior employment for at least 60 consecutive days. Employers should contact the appropriate State Directory of New Hires to find out how to submit a copy of the completed Form W-4. For information and links to each designated State Directory of New Hires (including for U.S. territories), go to www.acf.hhs.gov/programs/css/employers.

If an employer is sending a copy of Form W-4 to a designated State Directory of New Hires to comply with the new hire reporting requirement for a newly hired employee, complete boxes 8, 9, and 10 as follows.

Box 8. Enter the employer's name and address. If the employer is sending a copy of this form to a State Directory of New Hires, enter the address where child support agencies should send income withholding orders.

Box 9. If the employer is sending a copy of this form to a State Directory of New Hires, enter the employee's first date of employment, which is the date services for payment were first performed by the employee. If the employer rehired the employee after the employee had been separated from the employer's service for at least 60 days, enter the rehire date.

Box 10. Enter the employer's employer identification number (EIN).

Personal Allowances Worksheet (Keep for your records.)

A	Enter "1" for yourself	A	_____
B	Enter "1" if you will file as married filing jointly	B	_____
C	Enter "1" if you will file as head of household	C	_____
D	Enter "1" if: { <ul style="list-style-type: none"> • You're single, or married filing separately, and have only one job; or • You're married filing jointly, have only one job, and your spouse doesn't work; or • Your wages from a second job or your spouse's wages (or the total of both) are \$1,500 or less. }	D	_____
E	<p>Child tax credit. See Pub. 972, Child Tax Credit, for more information.</p> <ul style="list-style-type: none"> • If your total income will be less than \$69,801 (\$101,401 if married filing jointly), enter "4" for each eligible child. • If your total income will be from \$69,801 to \$175,550 (\$101,401 to \$339,000 if married filing jointly), enter "2" for each eligible child. • If your total income will be from \$175,551 to \$200,000 (\$339,001 to \$400,000 if married filing jointly), enter "1" for each eligible child. • If your total income will be higher than \$200,000 (\$400,000 if married filing jointly), enter "-0-" 	E	_____
F	<p>Credit for other dependents.</p> <ul style="list-style-type: none"> • If your total income will be less than \$69,801 (\$101,401 if married filing jointly), enter "1" for each eligible dependent. • If your total income will be from \$69,801 to \$175,550 (\$101,401 to \$339,000 if married filing jointly), enter "1" for every two dependents (for example, "-0-" for one dependent, "1" if you have two or three dependents, and "2" if you have four dependents). • If your total income will be higher than \$175,550 (\$339,000 if married filing jointly), enter "-0-" 	F	_____
G	Other credits. If you have other credits, see Worksheet 1-6 of Pub. 505 and enter the amount from that worksheet here	G	_____
H	Add lines A through G and enter the total here	H	_____

For accuracy, **complete all worksheets that apply.**

- If you plan to **itemize** or **claim adjustments to income** and want to reduce your withholding, or if you have a large amount of nonwage income and want to increase your withholding, see the **Deductions, Adjustments, and Additional Income Worksheet** below.
- If you **have more than one job at a time** or are **married filing jointly and you and your spouse both work**, and the combined earnings from all jobs exceed \$52,000 (\$24,000 if married filing jointly), see the **Two-Earners/Multiple Jobs Worksheet** on page 4 to avoid having too little tax withheld.
- If **neither** of the above situations applies, **stop here** and enter the number from line H on line 5 of Form W-4 above.

Deductions, Adjustments, and Additional Income Worksheet

Note: Use this worksheet *only* if you plan to itemize deductions, claim certain adjustments to income, or have a large amount of nonwage income.

1	Enter an estimate of your 2018 itemized deductions. These include qualifying home mortgage interest, charitable contributions, state and local taxes (up to \$10,000), and medical expenses in excess of 7.5% of your income. See Pub. 505 for details	1	\$ _____
2	Enter: { <ul style="list-style-type: none"> \$24,000 if you're married filing jointly or qualifying widow(er) \$18,000 if you're head of household \$12,000 if you're single or married filing separately }	2	\$ _____
3	Subtract line 2 from line 1. If zero or less, enter "-0-"	3	\$ _____
4	Enter an estimate of your 2018 adjustments to income and any additional standard deduction for age or blindness (see Pub. 505 for information about these items)	4	\$ _____
5	Add lines 3 and 4 and enter the total	5	\$ _____
6	Enter an estimate of your 2018 nonwage income (such as dividends or interest)	6	\$ _____
7	Subtract line 6 from line 5. If zero, enter "-0-". If less than zero, enter the amount in parentheses	7	\$ _____
8	Divide the amount on line 7 by \$4,150 and enter the result here. If a negative amount, enter in parentheses. Drop any fraction	8	_____
9	Enter the number from the Personal Allowances Worksheet , line H above	9	_____
10	Add lines 8 and 9 and enter the total here. If zero or less, enter "-0-". If you plan to use the Two-Earners/Multiple Jobs Worksheet , also enter this total on line 1, page 4. Otherwise, stop here and enter this total on Form W-4, line 5, page 1	10	_____

Two-Earners/Multiple Jobs Worksheet

Note: Use this worksheet *only* if the instructions under line H from the **Personal Allowances Worksheet** direct you here.

- 1** Enter the number from the **Personal Allowances Worksheet**, line H, page 3 (or, if you used the **Deductions, Adjustments, and Additional Income Worksheet** on page 3, the number from line 10 of that worksheet) **1** _____
 - 2** Find the number in **Table 1** below that applies to the **LOWEST** paying job and enter it here. **However**, if you're married filing jointly and wages from the highest paying job are \$75,000 or less and the combined wages for you and your spouse are \$107,000 or less, don't enter more than "3" **2** _____
 - 3** If line 1 is **more than or equal to** line 2, subtract line 2 from line 1. Enter the result here (if zero, enter "-0-") and on Form W-4, line 5, page 1. **Do not** use the rest of this worksheet **3** _____
- Note:** If line 1 is **less than** line 2, enter "-0-" on Form W-4, line 5, page 1. Complete lines 4 through 9 below to figure the additional withholding amount necessary to avoid a year-end tax bill.
- 4** Enter the number from line 2 of this worksheet **4** _____
 - 5** Enter the number from line 1 of this worksheet **5** _____
 - 6** **Subtract** line 5 from line 4 **6** _____
 - 7** Find the amount in **Table 2** below that applies to the **HIGHEST** paying job and enter it here **7** \$ _____
 - 8** **Multiply** line 7 by line 6 and enter the result here. This is the additional annual withholding needed **8** \$ _____
 - 9** **Divide** line 8 by the number of pay periods remaining in 2018. For example, divide by 18 if you're paid every 2 weeks and you complete this form on a date in late April when there are 18 pay periods remaining in 2018. Enter the result here and on Form W-4, line 6, page 1. This is the additional amount to be withheld from each paycheck **9** \$ _____

Table 1				Table 2			
Married Filing Jointly		All Others		Married Filing Jointly		All Others	
If wages from LOWEST paying job are—	Enter on line 2 above	If wages from LOWEST paying job are—	Enter on line 2 above	If wages from HIGHEST paying job are—	Enter on line 7 above	If wages from HIGHEST paying job are—	Enter on line 7 above
\$0 - \$5,000	0	\$0 - \$7,000	0	\$0 - \$24,375	\$420	\$0 - \$7,000	\$420
5,001 - 9,500	1	7,001 - 12,500	1	24,376 - 82,725	500	7,001 - 36,175	500
9,501 - 19,000	2	12,501 - 24,500	2	82,726 - 170,325	910	36,176 - 79,975	910
19,001 - 26,500	3	24,501 - 31,500	3	170,326 - 320,325	1,000	79,976 - 154,975	1,000
26,501 - 37,000	4	31,501 - 39,000	4	320,326 - 405,325	1,330	154,976 - 197,475	1,330
37,001 - 43,500	5	39,001 - 55,000	5	405,326 - 605,325	1,450	197,476 - 497,475	1,450
43,501 - 55,000	6	55,001 - 70,000	6	605,326 and over	1,540	497,476 and over	1,540
55,001 - 60,000	7	70,001 - 85,000	7				
60,001 - 70,000	8	85,001 - 90,000	8				
70,001 - 75,000	9	90,001 - 100,000	9				
75,001 - 85,000	10	100,001 - 105,000	10				
85,001 - 95,000	11	105,001 - 115,000	11				
95,001 - 130,000	12	115,001 - 120,000	12				
130,001 - 150,000	13	120,001 - 130,000	13				
150,001 - 160,000	14	130,001 - 145,000	14				
160,001 - 170,000	15	145,001 - 155,000	15				
170,001 - 180,000	16	155,001 - 185,000	16				
180,001 - 190,000	17	185,001 and over	17				
190,001 - 200,000	18						
200,001 and over	19						

Privacy Act and Paperwork Reduction Act Notice. We ask for the information on this form to carry out the Internal Revenue laws of the United States. Internal Revenue Code sections 3402(f)(2) and 6109 and their regulations require you to provide this information; your employer uses it to determine your federal income tax withholding. Failure to provide a properly completed form will result in your being treated as a single person who claims no withholding allowances; providing fraudulent information may subject you to penalties. Routine uses of this information include giving it to the Department of Justice for civil and criminal litigation; to cities, states, the District of Columbia, and

U.S. commonwealths and possessions for use in administering their tax laws; and to the Department of Health and Human Services for use in the National Directory of New Hires. We may also disclose this information to other countries under a tax treaty, to federal and state agencies to enforce federal nontax criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism.

You aren't required to provide the information requested on a form that's subject to the Paperwork Reduction Act unless the form displays a valid OMB control number. Books or records relating to a form or its instructions must be

retained as long as their contents may become material in the administration of any Internal Revenue law. Generally, tax returns and return information are confidential, as required by Code section 6103.

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

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

LOCAL SERVICES TAX – EXEMPTION CERTIFICATE

2018 Tax Year

APPLICATION FOR EXEMPTION FROM LOCAL SERVICES TAX

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

Name: _____ Soc. Sec. #: _____
 Address: _____ Phone #: _____
 City/State: _____ Zip: _____

REASON FOR EXEMPTION

1. _____ **MULTIPLE EMPLOYERS:** Attach a copy of a current pay statement from your principal employer that shows the name of the employer, the length of the payroll period and the amount of Local Services Tax withheld. List all employers on the reverse side of this form. You must notify your other employers of a change in principal place of employment within two weeks of the change.
2. _____ **EXPECTED TOTAL EARNED INCOME AND NET PROFITS FROM ALL SOURCES WITHIN**
Richland Township (municipality or school district)
WILL BE LESS THAN \$12,000: Attach copies of your last pay statements or your W-2 for the year prior. If you are self-employed, please attach a copy of your PA Schedule C, F, or RK-1 for the prior year.
3. _____ **ACTIVE DUTY MILITARY EXEMPTION:** Please attach a copy of your orders directing you to active duty status. Annual training is not eligible for exemption. You are required to advise the tax office when you are discharged from active duty status.
4. _____ **MILITARY DISABILITY EXEMPTION:** Please attach copy of your discharge orders and a statement from the United States Veterans Administrator documenting your disability. Only 100% permanent disabilities are recognized for this exemption.

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

**Tax Office:
Richland Tax Office**

IMPORTANT NOTE TO EMPLOYERS

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

LST Exemption 10-07

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

1. PRIMARY EMPLOYER 2.

3.

Employer Name			
Address			
Address 2			
City, State Zip			
Municipality			
Phone			
Start Date			
End Date			
Status (FT or PT)			
Gross Earnings			

4.

5.

6.

Employer Name			
Address			
Address 2			
City, State Zip			
Municipality			
Phone			
Start Date			
End Date			
Status (FT or PT)			
Gross Earnings			

PLEASE NOTE:

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

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

SIGNATURE: _____ **DATE:** _____

LST Exemption 10-07



University of Pittsburgh

Voluntary Self Identification Form (Post Offer Information)

The University of Pittsburgh is committed to nondiscrimination, equal opportunity and affirmative action in accordance with federal, state, and local laws and regulations. As an employer that conducts business with the federal government, we are required to implement affirmative action programs.

To assist us with our affirmative action programs, we are asking you to self-identify the requested information below. Submission of this information is voluntary and refusal to provide it will not subject you to any adverse treatment. The information obtained will be kept confidential and may only be used in accordance with the provisions of applicable Federal laws, executive orders, and regulations, including those which require the information to be summarized and reported to the Federal Government for civil rights enforcement purposes.

If you choose not to self-identify your race/ethnicity at this time, the Federal Government requires this employer to determine this information by visual survey and/or other available information. All information will be reported using the race/ethnic categories currently approved by the DOE and EEOC.

1. What is your date of birth? _____ / _____ / _____
2. What is your gender? ___ Male ___ Female
3. Are you Hispanic or Latino? ___ Yes ___ No
4. Please identify your race and ethnicity by selecting all applicable box(s) below:
(Definitions listed below)

- American Indian or Alaska Native
- Asian
- Black or African American
- Native Hawaiian or Other Pacific Islander
- White

<u>Race/Ethnicity Definitions</u>	
1.	<u>Hispanic or Latino</u> - A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin regardless of race
2.	<u>White</u> - A person having origins in any of the original peoples of Europe, the Middle East, or North Africa
3.	<u>Black or African American</u> - A person having origins in any of the black racial groups of Africa
4.	<u>Native Hawaiian or Other Pacific Islander</u> - A person having origins in any of the peoples of Hawaii, Guam, Samoa, or other Pacific Islands
5.	<u>Asian</u> - A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian Subcontinent, including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam
6.	<u>American Indian or Alaskan Native</u> - A person having origins in any of the original peoples of North and South America (including Central America), and who maintain tribal affiliation or community attachment

5. What is the highest level of education you have completed? _____
(See list below)

<u>Education Level</u>	
1. Associate	9. Optometry (OD)
2. Baccalaureate	10. Osteopathy (DO)
3. Dentistry (DMD or DDS)	11. Other professional Doctorate
4. Education (EdD)	12. PhD or ScD
5. High School Diploma or GED	13. Podiatry (DPM or DP or PodD)
6. Law (JD or LDD)	14. Professional Certificate
7. Master's	15. Theological
8. Medicine (MD)	16. Trade or Craft Certificate
	17. Veterinary (DVM)

Voluntary Self-Identification of Veteran Status

As a Government contractor subject to VEVRAA, we are required to submit a report to the United States Department of Labor each year identifying the number of our employees belonging to each specified “protected veteran” category. If you believe you belong to any of the categories of protected veterans listed below, please indicate by checking the appropriate box below.

I belong to the following classification of protected veterans (Choose ALL that apply):
(Definitions listed below)

- Disabled Veteran
- Recently Separated Veteran
- Active Wartime or Campaign Badge Veteran
- Armed Forces Service Medal Veteran

A “**disabled veteran**” is one of the following:

- A veteran of the U.S. military, ground, naval or air service who is entitled to compensation (or who but for the receipt of military retired pay would be entitled to compensation) under laws administered by the Secretary of Veterans Affairs; or
- A person who was discharged or released from active duty because of a service-connected disability.

A “**recently separated veteran**” means any veteran during the three-year period beginning on the date of such veteran's discharge or release from active duty in the U.S. military, ground, naval, or air service.

An “**active duty wartime or campaign badge veteran**” means a veteran who served on active duty in the U.S. military, ground, naval or air service during a war, or in a campaign or expedition for which a campaign badge has been authorized under the laws administered by the Department of Defense.

An “**Armed Forces service medal veteran**” means a veteran who, while serving on active duty in the U.S. military, ground, naval or air service, participated in a United States military operation for which an Armed Forces service medal was awarded pursuant to Executive Order 12985.

- I am a protected veteran, but I choose not to self-identify the classifications to which I belong.
- I am NOT a protected veteran.
- I don't wish to answer.

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

Submission of this information is voluntary and refusal to provide it will not subject you to any adverse treatment. The information provided will be used in ways that are not consistent with the Vietnam Era Veteran's Readjustment Assistance Act of 1974, as amended. The information you submit will be kept confidential, except that (i) supervisors and managers may be informed regarding restrictions on the work or duties of disabled veterans, and regarding necessary accommodations; (ii) first aid and safety personnel may be informed, when and to the extent appropriate, if you have a condition that might require emergency treatment; and (iii) Government officials engaged in enforcing laws administered by the Office of Federal Compliance Programs, or enforcing the Americans with Disabilities Act, may be informed. If you want to discuss accommodations, please contact our Disability Resources and Services at 412.648.7890 or visit their website at <http://www.studentaffairs.pitt.edu/drswelcome>.

The University of Pittsburgh, as an educational institution and as an employer, values equality of opportunity, human dignity, and racial/ethnic and cultural diversity. Accordingly, as fully explained in Policy 07-01-03, the University prohibits and will not engage in discrimination or harassment on the basis of race, color, religion, national origin, ancestry, sex, age, marital status, familial status, sexual orientation, gender identity and expression, genetic information, disability, or status as a veteran. The University also prohibits and will not engage in retaliation against any person who makes a claim of discrimination or harassment or who provides information in such an investigation. Further, the University will continue to take affirmative steps to support and advance these values consistent with the University's mission. This policy applies to admissions, employment, access to and treatment in University programs and activities. This is a commitment made by the University and is in accordance with federal, state, and/or local laws and regulations.

Print Employee Name: _____ Employee Signature: _____

Date: ___/___/___

HR USE ONLY
Entered: _____
Verified: _____

Voluntary Self-Identification of Disability

Form CC-305
OMB Control Number 1250-0005
Expires 1/31/2017
Page 1 of 2

Why are you being asked to complete this form?

Because we do business with the government, we must reach out to, hire, and provide equal opportunity to qualified people with disabilities.¹ To help us measure how well we are doing, we are asking you to tell us if you have a disability or if you ever had a disability. Completing this form is voluntary, but we hope that you will choose to fill it out. If you are applying for a job, any answer you give will be kept private and will not be used against you in any way.

If you already work for us, your answer will not be used against you in any way. Because a person may become disabled at any time, we are required to ask all of our employees to update their information every five years. You may voluntarily self-identify as having a disability on this form without fear of any punishment because you did not identify as having a disability earlier.

How do I know if I have a disability?

You are considered to have a disability if you have a physical or mental impairment or medical condition that substantially limits a major life activity, or if you have a history or record of such an impairment or medical condition.

Disabilities include, but are not limited to:

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

Please check one of the boxes below:

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

Your Name

Today's Date

Voluntary Self-Identification of Disability

Form CC-305
OMB Control Number 1250-0005
Expires 1/31/2017
Page 2 of 2

Reasonable Accommodation Notice

Federal law requires employers to provide reasonable accommodation to qualified individuals with disabilities. Please tell us if you require a reasonable accommodation to apply for a job or to perform your job. Examples of reasonable accommodation include making a change to the application process or work procedures, providing documents in an alternate format, using a sign language interpreter, or using specialized equipment.

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

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