New Hire Packet and Required Documents Checklist

NOTE: Incomplete packets will not be processed unless approved by GME office beforehand. Additionally, ALL House Officers must be issued a license/permit by the LSBME to begin training.

Name: John Q. Smith, MD **Program:** Medicine - Internal Medicine

HO Level: HO 1 **Appointment Date:** 7/1/2024 **PS Work Location #:** 449-64-0001

Academic Year Appointment Electronic Forms/Submissions:

Due May 31

Submitted House Officer Agreement (Contract) [a]

_____ Annual TB Test and supporting documents [b]

New Hire Electronic Forms:

Electronically sent to House Officer's LSU email address. To be initiated by GME Office on May 15th. Due June 15th.

Submitted FCVS Release Form

Submitted LSBME Release Form

Submitted House Officer Moonlighting Form

Submitted Health Requirement Worksheet and supporting documents

Submitted COVID Release Form

Submitted House Officer Manual Form

New Hire Packet:

Due ASAP but no Later than May 31st. Attach and label documents in the following order

✓ **GME-1** - This Checklist

✓ **GME-2** - GME Data Sheet

Human Resource Management New Hire Documents:

✓ **PER 2** - Personnel Form (Signed by Business Manager)

✓ **HR-1** - Biographical data form (Must include College & Medical School Info & Graduation dates)

✓ **HR-2**[c] - Background Check clearance email (Must be dated prior to appointment/start date)

✓ **HR-3**[c] - Drug Screen clearance email notification (Must be dated prior to appointment/start date)

✓ **HR-4** - Drug Screen: Drug Screening Instructions (Must be signed by house officer)

✓ **HR-5** - Drug Screen: Agreement to submit to Drug/Alcohol Testing Form

N/A **HR-6A** - Alien Tax Information Request (Only Non-US Citizens)

N/A **HR-7A**[c] - Alien / Foreign National Identification Documents:

- N/A J-1Visa[d] or Permanent Resident Card (Green Card)
- N/A DS 2019 (if on J-1 Visa)
- N/A Foreign Passport
- N/A I-94

✓ **HR-8** - Oath of Affirmation

✓ **HR-9** - W-4 Form

✓ **HR-10** - L-4 Form

✓ **HR-11** - Act 372 – Selective Service Registration

✓ **HR-12** - Data Protection Form

✓ **HR-13** - Direct Deposit with Voided Check

✓ **HR-14** - Veteran Self-Identification

✓ **HR-15** - Disability Self-Identification

✓ **HR-16** - Copy of Social Security Card (Signed by employee; copy needed for HRM benefits)

Additional Documents Due to GME:

May be included in New Hire Packet or submitted separately

_____ Medical School Graduation Certificate/Diploma [c]

N/A ECFMG Certificate (if applicable) [c]

N/A Internship completion Certificate/Diploma (if applicable) [c]

N/A Residency completion Certificate/Diploma (if applicable) [c]

a This document will be electronically initiated by Residency Program Coordinator

b These documents must be electronically submitted at https://www.medschool.lsuhsc.edu/medical_education/graduate/fileSubmission/

c These documents (HR-2, HR-3, HR-7A, HR-14) must be manually labeled in the bottom left hand corner with the correct document number

d Canadian citizens on J-1 Visas will not have a physical visa document

Revised March 2024

Errors and items to check/verify

New Hire Packet Checklist

Instructions: Each entry listed in this box on each page should be double-checked by the coordinator. The headings indicate who is responsible for entering/completing the relevant section of the forms. Headings are highlighted with the color matching the highlighted form sections above.

Program Coordinator – Please check each individual item as you attach it to this checklist. All items in the New Hire Packet should be checked off when submitted to the GME Office. The Appointment Packet and Additional Documents may be included in this packet, and relevant items should be checked if included.

LSU Health NEW ORLEANS

GME Data Sheet

Department: Medicine PS Location Code: 449-64-0001

Training Program Name: Internal Medicine

☑ Residency ☐ Fellowship House Officer Level: HO 1 Start Date: 7/1/2024 Expected Graduation: 6/30/2027

Name: Resident, John Quentin Sex: ✓ Male ____ Female
Last *First* *Middle*

Mailing Address: 2020 Imaginary Street Apartment D9 New Orleans, LA 70112 Type: Permanent Local

Cell Number: 504-599-1453 National Provider Identifier (NPI): 1234567890

Immigration Status: ✓ U. S. Citizen __Permanent Resident __J1 Visa Social Security Number: 999-88-7777

Citizenship: United States Place of Birth: New Orleans, LA USA

Date of Birth: 9/11/1991 Marital Status: ☑ S ☐ M ☐ W ☐ D Spouse's Name: _____

Race/Ethnicity: __Asian __Black/African American __Hispanic/Latino __Native American/Alaskan

__Native Hawaiian / Other Pacific Islander __Non-Hispanic/Latino ✓ White __ Other: _____

List Person to Contact in case of Emergency: Betty Brown

Relationship: Mother Telephone: 504-568-1234

This section MUST be completed or form will be returned

EDUCATION:

College: Tulane University City, State: New Orleans, LA

Dates Attended: 8/1/2016-5/1/2020 Degree: BS, Premed

Medical School: Tulane University School of Medicine City, State: New Orleans, LA

Dates Attended: 8/15/2020-5/30/2024 Degree: MD

Dental School: _____ City, State: _____

Dates Attended: - Degree: _____

FMGEM, ECFMG or NBMEE Number and Date: _____
(please provide us with a copy of your ECFMG Certificate)

John Q Resident

Signature

3/14/2024
Date

GME-2

SAMPLE

Revised May 2023

Errors and items to check/verify

GME Data Sheet

Resident – Check that form is completed and ensure that resident has signed and dated form.

LSU Health NEW ORLEANS

Name: John Quentin Resident

A continuous and inclusive list of internships, residencies, fellowships, staff positions, leave of absences, etc., must be provided from Medical School graduation through the current internship, residency or fellowship. Explain any gaps that are longer than 1 month—use additional copies of this page if necessary.

Beginning Date **(Month/Day/Year)**: 7/1/2024

End Date **(Month/Day/Year)**: 6/30/2027

Position/Status: Internal Medicine

Facility/Institution/Place Name: LSU School of Medicine

City/State/Country: New Orleans, LA

Beginning Date **(Month/Day/Year):** _____

End Date **(Month/Day/Year):** _____

Position/Status_____

Facility/Institution/Place Name _____

City/State/Country: _____

Beginning Date **(Month/Day/Year):** _____

End Date **(Month/Day/Year):** _____

Position/Status_____

Facility/Institution/Place Name _____

City/State/Country: _____

Beginning Date **(Month/Day/Year):** _____

End Date **(Month/Day/Year):** _____

Position/Status_____

Facility/Institution/Place Name _____

City/State/Country: _____

John Q Resident

Signature

3/14/2024

Date

SAMPLE

Errors and items to check/verify

GME Data Sheet (Page 2)

NOTE: Page 2 is not needed for incoming residents who are graduating from Medical School in May of this year.

Resident – Ensure all time is accounted for, from medical school graduation to current appointment. Current appointment should be listed first, and should go in reverse chronological order. **There should be no gaps in time**

Resident – Should be signed and dated.

Per 2

LSU HEALTH SCIENCES CENTER - NEW ORLEANS CAMPUS

Personnel Appointment (Per 2) Form

R. 12/17

1 *Effective Date* **7/1/2024** *Appt End Date* _____ *Last 4 digit SS#* 7777 *PS Pos#* **00012345**

2 *Name* **Resident** (Last) **John** (First) **Quentin** (Middle)

3 *Title* HOUSE OFFICER 1

4 *Appointment Track* _____ *Tenure Review Date* _____

5 *School/Division* Medicine *Dept.* Med-Comprehensive Medicine (IM-NO)

6 *Work Location* NO1492150 (PPS Dept. Code) 449-64-0001 (Location Code) 504-568-5600 (Phone) _____ (Parish)

7 *Educational level or college degrees, granted by month and year each received*

Degree	Institution	Date	Discipline	Personnel Coding: School	Deg.	Discipline
Medicl Doc	Tulane U of Louisiana	5/1/24	Medicine, General	002029	40	181001
Bachelor's	Tulane U of Louisiana	5/1/20	Pre-Medicine	002029	20	181801

8 *Percent of Effort* 100% *Empl ID* 0000000 N/A *I-9 Doc. attached* ☐ *Letter of offer attached*

9 *Remarks*

10 *SALARY AND DISTRIBUTION* *Base Rate of Pay* **19.71** Hourly *ON THE BASIS OF:* Fiscal Yr

Base Pay Compensation

Description	Dept.	Fund	Program	Class	Project/Grant/ Speed Type	Account	% Dist	Proposed Amount
Resident Suspense	1980003	911	99001	99100	9980000109	509899	100.000	57,706.00

Original

Total **$ 57,706.00** as of 1/2024

Signed Business Manager (Initiating Officer) 03/14/24 (Date) *Approved* _____ (Human Resources)

Approved _____ (Dean or Director) _____ (Date) *Approved* _____ (Vice Chancellor)

Approved _____ (Initials) _____ (Date) _____ (Initials) _____ (Date) *Approved* _____ (Chancellor)

Approved _____ (President)

GME - 3/14/2024

Errors and items to check/verify

Per 2

Program Coordinator –Last 4 SSN digits should be entered and checked against SS card and resident completed forms. If pending, write PENDING on form. Submit SS card ASAP when received.

Imported From New Innovations – Ensure that name matches legal name on identification documents submitted.

Program Coordinator –Medical degree **and** undergraduate degree (BS and MD) must both be entered. MBBS and other combined BS/MD type programs will only need one degree listed (only foreign schools do this). LSU BR code is 002010; LSUHSC is 002014.

Program Coordinator – Enter department phone number.

Business Manager – Per 2 should be signed.

LSU HEALTH SCIENCES CENTER – NEW ORLEANS BIOGRAPHICAL DATA FORM

1. Name: John Quentin Resident
2. SS#: XXX-XX- 7777
3b. Sex: M
3a. Race: ☐ American Indian/Alaskan Native ☐ Black/African American ☐ Native Hawaiian/Pacific Is. ☐ Asian ☑ White ☐ Other _____
4. Address: 2020 Imaginary Street Apartment D9
5. Home Phone: 504-599-1453
New Orleans, LA 70112 Type: Permanent Local
6. Marital Status: Single
7. Birth Date: 9/11/1991
8. Birth City: New Orleans
8a. Birth State: LA
Ethnicity: ☐ Hispanic /Latino ☐ Non-Hispanic/Latino
9. Country of Citizenship: United States

EDUCATION DATA

10. High School Graduate/GED? X
Highest Grade Completed (1-18+) MD

11. College/University Attended	Degree Received	Major	Date Received (Month/day/year)
Tulane University School of Medicine	MD	Medicine	5/30/2024
Tulane University	BS	Premed	5/1/2020

BACKGROUND

(Please include current application, curriculum vitae, or resume)

If you answer yes to any of the following questions, please provide additional information under item number 16.

12. Do you have a relative employed by LSU? (If yes, provide name, relationship, department, and position held). ☐ Yes ☑ No
13. Have you previously been employed by any LSU campus (If yes, indicate campus, original appointment date, and total length of LSU service in months). ☐ Yes ☑ No
14. Do you have prior State Service? (If yes, indicate name of agency, position(s) held and dates of service) ☐ Yes ☑ No
15. Are you a member of any professional organization, society, or hold licenses in any area? (If so, indicate name of organization or society, license held and certificate number, if applicable) ☐ Yes ☑ No

WORK EXPERIENCE

Employer	Location	Dates	Position/Title
Tulane University	New Orleans, LA	8/15/2016-5/15/2017	Student Worker
Tulane University	New Orleans, LA	8/1/2017-5/30/2018	Resident Assistant
Quest Diagnostics	New Orleans, LA	1/11/2023-11/1/2023	Lab Technician

EMERGENCY NOTIFICATION DATA: In case of emergency, please notify the following individual:

Name: Betty Brown
Relationship: Mother
Address: 123 Canal Street
New Orleans, LA, 70112
Home Phone: 504-568-1234
Work Phone: 504-599-1422

16. Remarks: If you answered "yes" to questions 12-15, please provide the requested information in the following spaces. The space may also be used to expand on any of the items listed on the top of the form. Please ensure that the item number is indicated for the area of continuation.

I certify that to the best of my knowledge and belief all the information on this form is correct.

Signature: John Q Resident
Date: 3/14/2024

HR-1

SAMPLE

Errors and items to check/verify

Biographical Data Form

Program Coordinator – Double-check data on form.

Resident – Form should be signed.

Residency Program Coordinator

From: Guillory, Cristina A.
Sent: Tuesday, May 9, 2024 8:33 AM
To: Residency Program Coordinator
Cc: HRM Employment and Talent
Subject: Hire Right CBC cleared-John Q. Resident

Good morning,

The Criminal Background Check has been processed and cleared for hire.

Please keep in mind that the drug test (if applicable) and hire packet must be received in HRM before start date. You may also initiate the electronic I-9/E-Verify once the Drug Test AND Criminal Background Check has been cleared.

E-Verify Company ID: LHS001

Thanks,

Cristina Guillory | *HR Generalist*
LSU Health Sciences Center-New Orleans
433 Bolivar Street, Suite 608
New Orleans, LA 70112

LSU Health NEW ORLEANS
Office of Human Resource Management

Click here and help us improve by sharing your most recent experience with us!

HR-2

Errors and items to check/verify

Background Check Clearance Email

Program Coordinator – Write **HR-2** in the bottom left corner.

Residency Program Coordinator

From: Drug Testing
Sent: Thursday, April 28, 2024 12:31 PM
To: Residency Program Coordinator
Cc: GME Onboarding
Subject: John Resident xxx-xx-7777 Clear for hire

John Resident xxx-xx-7777 Clear for hire

Shauntel Jones
Administrative Coordinator
LSUHSC Campus Assistance Program
LSUHSC Drug Testing Program
Human Development Center
411 S. Prieur St., Suite 233
New Orleans, LA 70112
Phone: (504) 568-8888
Fax: (504)568-3892
sjone7@lsuhsc.edu

CONFIDENTIALITY NOTICE: The information contained in this email message is intended solely for the use of the recipient designated above. Document(s) transmitted herewith may contain information which is **confidential** and **privileged.** Delivery, distribution, or dissemination of this information to anyone other than the intended recipient is strictly prohibited.
If you have received this information in error, please notify our office immediately. Your cooperation is greatly appreciated

HR-3

Errors and items to check/verify

Drug Testing Clear For Hire Email

Program Coordinator – Write **HR-3** in the bottom left corner.

LSUHSC NEW ORLEANS CAMPUS POST JOB OFFER DRUG TESTING INSTRUCTIONS FOR JOB CANDIDATES & HOUSE OFFICERS

The following is being provided to you in order to comply with the Louisiana State University Health Sciences Center, New Orleans (LSUHSC-NO) campus Substance Abuse and Drug Free Workplace Policy. LSUHSC-NO requires drug testing of all full time faculty, staff, and house officers once a position has been offered. If you have accepted the position, please follow these steps closely. Failure to comply with these guidelines could result in ineligibility for employment. If you have any questions, please contact the department who is hiring you.

LSUHSC-NO and its drug testing third party administrator (TPA), Premier Biotech, has established several *Pre-Authorized Collection Site*s within the New Orleans Metropolitan Area, Louisiana, and all 50 states. Only authorized collection sites can be used for your post job offer drug screen. LSUHSC-NO will pay for your post job offer drug screen performed at another location only if prior authorization is obtained. You will have five (5) working days to obtain this drug test after notification.

Please follow the sets of instructions carefully.

1. **PRE-AUTHORIZED COLLECTION SITES**
   - The "*Agreement To Submit To An Alcohol And/Or Drug Test And Authorization For The Release Of Test Results*" form will be provided to you by either your business office manager, program coordinator, or Human Resource Management.
   - Read, complete, and sign the *Agreement To Submit To An Alcohol And/Or Drug Test And Authorization For The Release Of Test Results* form and return the document to your business office manager, program coordinator, or Human Resource Management **prior** to taking your post job offer drug screen.
   - You will receive an email from **Premier Biotech** or **i3screen** with a "Donor Pass." The "Donor Pass" will have the name and address of the approved collection site, collection site hours, your order number, and collection deadline.
   - Take the "Donor Pass" and one of the following with you to the approved collection site: 1) valid driver's license, 2) valid picture state identification, or 3) passport.
   - You must take your post job offer drug screen by the collection deadline date.
   - If you are in a location where there are no pre-authorized collection sites in a reasonable distance, Premier Biotech and the LSUHSC Drug Testing office will attempt to locate an alternate collection site for you.
2. **PRESCRIPTION MEDICATION**
   - If you are taking prescription medication(s) that could result as non-negative on your post job offer drug screen, you do not have to share this information with your department, Human Resource Management, or the collection site.
   - The MRO (physician trained to determine urine drug screen results) will contact you and request medical information and prescription(s) pertaining to any medications that have shown up on your post job offer drug screen. If the MRO or a staff member from the LSUHSC Drug Testing Program calls you about your drug test results, you must respond within 72 hours. If you fail to do so, the results will be reported without your input.
3. **CHALLENGE THE RESULTS OF A DRUG TEST**
   - LSUHSC-NO allows any individual who wishes to challenge the drug test results to do so. You must do so within 72 hours of notification of a positive test result.
   - If you believe a drug test is in error or wish to challenge the drug test results, it is your responsibility to notify the MRO and the appropriate Administrative Body or their designee. You must have the same sample retested at your own expense at a laboratory that is SAMHSA certified. The second test must be of equal or greater sensitivity for the drug in question as was the initial test.
4. **PRE-EMPLOYMENT DRUG TESTING WILL SCREEN FOR THE FOLLOWING:**
   - Amphetamines, Barbiturates, Benzodiazepines, Cannabinoids, Cocaine, Opiates, Phencyclidine
   - LSUHSC New Orleans Campus complies with the Federal Drug-Free Workplace Act which prohibits cannabis use.
   - **Note:** Certain CBD products can test positive for Cannabis which will disqualify you from employment if test results are positive.
5. Questions concerning your hiring and your *"Agreement To Submit To An Alcohol And/Or Drug Test And Authorization For The Release Of Test Results"* form should be directed to the department who is hiring you.

I have read and understand these instructions.

Signature: John Q Resident Date: 3/14/2024

T:Drive/Campus Health Forms / Drug Testing Forms/RV January 3, 2023

SAMPLE

Errors and items to check/verify

Drug Testing Instructions

Resident – Should be signed and dated.

AGREEMENT TO SUBMIT TO AN ALCOHOL AND/OR DRUG TEST AND AUTHORIZATION FOR THE RELEASE OF TEST RESULTS

I have been requested by **LSUHSC** to submit to an alcohol and/or drug test.
(Referring Source)

I have been informed and I understand that my agreement to submit to the requested alcohol and/or drug test is completely voluntary on my part and that I have the right to refuse to submit to the test(s). I am aware and have been told that my refusal to submit to the tests will make me ineligible to be considered for employment and I will be disqualified from employment to an LSUHSC facility for up to one year or may be grounds for disciplinary action against me up to and including termination/expulsion. I am aware that if I refuse to submit to drug screening or if my test is positive, I will be disqualified for employment or appointment. Additionally, a prospective employee who intentionally tampers with the sample, the chain of custody (COC), identification procedures, or test results may be disqualified from employment for a period of three years.

I understand that if the Medical Review Officer (MRO) (and/or the MRO agent and/or staff) or Drug Testing Coordinator (DTC) calls me about my drug test results I should call them back immediately. **I understand that if I do not contact and talk with the MRO** (and/or the MRO agent and/or staff) **then I have turned down the opportunity to discuss the results and the MRO** (and/or the MRO agent and/or staff) **will report my drug test as a positive.**

I have been informed and am aware that the results of the alcohol and/or drug test(s) are protected by confidentiality requirements for alcohol and drug patient records under Federal laws and regulations. Therefore, I voluntarily agree to the below stated release of the test results.

I, John Quentin Resident (please print), authorize the MRO (and/or the MRO agent and/or staff) and the DTC who will receive the results of my alcohol and/or drug test to disclose the results of the test(s) to the appropriate Human Resource Director, my supervisor (as appropriate for employees, students, non-employees, or job applicants), the Administrative Body over me, and/or their designee for the purpose of determining the appropriateness of my eligibility for continued employment/enrollment. I authorize the above individuals and/or their designee to disclose those results to other Human Resource Directors, divisions, hospitals, facilities or their designees within the LSUHSC, and to other state and federal agencies, including the Department of State Civil Service, and LSU Health Care Network if appropriate, and /or to the above mentioned referring source.

I understand that the MRO (and/or the MRO staff) may inform the Human Resource Director, my supervisor (as appropriate for employees, students, non-employees, or job applicants), the Administrative Body over me, their designee and/or above referring source of any legally obtained prescription medication I may be taking if it is felt that the usage of this medication(s) can or has compromised my fitness for duty in my capacity as an employee, student, or non-employee.

I also understand that withdrawal of this permission prior to, or any time after, the release of the results of the alcohol and/or drug test to the above named individuals is grounds for terminating my employment/enrollment.

Daytime Phone # 504-599-1453 Evening Phone # 504-599-1453

Date of Birth 9/11/1991 Social Security # 999-88-7777

Street Address 2020 Imaginary Street Apartment D9

City New Orleans State LA Zip Code 70112

Signature: John Q Resident Date: 3/14/2024

Witness Signature: [signature] Date: 3/14/2024

********** **TO BE COMPLETED BY LSUHSC-NO DESIGNATED AUTHORITY ONLY** **********

Collection Deadline: _____

Dept: _____ Peoplesoft # _____

Designated Administrative Body _____

Email Address for Results _____

"This consent form is subject to revocation at anytime except to the extent that the program which is to make the disclosure has already taken action in reliance on it. If not previously revoked this consent will terminate upon conclusion of any proceedings, administrative, judicial or internal, as to which the test results are sought to be used."

NOTE: To the Party receiving this information: This information has been disclosed to you from the records whose confidentiality is protected by federal law. Federal regulations (42 CFR Part 2.31(a)(2)) prohibit you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not for this purpose.

Errors and items to check/verify

Drug Testing Authorization

Resident – Should be signed and dated.

Witness (Can be Program Coordinator) – Should be signed and dated.

OATH OF AFFIRMATION TO SUPPORT THE CONSTITUTION AND LAWS OF THE UNITED STATES AND OF THIS STATE OF LOUISIANA

"I John Quentin Resident do solemnly swear (or affirm) that I will support the Constitution and laws of the United States and the Constitution and laws of this State; and I will faithfully and impartially discharge and perform all the duties incumbent upon me as House Officer and according to the best of my ability and understanding. So help me God."

Signature

3/14/2024
Date

Medicine
Department

HR-8

SAMPLE

Errors and items to check/verify

Oath of Affirmation

Resident – Form should be signed.

Form **W-4**

Department of the Treasury
Internal Revenue Service

Employee's Withholding Certificate

Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay.
Give Form W-4 to your employer.
Your withholding is subject to review by the IRS.

OMB No. 1545-0074

2024

Step 1: Enter Personal Information

(a) First name and middle initial	Last name	(b) Social security number
John Q	Resident	999-88-7777

Address: 2020 Imaginary Street Apartment D9

City or town, state, and ZIP code: New Orleans, LA 70112

Does your name match the name on your social security card? If not, to ensure you get credit for your earnings, contact SSA at 800-772-1213 or go to *www.ssa.gov*.

(c) ☑ **Single** or **Married filing separately**
☐ **Married filing jointly** or **Qualifying surviving spouse**
☐ **Head of household** (Check only if you're unmarried and pay more than half the costs of keeping up a home for yourself and a qualifying individual.)

Complete Steps 2–4 ONLY if they apply to you; otherwise, skip to Step 5. See page 2 for more information on each step, who can claim exemption from withholding, and when to use the estimator at *www.irs.gov/W4App*.

Step 2: Multiple Jobs or Spouse Works

Complete this step if you (1) hold more than one job at a time, or (2) are married filing jointly and your spouse also works. The correct amount of withholding depends on income earned from all of these jobs.

Do **only one** of the following.

(a) Use the estimator at *www.irs.gov/W4App* for most accurate withholding for this step (and Steps 3–4). If you or your spouse have self-employment income, use this option; **or**

(b) Use the Multiple Jobs Worksheet on page 3 and enter the result in Step 4(c) below; **or**

(c) If there are only two jobs total, you may check this box. Do the same on Form W-4 for the other job. This option is generally more accurate than (b) if pay at the lower paying job is more than half of the pay at the higher paying job. Otherwise, (b) is more accurate . . . . . ☐

Complete Steps 3–4(b) on Form W-4 for only ONE of these jobs. Leave those steps blank for the other jobs. (Your withholding will be most accurate if you complete Steps 3–4(b) on the Form W-4 for the highest paying job.)

Step 3: Claim Dependent and Other Credits

If your total income will be $200,000 or less ($400,000 or less if married filing jointly):

Multiply the number of qualifying children under age 17 by $2,000 $ _____

Multiply the number of other dependents by $500 . . . . . $ _____

Add the amounts above for qualifying children and other dependents. You may add to this the amount of any other credits. Enter the total here . . . . . **3** $

Step 4 (optional): Other Adjustments

(a) Other income (not from jobs). If you want tax withheld for other income you expect this year that won't have withholding, enter the amount of other income here. This may include interest, dividends, and retirement income . . . . . **4(a)** $

(b) Deductions. If you expect to claim deductions other than the standard deduction and want to reduce your withholding, use the Deductions Worksheet on page 3 and enter the result here . . . . . **4(b)** $

(c) Extra withholding. Enter any additional tax you want withheld each **pay period** . . **4(c)** $

Step 5: Sign Here

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

John Q Resident

Employee's signature (This form is not valid unless you sign it.)

3/14/2024

Date

Employers Only

Employer's name and address	First date of employment	Employer identification number (EIN)
LSUHSC-NEW ORLEANS 433 BOLIVAR STREET NEW ORLEANS LA 70112-2223		72-6087770

For Privacy Act and Paperwork Reduction Act Notice, see page 3. Cat. No. 10220Q Form **W-4** (2024)

SAMPLE

HR-9

Errors and items to check/verify

W-4

(HR-9)

Resident – Form should be signed.

R-1300 (4/11)

LDR Contributing to a better quality of life

Employee Withholding Exemption Certificate (L-4)

Louisiana Department of Revenue

Purpose: Complete form L-4 so that your employer can withhold the correct amount of state income tax from your salary.

Instructions: Employees who are subject to state withholding should complete the personal allowances worksheet indicating the number of withholding personal exemptions in Block A and the number of dependency credits in Block B.

- Employees must file a new withholding exemption certificate within 10 days if the number of their exemptions decreases, except if the change is the result of the death of a spouse or a dependent.
- Employees may file a new certificate any time the number of their exemptions increases.
- Line 8 should be used to increase or decrease the tax withheld for each pay period. Decreases should be indicated as a negative amount.

Penalties will be imposed for willfully supplying false information or willful failure to supply information that would reduce the withholding exemption.

This form must be filed with your employer. If an employee fails to complete this withholding exemption certificate, the employer must withhold Louisiana income tax from the employee's wages without exemption.

Note to Employer: Keep this certificate with your records. If you believe that an employee has improperly claimed too many exemptions or dependency credits, please forward a copy of the employee's signed L-4 form with an explanation as to why you believe that the employee improperly completed this form and any other supporting documentation. The information should be sent to the Louisiana Department of Revenue, Criminal Investigations Division, PO Box 2389, Baton Rouge, LA 70821-2389.

Block A

- Enter "0" to claim neither yourself nor your spouse, and check "*No exemptions or dependents claimed*" under number 3 below. You may enter "0" if you are married, and have a working spouse or more than one job to avoid having too little tax withheld.
- Enter "1" to claim yourself, and check "*Single*" under number 3 below. if you did not claim this exemption in connection with other employment, or if your spouse has not claimed your exemption. Enter "1" to claim one personal exemption if you will file as head of household, and check "Single" under number 3 below.
- Enter "2" to claim yourself and your spouse, and check "Married" under number 3 below.

Block B

- Enter the number of dependents, not including yourself or your spouse, whom you will claim on your tax return. If no dependents are claimed, enter "0."

A.	1
B.	0

Cut here and give the bottom portion of certificate to your employer. Keep the top portion for your records.

Form **L-4**
Louisiana Department of Revenue

Employee's Withholding Allowance Certificate

1. Type or print first name and middle initial John Q	Last name Resident
2. Social Security Number 999-88-7777	**3.** Select one ☐ No exemptions or dependents claimed ☑ Single ☐ Married
4. Home address (number and street or rural route) 2020 Imaginary Street Apartment D9	
5. City New Orleans	State LA / ZIP 70112
6. Total number of exemptions claimed in Block A	**6.** 1
7. Total number of dependents claimed in Block B	**7.** 0
8. Increase or decrease in the amount to be withheld each pay period. Decreases should be indicated as a negative amount.	**8.**

I declare under the penalties imposed for filing false reports that the number of exemptions and dependency credits claimed on this certificate do not exceed the number to which I am entitled.

Employee's signature John Q Resident	Date 3/14/2024

The following is to be completed by employer.

9. Employer's name and address	**10.** Employer's state withholding account number

HR-10

SAMPLE

Errors and items to check/verify

L-4

(HR-10)

Resident – Ensure number of exceptions is entered.

Resident – Form should be signed.

Act 372
Selective Service Registration for Hiring

Act 372 of the 1999 Regular Session of the Legislature became effective August 15, 1999. It requires that any male who is required to register with the Selective Service for a federal draft must do so before he is eligible to be hired in either a state classified or unclassified position.

Act 372

To amend and reenact R.S. 42:33, relative to civil service; to provide relative to employment in the state civil service; to require proof of draft registration to be eligible for certain classified and unclassified state civil service employment; and to provide for related matters.

Be it enacted by the Legislature of Louisiana:
Section 1. R.S 42:33 is hereby amended and reenacted to read as follows:

- 33. State civil service positions; Selective Service System registration required

A. Except as provided in Subsections B and C of this Section, no person who is required to register for the federal draft under Section 3 of the Military Selective Service Act (50 U.S.C App. 453) shall be eligible for employment or appointment in a state civil service position, whether classified or unclassified, until such person has registered for such draft, as evidenced by a statement of compliance pursuant to rules and regulations promulgated by the State Civil Service Commission.

B. A veteran of the armed forces of the United States may submit a copy of his discharge papers or his discharge certificate in lieu of the statement of compliance required by Subsection A of this section.

C. A person who has not registered for the federal draft, as provided in Subsection A of this Section shall be eligible for employment or appointment in a state civil service position if the requirement for the person to register has terminated or become inapplicable to the person. The State Civil Service Commission may adopt rules for documentation of termination or inapplicability of such requirement.

Approved by the Governor, June 16, 1999
Published in the Official Journal of the State; July 13, 1999

In summary, this law requires LSUHSC to ask all male applicants between the ages of 18 and 25 if they are registered for the draft. If they are not, and one of the exemptions listed in the above statute is not applicable, the person cannot be hired until they register for the draft. A person can register on line at http://www.sss.gov.

Name: John Quentin Resident

Last 4 digits of SS#: 7777

Selective Service No.; if applicable 123556984

Signature: John Q Resident

HR-11

SAMPLE

Errors and items to check/verify

Selective Service Form

Male Residents – Selective Service Number should be entered and form should be signed.

Female Residents – Selective Service Number may have N/A or be left blank. Form should be signed.

Data Protection

IMPORTANT – Public Records Act 44

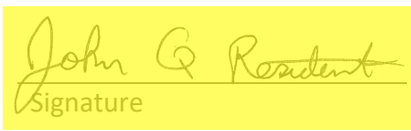
Occasionally LSU Health Sciences Center receives a request for information under Title 44, Public Records and Recorders Act. Responding to such a request may involve disclosing data from your LSUHSC Payroll/Personnel file.

You may elect to have your home address and home telephone number made "confidential" and thus not subject to disclosure under the Public Records Act. Please complete the data below and return this form to the Benefits Section, Room 608, Resource Center. A copy of your election will be placed in your personnel file.

DATA PROTECTION DESIGNATION

☑ I would like to have my home address and telephone number kept confidential. I am electing to keep the data protection option.

☐ I do not want my home address and telephone number designated as confidential. It can be released when designated by a signed consent form. I am waiving the data protection option.

John Quentin Resident	
Name (Please print)	Signature
2020 Imaginary Street Apartment D9 New Orleans, LA 70112	504-599-1453
Home Address	Home Telephone Number
7777	3/14/2024
Last 4 digits of SS#	Date

HR-12

Errors and items to check/verify

Data Protection Form

Resident – Data Protection Designation should be chosen.

Resident – Form should be signed.

DIRECT DEPOSIT AUTHORIZATION FORM

For Payroll and Employee Travel Expense Reimbursements

Submit this form to: **Payroll Department 433 Bolivar Street, Room 611**
Tel (504) 568-8460 Fax (504) 568-2366

Employee Name: John Quentin Resident

Employee's Last 4 digits SSN: 7777 Employee ID: 0000000

Department: Medicine Work Phone Number: 504-568-5600

Bank Name: Imaginary Bank

Bank Routing Number: 12345678 (Nine Digit Number)

☑ Checking Account #012345678910 Deposit Amount: Net Pay
(Net Pay or an Amount)

☐ Savings Account #_____ Deposit Amount: _____
(Net Pay or an Amount)

IMPORTANT (Please Attach a Copy of Voided Check)
A separate form must be completed and a voided check attached for each account where funds are to be deposited.

I hereby authorize LSU Health New Orleans to initiate credit entries or if necessary debit entries and adjustments for any credit entry made in error to my account at the indicated financial institution, and I hereby authorize the indicated institution to accept and post such entries to my account.

Direct deposits will be made to the accounts listed above. The primary account will also be used for direct deposits of employee travel expense reimbursements. I understand that I will be notified by e-mail to my official University e-mail address for any employee expense reimbursements made to my primary account.

This authorization may be terminated by LSU Health New Orleans at any time.

You will receive paper checks until your direct deposit accounts become active, which may take two or more pay periods. Please note that this banking procedure is a courtesy extended by LSU Health New Orleans and does not guarantee the bank's posting of the deposit by any given date.

Employee Signature John Q Resident Date 3/14/2024

HR-13

SAMPLE

Errors and items to check/verify

Direct Deposit Authorization

Resident – Bank account information should be entered and form should be signed.

DIRECT DEPOSIT CANCELLED CHECK

For Payroll and Employee Travel Expense Reimbursements

Submit this form to: **Payroll Department 433 Bolivar Street, Room 611**
Tel (504) 568-8460 Fax (504) 568-2366

Employee Name: John Quentin Resident

Employee's Last 4 digits SSN: 7777 Employee ID: 0000000

Department: Medicine Work Phone Number: 504-568-5600

HR-13

SAMPLE

Errors and items to check/verify

Direct Deposit Authorization – Voided Check

Resident – Voided check should be attached.

LSU Health NEW ORLEANS

Office of Human Resource Management

Last Updated: 04/24/2023

Invitation to Voluntarily Self-Identify Veteran Status (post-offer)

The Louisiana Health Sciences Center- New Orleans is committed to equal opportunity and affirmative action in all aspects of employment for qualified protected veterans. We ask that you please consider completing this Invitation to Voluntarily Self-Identify Veteran Status to help us fulfill our commitments to equal opportunity and affirmative action and to meet our obligations as a government contractor under the Vietnam Era Veterans' Readjustment Assistance Act of 1974, as amended by the Jobs for Veterans Act of 2002, 38 U.S.C. 4212 (VEVRAA). VEVRAA requires us to take affirmative action to employ and advance in employment protected veterans.

While the University is required by VEVRAA to submit an annual report to the U.S. Department of Labor identifying the total number of employees who are "protected veterans" based on the categories listed below, submission of this information is voluntary on your part and refusal to provide it will not subject you to any adverse treatment. The information provided will be used only in a manner consistent with VEVRAA.

How Do You Know if You Are a Veteran Protected by VEVRAA?

1. 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.

2. 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.

3. 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, (Period of War Dates: Korean Conflict June 27, 1950 – January 31,1955; Vietnam Era February 28, 1961 – May 7, 1975 for veterans serving in the Republic of Vietnam or August 5, 1964 – May 7, 1975 for all other cases; Persian Gulf War August 2, 1990 – current).

4. 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.

Self-Identification

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

☐ I AM A PROTECTED VETERAN
☐ I AM A VETERAN, BUT NOT A PROTECTED VETERAN
☐ I DO NOT WISH TO ANSWER

☑ I AM NOT A VETERAN

John Quentin Resident _____ 3/14/2024 _____

Name Date

Reasonable Accommodation Notice: If you are a disabled veteran and require a reasonable accommodation that would enable you to perform the essential functions of the job, including special equipment, changes in the physical layout of the job, changes in the way the job is customarily performed, provision of personal assistance services or other accommodations, please contact us at HRMADA@lsuhsc.edu.

HR-14

SAMPLE

Errors and items to check/verify

Invitation to Voluntarily Self-Identify Veteran Status

(HR-14)

Resident – Self-identification status should be chosen

Voluntary Self-Identification of Disability

Form CC-305
Page 1 of 1

OMB Control Number 1250-0005
Expires 04/30/2026

Name: John Quentin Resident
Employee ID: 0000000 (if applicable)

Date: 3/14/2024

Why are you being asked to complete this form?

We are a federal contractor or subcontractor. The law requires us to provide equal employment opportunity to qualified people with disabilities. We have a goal of having at least 7% of our workers as people with disabilities. The law says we must measure our progress towards this goal. To do this, we must ask applicants and employees if they have a disability or have ever had one. People can become disabled, so we need to ask this question at least every five years.

Completing this form is voluntary, and we hope that you will choose to do so. Your answer is confidential. No one who makes hiring decisions will see it. Your decision to complete the form and your answer will not harm you in any way. If you want to learn more about the law or this form, visit the U.S. Department of Labor's Office of Federal Contract Compliance Programs (OFCCP) website at www.dol.gov/ofccp.

How do you know if you have a disability?

A disability is a condition that substantially limits one or more of your "major life activities." If you have or have ever had such a condition, you are a person with a disability. **Disabilities include, but are not limited to:**

- Alcohol or other substance use disorder (not currently using drugs illegally)
- Autoimmune disorder, for example, lupus, fibromyalgia, rheumatoid arthritis, HIV/AIDS
- Blind or low vision
- Cancer (past or present)
- Cardiovascular or heart disease
- Celiac disease
- Cerebral palsy
- Deaf or serious difficulty hearing
- Diabetes
- Disfigurement, for example, disfigurement caused by burns, wounds, accidents, or congenital disorders
- Epilepsy or other seizure disorder
- Gastrointestinal disorders, for example, Crohn's Disease, irritable bowel syndrome
- Intellectual or developmental disability
- Mental health conditions, for example, depression, bipolar disorder, anxiety disorder, schizophrenia, PTSD
- Missing limbs or partially missing limbs
- Mobility impairment, benefiting from the use of a wheelchair, scooter, walker, leg brace(s) and/or other supports
- Nervous system condition, for example, migraine headaches, Parkinson's disease, multiple sclerosis (MS)
- Neurodivergence, for example, attention-deficit/hyperactivity disorder (ADHD), autism spectrum disorder, dyslexia, dyspraxia, other learning disabilities
- Partial or complete paralysis (any cause)
- Pulmonary or respiratory conditions, for example, tuberculosis, asthma, emphysema
- Short stature (dwarfism)
- Traumatic brain injury

Please check one of the boxes below:

☐ Yes, I have a disability, or have had one in the past
☑ No, I do not have a disability and have not had one in the past
☐ I do not want to answer

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.

For Employer Use Only

Employers may modify this section of the form as needed for recordkeeping purposes.
For example:
Job Title: House Officer Date of Hire: 7/1/2024

HR-15

SAMPLE

Errors and items to check/verify

Voluntary Self-Identification of Disability

(HR-15)

Resident – Self-identification status should be chosen

HR-16

Errors and items to check/verify

Social Security Card

Program Coordinator - Provide **legible copies** of Social Security Card (for Benefits Office) and write **HR-14** in the bottom left corner.