PART TIME CLASSIFIED HIRE CHECKLIST
Welcome to Alaska Gateway School District

___ Personnel Action (this form needs to be given to the principal to complete and you must sign it also and return to the Business Office)

___ Public Retirement System Notification of Employment

___ Public Retirement Beneficiary Designation Form, if you worked for the State of Alaska prior to July 1st, 2006 please let us know before you fill out this form so we can give you a different form for prior to 07/01/2006.

___ Technology Use Agreement

___ Alaska Gateway Sick Leave Bank enrollment

___ Direct Deposit enrollment form (must have a copy of voided check)

___ Second injury form/Health Questionnaire (2 forms)

___ Classified Negotiated Agreement -- Download from Website

___ Finger print cards, please make an appointment with Deb Sparks at District Office. She will do your finger prints.

___ Physical Form (this can be reimbursed up to $250.00) Please have a Dr.date and sign your form)

___ PERS Great West Retirement services, please sign and return the last page, we will send in with your first contribution, they will send you a packet as soon as they receive the signed sheet.

___ W-4 and I-9 (the I-9 must be verified by an AGSD employee and include copies of the forms used for your ID, passport, driver's license, social security card etc. see approved list on your I-9 form)

All forms must be completed prior to starting work.

Thank you,

If you have any questions on these forms, please call 883-5151 Debbie Sparks ext 101 or Robbie MacManus Ext 109.

ALASKA GATEWAY SCHOOL DISTRICT
CLASSIFIED EMPLOYEES
PERSONNEL ACTION

LOCATION _____
POSITION _____
SCHOOL YEAR _____
BUDGET A/C # _____

EMPLOYEE'S NAME _____ DATE _____

Nature of Action:

Confirmation of Re-appointment for next school year _____

**New Appointment _____

Change in Status _____

Change in Location _____

Termination _____

Reason for Termination _____

_____

Comments on Action _____

_____

Rate of Pay: Start _____ Change _____
Range/Step Amount Range/Step Amount

Type of Payroll: _____ Monthly _____ Hourly

Eligible to Accrue Annual Leave: _____ Yes _____ No

Eligible to Accrue Sick Leave: _____ Yes _____ No

Number of hours per day that Employee will work: _____

Number of months that Employee will work: _____

Began work on: _____

Dates of Previous Alaska Gateway School District Employment:

From: _____ to _____

Recommended by: _____ Approved by: _____

Date: _____ Date: _____

_____ _____
Signature of Employee Signature of Principal/Teacher

** For new employees:

Original to Employee
2nd Copy to Payroll
3rd Copy to Personnel

Dragon Press, Delta Junction, Alaska

Notification of Employment

Division of Retirement and Benefits
Public Employees' Retirement System (PERS)
P.O. Box 110203
Juneau, Alaska 99811-0203
Phone: Juneau—(907) 465-4460, Anchorage—(907) 563-5885

FAX: (907) 465-3086 or TDD: (907) 465-2805

☐ ORIGINAL ☐ CHANGE

Section I. Personal Data

Employee's Name Last First M.I. Prior		Social Security Number
Mailing Address (Street or P.O. Box, City, State, ZIP)		Phone Number Work ( )
Employer (State or Political Subdivision)		Home ( )
Date of Birth (Month/Day/Year)	Marital Status ☐ Single ☐ Married	Sex ☐ Male ☐ Female

Section II. Prior Service

Do you have past service with the Public Employees' Retirement System (PERS)? ☐ Yes ☐ No

If yes, list your last employer and date of termination.

☐ State of Alaska

☐ Political Subdivision _____ Date _____

Employee's Signature	Date

Section III. For Employer Use Only

Date of Hire or change (Mo./Day/Yr.)	Employer No.	OCCUPATIONAL CATEGORY		STATUS
		☐ E-Elected Officials	☐ P-Peace Officer	☐ Full-Time
		☐ F-Firefighter	☐ M-IBU	☐ Part-Time
	Location	☐ C-Masters, Mates & Pilots (MMP)	☐ A-All Others	☐ Leave-Without-Pay

For Geographic Differential Use Only

This section must be completed if the employee (1) will be paid a cost of living salary differential because of geographical location, and (2) was first hired under the PERS after December 31, 1986.

Enter below the percentage of base salary which represents the cost of living differential. For example, if the base salary is $2,000 and the differential is $200, the percentage is 10% ($200 ÷ $2,000 = 10%). Also enter the number of pay steps which represent the cost of living differential, if available.

Number of Steps _____ Percentage of Base Salary _____ %

Employer Signature	Title	Date

Remarks:

PERS and TRS Defined Contribution Retirement Plan

Beneficiary Designation 401(a) Plan

State of Alaska Public Employees' Tier IV Defined Contribution Retirement Plan 98214-04

For My Information

- *For questions regarding this form, visit the website at www.akdrb.com or contact Service Provider at 1-800-232-0859.*
- *Use black or blue ink when completing this form.*

A Participant Information

Account extension, if applicable, identifies funds transferred to a beneficiary due to participant's death, alternate payee due to divorce or a participant with multiple accounts.

Account Extension

Social Security Number *(Must provide all 9 digits)* ☐☐☐-☐☐-☐☐☐☐

Last Name | First Name | M.I. | Date of Birth (/ /)

Email Address | Daytime Phone Number ( )

❑ Married ❑ Unmarried | Alternate Phone Number ( )

B Beneficiary Designation *(Attach an additional sheet to name additional beneficiaries.)*

Primary Beneficiary Designation ***(Primary beneficiary designations must total 100% - percentage can be made out to two decimal places.)***

- If I am married, my Plan requires my spouse to be named as primary beneficiary for at least 50% of my account balance, or my spouse must consent to my beneficiary designation.
- See the attached examples on how to complete the below beneficiary designations if the beneficiary is a non-individual, such as a trust, charity or estate.

% of Account Balance	Primary Beneficiary Name *(Name of Individual, Trust, Charity, etc.)*	Relationship	Social Security or Taxpayer Identification Number	Date of Birth or Trust Date
%				/ /
Street Address	City		State	Zip Code
Phone Number *(Optional)* ( )				
%				/ /
Street Address	City		State	Zip Code
Phone Number *(Optional)* ( )				
%				/ /
Street Address	City		State	Zip Code
Phone Number *(Optional)* ( )				

Contingent Beneficiary Designation ***(Contingent beneficiary designations must total 100% - percentage can be made out to two decimal places.)***

% of Account Balance	Contingent Beneficiary Name *(Name of Individual, Trust, Charity, etc.)*	Relationship	Social Security or Taxpayer Identification Number	Date of Birth or Trust Date
%				/ /
Street Address	City		State	Zip Code
Phone Number *(Optional)* ( )				

Last Name _____ First Name _____ M.I. _____ Social Security Number _____ 98214-04 Number

C Signatures and Consent *(Signatures must be on the lines provided.)*

Spousal Consent for Beneficiary Designation *(If applicable, please have the Spouse sign on the 'Spouse's Signature' line below.)*

I, *(name of spouse)* _____, the current spouse of the participant, hereby voluntarily consent to the participant's primary beneficiary designation above and understand its effect. I understand that my spouse's beneficiary designation means that I will not receive 100% of his or her vested account balance under the Plan and that my spouse's election is not valid unless I consent to it. I understand that my consent is irrevocable unless my spouse changes the beneficiary designation, or designates me to receive 100% of his or her vested account balance.

Spouse's Signature _____ **Date *(Required)*** _____

A handwritten signature is required on this form. An electronic signature will not be accepted and will result in a significant delay.

For Residents of all states (except California), please have your notary complete the section below.

Notice to California Notaries using the California Affidavit and Jurat Form the following items must be completed by the notary on the state notary form: the title of the form, the plan name, the plan number, the document date, my name and my spouse's name. The notary forms not containing this information will be rejected and it will delay this request.

My signature must be notarized by a Notary Public or witnessed by my spouse's Plan Administrator. The date I sign this form in the 'My Consent' section must match the date on which my signature is notarized or witnessed in this section.

This form may also be signed in front of a Postmaster or Division of Retirement and Benefits Representative.

Statement of Notary

State of _____)
Judicial District or
County of _____))ss.

NOTE: Notary seal must be visible.

The consent to this request was subscribed and sworn *(or affirmed)* to before me on this_____ day of _____, year _____, by ***(name of spouse)*** _____

proved to me on the basis of satisfactory evidence to be the person who appeared before me, who affirmed that such consent represents his/her free and voluntary act.

SEAL

Notary Public _____ My commission expires ____/____/____

A handwritten signature is required on this form. An electronic signature will not be accepted and will result in a significant delay.

Authorized Plan Administrator Signature *(Please sign on the 'Authorized Plan Administrator Signature' line below.)*

I accept the information provided by the participant on this form.

If Spousal Consent notarization is not obtained, I certify that the consent was signed by the spouse of the participant in my presence. The date that I sign this form must match the date the participant's spouse has signed.

Authorized Plan Administrator Signature _____ **Date *(Required)*** _____

A handwritten signature is required on this form. An electronic signature will not be accepted and will result in a significant delay.

Print Full Name _____

D Mailing Instructions

After all signatures have been obtained, this form can be sent by

Fax to:
Empower Retirement
1-303-801-5800

OR

Regular Mail to:
Empower Retirement
PO Box 173764
Denver, CO 80217-3764

OR

Express Mail to:
Empower Retirement
8515 E. Orchard Road
Greenwood Village, CO 80111

Last Name	First Name	M.I.	Social Security Number	98214-04 Number

B **Beneficiary Designation** ***(Attach an additional sheet to name additional beneficiaries.)***

Contingent Beneficiary Designation ***(Contingent beneficiary designations must total 100% - percentage can be made out to two decimal places.)***

%				/ /
% of Account Balance	Contingent Beneficiary Name *(Name of Individual, Trust, Charity, etc.)*	Relationship	Social Security or Taxpayer Identification Number	Date of Birth or Trust Date

Street Address	City	State	Zip Code

( ) Phone Number *(Optional)*

%				/ /
% of Account Balance	Contingent Beneficiary Name *(Name of Individual, Trust, Charity, etc.)*	Relationship	Social Security or Taxpayer Identification Number	Date of Birth or Trust Date

Street Address	City	State	Zip Code

( ) Phone Number *(Optional)*

C **Signatures and Consent** *(Signatures must be on the lines provided.)*

Participant Consent for Beneficiary Designation *(Please sign on the 'Participant Signature' line below.)*

I have completed, understand and agree to all pages of this Beneficiary Designation form. Subject to and in accordance with the terms of the Plan, I am making the above beneficiary designations for my vested account in the event of my death. If I have more than one primary beneficiary, the account will be divided as specified. If a primary beneficiary predeceases me, his or her benefit will be allocated to the surviving primary beneficiaries. Contingent beneficiaries will receive a benefit only if there is no surviving primary beneficiary, as specified. If a contingent beneficiary predeceases me, his or her benefit will be allocated to the surviving contingent beneficiaries. If I fail to designate beneficiaries, amounts will be paid pursuant to the terms of the Plan or applicable law. This designation is effective upon execution and delivery to Service Provider. If any information is missing, additional information may be required prior to recording my designation.

This designation supersedes all prior designations. Beneficiaries will share equally if percentages are not provided and any amounts unpaid upon death will be divided equally. **Primary and contingent beneficiaries must separately total 100%. The percentages can be divided up to two decimal points (Example: 33.33%).**

I understand that Service Provider is required to comply with the regulations and requirements of the Office of Foreign Assets Control, Department of the Treasury ("OFAC"). As a result, Service Provider cannot conduct business with persons in a blocked country or any person designated by OFAC as a specially designated national or blocked person. For more information, please access the OFAC website at: http://www.treasury.gov/about/organizational-structure/offices/Pages/Office-of-Foreign-Assets-Control.aspx.

Important Notice: If I am married and I elect a primary beneficiary other than my spouse or in addition to my spouse, my spouse must consent by signing the Spousal Consent for Beneficiary Designation section of this form.

Any person who presents a false or fraudulent claim is subject to criminal and civil penalties.

Participant Signature _____ **Date *(Required)*** _____

A handwritten signature is required on this form. An electronic signature will not be accepted and will result in a significant delay.

Alaska Gateway School District - *Employee Technology Use Agreement*

User name, (Printed):_____

I, the undersigned, understand that the use of district technology and accounts is necessary for the completion of most district jobs. I also understand that use of district technology is a privilege that comes with responsibilities. If this privilege is lost due to failure to follow established rules and policies, it may leave me unable to adequately fulfill my job duties. I understand that there is no expectation of privacy with district accounts or devices, and that the district has the right to review the contents of my district accounts or devices at any time, including sent and received email.

1. I will keep my passwords and accounts secure. *Do not share your accounts or passwords with anyone else, ever. You will be held responsible for anything that is traced back to your account.*
2. I will not dismantle, abuse, or vandalize District equipment and hardware. *Repair costs to District equipment may be charged to staff if damage results from negligence or abuse.*
3. I will not attempt to access other people's files or accounts, or to bypass system security or guess passwords, including, but not limited to wireless, student data management, email or other account passwords. Attempting to gain unauthorized access to accounts, websites, or content hosting services outside of the district is also strictly prohibited. *If you become aware of a security problem, inform your supervisor.*
4. I will not intentionally disrupt, misuse, or waste District technology resources. *Academic use of resources has priority over all other uses. Bandwidth and computer resources should be utilized only for educational purposes during work hours. Chain letters and junk email are expressly prohibited. Posting to social media, image, audio, or video hosting sites during work time is strictly prohibited unless it is done for educational or school related purposes.*
5. I will not use District equipment or accounts to create, access, or transmit inappropriate material. *Inappropriate materials include web pages or files about pornography, gambling, illegal activities, or which are meant to intimidate or bully, or which includes personal information about students. It is also inappropriate to create or transmit material that slanderous or harassing in nature, or that is intended to discredit or disparage an individual, school, school district, organization, or business.*
6. I will not use devices, including but not limited to cell phones, (except during emergencies), or other image or audio capturing devices at school or my workplace, to capture images or recordings of students on school grounds or at school activities at any time, except with the express written approval of site and/or district administration. I will not disseminate or share the personal information of any other individual, including, but not limited to students.
7. I will not use technology to bully, or cyberbully anyone, and I will report any bullying or cyberbullying I see taking place to my supervisor. *Cyberbullying is using technology to harass, bully, embarrass, threaten, or target another person.*
8. I understand that violation of this agreement may result in consequences not limited to a loss of access to district technology and accounts, as well as reprimand, demotion, reassignment and/or dismissal, and may also lead to legal action.

While the District has installed Internet content filtering software, it is acknowledged that there is not, nor never will be, any system in existence which can absolutely guarantee that access to all inappropriate content on the Internet is blocked.

Persons not associated with the District must have written approval of the Superintendent or other designated person in order to receive access to the district computer system.

Signature of User: _____ Date: _____

District Approval: _____ Date: _____

ALASKA GATEWAY SCHOOL DISTRICT

SICK LEAVE BANK

_____ I hereby contribute to the Alaska Gateway School District Sick Leave Bank, one (1) sick leave day, thus meeting qualifications for membership in the bank.

Requests for withdrawals from the bank will be considered when the criteria outlined in the Negotiated Agreement have been met.

_____ I choose not to join the sick leave bank.

_____ _____

Member's signature Date

_____

Member's printed name

For Office use only

_____

_____daily rate (certified) _____hourly rate (classified) _____#hours

_____coding _____JE date and _____# entered

SCHOOL DISTRICT
P.O. BOX 226, TOK, AK 99780
907-883-5151
Fax: 907-883-5154

____ADD
____CHANGE
____CANCEL

AUTHORIZATION AGREEMENT FOR AUTOMATIC PAYROLL DEPOSIT

Use this form to begin, change, or cancel a direct deposit. A direct deposit requests net pay to be deposited into one account. **It is the employee's responsibility to make sure the financial institution will accept it.**

EMPLOYEE INFORMATION:

Name: _____Social Security#_____
Address: _____Location: _____
City: _____ State: _____Zip:_____

You are authorized and requested to pay the net amount of salaries or wages due me by credit to my account with the financial institution designated below. Please begin with pay for the next pay period and continue until cancelled by me in writing. I have attached a copy of a***deposit slip or****voided check** for this account as requested below. **A deposit returned because of a closed account or incorrect information provided by the employee will result in a delay in receiving their paycheck.**

FINANCIAL INSTITUTION INFORMATION:

Bank Name: _____ Account#_____
Address: _____*Transit/Routing#_____
City: _____ State: _____Zip: _____
Phone: _____ Bank Contact Name:_____

Signature of Employee:_____ Date:_____

***This number is shown on the bottom left side of your check blank. It may or may not be the same as the number on your deposit slip.**

Please select one of the following: ☐ **Checking Account** (**Attach copy of ****voided check**)
☐ **Savings Account** (**Attach copy of *deposit slip**)

Note: This form may not be processed unless accompanied by the above requested voided check or deposit slip.

PAYROLL DEPARTMENT USE ONLY
Pre-notification Completed_____
Actual date of first deposit will be_____

"Where Teachers Are The Gateway To Learning"

DotLake	Eagle	Mentasta	Northway	Tok	Tanacross	Tetlin
907-882-2663	907-547-2210	907-291-2327	907-778-2287	907-883-5161	907-883-4391	907-324-2104
Fax: 907-882-2112	Fax: 907-547-2302	Fax: 907-291-2325	Fax: 907-778-2221	Fax: 907-883-5165	Fax: 907-883-4390	Fax: 907-324-2114

Post Hire Questionnaire For Second Injury Fund Qualification

The purpose of this questionnaire is to preserve the Employer's right to obtain Second Injury Fund reimbursement if you suffer a work-related injury in employment. If the resulting disability is greater due to aggravation of a pre-existing condition, or because the injury combines with the pre-existing condition, the Employer may be able to obtain reimbursement from the Fund of some workers' compensation benefits paid to you. The completed questionnaire will be retained in your confidential medical file. You may update the information at any time.

Department_____

Name_____ Social Security No._____

Address_____ Date of Birth_____

_____ Telephone_____

Have you ever had, or do you now have, any of the following conditions? *Note: this list is derived from Alaska Statute 23.30.205. PLEASE COMPLETE BOTH COLUMNS.*

YES	NO		YES	NO	
____	____	EPILEPSY	____	____	DIABETES
____	____	MUSCULAR DYSTROPHY (any form)	____	____	HYPERINSULINISM
____	____	PARKINSON'S DISEASE	____	____	TUBERCULOSIS
____	____	POLIOMYELITIS residuals	____	____	LOSS OF SIGHT one or two eyes
____	____	CEREBRAL PALSY	____	____	VISION LOSS greater than 75% bilaterally, uncorrected
____	____	CEREBRAL VASCULAR ACCIDENT(Stroke)			
____	____	MULTIPLE SCLEROSIS	____	____	VARICOSE VEINS
____	____	CHRONIC OSTEOMYELITIS	____	____	THROMBPHLEBITIS
____	____	RUPTURED (HERNIATED) INTERVETEBRAL	____	____	ARTERIOSCLEROSIS
		DISC (SPINAL DISK OR H.N.P.)	____	____	CARDIAC DISEASE of any kind
____	____	ANKYLOSIS OF JOINTS (Fused joints)	____	____	SILICOSIS
____	____	OSTEOPOROSIS	____	____	COMPRESSED AIR SEQUELAE
____	____	ARTHRITIS of any kind	____	____	HEAVY METAL POISONING
____	____	SPONDYLOLISTHESIS	____	____	IONIZING RADIATION INJURY
____	____	HEMOPHILIA	____	____	AMPUTATION foot, leg, arm,hand

Have you ever had, or do you now have any condition, disease or injury which resulted in 200 weeks or more of inability to work? *The 200 weeks need not be continuous. If your answer is yes, please briefly describe the condition or injury.*_____

Have you ever had a permanent impairment rating, single or combined, of 35% of the whole person or greater? *If your answer is yes, please state the condition or injury(ies) which led to the rating.*_____

READ CAREFULLY, SIGN AND DATE:

I understand that the State is relying on me to be honest in my answers, and that concealment of a qualifying condition may result in the State having to pay more for workers' compensation benefits than it would if I had disclosed a qualifying condition. I have answered the above questions to the best of my knowledge. I understand that if I knowingly make a false statement regarding my physical condition, I may not receive Workers' Compensation benefits under AS 23.30, the Alaska Workers' Compensation Act. I understand that this information will be kept in my confidential medical file and will be used for workers' compensation purposes only.

Signed _____ Dated _____

Rev. May 2005

Health Questionnaire

Name **Position** **Social Security #**

PERSONAL MEDICAL HISTORY: Please mark answers to all questions. Have you ever had or have you ever been treated for:

Item		Y	N
1.	Amputated foot, leg, arm or hand		
2.	Ankylosis (fixation or fusion) of a joint		
3.	Arteriosclerosis (hardening arteries)		
4.	Arthritis		
5.	Asbestosis		
6.	Asthma/Bronchitis/Chronic Obstructive pulmonary disease		
7.	Back or Neck Injury		
8.	Cardiac (Heart) Disease		
9.	Carpal Tunnel Syndrome		
10.	Cerebal Palsy		
11.	Cerebal Vascular Accident (stroke)		
12.	Chronic Osteomyelitis (bone infection)		
13.	Compressed Air Sequelae		
14.	Diabetes		
15.	Dizzy Spells or Fainting		
16.	Epilepsy		
17.	Head Injury or Loss of Consciousness		
18.	Heart Problems or Conditions		
19.	Heavy Metal Poisoning		
20.	Hemophilia		
21.	Hernia		
22.	Hyperinsulinism (excessive insulin)		
23.	Hypertension (High Blood Pressure)		
24.	Ionizing radiation injury		
25.	Joint Injury/Joint Pain/Joint Stiffness		
26.	Kidney Disease		

Item		Y	N
27.	Loss of sight of one or both eyes or a partial loss of uncorrected vision of more than 75% bilaterally		
28.	Lung of Breathing Problems of Diseases		
29.	Multiple Sclerosis		
30	Muscular Dystrophy		
31.	Osteoporosis (thinning of bones)		
32.	Parkinson's Disease		
33.	Residuals disability from Polio		
34.	Ruptured Intervertebral Disc or Herniated Disc in your Back or Neck		
35.	Silicosis (a lung disease)		
36.	Spondylolisthesis		
37.	Thrombophlebitis (a vein with blood clot)		
38.	Tuberculosis		
39.	Varicose Veins		
40.	Whole/partial loss of hearing		
41.	Have you ever been hospitalized?		
42.	Have you ever had or been advised to have surgery?		
43.	In the lat 30 days have you taken any medication or drugs, prescription or nonprescription?		
44.	Have you ever been advised by a physical or medical provider to limit your physical activities in any way?		
45.	Have you treated with a health professional for any condition in the last five years?		

Employer does not discriminate in hiring, promotion or retention policies or practices against persons who have or have had disabilities, impairment or medical conditions. Employer does and will consider

employee's safety practices and mental and physical ability to carry out the essential duties of the position.

If the answer to **any** of the previous questions is marked "yes", complete the following:

Item #	Further Explanation of Medical Condition or Injury	Year Diagnosed	Treating Physician Name & Address	Description of any physcial limitations due to medical condition and restrictions or ever recommended by a physician.

EMPLOYMENT DISCLOSURE

Alaska state law, AS 23.30.022, provides:
An employee who knowingly makes a false statement as to the employee's physical condition on a medical inquiry or exam may not receive benefits under the Alaska Workers' Compensation Act if:

1. The employer relied upon the false reprensentation and this reliance was a substantial factor in hiring, and;
2. There was a casual connection between the false representation and inquiry to the employees.

This means that if you lie about your physical/mental condition on the employment application or employment questionnaire and you are injured on the job, you may lose your right to collect workers' compensation benefits if you have a work-related injury.

ACKNOWLEDGMENT

I understand the importance of answering this questionnaire completely and accurately. I understand that any misrepresentation or omission of facts may result in denial of workers' compensation benefits. I further understand that the employer will rely on my answers, and that any misrepresentations or omission of facts will be considered by the employer to be a serious matter justifying termination or other adverse action, consistent with the law.

_____ _____

Employee Signature Date Signed

MAKE IN DUPLICATE
1 COPY TO SCHOOL DISRICT
1 COPY TO DOCTOR'S FILE

TO: Alaska Gateway School District
P.O. Box 226
Tok, Alaska 99780

DOCTOR'S CERTIFICATION

_____

Applicant/Employee's Name

I have examined the above named applicant/employee and :

( ) 1. Declare him/her physically and mentally ready for employment

( ) 2. Declare him/her unfit for employment on the basis of physical and/or mental deficiency.

( ) 3. Recommend the applicant have a follow-up examination as indicated:

_____

( ) 4. Recommend the following procedures before approval can be given.

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

_____ _____

Date of examination Signature

Alaska Gateway School District

MEDICAL HISTORY
(To be completed by Examinee)

Name:_____ Age:_____ Marital Status:_____
School:_____ Position:_____

A. Do you have any impairment of:
Hearing? Yes ___ No ___ Breathing? Yes _____ No _____
Vision? Yes ___ No ___ If Yes, do you wear glasses? Yes _____ No _____

B. Do you have
Sever recurrent headaches? Yes _____ No _____
Chronic colds or sore throat? Yes _____ No _____
A thyroid disorder? Yes _____ No _____
A heart condition or abnormal blood pressure? Yes _____ No _____
A respiratory problem (including asthma and/or tuberculosis)? Yes _____ No _____
A digestive problem (including ulcer, a gallbladder condition, colitis, or hemroids)? Yes _____ No _____
Arthritis? Yes _____ No _____
Excessive fatigue? Yes _____ No _____
Any other medical condition which would affect your capacity to perform your work? Yes _____ No _____

Explain: _____
_____

C. Have you had any illness or injury which has left you with residual disability? Yes _____ No _____

D. Do you have any allergies? Yes _____ No _____

Explain: _____
_____

E. Please list any important operations you have had: Yes _____ No _____

Date	Nature of Operation
_____	_____
_____	_____
_____	_____

F. Most recent chest x-ray? _____ (Date) _____ (Result)

G. Immunizations:

Diphtheria:	(Date)	_____	Smallpox:	(Date)	_____
Tetanus:	(Date)	_____	Polio:	(Date)	_____
Typhoid:	(Date)	_____	Measles:	(Date)	_____

The information above is complete and true to the best of my knowledge. I authorize release of the above information and the physical examination findings to the Commissioner Department of Education.

_____
(Signature of Applicant)

PART II. MEDICAL EXAMINATION

A. GENERAL

Height: _____ **Weight:** _____ **Pulse:** _____ **Blood Pressure:** _____

DOCTOR: If condition is satisfactory for intended employment, signify by checking each item. If unsatisfactory, please specify at end of section.

Ears	_____	Heart	_____
Eyes	_____	Lungs	_____
Nose and sinuses	_____	Abdomen	_____
Mouth and Teeth	_____	Hernia	_____
Throat	_____	Back	_____
Neck	_____	Extremities	_____
Chest Breast	_____	Psychiatric	_____

Abnormalities: _____

_____

_____

B. LABORATORY STUDIES

Chest X-ray: (Date) _____ Within normal limits _____ Abnormal _____

If abnormal, specify: _____

Urinalysis: (Date) _____ Within normal limits _____ Abnormal _____

If abnormal, specify: _____

Serology: (Date) _____ Non-reactive _____ Positive _____

C. IMMUNIZATIONS
(If Administered)

Diphtheria	(Date) _____	Smallpox	(Date) _____
Measles	(Date) _____	Polio	(Date) _____
Tetanus	(Date) _____	Typhoid	(Date) _____

Great-West RETIREMENT SERVICES®

AdvisedAssetsGroup
Put Our Power Behind You℠

PERS/TRS Defined Contribution Retirement Plan

Dear Plan Participant,

Welcome to the PERS/TRS Defined Contribution Retirement Plan. **As part of the Plan, you will be automatically enrolled in the new Reality Investing℠ Managed Account service on your first payroll period.**

Managed Accounts: Diversified, Personalized, Simplified

With the Managed Account service, provided by Advised Assets Group, LLC (AAG), a highly experienced and qualified investment advisory firm selects an asset allocation model based on the investment options available within your Plan–in essence, managing your retirement account for you. Your portfolio is tailored to fit your unique retirement goals and financial situation. Each quarter, your account will undergo analysis to determine whether any adjustments are needed to keep you on course and assist you with your financial future. Any adjustments then occur automatically.

Put a Team of Professionals on Your Side

AAG, a wholly owned subsidiary of Great-West Life & Annuity Insurance Company, has teamed up with Ibbotson Associates, a recognized leader in asset allocation and investment analytics tools, to offer you a portfolio designed for diversification over time. AAG acts as your investment manager and adviser, and Ibbotson Associates supplies the portfolio management methodology and technology.

Keeping Us Informed, Keeping You Involved

You will receive a Managed Account Welcome Kit at your home within 15 business days after your first pay period which will describe the investment options in your Plan that AAG and Ibbotson are using for your account, as well as your overall asset allocation strategy. In the Welcome Kit, we ask you to review the information that was used to assign your portfolio and to contact AAG with any changes or additional information. Remember, AAG and Ibbotson uses information provided by your employer to process your Managed Account enrollment. If this information is inaccurate, please let us know immediately. Similarly, as your retirement goals and financial status change over time, your allocation strategy should follow suit. Each year, you'll receive a document around the time of your birthday that lists the information being used to manage your account. If your goals and finances have changed, there will be a form enclosed that you can use to initiate the appropriate changes in your account. You can also update your information at any time, in whichever way is most convenient for you—via phone, mail or through your Plan Web site.

(over)

ADVISED ASSETS GROUP, LLC
Advisory Services Agreement

Please read the following terms and conditions carefully before using or enrolling in any of the services described below. Your use of any service will signify your consent to be bound by the terms and conditions set forth in this Agreement.

Automatic Enrollment into Managed Accounts

Once your payroll information has been received by the record keeper, you will be automatically enrolled in the Managed Accounts feature provided by Advised Assets Group, LLC. Please read the following terms and conditions for the Managed Accounts service provided below. You will have 60 days from your enrollment date to review the service at no charge. If you determine you wish to opt out of the Managed Account feature in favor of one of the other two financial advice or assistance features, you may do so at any time. However, if you have not opted out of Managed Accounts before the 60 day free view period has elapsed, you will be charged for this service on a quarterly basis.

Fees for the Service

Fees for each service are shown below. The fees are assessed on a quarterly basis and the chart below reflects the quarterly and annually fee amount.

Guidance	Quarterly Fee	Annual Fee
	No Fee	No Fee

Advice	Quarterly Fee	Annual Fee
	$6.25	$25

Managed Accounts	Quarterly Fee	Annual Fee
Participant Account Balance		
<$100,000	0.125%	0.50 %
Next $150,000	0.10%	0.40 %
Next $150,000	0.075%	0.30 %
>$400,000	0.05%	0.20 %

For example, if your account balance subject to Managed Accounts is $50,000, the maximum annual fee is 0.50 % of the account balance. The amount collected quarterly would be 0.125% based upon your account balance on the day of fee assessment as described above. If your account balance subject to Managed Accounts is $500,000, the first $100,000.00 will be subject to a maximum annual fee of 0.50 % (quarterly 0.125%), the next $150,000 will be subject to a maximum annual fee of 0.40 % (0.10%), the next $150,000 will be subject to a maximum annual fee of 0.30 % (0.075%), and any amounts over $400,000 will be subject to a maximum annual fee of 0.20 % (0.05%). All fees are assessed on a quarterly basis. For example, the maximum quarterly fee for an account balance less than $100,000 (subject to maximum annual fee of 0.50%) would be 0.125% as demonstrated above.

The fees for Advice and Managed Accounts will generally be debited from your account within the last five (5) to seven (7) business days of each quarter; however, if you cancel participation in Managed Account Investor, the fee will be based on your account balance on the date of cancellation and will be debited from your account within five (5) to seven (7) business days of the cancellation date. Use

INDEMNIFICATION

You agree to indemnify, defend and hold harmless AAG and its officers, directors, shareholders, parents, subsidiaries, affiliates, employees, consultants, agents and licensors from and against any and all third party claims, liability, damages and/or costs (including but not limited to reasonable attorneys' fees) arising from your failure to comply with this Agreement, the information you provide us, your infringement of any intellectual property or other right of a third party, or from your violation of applicable law.

DESCRIPTION OF SERVICES

Your plan sponsor has agreed to make the below services offered by AAG available to you. **New participants are automatically enrolled in the Managed Account Investor Service but can choose to opt out in favor of any of the other services offered.** AAG offers the following investment advisory services; guidance, advice, and managed accounts through Advisory Services:

On-Line Investment Guidance: The On-Line Guidance Investor is geared toward participants who wish to manage their own retirement accounts. Participants are provided access to on-line guidance tools.

On-Line Advice Investor: On-Line Advice Investor is geared toward participants who wish to manage their own retirement plans while taking advantage of on-line guidance and investment advice. You are provided on-line guidance and investment advice for a personalized recommended investment portfolio. The recommended investment portfolio is based on information drawn from your Plan account profile and from the investment options available in your Plan. You may then implement the recommended investment portfolio and manage your retirement account on-line. AAG does not provide advice for, or recommend allocations of, individual stocks (including employer stock), self-directed brokerage accounts, guaranteed certificate funds, or employer-directed monies.

Managed Account Investor: Managed Account Investor is geared toward participants who wish to have a qualified financial expert select among the available investment options and manage their retirement accounts for them. You will receive a personalized investment portfolio that reflects your Plan investment options and your retirement timeframe, life stages and overall financial picture, including assets held outside the Plan (if you elect to provide this information), which may be taken into consideration when determining the allocation of assets in your Plan account (AAG will not provide advice for, recommend allocations of, or manage your outside or non-Plan assets). Under the Managed Account Investor service, AAG has discretionary authority over allocating your assets among the core investment options, without your prior approval of each transaction. AAG is not responsible for either the selection or maintenance of the investment options available within your Plan. AAG does not provide advice for, or recommend allocations of, individual stocks (including employer stock), self-directed brokerage accounts, guaranteed certificate funds, or employer-directed monies. Your balances in any of these investment options or vehicles may be liquidated, subject to your Plan's and/or investment provider's restrictions.

Managed Account Investor account assets in the Plan's core investment options will be automatically monitored, rebalanced and reallocated every quarter by AAG, based on data resulting from the methodologies and software employed by the Independent Financial Expert, to respond to market performance and to ensure optimal account performance over time. You will receive an account update and forecast statement annually and can update your personal information at any time by calling AAG at your Plan's existing toll-free customer service number or by visiting your Plan's web site.

thereof or of any prior or subsequent breach of this Agreement by you, nor shall the exercise of any such right or remedy preclude any other or future exercise thereof or exercise of any other right or remedy in connection with this Agreement. Any waiver must be in writing and signed by AAG. All terms and provisions of this Agreement, including without limitation "Disclaimers," "Limitation of Liability," "Indemnification," "Intellectual Property," and "Privacy Policy," which should by their nature survive the termination of this Agreement, shall so survive. This Agreement will automatically terminate upon termination of your Plan's agreement with AAG, or upon termination of your Plan's service agreement with Great-West. Nothing in this Agreement shall be construed to waive compliance with the Advisors Act, ERISA, or any applicable rule or order of the Department of Labor under ERISA. AAG shall not be liable for any delay or failure to perform its obligations hereunder if such delay or failure is caused by an unforeseeable event beyond its reasonable control, including without limitation: act of God; fire; flood; earthquake; labor strike; sabotage; fiber cut; embargoes; power failure; lightning; supplier's failures; act or omissions of telecommunications common carriers; material shortages or unavailability or other delay in delivery; government codes, ordinances, laws, rules, regulations or restrictions; war or civil disorder, or acts of terrorism. AAG reserves the right to modify this Agreement at any time. You agree to review this Agreement periodically so that you are aware of any such modifications. Your continued participation in Advisory Services shall be deemed to be your acceptance of the modified terms of this Agreement. This Agreement shall inure to the benefit of AAG's successor and assigns.

INTELLECTUAL PROPERTY

All content provided as part of Advisory Services, including without limitation names, logos, methodologies, and news or information provided by third parties, is protected by copyrights, trademarks, service marks, patents, or other intellectual property and proprietary rights and laws ("Intellectual Property") and may constitute trade secrets, as defined by applicable law. All such Intellectual Property is the property of their respective owners and no rights or licenses are granted to you as a result of your participation in Advisory Services.

PRIVACY POLICY

AAG protects your privacy. We have strict policies in place to keep your personal information private. A summary of AAG policies and procedures to protect the privacy and security of your personal information is set forth below.

Types of Information We Collect. AAG collects personal information about you from your plan sponsor or employer, from applications or other forms that you complete, from your plan or service provider, and from our affiliates you have conducted business with. Such information includes without limitation, your name, address, age, salary, number of dependents, plan account balances and contributions. You may provide us with additional personal information about your investments and preferences at any time. We also keep records of all transactions in your account and any communications about your account.

Security of Your Information. We have strict procedures to protect your privacy. They include physical, administrative, and technical safeguards.

Access to Information. The only employees who have access to your personal information are those who need it to service your account, or to provide you with products or services.

Ibbotson Associates, founded by Professor Roger Ibbotson in 1977, is a leading authority on asset allocation, providing products and services to help investment professionals obtain, manage and retain assets. The company's business lines include investment consulting and research, planning and analysis software, wealth forecasting, educational services and a widely used line of NASD-reviewed presentation materials.

With offices in Chicago, New York and Tokyo, Ibbotson Associates markets its integrated product line to institutional money managers, insurance companies, plan sponsors and consultants, financial planners, brokers, mutual fund firms, hedge funds, banks and small money managers.

AAG reserves the right to replace the Independent Financial Expert in its sole discretion and without your approval. AAG will notify you of any fee changes resulting from the Independent Financial Expert being replaced. In the event AAG terminates its relationship with the current Independent Financial Expert and is unable to contract with a suitable replacement Independent Financial Expert, this Agreement shall automatically terminate upon written notice from AAG.

ACCEPTANCE OF TERMS AND CONDITIONS OF ADVISORY SERVICES AGREEMENT

Your plan sponsor has agreed to make all services listed in this agreement available to you.

If you agree to the terms and conditions set forth herein, you will be enrolled the service you requested that is offered under Advisory Services. Your acceptance of the terms and conditions shall signify your consent to be bound by the applicable provisions of this Agreement, as they relate to the Online Investment Guidance, Online Investment Advice, or Managed Account services. Please note that upon enrollment in the Managed Account service, any currently initiated transfers or transactions will be cancelled, unless the market has already closed for the day.

If you do not agree to the terms and conditions set forth herein, you will not be enrolled the service you requested that is offered under Advisory Services.

Cancellation at Any Time

If you do not want the Managed Account service, you can opt out within the first sixty (60) days and your fees will be refunded to you. However, please note that any losses that may have occurred from the investment performance are not refundable. You can cancel the service at any time via the phone number below or the participant web site at www.gwrs.com. Reality Investing also offers Online Guidance and Online Advice (there is a fee for the Online Advice) services. Go to www.state.ak.us/drb for more information.[1] *Please consider the investment objectives, risks, fees and expenses carefully before investing. For this and other important information you may obtain prospectuses for mutual funds, any applicable annuity contract and the annuity's underlying funds and/or disclosure documents from your registered representative. Read them carefully before investing.*

Creating Peace of Mind

You can rest easy knowing that a leading investment advisory firm regularly monitors and adjusts your account for the optimal diversification to help make your retirement dreams a reality. Please keep the attached Terms of Service for your records.

If you have any questions or need more information, call us toll free at (800) 232-0859 (option 3) and ask to speak to an AAG Adviser Representative (extension 41066).

By signing below, I acknowledge that I have received and read the enclosed information and agree to the terms and conditions set forth herein.

_____ _____

Signature Date

_____ _____

Print Name Social Security Number

Original to be returned to:
Alaska Division of Retirement and Benefits
P.O. Box 110203
Juneau, AK 99811-0203

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1 Access to KeyTalk® and the Web site may be limited or unavailable during periods of peak demand, market volatility, systems upgrades/maintenance, or other reasons.

Form W-4 (2017)

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. If you are exempt, complete **only** lines 1, 2, 3, 4, and 7 and sign the form to validate it. Your exemption for 2017 expires February 15, 2018. See Pub. 505, Tax Withholding and Estimated Tax.

Note: If another person can claim you as a dependent on his or her tax return, you can't claim exemption from withholding if your total income exceeds $1,050 and includes more than $350 of unearned income (for example, interest and dividends).

Exceptions. An employee may be able to claim exemption from withholding even if the employee is a dependent, if the employee:

- Is age 65 or older,
- Is blind, or
- Will claim adjustments to income; tax credits; or itemized deductions, on his or her tax return.

The exceptions don't apply to supplemental wages greater than $1,000,000.

Basic instructions. If you aren't exempt, complete the **Personal Allowances Worksheet** below. The worksheets on page 2 further adjust your withholding allowances based on itemized deductions, certain credits, adjustments to income, or two-earners/multiple jobs situations.

Complete all worksheets that apply. However, you may claim fewer (or zero) allowances. For regular wages, withholding must be based on allowances you claimed and may not be a flat amount or percentage of wages.

Head of household. Generally, you can claim head of household filing status on your tax return only if you are unmarried and pay more than 50% of the costs of keeping up a home for yourself and your dependent(s) or other qualifying individuals. See Pub. 501, Exemptions, Standard Deduction, and Filing Information, for information.

Tax credits. You can take projected tax credits into account in figuring your allowable number of withholding allowances. Credits for child or dependent care expenses and the child tax credit may be claimed using the **Personal Allowances Worksheet** below. See Pub. 505 for information on converting your other credits into withholding allowances.

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 may owe additional tax. If you have pension or annuity income, see Pub. 505 to find out if you should adjust your withholding on Form W-4 or W-4P.

Two earners or multiple jobs. If you have a working spouse or more than one job, figure the total number of allowances you are entitled to claim on all jobs using worksheets from only one Form W-4. Your withholding usually will be most accurate when all allowances are claimed on the Form W-4 for the highest paying job and zero allowances are claimed on the others. See Pub. 505 for details.

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

Check your withholding. After your Form W-4 takes effect, use Pub. 505 to see how the amount you are having withheld compares to your projected total tax for 2017. See Pub. 505, especially if your earnings exceed $130,000 (Single) or $180,000 (Married).

Future developments. Information about any future developments affecting Form W-4 (such as legislation enacted after we release it) will be posted at *www.irs.gov/w4*.

Personal Allowances Worksheet (Keep for your records.)

A	Enter "1" for **yourself** if no one else can claim you as a dependent	**A** ____
B	Enter "1" if: • You're single and have only one job; or • You're married, 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.	**B** ____
C	Enter "1" for your **spouse.** But, you may choose to enter "-0-" if you are married and have either a working spouse or more than one job. (Entering "-0-" may help you avoid having too little tax withheld.)	**C** ____
D	Enter number of **dependents** (other than your spouse or yourself) you will claim on your tax return	**D** ____
E	Enter "1" if you will file as **head of household** on your tax return (see conditions under **Head of household** above)	**E** ____
F	Enter "1" if you have at least $2,000 of **child or dependent care expenses** for which you plan to claim a credit (**Note:** Do **not** include child support payments. See Pub. 503, Child and Dependent Care Expenses, for details.)	**F** ____
G	**Child Tax Credit** (including additional child tax credit). See Pub. 972, Child Tax Credit, for more information. • If your total income will be less than $70,000 ($100,000 if married), enter "2" for each eligible child; then **less** "1" if you have two to four eligible children or **less** "2" if you have five or more eligible children. • If your total income will be between $70,000 and $84,000 ($100,000 and $119,000 if married), enter "1" for each eligible child.	**G** ____
H	Add lines A through G and enter total here. (**Note:** This may be different from the number of exemptions you claim on your tax return.) ▶	**H** ____

For accuracy, complete all worksheets that apply.

- If you plan to **itemize** or **claim adjustments to income** and want to reduce your withholding, see the **Deductions and Adjustments Worksheet** on page 2.
- If you are **single and have more than one job** or are **married and you and your spouse both work** and the combined earnings from all jobs exceed $50,000 ($20,000 if married), see the **Two-Earners/Multiple Jobs Worksheet** on page 2 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 below.

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

Form **W-4**
Department of the Treasury
Internal Revenue Service

Employee's Withholding Allowance Certificate

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

OMB No. 1545-0074

2017

1	Your first name and middle initial	Last name	**2** Your social security number
	Home address (number and street or rural route)	**3** ☐ Single ☐ Married ☐ Married, but withhold at higher Single rate. **Note:** If married, but legally separated, or spouse is a nonresident alien, check the "Single" box.	
	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 1-800-772-1213 for a replacement card.** ▶ ☐	
5	Total number of allowances you are claiming (from line **H** above **or** from the applicable worksheet on page 2)		**5**
6	Additional amount, if any, you want withheld from each paycheck		**6** $
7	I claim exemption from withholding for 2017, and I certify that I meet **both** of the following conditions for exemption. • 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 ▶		**7**

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 lines 8 and 10 only if sending to the IRS.)	**9** Office code (optional)	**10** Employer identification number (EIN)

Employment Eligibility Verification

Department of Homeland Security
U.S. Citizenship and Immigration Services

USCIS
Form I-9
OMB No. 1615-0047
Expires 08/31/2019

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

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

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

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

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

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

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

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

☐ 1. A citizen of the United States

☐ 2. A noncitizen national of the United States *(See instructions)*

☐ 3. A lawful permanent resident (Alien Registration Number/USCIS Number): _____

☐ 4. An alien authorized to work until (expiration date, if applicable, mm/dd/yyyy): _____
Some aliens may write "N/A" in the expiration date field. *(See instructions)*

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

1. Alien Registration Number/USCIS Number: _____
OR
2. Form I-94 Admission Number: _____
OR
3. Foreign Passport Number: _____
Country of Issuance: _____

QR Code - Section 1
Do Not Write In This Space

Signature of Employee	Today's Date *(mm/dd/yyyy)*

Preparer and/or Translator Certification (check one):

☐ I did not use a preparer or translator. ☐ A preparer(s) and/or translator(s) assisted the employee in completing Section 1.
(Fields below must be completed and signed when preparers and/or translators assist an employee in completing Section 1.)

I attest, under penalty of perjury, that I have assisted in the completion of Section 1 of this form and that to the best of my knowledge the information is true and correct.

Signature of Preparer or Translator	Today's Date *(mm/dd/yyyy)*

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

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

STOP *Employer Completes Next Page* STOP

Employment Eligibility Verification

Department of Homeland Security
U.S. Citizenship and Immigration Services

USCIS
Form I-9
OMB No. 1615-0047
Expires 08/31/2019

Section 2. Employer or Authorized Representative Review and Verification

(Employers or their authorized representative must complete and sign Section 2 within 3 business days of the employee's first day of employment. You must physically examine one document from List A OR a combination of one document from List B and one document from List C as listed on the "Lists of Acceptable Documents.")

Employee Info from Section 1	Last Name *(Family Name)*	First Name *(Given Name)*	M.I.	Citizenship/Immigration Status

List A — **Identity and Employment Authorization**

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

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

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

OR

List B — **Identity**

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

AND

List C — **Employment Authorization**

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

Additional Information

QR Code - Sections 2 & 3
Do Not Write In This Space

Certification: I attest, under penalty of perjury, that (1) I have examined the document(s) presented by the above-named employee, (2) the above-listed document(s) appear to be genuine and to relate to the employee named, and (3) to the best of my knowledge the employee is authorized to work in the United States.

The employee's first day of employment *(mm/dd/yyyy)*: _____ ***(See instructions for exemptions)***

Signature of Employer or Authorized Representative	Today's Date *(mm/dd/yyyy)*	Title of Employer or Authorized Representative

Last Name of Employer or Authorized Representative	First Name of Employer or Authorized Representative	Employer's Business or Organization Name

Employer's Business or Organization Address (Street Number and Name)	City or Town	State	ZIP Code

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

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

C. If the employee's previous grant of employment authorization has expired, provide the information for the document or receipt that establishes continuing employment authorization in the space provided below.

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

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

Signature of Employer or Authorized Representative	Today's Date *(mm/dd/yyyy)*	Name of Employer or Authorized Representative

LISTS OF ACCEPTABLE DOCUMENTS
All documents must be UNEXPIRED

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

LIST A Documents that Establish Both Identity and Employment Authorization	OR	LIST B Documents that Establish Identity	AND	LIST C Documents that Establish Employment Authorization
1. U.S. Passport or U.S. Passport Card		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		1. A Social Security Account Number card, unless the card includes one of the following restrictions: (1) NOT VALID FOR EMPLOYMENT (2) VALID FOR WORK ONLY WITH INS AUTHORIZATION (3) VALID FOR WORK ONLY WITH DHS AUTHORIZATION
2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551)		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		2. Certification of report of birth issued by the Department of State (Forms DS-1350, FS-545, FS-240)
3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa		3. School ID card with a photograph		3. Original or certified copy of birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal
4. Employment Authorization Document that contains a photograph (Form I-766)		4. Voter's registration card		4. Native American tribal document
5. For a nonimmigrant alien authorized to work for a specific employer because of his or her status: a. Foreign passport; and b. Form I-94 or Form I-94A that has the following: (1) The same name as the passport; and (2) An endorsement of the alien's nonimmigrant status as long as that period of endorsement has not yet expired and the proposed employment is not in conflict with any restrictions or limitations identified on the form.		5. U.S. Military card or draft record		5. U.S. Citizen ID Card (Form I-197)
		6. Military dependent's ID card		6. Identification Card for Use of Resident Citizen in the United States (Form I-179)
		7. U.S. Coast Guard Merchant Mariner Card		7. Employment authorization document issued by the Department of Homeland Security
		8. Native American tribal document		
		9. Driver's license issued by a Canadian government authority		
		For persons under age 18 who are unable to present a document listed above:		
		10. School record or report card		
		11. Clinic, doctor, or hospital record		
		12. Day-care or nursery school record		
6. Passport from the Federated States of Micronesia (FSM) or the Republic of the Marshall Islands (RMI) with Form I-94 or Form I-94A indicating nonimmigrant admission under the Compact of Free Association Between the United States and the FSM or RMI				

Examples of many of these documents appear in Part 13 of the Handbook for Employers (M-274).

Refer to the instructions for more information about acceptable receipts.