LSU Health Sciences Center
NEW ORLEANS
School of Medicine
Office of Medical Education

School of Medicine
School of Dentistry
School of Nursing
School of Allied Health Professions
School of Graduate Studies
School of Public Health

March 16, 2009

Dear Incoming House Officer:

Congratulations and welcome to LSU! You are entering the most exciting phase of your medical career where you finally get to concentrate on your chosen field. In addition, you will be training in an environment where each house officer can develop at his/her own pace and in a city and region unlike any other in the U.S. The GME Office stands ready to help you in any way we can. Over the next few years you will witness major positive developments in the LSU medical complex which will enhance your graduate and post-graduate education. We look forward to meeting you at the Orientation scheduled on Tuesday, June 23, 2009 at 8:30a.m in the Medical Education Building, 1901 Perdido, Lecture Room B.

Again, welcome to our institution and to the most stimulating years of your life.

Sincerely,

Charles Hilton

Charles Hilton, M.D.
Associate Dean for Academic Affairs
Designated Institutional Official (DIO)

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March 16, 2009

TO: All Incoming House Officers

CC: Clinical Department Heads
Clinical Business Managers
Residency and Fellowship Program Directors
Residency and Fellowship Program Coordinators

FROM: Charles Hilton, MD
Associate Dean for Academic Affairs
Designated Institutional Official (DIO)

RE: 2009-2010 Incoming House Officer Orientation Schedule

Two MANDATORY Orientation sessions for all Incoming (New) House Officers will be held in late June.

The **LSUHSC Orientation** will be held on **Tuesday, June 23, 2009, from 8:30 a.m. to 2 p.m. in the Medical Education Building, 1901 Perdido, Lecture Room B**. Lunch will be provided. For your convenience, access to a map of the LSUHSC Downtown campus is available at http://www.medschool.lsuhsc.edu/location.asp. Campus parking for this event has yet to be confirmed. For this and other information concerning Orientation, please check the website at http://www.medschool.lsuhsc.edu/medical_education/graduate. If you have any questions regarding the LSUHSC Orientation, please feel free to contact the Graduate Medical Education Office at 504-568-4006.

In addition, the **Medical Center of Louisiana in New Orleans (MCLNO)** will host a separate Orientation the following day, **Wednesday, June 24, 2009, from 8:00a.m. – 2:30p.m. at University Hospital in the Basement Area.** This Orientation is sponsored by MCLNO's Medical Staff Office. If you have any further questions regarding the MCLNO Orientation, please contact Senora Paul, 504-903-0381.

Louisiana State University Health Sciences Center • 2020 Gravier Street, Suite 716 • New Orleans, Louisiana 70112
phone (504) 568-4006 **fax** (504) 599-1453 **www**.lsuhsc.edu

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TO: All Incoming LSUHSC House Officers

CC: Program Directors/Program Coordinators

From: Charles Hilton, MD
Associate Dean for Academic Affairs

RE: Drug testing for incoming house officers 2009-2010

In Order for incoming house officers to begin training and be paid through the payroll system, they must undergo pre-employment drug testing on or after March 25th, 2009. Testing after May 15th, 2009 could result in an administrative delay in processing your payroll documents and delay the start of your residency/fellowship training.

*Instructions regarding the drug testing procedures will follow your initial communication with your department coordinator.

All incoming House Officers must contact their program coordinator, ____________________ at ____________________(phone) to schedule the drug test.

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March 16, 2009

TO: All Incoming LSUHSC House Officers

FROM: Charles Hilton, MD
Associate Dean for Academic Affairs
Designated Institutional Official (DIO)

RE: **Health Requirements for Incoming House Officers**

Written documentation of health requirements is required prior to starting your training program. **All documents must be submitted before May 1, 2009. The following health requirements must be provided:**

1. PPD skin test within 6 months prior to start date (include results)
2. Rubella (German measles) immunity proven by titer or documentation of vaccination as per the CDC guidelines.
3. Measles immunity proven by titer or documentation of vaccination as per the CDC guidelines.
4. Varicella (Chicken pox) - Proof of immunity by titer or proof of varicella vaccination as per the CDC guidelines.
5. Proof of Hepatitis B vaccine or proof of antibodies to Hepatitis B.

All Health Requirements documentation should be forwarded to:

Graduate Medical Education
LSU School of Medicine
2020 Gravier Street, Suite 716
New Orleans, LA 70112
Attn: Kim Cannon

If you have any questions, please contact the Graduate Medical Education Office at 504-568-4006.

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LSUHSC-NO INCOMING HOUSE OFFICER HEALTH REQUIREMENTS

Documentation of immunizations MUST BE ATTACHED TO THIS FORM.
All documents must be submitted before May 1, 2009.
Forward all documentation to:

Graduate Medical Education
LSU School of Medicine
2020 Gravier Street, Suite 716
New Orleans, LA 70112
Attn: Kim Cannon

PLEASE PRINT CLEARLY OR TYPE:

NAME: ____

MAILING ADDRESS: ____

SS# ________________________ DATE OF BIRTH: ________________________

TRAINING PROGRAM: _______________________ START DATE: _________

Please complete this form and attach written documentation of health requirements.

1. PPD skin test within 6 months prior to start date (include results)
   If positive, please furnish the following information:
   Date of Positive PPD ____________
   INH taken? ☐ (Yes) ☐ (No) How Long? ☐ (6 months) ☐ (1 year)
   Date of last CXR ________________ Results ________________________
   BCG received? ☐ (Yes) ☐ (No) Year ________________
   *NOTE: If BCG received more than 8 years ago, a PPD skin test is required.

2. Rubella (German measles) immunity proven by titer or documentation of vaccination as per the CDC guidelines.

3. Measles immunity proven by titer or documentation of vaccination as per the CDC guidelines.

4. Varicella (Chicken pox) - Proof of immunity by titer or proof of varicella vaccination as per the CDC guidelines.

5. Proof of Hepatitis B vaccine or proof of antibodies to Hepatitis B.

6. Proof of Td/Tdap (Tetanus) within past 10 years. *New for the 2009-2010 Year.

If you have any questions, please contact the Graduate Medical Education Office at 504-568-4006 or email kcanno@lsuhsc.edu.

LSU HEALTH SCIENCES CENTER – NEW ORLEANS BIOGRAPHICAL DATA FORM

CODING DATA

1. Name ______ 2. SS# ______ 3b. Sex __ 3a. Race

☐ American Indian/Alaskan Native
☐ Black/African American
☐ Native Hawaiian/Pacific Is.
☐ Asian ☐ White
☐ Other ____

4. Address ______ 5. Home Phone ______

6. Marital Status ______

7. Birth Date ______ 8. Birth City ______ 8a. Birth State ______

Ethnicity ☐ Hispanic /Latino ☐ Non-Hispanic /Latino

9. Country of Citizenship ______ Visa Status ______ Permanent Resident Nbr. ______

EDUCATION DATA

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

11. College/University Attended | Degree | Major | Date Received

College/University Attended	Degree	Major	Date Received

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

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

Name ______ Relationship ______

Address ______ Home Phone ______

______ Work Phone ______

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.

Signature ______ Date ______

R-1300 (4/01)

State of Louisiana
Department of Revenue

Employee Withholding Exemption Certificate (L-4)

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

Basic Instructions: Employees who are subject to state withholding should complete the personal allowances worksheet below. Do not claim more than your correct withholding personal exemptions and the correct number of withholding dependency credits. Do not claim additional withholding exemptions if you qualify as head-of-household. In such cases, only the withholding personal exemption applicable to single individuals is allowable. You must file a new certificate within 10 days if the number of your exemptions decreases, except where the change occurs as the result of death of a spouse or a dependent. You may file a new certificate at any time the number of your exemptions increases. Penalties are 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. Otherwise, he must withhold Louisiana income tax from your wages without exemption.

Note to Employer: Keep this certificate with your records. If the employee is believed to have claimed too many exemptions or dependency credits, the Secretary of Revenue should be so advised by forwarding a copy of the employee's signed L-4 form to the Department.

Personal Allowances Worksheet

A. In Block A, enter "0" if you claim neither yourself nor your spouse, or

In Block A, enter "1" if you claim yourself, provided you do not claim this exemption in connection with other employment or your spouse has not claimed your exemption, or

In Block A, enter "2" if you claim yourself and your spouse. You may choose to enter "0" if you are married, and have either a working spouse, or more than one job. (This may help you avoid having too little tax withheld.)

A.

B. In Block B, enter the number of dependents (other than your spouse or yourself) whom you will claim on your tax return. If no credits are claimed, enter "0".

B.

— — **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 — Last name

2. Social Security Number

3. ◯ No exemptions or dependents claimed ◯ Single ◯ Married

4. Home address (number and street or rural route)

5. City, State, ZIP

6. Total number of exemptions you are claiming (from Block A above) — **6.**

7. Total number of dependents you are claiming (from Block B above) — **7.**

8. Additional amount, if any, you want withheld each pay period — **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 — Date

The following is to be completed by employer.

9. Employer's name and address

10. Employer's state withholding account number

Form W-4 (2009)

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 2009 expires February 16, 2010. See Pub. 505, Tax Withholding and Estimated Tax.

Note. You cannot claim exemption from withholding if (a) your income exceeds $950 and includes more than $300 of unearned income (for example, interest and dividends) and (b) another person can claim you as a dependent on their tax return.

Basic instructions. If you are not 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-earner/multiple job 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 may 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. 919, How Do I Adjust My Tax Withholding, 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. 919 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. 919 for details.

Nonresident alien. If you are a nonresident alien, see the Instructions for Form 8233 before completing this Form W-4.

Check your withholding. After your Form W-4 takes effect, use Pub. 919 to see how the amount you are having withheld compares to your projected total tax for 2009. See Pub. 919, especially if your earnings exceed $130,000 (Single) or $180,000 (Married).

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 are single and have only one job; or
- You are married, have only one job, and your spouse does not 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 $1,800 of **child or dependent care expenses** for which you plan to claim a credit . . **F** ______

(**Note.** Do **not** include child support payments. See Pub. 503, Child and Dependent Care Expenses, for details.)

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 $61,000 ($90,000 if married), enter "2" for each eligible child; then **less** "1" if you have three or more eligible children.
- If your total income will be between $61,000 and $84,000 ($90,000 and $119,000 if married), enter "1" for each eligible child plus "1" **additional** if you have six or more eligible children. **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 have **more than one job** or are **married and you and your spouse both work** and the combined earnings from all jobs exceed $40,000 ($25,000 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.

Cut 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

2009

1 Type or print 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 2009, 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
(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)

Deductions and Adjustments Worksheet

Note. Use this worksheet *only* if you plan to itemize deductions, claim certain credits, adjustments to income, or an additional standard deduction.

1 Enter an estimate of your 2009 itemized deductions. These include qualifying home mortgage interest, charitable contributions, state and local taxes, medical expenses in excess of 7.5% of your income, and miscellaneous deductions. (For 2009, you may have to reduce your itemized deductions if your income is over $166,800 ($83,400 if married filing separately). See *Worksheet 2* in Pub. 919 for details.) . . . **1** $

2 Enter: { $11,400 if married filing jointly or qualifying widow(er); $ 8,350 if head of household; $ 5,700 if single or married filing separately } . . . **2** $

3 **Subtract** line 2 from line 1. If zero or less, enter "-0-" . . . **3** $

4 Enter an estimate of your 2009 adjustments to income and any additional standard deduction. (Pub. 919) . . . **4** $

5 **Add** lines 3 and 4 and enter the total. (Include any amount for credits from *Worksheet 8* in Pub. 919.) . **5** $

6 Enter an estimate of your 2009 nonwage income (such as dividends or interest) . . . **6** $

7 **Subtract** line 6 from line 5. If zero or less, enter "-0-" . . . **7** $

8 **Divide** the amount on line 7 by $3,500 and enter the result here. Drop any fraction . . . **8**

9 Enter the number from the **Personal Allowances Worksheet,** line H, page 1 . . . **9**

10 **Add** lines 8 and 9 and enter the total here. If you plan to use the **Two-Earners/Multiple Jobs Worksheet,** also enter this total on line 1 below. Otherwise, **stop here** and enter this total on Form W-4, line 5, page 1 **10**

Two-Earners/Multiple Jobs Worksheet (See *Two earners or multiple jobs* on page 1.)

Note. Use this worksheet *only* if the instructions under line H on page 1 direct you here.

1 Enter the number from line H, page 1 (or from line 10 above if you used the **Deductions and Adjustments Worksheet**) **1**

2 Find the number in **Table 1** below that applies to the **LOWEST** paying job and enter it here. **However,** if you are married filing jointly and wages from the highest paying job are $50,000 or less, do not enter more than "3." . . . **2**

3 If line 1 is **more than or equal to** line 2, subtract line 2 from line 1. Enter the result here (if zero, enter "-0-") and on Form W-4, line 5, page 1. **Do not** use the rest of this worksheet . . . **3**

Note. If line 1 is *less than* line 2, enter "-0-" on Form W-4, line 5, page 1. Complete lines 4–9 below to calculate the additional withholding amount necessary to avoid a year-end tax bill.

4 Enter the number from line 2 of this worksheet . . . **4**

5 Enter the number from line 1 of this worksheet . . . **5**

6 **Subtract** line 5 from line 4 . . . **6**

7 Find the amount in **Table 2** below that applies to the **HIGHEST** paying job and enter it here . . . **7** $

8 **Multiply** line 7 by line 6 and enter the result here. This is the additional annual withholding needed . . **8** $

9 Divide line 8 by the number of pay periods remaining in 2009. For example, divide by 26 if you are paid every two weeks and you complete this form in December 2008. Enter the result here and on Form W-4, line 6, page 1. This is the additional amount to be withheld from each paycheck . . . **9** $

Table 1

Married Filing Jointly: If wages from **LOWEST** paying job are—	Enter on line 2 above	All Others: If wages from **LOWEST** paying job are—	Enter on line 2 above
$0 - $4,500	0	$0 - $6,000	0
4,501 - 9,000	1	6,001 - 12,000	1
9,001 - 18,000	2	12,001 - 19,000	2
18,001 - 22,000	3	19,001 - 26,000	3
22,001 - 26,000	4	26,001 - 35,000	4
26,001 - 32,000	5	35,001 - 50,000	5
32,001 - 38,000	6	50,001 - 65,000	6
38,001 - 46,000	7	65,001 - 80,000	7
46,001 - 55,000	8	80,001 - 90,000	8
55,001 - 60,000	9	90,001 - 120,000	9
60,001 - 65,000	10	120,001 and over	10
65,001 - 75,000	11		
75,001 - 95,000	12		
95,001 - 105,000	13		
105,001 - 120,000	14		
120,001 and over	15		

Table 2

Married Filing Jointly: If wages from **HIGHEST** paying job are—	Enter on line 7 above	All Others: If wages from **HIGHEST** paying job are—	Enter on line 7 above
$0 - $65,000	$550	$0 - $35,000	$550
65,001 - 120,000	910	35,001 - 90,000	910
120,001 - 185,000	1,020	90,001 - 165,000	1,020
185,001 - 330,000	1,200	165,001 - 370,000	1,200
330,001 and over	1,280	370,001 and over	1,280

Privacy Act and Paperwork Reduction Act Notice. We ask for the information on this form to carry out the Internal Revenue laws of the United States. The Internal Revenue Code requires this information under sections 3402(f)(2)(A) and 6109 and their regulations. Failure to provide a properly completed form will result in your being treated as a single person who claims no withholding allowances; providing fraudulent information may also subject you to penalties. Routine uses of this information include giving it to the Department of Justice for civil and criminal litigation, to cities, states, the District of Columbia, and U.S. commonwealths and possessions for use in administering their tax laws, and using it in the National Directory of New Hires. We may also disclose this information to other countries under a tax treaty, to federal and state agencies to enforce federal nontax criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism.

You are not required to provide the information requested on a form that is subject to the Paperwork Reduction Act unless the form displays a valid OMB control number. Books or records relating to a form or its instructions must be retained as long as their contents may become material in the administration of any Internal Revenue law. Generally, tax returns and return information are confidential, as required by Code section 6103.

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

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

LSU Health Sciences Center
NEW ORLEANS

Code of Conduct

As an LSUHSC-NO employee or affiliate, I understand the important role trust plays in the accomplishment of our mission. In the execution of my duties I will strive to act in ways that earn the trust of my coworkers, and the people I serve.

I will always act with integrity and carry out my duties in accordance with the highest ethical standards. I will always perform my duties solely for the purpose, benefit and interest of the university and those it serves, and shall avoid any conflict or appearance of conflict with those interests.

In all my decisions, I will strive to make the choices based on sound professional judgment that produce the best possible outcomes for our students, our patients, our coworkers and the people of Louisiana.

I will keep myself well educated on the latest developments in my field of expertise and will complete all training requirements mandated by law, my profession, and LSUHSC-NO.

I will treat our students, patients and coworkers with the same degree of respect and dignity in the performance of my duties that I would wish to receive if the situations were reversed.

I will perform my duties in compliance with all applicable federal and state laws and regulations, and university policies and procedures.

I will look continuously for ways to improve the performance of my duties, and to ensure my work is always responsive to the conditions around me and needs of the people who depend on me.

I am an agent for improvement in LSUHSC-NO. I will always report cost-saving and improvement opportunities to those who have authority to act on these. I will report adverse events promptly to mitigate any harmful effects and maintain the university's image of trust and integrity. I will cooperate fully with requests from oversight agencies. I will report non-compliant behavior to the Office of Compliance Programs and understand, if so desired, my report will be kept confidential.

I will perform all my duties to the best of my ability to ensure the highest degree of excellence in everything I do. I will educate and encourage others through my example.

Code of Conduct Attestation Form

By signing below, I acknowledge receipt of the LSUHSC-NO Code of Conduct. I understand that adherence to the LSUHSC-NO Code of Conduct is a condition of my employment and/or affiliation with the University, and, my failure to adhere to the Code of Conduct can result in disciplinary action up to and including termination of employment and/or affiliation.

Print Name (Legal Name):____
(write legibly or you will not be given credit)

Signature ____

Date ___/___/___

Employee or Student (Please Circle One)

Department: ____

Department Telephone Number: ________________________

Upon completion, return this page to:

The Office of Compliance Programs
433 Bolivar St.
Suite 811
New Orleans, LA 70112

Attn: Kelly Guth

Please keep a copy for your records.

Revised 06-22-06kg

Reset Form

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 Service Center, 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.

Name (please print)	Signature
Home Address	Home Telephone Number
Social Security Number	Date

LSU Health Sciences Center

Reset Form

INVITATION FOR SELF IDENTIFICATION

FOR
PERSONS WITH DISABILITIES
SPECIAL DISABLED VETERANS
VETERANS OF THE VIETNAM ERA
AND MILITARY RESERVES

LSU Health Sciences Center-New Orleans is a Federal Contractor subject to the requirements of the Vietnam Era Veterans Readjustment Assistance Act of 1974, as amended (38USC 2012), and to the requirements of Section 503 of the Rehabilitation Act of 1973 as amended, and their implementing regulations.

These Acts and regulations require that LSU Health Sciences Center-New Orleans take affirmative action to employ, and to advance in employment, qualified persons with disabilities, special disabled veterans, and veterans of the Vietnam era.

If you are a person with a disability, a special disabled veteran, or a veteran of the Vietnam era, and would like to be considered under the Affirmative Action Program, please tell us. Provision of this information is voluntary. If you do not wish to identify yourself at this time as a person with a disability, a special disabled veteran, or veteran of the Vietnam era, you will not be subject to any adverse treatment. If you do wish to identify yourself, the information provided will be used only in accordance with the Acts and the regulations. This means that the information provided will be:

1. Kept confidential, except that:
   A. Supervisors and managers may be informed of any restrictions of work or duties of persons with disabilities or special disabled veterans, and of any necessary accommodations;
   B. First aid and safety personnel may be informed, when and to the extent appropriate, if a particular handicap or disability may require emergency treatment;
   C. Government officials investigating compliance with the Acts shall be informed;
2. Used only in accordance with the Acts and their implementing regulations; and
3. Will be used to ensure proper placement. In order to assist us in making proper placement, we ask that if you have a handicap or disability which might affect your job performance or create a hazard to yourself or others in connection with the job for which you are applying, you inform us;
   A. What skills and/or procedures you use or intend to use to perform the job notwithstanding the disability, and
   B. What accommodations we could make which would enable you to perform the job properly and safely. This might include special equipment, changes in the physical layout of the job, elimination of certain non-essential duties, or other accommodations.

I certify that I have read the above "INVITATION OF SELF IDENTIFICATION" and that I understand its terms. I further attest, by checking the appropriate space and signing below, that I am:

☐ A person with a handicap/disability
☐ A special disabled veteran
☐ A veteran of the Vietnam era
☐ A member of the Military Reserves
☐ None of the above

*Please check all that apply. Should your status change, please notify HR immediately.

NAME (PLEASE PRINT)____________________ SOCIAL SECURITY NO ____________

SIGNATURE ____________________ DATE ____________

LSU Health Sciences Center
Bank Deposit Authorization

Reset Form

Complete Entire Page
(Attach a Copy of Voided Check)

NOTE: Changing Banks or Account numbers may cause your next paycheck to be a physical check and not a non-negotiable stub.

Name: ______________________ Date: ______________

Social Security Number: ______________

It is understood that this banking procedure is a courtesy extended by LSU Health Sciences Center and DOES NOT GUARANTEE the bank's posting of the deposit by any given date.

Begin Deposit: ______________________

Name of Bank: ______________________

Address: ______________________

City, State, Zip: ______________________

Account Name: ______________________
(As shown on bank statement)

☐ Checking ☐ Savings Account #______________

Deposit Amount: ______________________
(Net Pay or an Amount)

Classification: ☐ Classified ☐ Faculty or Unclassified ☐ Resident ☐ Student

____
Employee's Signature

LSU Health Sciences Center

NEW ORLEANS

I acknowledge that I have read and understand the LSUHSC-NO Policy and Procedure for Recoupment of Overpayment and that if I am overpaid, the overpayment shall be recouped in accordance with the Policy. I further understand and hereby agree and authorize LSUHSC-NO to recover any amount overpaid to me by reducing my future payroll checks so that the overpayment will be repaid or recouped within a reasonable number of months [not to exceed twelve months].

I also understand that failure to comply with this Policy is cause for disciplinary action and/or termination.

______________________________________ ______________

Employee Signature Date

______________________________ ______________________

Print Name Social Security Number

March 2, 2007

A. Policy:

It is the policy of Louisiana State University Health Sciences Center – New Orleans (LSUHSC – NO) to recoup overpayments made to employees in accordance with La. Rev. Stat. 42:460 as promulgated by the Louisiana Administrative Code Title 4, Part III, Chapter 7.

Overpayments occur when compensation that is not owed to the employee is paid in error. This includes but is not limited to overpayment of wages, annual leave paid in error, and erroneous refunds of deductions. Unearned payments to employees are prohibited by Article 7, Section 14 of the Louisiana State Constitution, which prohibits the donation of public funds. Therefore, LSUHSC – NO is required to recoup overpayments to both active and separated employees.

B. Definitions:

Active Employee - employee currently working for LSUHSC – NO.
Deduction - any voluntary or involuntary reduction in net pay (e.g., health insurance, United Way, taxes).
Direct Deposit Reversal - a formal request to the financial institution to return funds deposited into an account.
Net Pay - the amount of compensation due to the employee after withholding all voluntary and involuntary deductions from the employee's wages and compensation earned.
Overpayment - unearned compensation of any and all funds administered by LSUHSC-NO to employees.
Prospective Employee – a new hire or an employee who has transferred from another state agency to LSUHSC - NO.
Recoupment - reimbursement of overpayment that was not due an employee.
Separated Employee - employee no longer working for LSUHSC - NO.
Wage - payment for services to an employee.

C. Notification of Overpayment:

Employees shall be notified immediately once LSUHSC - NO determines that an overpayment has been made. Written notification (Notification of Overpayment) to the employee will be provided by the Payroll Department of LSUHSC - NO prior to withholding the recoupment from future payments. The Notification of Overpayment to the employee shall include the following:

1. Pay date(s) the overpayment occurred;
2. Amount of the overpayment;
3. Reason for overpayment;
4. LSUHSC - NO plan of action for recoupment of overpayment;
5. Employee options for reimbursement of overpayment, as appropriate; and
6. Procedure by which the proposed recoupment can be disputed.

D. Plan of Action for Recoupment from Active Employees:

LSUHSC – NO will recoup overpayments made to Active Employees in one of the following ways:

1. Direct deposit reversal.
2. One-time deduction from a subsequent paycheck:
   - A one-time payment will occur from a subsequent check as long as the deducted amount does not bring the employee's bi-weekly gross hourly wage amount below the federal minimum wage unless indicated by written approval from the employee.
3. Payment plan as agreed upon by LSUHSC - NO for a period not to exceed twelve (12) months:
   - The number of recurring deductions will be determined by the Executive Director of Financial Services upon recommendation of the Assistant Director of Human Resource Management (HRM) based on the amount of overpayment, as long as the deducted amount does not bring the employee's biweekly gross hourly wage amount below the federal minimum wage unless indicated by written approval from the employee.
4. Personal payment from employee:
   - Personal payment may be in the form of check or money order made payable to LSUHSC - NO.

If an employee, who has been overpaid is separating or being terminated, the amount of the overpayment shall be withheld from the employee's final paycheck. If the full amount is not recovered by such withholding, LSUHSC shall proceed under the Plan of Action for Recoupment from Separated Employees, contained in this Policy.

E. Plan of Action for Recoupment from Employees Transferring to Another State Agency:

If an overpaid employee is transferring to another state agency, and LSUHSC – NO has not completed the recoupment process, LSUHSC – NO shall notify the new agency that the employee has an outstanding balance due LSUHSC - NO. LSUHSC - NO shall provide pertinent documentation regarding the details of the overpayment and the recoupment plan established. The two agencies will then work together to determine a reasonable solution for recouping the overpayment from the employee and for transferring funds received at the new agency back to LSUHSC - NO. If a payment plan is established in the payroll system of the new agency, the amount to be recouped in a onetime payment or in recurring payments shall not bring the employee's biweekly gross hourly wage amount below the federal minimum wage, unless the employee agrees to have a larger amount withheld in writing.

F. Plan of Action for Recoupment from Separated Employees:

If an overpayment was made to an employee and recoupment is first attempted after the employee has separated from or terminated employment with LSUHSC – NO, the debt shall not be forgiven. LSUHSC – NO will notify the employee of the overpayment according to guidelines for Notification of Overpayment, contained in this Policy, and repayment will be demanded. The following repayment options are available:

1. One-time personal payment from employee:
    - A one-time personal payment will be required in the form of a check or money order made payable to LSUHSC - NO.
2. Payment plan as agreed upon by LSUHSC – NO for a period not to exceed twelve (12) months:
    - A payment plan of multiple payments may be established by the Executive Director of Financial Services upon recommendation of the Assistant Director of HRM.

If LSUHSC – NO is unable to recover overpayments from a separated employee, the legal department will be consulted to determine if legal recourse is warranted.

G. Notification of Recoupment Policy

All current employees will be notified of this Policy.

As a condition of employment, all prospective employees shall sign a statement acknowledging his/her understanding of the recoupment policy and that, if overpaid, the overpayment may be recouped in a future pay period after notification from LSUHSC - NO in accordance with this Policy. Job offers will be withheld to prospective employees who fail to comply with this Policy.

H. Collection and Reporting of Accounts Receivable

LSUHSC – NO shall handle all applicable reimbursed overpayments in compliance with the policies and procedures for the collection and reporting of accounts receivable which are published in the November 20, 2002 edition of the Louisiana Register.

I. Dispute Procedure

If an employee/separated employee does not agree with LSUHSC – NO's claim of overpayment, the employee/separated employee may file an appeal with HRM. The appeal must be received by HRM no later than fourteen (14) days from the date of Notification of Overpayment from the Payroll Department. The appeal must be in writing, explain why the employee/separated employee believes recoupment is not warranted, and must contain any supporting documentation to be considered for review. The Assistant Director of HRM shall make a recommendation to the Executive Director of Financial Services. The Executive Director of Financial Services or his/her designee shall accept, reject, or modify the recommendation. The decision of the Executive Director of Financial Services shall be final. The decision shall be in writing and sent to the employee/separated employee, and a copy shall be sent to the Payroll Department.

Signed: Larry H. Hollier, Chancellor

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

"I ______________________________ 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 ______________________________ and according to the best of my ability and understanding. So help me God."

____
Signature

____
Date

____
Department

EFFECTIVE DECEMBER 1, 2005
NOTICE REGARDING LOUISIANA OFFICE OF RISK MANAGEMENT
WORKERS' COMPENSATION INSURANCE
LOUISIANA SECOND INJURY FUND
POST-OFFER, MEDICAL QUESTIONNAIRE
E-2 FORM

This Notice and Procedures regarding the Louisiana Second Injury Fund Post-Offer, Pre-existing Conditions Medical Inquiry Questionnaire (E-2) are to be distributed with the form to all State agencies insured for workers compensation by the Office of Risk Management. The purpose of the E-2 form is to request pre-existing medical condition information, in accordance with Louisiana R.S. 23:1208.1 of the Workers' Compensation Law.

The form will be used only in the event the employee experiences a work-related injury and becomes eligible for workers' compensation benefits. The Second Injury Fund statute allows for reimbursement of a portion of the funds spent on workers' compensation claims if the employer can show it knowingly retained or knowingly hired an employee with a pre-existing disability. To establish this fact, ORM requires all employees to complete the attached questionnaire upon hire and once every two years thereafter. Employees who have not previously completed an E-2 form should do so now. Agencies are to immediately destroy ALL previous versions of the E-2 form and begin using this form.

IMPORTANT: The completed E-2 form MUST be treated as confidential medical information and kept in a Second Injury Fund Medical file separate from the employee's personnel file. It must be used only in the event an employee receives workers' compensation benefits, and for the specific purpose of submitting a claim to the Second Injury Fund. If the employee sustains a work-related accident, the agency of employment must notify ORM that there is a completed E-2 form on file at the same time that it is notified of the Employers' First Report of Occupational Injury or Disease Form (E-1).

The Americans with Disabilities Act (ADA) permits such medical inquiries only in the "post offer" stage of employment. This is the period between the time when an applicant is given a job offer and before starting work. Therefore, the employer should only require the completion of this form after the offer of employment is made. Furthermore, the information obtained from this form cannot be used to discriminate against qualified individuals with disabilities who can perform the essential functions of the job, with or without accommodation. Your agency should consult its own legal counsel regarding any questions about the appropriate use of this form.

R. S. 23:1208.1 of the Louisiana Workers' Compensation Law reads:

> Nothing in this title shall prohibit an employer from inquiring about previous injuries, disabilities, or other medical conditions and the employee shall answer truthfully; failure to answer truthfully shall result in the employee's forfeiture of benefits under this chapter, provided said failure to answer directly relates to the medical condition for which a claim for benefits is made or affects the employer's ability to receive reimbursement from the second injury fund. This Section shall not be enforceable unless the written form on which the inquiries about previous medical conditions are made contains a notice advising the employee that his failure to answer truthfully may result in his forfeiture of workers' compensation benefits under R. S. 23:1208.1. Such notice shall be prominently displayed in bold faced block lettering of no less than ten point type.

PROCEDURES FOR SOLICITATION AND MAINTENANCE

OF

LOUISIANA SECOND INJURY FUND QUESTIONNAIRE

PRE-EXISTING CONDITIONS MEDICAL INQUIRY

1. Read the NOTICE regarding the Workers' Compensation Insurance Second Injury Fund, Post- Offer, Medical Questionnaire.

2. All State agencies should require, after an offer of employment is made, and every two years thereafter, the completion of the LOUISIANA SECOND INJURY FUND PRE-EXISTING CONDITIONS MEDICAL INQUIRY form (E-2).

3. The completed E-2 form must be signed and dated by the employee and by a representative of the agency, placed in an envelope and immediately sealed. The envelope should be sent out along with the form, so that the form can immediately be protected from public view. The completed E-2 form MUST be treated as confidential medical information and kept in a Second Injury Fund Medical file separate from the employee's personnel file.

4. The envelope containing the completed E-2 form must be clearly labeled. A sample is below.

sample label

LOUISIANA SECOND INJURY FUND QUESTIONNAIRE POST-OFFER, PRE-EXISTING CONDITIONS MEDICAL INQUIRY John Q. Public SSN: _ _ _ - _ _ - _ _ _ _ CONFIDENTIAL MEDICAL INFORMATION

5. In the event the employee sustains a work-related injury or illness, a statement must be attached to the E-1 (Employer's Final Report of Occupational Injury or Disease) indicating there is a completed E-2 form on file with the employer. This notification will be followed up with a visit from the representative filing claims for the Second Injury Fund.

6. The representative will unseal the envelope and make a copy of the E-2 form to file a claim with the Second Injury Fund. The original form will be placed back in the same envelope, sealed, and placed back into the confidential medical file.

7. Steps 5 and 6 above are to be followed <u>each time</u> there is a work related injury, even if the injured worker has filed or will file multiple claims.

8. These procedures shall apply to both the one-page E-2 form previously solicited as well as to this new, revised E-2 form.

Name: ____ **Date**___________________________________

Agency/Department: _________________________________ **Position:** ______________________________

LOUISIANA SECOND INJURY FUND
POST OFFER, PRE-EXISTING CONDITIONS, INJURIES OR ILLNESSES
MEDICAL INQUIRY (E-2)

NOTICE TO EMPLOYEES:
Your employer is committed to providing Workers' Com pensation benefits, in accordanc e with state law, if you sustain an employment-related injury. This form reques ts medical information and will be kept confidential and separate from your personnel file. It will be used only in the event you experience a work-related injury and become eligible for Workers' Compensation benefits. The employer requires that all employees complete this questionnaire upon hire and every two years thereafter. The information is needed because if a work-related injury or disability is caused or made worse by a pre-existing condition, your employer may be able to seek reimbursement of the benefits paid from the Louisiana Second Injury Fund. This reimbursement would not reduce your workers' compensation benef its. In order to be considered for reimbursement, an employer must show it knowingly hired or knowingly retained an employ ee with a pre-existing disability. Disclosure of a pre-existing condition shall not be used for any discriminatory purpose. THE FAILURE TO ANSWER TRUTHFULLY ANY OF THE QUESTIONS ON THIS FORM MAY RESULT IN THE FORFEITURE OF WORKERS' COMPENSATION BENEFITS UNDER LA. R.S. 23:1208.1.

SECTION 1: DO YOU HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING?

Do not leave any blank unanswered. Please provide explanations for all "yes" responses under Remarks.

YES	NO		YES	NO	
☐	☐	Amputation (foot, leg, arm, hand, or total loss thereof)	☐	☐	Loss of Use of Limbs
			☐	☐	Mental Disorders
☐	☐	Ankylosis of Joints	☐	☐	Mental Retardation
☐	☐	Arteriosclerosis	☐	☐	Multiple Sclerosis
☐	☐	Arthritis	☐	☐	Muscle, Ligament or Tendon Injury
☐	☐	Asbestosis	☐	☐	Muscular Dystrophy
☐	☐	Asthma	☐	☐	Nervous Disorders
☐	☐	Back/Neck Problem	☐	☐	Numbness of Extremities
☐	☐	Brain Damage	☐	☐	Parkinson's Disease
☐	☐	Bronchitis	☐	☐	Psychoneurotic Disability
☐	☐	Cancer (following			treatment in a
☐	☐	Cardiac Disease			recognized medical or mental
☐	☐	Carpal Tunnel Syndrome			institution)
☐	☐	Cerebral Vascular Accident	☐	☐	Reflex Sympathetic Dystrophy
☐	☐	Chronic Headaches	☐	☐	Repetitive Motion Injury
☐	☐	Chronic Osteomyelitis	☐	☐	Residual Disability from Polio
			☐	☐	Rheumatism
☐	☐	Compressed Air Sequelae	☐	☐	Rotator Cuff Injury
☐	☐	Diabetes	☐	☐	Ruptured Intervertebral Disc
☐	☐	Dizziness	☐	☐	Silicosis
☐	☐	Double Vision (blurred sight)	☐	☐	Spinal Fusion
☐	☐	Emphysema	☐	☐	Stroke
☐	☐	Epilepsy	☐	☐	Sugar in Urine
☐	☐	Head Injury	☐	☐	Surgical Removal of Intervertebral
☐	☐	Heart Condition Disc			
☐	☐	Heavy Metal Poisoning	☐	☐	Thrombophlebitis
☐	☐	Hemophilia	☐	☐	Thoracic Outlet Syndrome
☐	☐	High/Low Blood Pressure	☐	☐	Thyroid Condition

☐	☐	Hodgkin's Disease	☐	☐	"Trick" Knee or Shoulder
☐	☐	Hyperinsulinism	☐	☐	Tuberculosis
☐	☐	Hypertension	☐	☐	Varicose Veins
☐	☐	Ionizing Radiation Injury			
☐	☐	Kidney Disorder			
☐	☐	Loss of Hearing (more than 75%)			
☐	☐	Loss of Sight (of one or both eyes or a partial loss of uncorrected vision)			

REMARKS: If you answered "yes" to any question above, indicate the nature of the injury/illness, name and address of the treating health care provider, area of specialty and approximate date/year of the illness/injury.

____

____

____

____

SECTION 2: PLEASE ANSWER THE FOLLOWING QUESTIONS AND PROVIDE AS MUCH INFORMATION AS POSSIBLE.

1. Has any doctor ever restricted your activities due to injury, disability or medical condition?

☐ **YES** ☐ **NO**

If yes, please describe the reason for the restrictions, the type of restrictions, whether the restrictions were temporary or permanent, and whether you presently have any restrictions on your physical activities.

____

____

2. Have you ever been assessed any percentage of permanent disability to any part of your body?

☐ **YES** ☐ **NO** If yes, please explain:

____

____

3. Are you presently or have you ever been under the care of a doctor, chiropractor, or other health care provider for any serious injury, disability or medical condition?

☐ **YES** ☐ **NO**

If yes, please list the condition, injury or illness(s) being treated, the name of the doctor(s), field of specialty, address and telephone number, and dates of treatment.

____

____

4. Are you presently or have you ever taken any medication for any serious injury, disability or medical condition?

☐ **YES** ☐ **NO**

If yes, please list the name or type of medication, the medical condition being treated, and the name, address and telephone number of the physician who prescribed the medication, area of specialty, and dates of treatment.

____

____

5. Have you ever had surgery (other than cosmetic) to any part of your body ? ☐ **YES** ☐ **NO**

If yes, please list the part(s) of the body operated on, the type of operation performed, the date (or approximate date), the hospital, and the name, address, and phone number of the doctor performing the surgery (if known).

____

____

____

6. Have you ever received treatment for your head, neck, back or extremities (arms, wrists, legs, knees, etc.) from a doctor, chiropractor, physical therapist or other health care provider?

☐ **YES** ☐ **NO**

If yes, please list the name, address and phone number of all doctors, chiropractors, physical therapists, and other health care providers who provided such treatment, the dates of the treatment and the diagnosis provided.

____

____

____

7. Are you aware of any physical condition or injury that might impair or limit your ability to work in this position? ☐ **YES** ☐ **NO** If yes, please describe the condition or injury.

____

____

8. Have you ever received workers' compensation benefits for an injury that occurred at work?

☐ **YES** ☐ **NO**

If yes, please list the name of the employer, the nature of the injury and the dates, and the dates you received compensation.

____

____

I HAVE READ ALL *3* PAGES OF THE LOUISIANA SECOND INJURY FUND POST OFFER OF EMPLOYMENT MEDICAL INQUIRY. I FULLY UNDERSTAND AND HAVE TRUTHFULLY AND FULLY ANSWERED ALL OF THE QUESTIONS, TO THE BEST OF MY KNOWLEDGE, INFORMATION AND BELIEF.

I UNDERSTAND THAT MY FAILURE TO TRUTHFULLY ANSWER ANY OF THE ABOVE QUESTIONS MAY RESULT IN THE FORFEITURE OF WORKERS' COMPENSATION AND MEDICAL BENEFITS UNDER THE LOUISIANA WORKERS' COMPENSATION STATUTE (LA.R.S. 23:1208.1).

SIGNATURE: ____ **DATE:** ________________

WITNESS: ____ **DATE:** ________________

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: ____________________

Social Security Number: ____________________

Date of Birth: ____________________

Selective Service No.; if applicable ____________________

Signature: ____________________

LOUISIANA STATE UNIVERSITY HEALTH SCIENCE SYSTEM

Alien Tax Information Request

All non-U.S. citizens who receive compensation from Louisiana State University Health Science Center must complete this form. The information you provide is used to determine your residency status for the purposes of U.S. tax withholding.

Please print.

1. PERSONAL INFORMATION

Last Name	First Name	Middle	U.S. Social Security Number

Street Address
(In home Country)

Postal Code	Province/Region	City	Country

2. STUDENT INFORMATION

Name of Academic Department

Are you a student?
☐ Yes ☐ No

If you have attended or currently attending another U.S. educational institution, provide:

Name of educational institution:

Period of attendance: From to

Degree Granted (if any):

Did you receive tax treaty benefits at another U.S. educational institution during the current year?

☐ Yes ☐ No

3. IMMIGRATION & ALIEN TAX INFORMATION
(Permanent residents with Green Cards may skip section 3.g, but must provide copy of documentation)

a. Date of first U.S. entry	b(1). Visa type upon first U.S. entry	b(2). If you arrived on spouse/dependent visa, what was the visa type of the primary visa holder (ex. visa type/student or non student)?

c. Current Visa type (check appropriate box):

☐ F-1 Student ☐ F-1 Student (on practical training) ☐ F-2 Spouse/Dependent of F-1 ☐ H-1 Distinguished Worker

☐ J-1 Student ☐ J-1 Student (on "academic training") ☐ J-2 Spouse/Dep. of J-1 Student ☐ TN – NAFTA Free Trade

☐ Other J-1 Visitor (_one)
- ☐ Short-term scholar
- ☐ Professor
- ☐ Research Scholar
- ☐ Other

☐ Other INS classification (list status): ______

☐ U. S. Permanent Resident (must provide documentation; e.g., copy of green card, etc.)

d. Country of Birth

e. Country of Citizenship

f. Country of Residence (for tax purposes)

g. Furnish the requested information to detail the number of days you were physically present in the United States during the calendar years listed below. Note: The term "calendar year" refers to the period January 1 to December 31.

	Calendar Year (e.g. 19)	Number of days present in U.S. during the year	Date of Entry	Date of Exit	Visa	J-1 Sub type (if applicable)	Did you receive tax treaty benefits?
Current Calendar year	2 0 0 9						☐ Yes ☐ No
Last Calendar year							☐ Yes ☐ No
Two years ago							☐ Yes ☐ No
Three years ago							☐ Yes ☐ No
Four years ago							☐ Yes ☐ No
Five years ago							☐ Yes ☐ No
Six years ago							☐ Yes ☐ No

RESIDENCE FOR TAX PURPOSES
Under Internal Revenue Service definitions,
For tax purposes I am considered a ☐ **RESIDENT ALIEN** ☐ **NONRESIDENT ALIEN**

4. CERTIFICATION OF INFORMATION

I certify to the best of my knowledge, all of the information I have provided above is true, correct and complete. Also, I understand it is my responsibility to keep my employment authorization documents including passport, IAP-66, I-20, I-688B, or other INS employment authorization current (un expired) at all times. To avoid being removed from the University payroll, I will inform Payroll of any extensions, renewals, or changes in status by completing an I-9 form in the International Services Office by the expiration date of the employment documentation.

Signature **Date Completed:**

LSU Health Sciences Center - New Orleans

Department of Human Resource Management

Annual Policy Newsletter

Revised May, 2008

Equal Employment Opportunity Policy

The Louisiana State University Health Sciences Center-New Orleans (LSUHSC-NO) recognizes its legal and moral obligations to guarantee equal employment opportunity to all persons in all segments of University life. We also recognize the historical denial of equal opportunity to certain segments of our population. We are, therefore, committed to providing equal opportunity at LSUHSC-NO to fulfill our legal and moral obligations.

It is with genuine concern for all the people that we publicly express our commitment to equal employment opportunity and a diverse workplace. This commitment includes not only providing equity in our present employment practices, but also a commitment to the removal of past barriers that hinder equal employment opportunities.

LSUHSC-NO is committed to this policy because it is our belief that it is morally right, it is good personnel management, and it is legally required by Title VII of the Civil Rights Act of 1964, as amended by Equal Employment Opportunity Act of 1972, Executive Order Number 11246, the Rehabilitation Act of 1973, as amended, Title IX of the Education Amendment of 1972, the Vietnam Era Veterans Readjustment Assistance Act of 1974, Governor Edwin Edwards' Executive Order Number 13, and Louisiana Fair Employment Practices Act.

LSUHSC-NO will take affirmative action to insure that the following will be implemented at all levels of administration.

1. Base employment decisions so as to further the principles of equal employment opportunity;
2. Ensure that all personnel actions, such as, compensation, tenure, benefits, transfers, layoffs, education, tuition assistance, social and recreational programs are administered without regard to race, color, religion, sex, age, national origin, handicap or veteran status, or any other non-merit factor.
3. Basic guidelines and methods of achieving the goal of equal employment opportunity will be set forth in the LSUHSC-NO Diversity Program.

Overall responsibility for the reaffirmation of policy and program is the responsibility of the Chancellor's Office. Implementation of the program coordination and monitoring to ensure compliance is the responsibility of Human Resource Management. Any persons having questions regarding this program should contact the Human Resource Management Labor Relations Manager, 568-2029.

Changes to The Family and Medical Leave Act extends to close relatives of Service Members

On January 28, 2008, President Bush signed into public law, the National Defense Authorization Act (NDAA). The NDAA amends the Family and Medical Leave Act of 1993 (FMLA) to provide eligible employees two new leave rights related to military service:

1) New Leave Entitlement which permits an eligible employee who is the "spouse, son, daughter, parent, or next of kin" to take up to 26 workweeks of leave to care for a "member of the Armed Forces, including a member of the National Guard or Reserves, who is undergoing medical treatment, recuperation, or therapy, is otherwise in outpatient status, or is otherwise on the temporary disability retired list, for a serious injury or illness."

2) New Qualifying Reason for Leave which permits an eligible employee to take 12 weeks of leave because of "any qualifying exigency" arising out of the fact that the spouse, or a son, daughter, or parent of the employee is on active duty or has been notified of an impending call or order to active duty in the Armed Forces in support of a contingency operation. By its express terms, this provision of the NDAA is not effective until the Secretary of Labor issues final regulations defining "any qualifying exigency." The Department of Labor has not issued the final regulation. For additional information on the FMLA changes contact the Labor Relation section of Human Resources

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Have you seen us on the web?

www.lsuhsc.edu/no/administration/hrm/

The Family and Medical Leave Act

The Family and Medical Leave Act (FMLA) requires that eligible employees be granted up to 12 weeks per year of unpaid, job protected leave for certain family and medical reasons. The State of Louisiana uses the "rolling year" method to determine the year.

Eligibility

Employees who have worked at least one (1) year and have worked at least 1,250 hours during the preceding 12 month period are eligible for FMLA. For employees not eligible for FMLA, LSUHSC-NO will review business considerations and the individual circumstances involved. Employees will be returned to the same or equivalent positions upon return from FMLA.

Leave

FMLA leave will consist of, and run concurrently with, appropriate accrued paid leave and unpaid leave. If leave is requested for an employee's own serious health condition, the employee must first use all of his/her accrued paid sick and annual leave. If leave is requested for reasons other than one's own health condition, the employee must first use all of his/her accrued annual leave. The remainder of the leave period will consist of unpaid leave. All leave, whether paid annual, paid sick, or unpaid, will also be recorded as FMLA.

Notice and Medical Certification

In all cases, an employee requesting FMLA must complete an "Application for Leave" form indicating that the intended leave is FMLA. Additionally, the employee is required to submit a completed "Certification of Physician or Practitioner" form.

An employee intending to take FMLA because of an expected or planned event, must submit an application for leave 30 days in advance of the leave, or as soon as the necessity for the leave arises.

When it is impossible, due to medical necessity, to provide advance notice, the leave will be granted conditionally based upon the information provided by the employee. Final approval or denial will be given upon receipt of the "Certification of Physician or Practitioner" form.

The law requires that the employer record leave as FMLA (even when the employee has not requested FMLA) when the employer has information that the absence is due to a qualifying event under FMLA.

Any additional information on the FMLA policy can be obtained from the Labor Relations Section of Human Resources , (504) 568-3916. The Family Medical Leave Act may be accessed through the LSUHSC-NO website (LSUHSC Policies-CM-50). http://www.lsuhsc.edu/no/administration/cm/cm-50.aspx

Americans With Disabilities Act of 1990 Policy

LSUHSC-NO is an equal opportunity employer and makes employment decisions on the basis of merit. We want to have the best available persons in every job. The LSUHSC-NO policy prohibits unlawful discrimination based on race, color, creed, sex, age, national origin, physical handicap, disability, medical condition or any other consideration made unlawful by federal, state, or local laws. All such discrimination is unlawful. To comply with applicable laws insuring equal employment opportunities to qualified individuals with disabilities, LSUHSC-NO will make reasonable accommodations for the known physical or mental limitations of an otherwise qualified individual with a disability who is an applicant or an employee unless undue hardship would result. Any applicant or employee who requires an accommodation in order to perform the essential functions of the job should contact their supervisor or the Department of Human Resource Management Labor Relations Manager, (504) 568-3916 and request such an accommodation. The individual with the disability should specify what accommodation he/she needs to perform the job.

For more information visit the Human Resources Management website at www.lsuhsc.edu/no/administration/hrm/labor%20relations/ada or the LSUHSC-NO Policies website (CM-26)

Discrimination Complaints

Make TRUST DIGNITY RESPECT The Foundation of Our Workplace

If you believe you have been subjected to any form of unlawful discrimination, provide a written complaint to the Department of Human Resource Management. If the complaint relates to personnel of the Department of Human Resource Management, submit the complaint to the Vice Chancellor for Administration and Finance. Your complaint should be specific and include the names of individuals involved and the names of witnesses. LSUHSC-NO will immediately undertake an effective, thorough, and objective investigation and attempt to resolve the situation. If LSUHSC-NO determines that unlawful discrimination has occurred, effective remedial action will be taken to deter any future discrimination. Whatever action is taken will be made known to you and LSUHSC-NO will take appropriate action to remedy any loss to you as a result of the discrimination. LSUHSC-NO will not retaliate against you for filing a complaint and will not willingly permit retaliation by management, employees or coworkers.

Questions or concerns should be directed to Human Resources Labor Relations (504) 568-3916.

Sexual Harassment

The policy of LSUHSC-NO always has been that all employees should be able to enjoy a work environment free from all forms of discrimination, including sexual harassment.

Sexual harassment is a form of misconduct which undermines the integrity of the employment relationship. No employee...either male or female… should be subjected to unsolicited and unwelcome sexual overtures or conduct, either verbal or physical. Sexual harassment does not refer to the occasional compliments of a socially acceptable nature. It refers to behavior which is not welcome, which therefore interferes with our work effectiveness.

Such conduct, whether committed by supervisors or non-supervisory personnel, is specifically prohibited. This includes: repeated offensive sexual flirtations, advances or propositions, graphic or degrading verbal comments about an individual or his/her appearance, the display of sexually suggestive objects or pictures, or any offensive or abusive physical conduct.

Accusations of sexual harassment which are found to be valid may subject the individual (s) involved to severe disciplinary action or termination of employment.

In addition, no one should imply or threaten that an applicant's or employee's "cooperation" of a sexual nature (or refusal thereof) will have any effect on the individual's employment, assignment, compensation, advancement, career development, or any other condition of employment.

Any questions regarding either this policy or a specific fact situation should be addressed to the appropriate supervisor, Director of Human Resource Management, or Labor Relations Manager. The Sexual Harassment policy –CM49 may be accessed through the LSUHSC website at http://www.lsuhsc.edu/no/administration/cm/cm-49.aspx

Sexual harassment is based on how the person being harassed is affected, not on the harasser's intent.

IMPORTANT: TAKE ALL THREATS SERIOUSLY

Violence in the Workplace

LSUHSC-NO recognizes that employees are its most valuable resource. Every employee has a reasonable expectation to perform his/her assigned duties in an atmosphere free of threats and assaults. LSUHSC-NO will take positive action to ensure that the following is implemented throughout all work environments within its jurisdiction:

1. The commitment of management and employees to promote a positive, respectful, and safe work environment that fosters employees' security, safety, and health.
2. Zero tolerance for the occurrence of violence, aggressive acts, verbal or non-verbal threatening behavior and harassment in the workplace.
3. Eliminating and prohibiting acts of threats of violence, by or against employees at all work sites and wherever LSUHSC-NO business is conducted.
4. Minimize the chance of exposure of employees to violent, threatening, or harassing situations by implementing effective security measures, procedures, and practices.
5. Educate employees to increase awareness about health, and safety concerns, and train them how to properly respond in the event a violent, threatening, or harassing situation occurs.

Maintaining a violence-free workplace requires the commitment, involvement, and cooperation of management and employees. Persons who fail to adhere to the violence-free workplace policy are subject to administrative disciplinary action.

Employees are required to report to the appropriate supervisor, Department Head, or University Police all threats or incidents of violent behavior in the workplace which they observe or of which they are informed. Examples of inappropriate behavior which shall be reported include (but not limited to):

- Unwelcome name-calling, obscene language, and other abusive behavior.
- Intimidation through direct or veiled verbal threats..
- Physically touching another employee in an intimidating, malicious, or sexually harassing manner, including such acts as hitting, slapping, poking, kicking, pinching, grabbing, and pushing.
- Physically intimidating others including such acts as obscene gestures, "getting in your face," fist-shaking, throwing any object.

If a situation is dangerous contact University Police at 568-8999; or local police at 821-2222; or 911.

The *Violence in the Workplace Prevention Plan* CM-44 can be accessed through the LSUHSC-NO website http://www.lsuhsc.edu/no/administration/cm/cm-44.aspx

Federal False Claims Act

The False Claims Act, 31 USC § 3279 is a federal statute that covers fraud involving any federally funded contract or program, including the Medicaid and Medicare programs. This act is commonly known as the "Lincoln Law" because it was first enacted to counter fraudulent activities involving military procurement during the Civil War. The act establishes liability for any person who knowingly presents or causes to be presented a false or fraudulent claim to the U.S. government for payment

Health care providers and suppliers who violate the False Claims Act can be subject to civil monetary penalties (CMP) ranging from $5,500 to $11,000 for each false claim submitted, can be required to pay three times the amount of damages sustained by the U.S. government and if convicted of a False Claims Act violation, the OIG may seek to exclude the provider or supplier from participation in federal health care programs.

"Qui Tam "Whistleblower" provisions encourage individuals to come forward and report misconduct involving false claims. The False Claims Act includes a "qui tam" or whistleblower provision."

It allows any person with actual knowledge of allegedly false claims to the government. Such persons are know as a "realtors." By way of example, the U.S. Department of Justice reports that the federal government obtained more than $1.4 billion in settlements and judgments for fraud committed against the government in 2004-2005.

Qui Tam Procedure

The relator must file his or her lawsuit on behalf of the government in a federal district court. The lawsuit will be file "under seal," meaning that the lawsuit is kept confidential while the government reviews and investigates the allegations contained in the lawsuit and decides how to proceed. If the government determines that the lawsuit has merit and decides to intervene, the prosecution of the lawsuit will be directed by the U.S. Department of Justice. If the government decides not to intervene, the whistleblower can continue with the lawsuit on his or her own. If the lawsuit is successful, and provided certain legal requirements are met, the qui tam relator may receive an award ranging from 15 to 30 percent of the amount recovered. The whistleblower may also be entitled to reasonable expenses including attorney's fees and costs for bringing the lawsuit. In addition to a financial award, the False Claims Act entitles whistleblowers to additional relief, including employment reinstatement, back pay, and any other compensation arising from retaliatory conduct against a whistleblower for filing an action under the False Claims Act or committing other lawful acts, such as investigating a false claim or providing testimony for, or assistance in, a False Claim Act action.

Louisiana State Law

Under Louisiana state law, the definition of a false or fraudulent claim is slightly broader, At LSA R.S. 46.437.--, "8) "False or fraudulent claim" means a claim which the health care provider

Federal False Claims Act Continued...

or his billing agent submits knowing the claim to be false, fictitious, untrue, or misleading in regard to any material information. “

Just as with the federal whistleblower statute, under Louisiana state law, “a private person (“Qui Tam plaintiff) may institute a civil action (“Qui Tam Action”) in the courts of this state on behalf of the medical assistance programs and himself to seek recovery

A person who is or was a public employee or public official or a person who is or was acting on behalf of the state shall not bring a qui tam action if the person has or had a duty or obligation to report, investigate, or pursue allegations of wrongdoing or misconduct by health care providers, or had access to the records of the state through the normal course and scope of his employment relative to activities of health care providers.

No employer of a qui tam plaintiff shall discharge, demote, suspend, threaten, harass, or discriminate against a qui tam plaintiff at any time arising out of the fact that the qui tam plaintiff brought an action pursuant to this Subpart unless the court finds that the qui tam plaintiff has instituted or proceeded with an action that is frivolous, vexatious, or harassing.

No employee shall be discharged, demoted, suspended, threatened, harassed, or discriminated against in any manner in the terms and conditions of his employment because of any lawful act engaged in by the employee or on behalf of the employee in furtherance of any action taken pursuant to this Part in regard to a health care provider or other person from whom recovery is or could be sought. Such an employee may seek any and all relief for his injury to which he is entitled under state or federal law.

No individual shall be threatened, harassed, or discriminated against in any manner by a health care provider or other person because of any lawful act engaged in by the individual or on behalf of the individual in furtherance of any action taken pursuant to this Part in regard to a health care provider or other person from whom recovery is or could be sought except that a health care provider may arrange for a recipient to receive goods, services, or supplies from another health care provider if the recipient agrees and the arrangement is approved by the secretary. Such an individual may seek any and all relief for his injury to which he is entitled under state or federal law.

Generally, if the secretary or the attorney general intervenes in the action brought by a qui tam plaintiff, the qui tam plaintiff shall receive at least ten percent, but not more than twenty percent, of recovery, exclusive of the civil monetary penalty provided in R.S. 46:439.6(C). In making a determination of award to the qui tam plaintiff the court shall consider the extent to which the qui tam plaintiff substantially contributed to investigations and proceedings related to the qui tam action.

State law provides that there may be a reward of up to two thousand dollars to an individual who submits information to the secretary which results in recovery pursuant to the provisions of this Part, provided such individual is not himself subject to recovery under this Part.

Louisiana State False Claims penalties include payment of actual damages, civil fine not to exceed 10,000 dollars per violation or a civil fine not to exceed three times the value of the illegal remuneration, whichever is GREATER, and payment of interest on the mandatory civil fine imposed.

LSUHSC_NO’s DRA Notice

http://www.lsuhsc.edu/no/administration/ocp/dranotice.aspx

LSUHSC-NO’s Whistleblower Policy

http://www.lsuhsc.edu/no/administration/cm/cm-53/PatientInformationpolicy5.aspx

The Office of Compliance Programs

INTEGRITY • TRUST • PRIVACY • ACCOUNTABILITY

Phone:(504)568-2350

Hotline:(855)561-4099

Fax:(504) 568-7399

LSUHSC Drug Testing Program

It is the policy of LSUHSC-NO to promote and safeguard the workplace from consequences of alcohol and drug use. Statistics show that approximately 60 percent of all illegal drug users are employed either full or part-time.

The purpose of implementing a drug testing program is threefold:

1. Consistently provide the highest quality service to patients and customers.
2. Comply with the Federal Drug Free Workplace Act of 1988.
3. Provide a safe and healthy environment for patients, employees, visitors, and all members of the community.

What are the Different Types of Testing?

There are basically 5 different types of urine testing and one type of alcohol testing at LSUHSC-NO.

Types of Urine Drug Testing:

Post Job Offer

Post-job offer testing is a requirement for all applicants that have completed the interview process and have been offered a position contingent upon a negative drug test result.

Reasonable Suspicion/For Cause

Any individual may be tested who is suspected of being under the influence of alcohol, legal and/or illegal drugs. Suspicion is based on observable behavior, physical symptoms, and/or evidence of drug tampering or physical symptoms, and/or evidence of drug tampering or misappropriation.

Periodic Monitoring/After Case

Upon the completion of an outpatient or inpatient treatment program for substance abuse, the employee will be required to submit to periodic and/or aftercare testing and monitoring.

Post-Accident

Any individual involved in a job-related accident, and who is suspected of drug or alcohol use will be subjected to a urine drug test as soon as possible.

Random

In accordance with State law, employees whose principal responsibility is to operate public vehicles, maintain public vehicles, or supervise any employee who drives or maintains public vehicles are subject to random drug testing.

Breath Alcohol Testing

The devices used for breath alcohol testing measure alcohol concentration in breath. Breath alcohol testing is done for reasonable suspicion/for cause, periodic monitoring/aftercare, post-accident, and random. Trained Breath Alcohol Technicians conduct the breath tests.

What are the Testing Methods?

Enzyme Multiplied Immuno-assay Technique (EMIT) is used for preliminary or initial screening on urine drug tests. A positive EMIT test result will undergo Gas Chromatography/ Mass Spectrometry (GC/MS) for confirmation. This combination of tests is sensitive, specific, and can identify all types of drugs in any body fluid. All alcohol breath tests are subject to a confirmation test on an evidential breath test device according to Department of Transportation regulations when the result of the screening test is 0.020 or greater.

May I Challenge a Positive Result?

Yes, you may challenge a positive urine drug test result. Once you have been notified of a positive drug test result by either the Medical Review Officer (MRO) or the Drug Testing Coordinator, you must: 1) provide the Human Resource Management Department and the MRO a written request to retest the original specimen, 2) provide the MRO a written explanation for the legitimate use of any drug(s) and, 3) have the MRO receive the repeat test results within 10 working days of the initial notification of a verified positive test.

Retesting is done on the original specimen and must be requested by the MRO. Testing is done at the expense of the client and must be performed at a NIDA or CAP-FUDT certified laboratory.

The results of alcohol testing are available immediately. All positive screening tests will be confirmed in the individual's presence.

Standards of Conduct and University Sanctions

The unlawful possession, use, manufacture, distribution or dispensation of illicit drugs or alcohol on LSUHSC-NO property, in the workplace by any employee or student of LSUHSC-NO, or as any part of any functions or activities by any employee or student of LSUHSC-NO is prohibited.

Violations of the LSUHSC Standards of Conduct by individuals covered under this policy will result in disciplinary action. Depending on the nature of the offense, disciplinary action can take the form of a written reprimand, suspension, demotion, reduction in pay, or termination of the individual's association with LSUHSC-NO and referral for prosecution by civil authorities in accordance with local, State, and Federal law.

Campus Assistance
is located in
Nursing / Allied Health Bldg
1900 Gravier Street
7th floor Room 745
New Orleans, LA 70112
568-8888

Invitation for Self Identification

LSU Health Sciences Center-New Orleans is a Federal Contractor subject to the requirements of the Vietnam Era Veterans Readjustment Assistance Act of 1974, as amended (38USC 2012), and to the requirements of Section 503 of the Rehabilitation Act of 1973 as amended, and their implementing regulations.

If you are a person with a disability, a special disabled veteran, or a veteran of the Vietnam era, please tell us. Provision of this information is voluntary. If you do not wish to identify yourself at this time as a person with a disability, a special disabled veteran, or veteran of the Vietnam era, you will not be subject to any adverse treatment.

If you do wish to identify yourself, the information provided will be used only in accordance with the Acts and the regulations.

PERSONS wishing to self identify may access the INVITATION FOR SELF IDENTIFICATION at http://www.lsuhsc.edu/no/Administration/hrm/Forms/INVITATION%20FOR%20SELF%20IDENTIFICATION.pdf.

The completed form should be submitted to Human Resources, Labor Relations section located at 433 Bolivar, Room 603, New Orleans, LA 70112. The information provided will be kept confidential, except that:

A. Supervisors and managers may be informed of any restrictions of work or duties of persons with disabilities or special disabled veterans, and of any necessary accommodations;

of persons with disabilities or special disabled veterans, and of any necessary accommodations;

B. First aid and safety personnel may be informed, when and to the extent appropriate, if particular handicap or disability may require emergency treatment;

C. Government officials investigating compliance with the Acts shall be informed.

Any questions regarding the Invitation for Self Identification should be directed to the Labor Relations section of Human Resource Management at (504) 568-3916.

Post Offer, Pre-existing Conditions, Injuries or Illnesses Medical Inquiry Worker's Compensation

LSUHSC-NO is committed to providing Workers' Compensation benefits, in accordance with Louisiana R.S. 23:1208.1 of the Workers' Compensation Law, if an employee sustains an employment-related injury. The Post Offer, Pre-existing Conditions, Injuries or Illnesses Medical Inquiry (E-2) form request medical information and will be kept confidential and separate from your personnel file. It will be used only in the event you experience a work-related injury and become eligible for Workers' Compensation benefits.

In accordance with Louisiana R.S. 23:1208.1 of the Workers' Compensation Law, LSUHSC-NO requires that all employees complete this questionnaire upon hire and every two years thereafter. The information is needed because if a work-related injury or disability is caused or made worse by a pre-existing condition, LSUHSC-NO may be able to seek reimbursement of the benefits paid from the Louisiana Second Injury Fund. This reimbursement would not reduce an employee's workers' compensation benefits. In order to be considered for reimbursement, an employer must show it knowingly hired or knowingly retained an employee with a pre-existing disability. Disclosure of a pre-existing condition shall not be used for any discriminatory purpose.

FAILURE TO ANSWER TRUTHFULLY ANY OF THE QUESTIONS ON THE (E-2) FORM MAY RESULT IN THE FORFEITURE OF WORKERS' COMPENSATION BENEFITS UNDER LA. R.S. 23:1208.1.

The Post Offer, Pre-existing Conditions, Injuries or Illnesses Medical Inquiry (E-2) form may be downloaded at http://www.lsuhsc.edu/no/administration/hrm/Forms.aspx. Every two years and upon hire each employee must submit a completed form to Human Resource Management, attention Labor Relation, in a sealed envelope with label including your full name, employee Identification number, and department.

Any questions regarding the Post Offer, Pre-existing Conditions, Injuries or Illnesses Medical Inquiry (E-2) form should be addressed to the Assistant Director of Human Resource Management (504) 568-4834.

Overpayments

Louisiana State University Health Sciences Center – New Orleans (LSUHSC – NO) is required to recoup overpayments from both active and separated employees.

It is the policy of Louisiana State University Health Sciences Center – New Orleans (LSUHSC – NO) to recoup overpayments made to employees in accordance with La. Rev. Stat. 42:460 as promulgated by the Louisiana Administrative Code Title 4, Part III, Chapter 7. Overpayments occur when compensation that is not owed to the employee is paid in error. This includes but is not limited to overpayment of wages, annual leave paid in error, and erroneous refunds of deductions. Unearned payments to employees are prohibited by Article 7, Section 14 of the Louisiana State Constitution, which prohibits the donation of public funds. Therefore, LSUHSC – NO is required to recoup overpayments to both active and separated employees.

For more information on CM-57 Policy and Procedure for Recoupment of Overpayment go to

http://www.lsuhsc.edu/no/administration/cm/cm-57.aspx

Return to Work

Louisiana State University System provides workers' compensation benefits to its faculty and staff in accordance with Louisiana law. This coverage includes the University's modified duty program designed to encourage employees, who have been released to perform work with limitations to return to work.

LSU will make reasonable efforts to place the returning employee into a meaningful assignment, which he/she can perform while on modified duty on a temporary basis. LSU cannot guarantee placement and is under no obligation to offer, create, or encumber any specific position for purposes of offering placement.

Applicability

This policy only applies to permanent employees of LSU who are on leave as a result of work related injuries or illnesses and who are receiving workers' compensation benefits.

Modified Work Requirements

For work to be considered suitable modified employment, specific condition must be met. For a list of conditions and more information on PM-70 Return to Work Policy for Employees on Workers' Compensation visit http://lsuhsc.edu/no/administration/pm/pm-70.aspx or call Human Resources Labor Relations at (504) 568-3916.

Worker's Compensation

Worker's Compensation coverage is provided to LSUHSC-NO employees through the Office of Risk Management, Office of Workers' Compensation, Baton Rouge, Louisiana. It is the responsibility of each employee to report to their supervisor and/or designated departmental liaison any occupational injury or disease, even if it is deemed to be minor. An injured employee must give notice to the University within thirty (30) days of the injury to be eligible for Worker's Compensation benefits.

When an occupational injury results in an employee being away from work for a period of seven (7) calendar days or more, the department must notify the Employee/Labor Relations office via telephone (504) 568-3916 immediately so that compensation for any lost wages the employee may incur can be filed.

If a serious injury occurs on the job, it is necessary for your department to notify Human Resource Management/Labor Relations via telephone at (504) 568-3916 ***immediately***.

The *Employer's Report of Injury/Illness* should then be completed and sent to Human Resource Management Labor Relations,433 Bolivar St, New Orleans, LA 70112. For access to the Employer's Report of Injury/Illness form, go to http://www.lsuhsc.edu/no/Administration/hrm/Forms/WorkersComp.xls

Please note, when an employee reports an injury or disease to a ***supervisor,*** it becomes the responsibility of the ***supervisor*** to submit the *Employer's Report of Injury/Illness* to Human Resource Management as soon as possible. Failure to report in a timely fashion may result in a $500 fine being levied against LSU Health Sciences Center. Your cooperation is needed to insure that no penalties are incurred and to insure that employees interests are protected.

When completing the *Employer's Report of Injury/Illness,* please note that the hourly time must be indicated on the form. Also, if the employee has not returned to work at the time the form is completed, please indicate that fact and telephone Human Resource Management/Labor Relations at (504) 568-3916 the day the employee returns to work.

Bills or receipts for all medical expenses associated with injuries covered by Worker's Compensation are to be forwarded to Labor Relations, Human Resource Management promptly for further processing for payment.

When a minor injury occurs and no medical costs will be incurred, the Office of Risk Management/Unit of Risk Analysis and Loss Prevention Incident/Accident Investigation Form should be completed. It can be downloaded from the LSUHSC Homepage - Intranet - LSUHSC Forms - Adobe PDF Formats.

http://www.lsuhsc.edu/no/Administration/hrm/Forms/ACCIDENT.doc

To report an injury or to gain further information on the program, please contact Paulette Albera at (504) 568-3916.

Acknowledgement of Policies

I hereby certify that I have received information on, and I understand that I will be accountable for conducting my duties in the workplace in accordance with the information contained in this packet on the following topics:

- Equal Employment Opportunity Policy
- Americans With Disabilities Act of 1990 Policy
- The Family and Medical Leave Act Policy
- Violence in the Workplace Policy
- Drug Prevention Program/Policy
- Drug Testing Program
- Sexual Harassment Policy
- CM-23 Drug Free Workplace Policy
- Discrimination Complaints
- Standards of Conduct and University Sanctions
- Overpayments
- Pre-existing conditions
- Worker’s compensation
- Deficit Reduction Act

______________________________ ______________________________
Legal Name (please print) Signature

_________________________ _________________________
Date of Signature EMPLID

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

Form I-9, Employment Eligibility Verification

Instructions

Please read all instructions carefully before completing this form.

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

What Is the Purpose of This Form?

The purpose of this form is to document that each new employee (both citizen and non-citizen) hired after November 6, 1986 is authorized to work in the United States.

When Should the Form I-9 Be Used?

All employees, citizens and noncitizens, hired after November 6, 1986 and working in the United States must complete a Form I-9.

Filling Out the Form I-9

Section 1, Employee: This part of the form must be completed at the time of hire, which is the actual beginning of employment. Providing the Social Security number is voluntary, except for employees hired by employers participating in the USCIS Electronic Employment Eligibility Verification Program (E-Verify). **The employer is responsible for ensuring that Section 1 is timely and properly completed.**

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

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

Employers must complete **Section 2** by examining evidence of identity and employment eligibility within three (3) business days of the date employment begins. If employees are authorized to work, but are unable to present the required document(s) within three business days, they must present a receipt for the application of the document(s) within three business days and the actual document(s) within ninety (90) days. However, if employers hire individuals for a duration of less than three business days, **Section 2** must be completed at the time employment begins. **Employers must record:**

1. Document title;
2. Issuing authority;
3. Document number;
4. Expiration date, if any; and
5. The date employment begins.

Employers must sign and date the certification. Employees must present original documents. Employers may, but are not required to, photocopy the document(s) presented. These photocopies may only be used for the verification process and must be retained with the Form I-9. **However, employers are still responsible for completing and retaining the Form I-9.**

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

A. If an employee's name has changed at the time this form is being updated/reverified, complete Block A.

B. If an employee is rehired within three (3) years of the date this form was originally completed and the employee is still eligible to be employed on the same basis as previously indicated on this form (updating), complete Block B and the signature block.

C. If an employee is rehired within three (3) years of the date this form was originally completed and the employee's work authorization has expired **or** if a current employee's work authorization is about to expire (reverification), complete Block B and:

1. Examine any document that reflects that the employee is authorized to work in the U.S. (see List A **or** C);
2. Record the document title, document number and expiration date (if any) in Block C, and
3. Complete the signature block.

What Is the Filing Fee?

There is no associated filing fee for completing the Form I-9. This form is not filed with USCIS or any government agency. The Form I-9 must be retained by the employer and made available for inspection by U.S. Government officials as specified in the Privacy Act Notice below.

USCIS Forms and Information

To order USCIS forms, call our toll-free number at **1-800-870-3676**. Individuals can also get USCIS forms and information on immigration laws, regulations and procedures by telephoning our National Customer Service Center at **1-800-375-5283** or visiting our internet website at **www.uscis.gov**.

Photocopying and Retaining the Form I-9

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

The Form I-9 may be signed and retained electronically, as authorized in Department of Homeland Security regulations at 8 CFR § 274a.2.

Privacy Act Notice

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

This information is for employers to verify the eligibility of individuals for employment to preclude the unlawful hiring, or recruiting or referring for a fee, of aliens who are not authorized to work in the United States.

This information will be used by employers as a record of their basis for determining eligibility of an employee to work in the United States. The form will be kept by the employer and made available for inspection by officials of U.S. Immigration and Customs Enforcement, Department of Labor and Office of Special Counsel for Immigration Related Unfair Employment Practices.

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

Paperwork Reduction Act

We try to create forms and instructions that are accurate, can be easily understood and which impose the least possible burden on you to provide us with information. Often this is difficult because some immigration laws are very complex. Accordingly, the reporting burden for this collection of information is computed as follows: **1)** learning about this form, and completing the form, 9 minutes; **2)** assembling and filing (recordkeeping) the form, 3 minutes, for an average of 12 minutes per response. If you have comments regarding the accuracy of this burden estimate, or suggestions for making this form simpler, you can write to: U.S. Citizenship and Immigration Services, Regulatory Management Division, 111 Massachusetts Avenue, N.W., 3rd Floor, Suite 3008, Washington, DC 20529. OMB No. 1615-0047.

OMB No. 1615-0047; Expires 06/30/09

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

Form I-9, Employment Eligibility Verification

Please read instructions carefully before completing this form. The instructions must be available during completion of this form.

ANTI-DISCRIMINATION NOTICE: It is illegal to discriminate against work eligible individuals. Employers CANNOT specify which document(s) they will accept from an employee. The refusal to hire an individual because the documents have a future expiration date may also constitute illegal discrimination.

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

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

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

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

- ☐ A citizen or national of the United States
- ☐ A lawful permanent resident (Alien #) A ____________
- ☐ An alien authorized to work until ____________
  (Alien # or Admission #) ____________

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

Preparer and/or Translator Certification. *(To be completed and signed if Section 1 is prepared by a person other than the employee.) I attest, under penalty of perjury, that I have assisted in the completion of this form and that to the best of my knowledge the information is true and correct.*

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

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

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

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

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

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

A. New Name *(if applicable)*	B. Date of Rehire *(month/day/year) (if applicable)*

C. If employee's previous grant of work authorization has expired, provide the information below for the document that establishes current employment eligibility.

Document Title: ____________ Document #: ____________ Expiration Date (if any): ____________

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

Signature of Employer or Authorized Representative	Date *(month/day/year)*

LISTS OF ACCEPTABLE DOCUMENTS

LIST A **Documents that Establish Both Identity and Employment Eligibility**	OR — LIST B **Documents that Establish Identity**	AND — LIST C **Documents that Establish Employment Eligibility**
1. U.S. Passport (unexpired or expired)	**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.** U.S. Social Security card issued by the Social Security Administration *(other than a card stating it is not valid for employment)*
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 Birth Abroad issued by the Department of State *(Form FS-545 or Form DS-1350)*
3. An unexpired foreign passport with a temporary I-551 stamp	**3.** School ID card with a photograph	**3.** Original or certified copy of a birth certificate issued by a state, county, municipal authority or outlying possession of the United States bearing an official seal
4. An unexpired Employment Authorization Document that contains a photograph (Form I-766, I-688, I-688A, I-688B)	**4.** Voter's registration card	**4.** Native American tribal document
	5. U.S. Military card or draft record	**5.** U.S. Citizen ID Card *(Form I-197)*
5. An unexpired foreign passport with an unexpired Arrival-Departure Record, Form I-94, bearing the same name as the passport and containing an endorsement of the alien's nonimmigrant status, if that status authorizes the alien to work for the employer	**6.** Military dependent's ID card	**6.** ID Card for use of Resident Citizen in the United States *(Form I-179)*
	7. U.S. Coast Guard Merchant Mariner Card	
	8. Native American tribal document	**7.** Unexpired employment authorization document issued by DHS *(other than those listed under List A)*
	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	

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

LSU Health Sciences Center
NEW ORLEANS
School of Medicine
Office of Medical Education

School of Medicine
School of Dentistry
School of Nursing
School of Allied Health Professions
School of Graduate Studies
School of Public Health

To: Incoming House Officers / 2009
CC: Program Coordinators

From: Kim Cannon-Ramirez
GME coordinator

RE: House officer pagers

The Graduate Medical Education office provides pagers to LSUHSC New Orleans House residents. The pager unit rental fee and cost of monthly service are of no charge to residents. We provide local (Louisiana and Mississippi) service to all pagers. The pager is, however, the resident's responsibility. If a pager is lost or stolen there is a $50.00 fee that is paid for by the resident to the GME office. Any damaged pagers can be returned to the GME office at no charge to the resident.

All pager requests or swaps need to go through your program coordinator. Your coordinator will email the request to the GME email for pager assistance. The GME email can be found in the global under "GME pagers". Your coordinator will need to put your pager number and your name on the email request.

Always maintain a *fresh battery* as the service gets interrupted when the batteries show low strength.

When pager swaps are requested and the coordinator is notified, the resident or coordinator must personally turn in the old pager to retrieve the new one: **No exceptions. (In those instances where the resident and coordinator are out of the city, I will fed-ex (using the requesting dept's Fed-ex number) the new pager and provide return packaging to me for the old one).**

*Paging services for FELLOWS are handled through the LSUHSC Purchasing Department. Amy Coburn is the contact.

<u>Coordinators:</u> Please maintain residency partner with any pager number changes, as these pager numbers need to always be accurate, especially for the yearly swap every June.

Thank you,

Kim Cannon-Ramirez
2020 Gravier Street Ste B
New Orleans, La 70112

DATA SHEET
LSU SCHOOL OF MEDICINE – GME OFFICE

PLEASE PRINT LEGIBLY OR TYPE

(Circle one):

Department: ______________________________ House Officer Level _________ Residency or Fellowship
(Level you will be in July)

Training Program Name ____
(State Combined name if is combined Program & Fellowship name if fellowship)

Name: ____
(Last) ***(First)*** ***(Middle)***

Mailing Address: ____
(Street) ***(City)*** ***(State)*** ***(Zip)***

Telephone Number ______________________________ Beeper Number ______________________________

Social Security # ____________________ NPI #: ____________________ Citizenship: ____________________

Date of Birth ____________________ Place of Birth: ____

Sex: ___ Male Female Marital Status: S M W D Spouse's Name: __________________________

Race: ***(Please check one)***
American Native _ _ Asian or Pacific Islander _ _ Hispanic _ _ White _ _ Black _ _

List Person to Contact in case of Emergency: ____

Relationship: ______________________________ Telephone ______________________________

This section MUST be completed or form will be returned

EDUCATION: **FMG** (Foreign Medical Grad) **Y/N**______

Medical School:____________________________________City,State:____________________________________

Dates Attended:____________________________________Degree Received:________________________________

Dental School:____________________________________City,State____________________________________

Dates Attended:____________________________________Degree Received:________________________________

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

Number: ________________________________ Date:________________________________

LA Medical License #______________________ License or Permit Expiration Date: ______________________

if no License, What type of Permit? Intern PGY2 GETP Interim Temp
(Circle one that applies above)

Signature: ____

Turn over and complete back of page.

Name: ____

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.

The first entry should be the program you will be training in as of July 1.

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

Expected End Date **(Month/Day/Year):** ____________________________________

Program: ____

Facility: ____

City and State: ____

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

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

Program: ____

Facility: ____

City and State: ____

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

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

Program: ____

Facility: ____

City and State: ____

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

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

Program: ____

Facility: ____

City and State: ____

Signature: ____

If needed, print another copy of page 2 and attach to the 2-sided copy completed.

Acknowledgement of policy regarding extracurricular medical activities for trainees of Louisiana State University School of Medicine programs

I understand that I must make a request to, and receive the explicit permission of, my Department Head at the School of Medicine (or Chief of Service at free-standing affiliated training programs) before engaging in any extracurricular medical practice. Further, I understand that I must receive such permission for any additional extracurricular medical practice which differs in location or nature from that which may have originally been approved, or for any substantive change (increase in frequency or duration) from that which may have been originally approved.

Foreign Medical Graduates sponsored for clinical training as a J-1 by ECFMG are not allowed to moonlight or perform activities outside of the clinical training program.

For purposes of this Acknowledgment, "extracurricular medical practice" activities shall mean medical practice which is not an official part of the undergraduate medical education program, or any post-graduate training medical education program of the School, or any of the School's free-standing affiliated post-graduate medical education programs.

I understand that the School, by its approval of permission to participated in extracurricular medical practice, is not a party to any such arrangement, nor will the School furnish medical malpractice insurance for extracurricular medical practice, nor defend any claim made against me (malpractice or otherwise) that arises out of, or is in connection with, any extracurricular medical practice.

______________________________ ________
Signature of Trainee (Date)

____
PRINTED NAME OF TRAINEE:

______________________________ ________
Signature of Department Head (Date)
(Or Chief of Service)

____
PRINTED NAME OF DEPARTMENT HEAD
(Or Chief of Service)

LSU Health Sciences Center
NEW ORLEANS

School of Medicine
Office of Medical Education

School of Medicine
School of Dentistry
School of Nursing
School of Allied Health Professions
School of Graduate Studies
School of Public Health

March 16, 2009

TO: All Incoming LSUHSC House Officers

CC: Clinical Department Heads
Clinical Business Managers
Residency and Fellowship Program Directors
Residency and Fellowship Program Coordinators

FROM: Charles Hilton, MD
Associate Dean for Academic Affairs
Designated Institutional Official (DIO)

RE: National Provider Identifier Application for Incoming House Officers FY 2009-2010

All Incoming House Officers must have a National Provider Identifier number to begin their Residency/Fellowship training. Please follow the attached instructions and complete the online application on or before May 1, 2009. **Applications initiated after May 1, 2009 could result in an administrative delay in processing your payroll documents and delay the start of your Residency/Fellowship training.**

Incoming residents/fellows with a valid FULL UNRESTRICTED Louisiana medical license
Complete the NPI online registration **for an individual** choosing the taxonomy code for the enrolled program, providing the Louisiana medical license number.

Incoming residents/fellows with a valid out-of-state medical license
Complete the NPI online registration **for an individual** (if not already done) or update current NPI registration choosing the appropriate taxonomy code for the specialty formerly in (whether an outside practice or previously enrolled in a program), providing the state license information. When granted a full unrestricted Louisiana medical license, update the NPI registration to include the enrolled specialty taxonomy code with the Louisiana license number.

Incoming residents/fellows applying for Louisiana permit
Complete the NPI online registration **for an individual** choosing the "**Student in an Organized Health Care Education/Training Program - 390200000X**" taxonomy code, which is located under the "**Student, Health Care**" category.

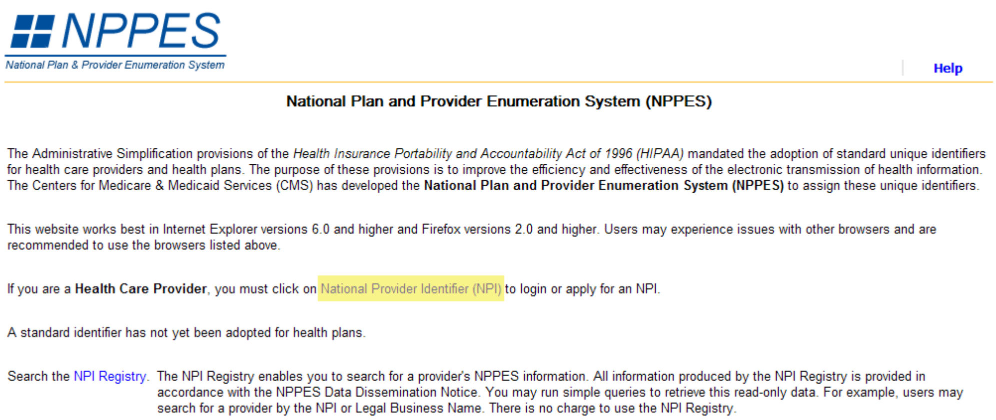
Louisiana State University Health Sciences Center • 2020 Gravier Street, Suite 716 • New Orleans, Louisiana 70112
phone (504) 568-4006 **fax** (504) 599-1453 **www.**lsuhsc.edu

National Provider Identification (NPI) Registration Instructions

The Federal Government now requires all practicing physicians to have a National Provider Identification Number. When you are assigned an NPI number, this will be your number for life. Outside of extenuating circumstances, this number will never change, and you will need to keep your information up-to-date in the National Plan and Provider Enumeration System.

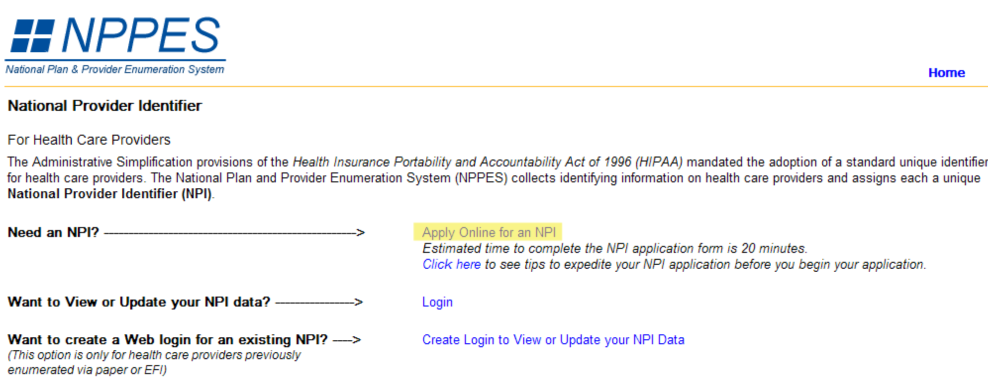
1. Go to the National Plan and Provider Enumeration System (NPPES) at https://nppes.cms.hhs.gov

2.



Click the **National Provider Identifier (NPI)** link

3.



Click **Apply Online for an NPI**

4.

NPPES
National Plan & Provider Enumeration System

Home | Help

NPI Application Instructions

Step 1: Before you begin, make sure you have the following information.
This information will be required to complete the NPI Application Form.
You will not be able to save your work if you quit before you have completed the application form.

- **Information Required for Individual Providers**
  Provider Name
  ** SSN (or ITIN if not eligible for SSN)
  Provider Date of Birth
  Country of Birth
  State of Birth *(if Country of Birth is U.S.)*
  Provider Gender
  Mailing Address
  Practice Location Address and Phone Number
  Taxonomy (Provider Type)
  * State License Information
  Contact Person Name
  Contact Person Phone Number and E-mail

- **Information Required for Organizations**
  Organization Name
  *** Employer Identification Number (EIN)
  Name of Authorized Official for the Organization
  Phone Number of Authorized Official for the Organization
  Organization Mailing Address
  Practice Location Address and Phone Number
  Taxonomy (Provider Type)
  Contact Person Name
  Contact Person Phone Number and E-mail

* *(required for certain taxonomies only)*
** *(SSN or ITIN information should only be reported in the SSN or ITIN field)*
*** *Do not report an SSN or IRS ITIN in the EIN field*

Online Help is available from each page of the Application / Update Form by clicking "Help" at the top right of the page.

If you need additional help or have any questions concerning your application, contact the NPI Enumerator.

NPI Enumerator Contact Information

By phone:	By e-mail at:	By mail at:
1-800-465-3203 (NPI Toll-Free) 1-800-692-2326 (NPI TTY)	customerservice@npienumerator.com	NPI Enumerator PO Box 6059 Fargo, ND 58108-6059

Step 2: Read the information below.
You must agree to the terms below when you submit your application:

I have read the contents of the application and the information contained herein is true, correct, and complete. If I become aware that any information in this application is not true, correct, or complete, I agree to notify the NPI Enumerator immediately.

I authorize the NPI Enumerator to verify the information contained herein. I agree to keep the NPPES updated with any changes to data listed on this application form within 30 days of the effective date of the change.

I understand that the information provided in this application may be used by other agencies in accordance with privacy regulations.

I have read and understand the Privacy Act Statement.

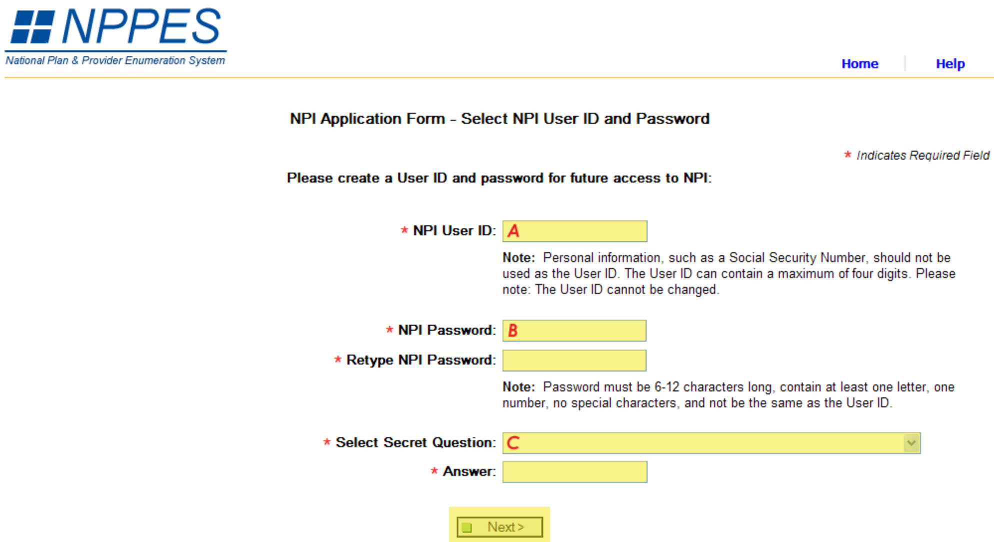
I have read and understand the ***Penalties for Falsifying Information*** *on the NPI Application / Update Form as stated in this application. I am aware that falsifying information will result in fines and/or imprisonment.*

Penalties for Falsifying Information on the NPI / Update Form:
18 U.S.C. 1001 authorizes criminal penalties against an individual who in any matter within the jurisdiction of any department or agency of the United States knowingly or willfully falsifies, conceals, or covers up by any trick, scheme or device a material fact, or makes any false, fictitious or fraudulent statements or representations, or makes any false writing or document knowing the same to contain any false, fictictious or fraudulent statement or entry. Individual offenders are subject to fines of up to $250,000 and imprisonment for up to five years. Offenders that are organizations are subject to fines of up to $500,000. 18 U.S.C. 3571(d) also authorizes fines of up to twice the gross gain derived by the offender if it is greater than the amount specifically authorized by the sentencing statute.

Step 3: Begin online application. Begin Application Form

Click the **Begin Application Form** button at the bottom of the page

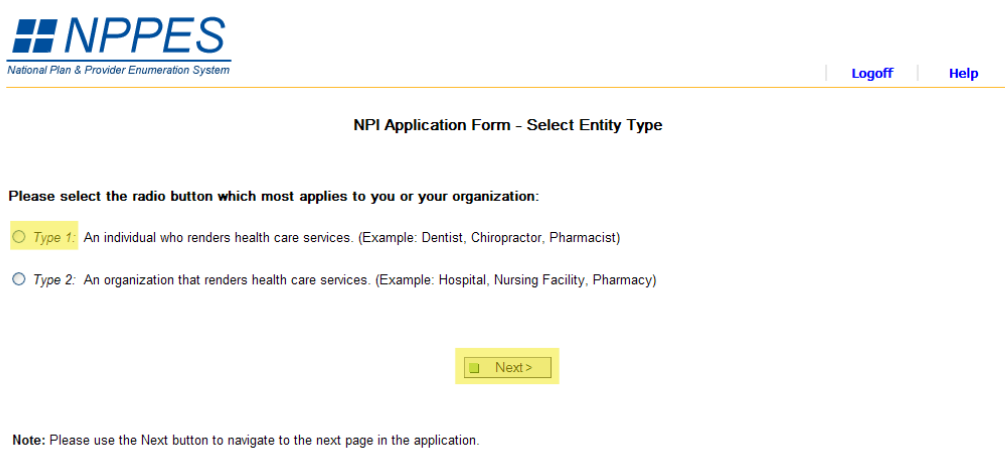
5.



Create an *NPI User ID* (A) and *Password* (B). Make sure to choose a *User ID* and *Password* that you will be able to remember. You will need this information to update your NPI registration during your residency. Choose a *Secret Question* (C) that will allow you to recover your *Password* if you forget it.

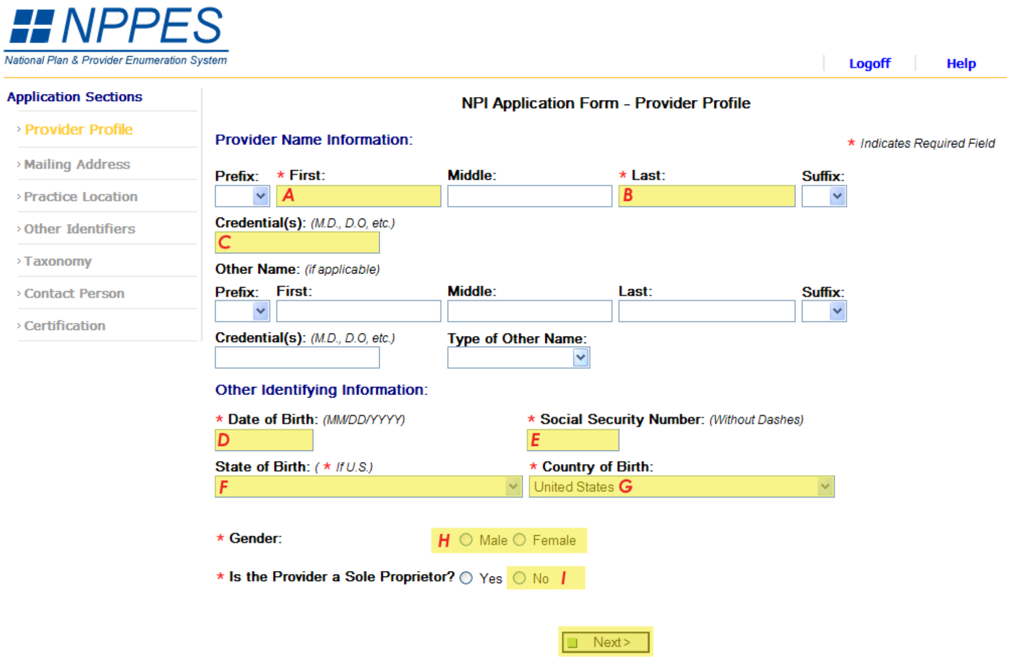
Click the **Next** > button.

6.



Choose ***Type 1*** and then click the **Next** > button.

7.



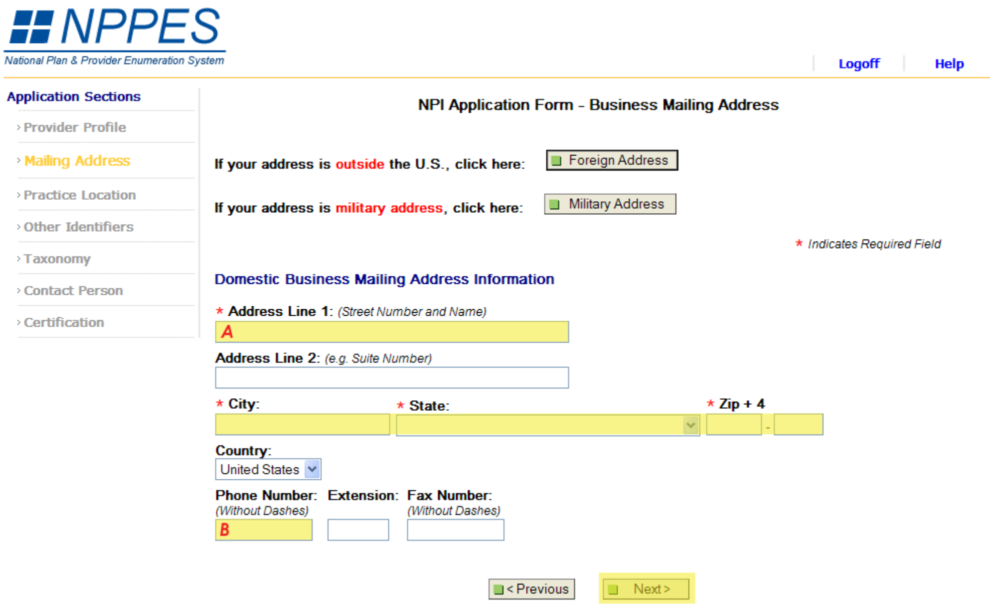
Fill out the *Provider Profile* information.

NOTE: This form is a LEGAL APPLICATION being submitted to the Federal Government. The name entered on this form **MUST** be your legal name as it is TODAY. If you will be getting married and changing your name before beginning your residency, you still must use your CURRENT legal name. After legally changing your name, you can come back to the NPPES system to change your name. Also, if you do not have a Social Security Number, you cannot complete this application until you have been assigned an SSN.

Fill out the *First Name* (A) and *Last Name* (B). Do not enter any *Credentials* (C), if you have not yet graduated from Medical School (this can be updated after graduation). Enter your *Date of Birth* (D), *Social Security Number* (E), *State of Birth* (F), *Country of Birth* (G), and *Gender* (H). Select **No** to the question about being a Sole Proprietor (I).

Click the **Next >** button.

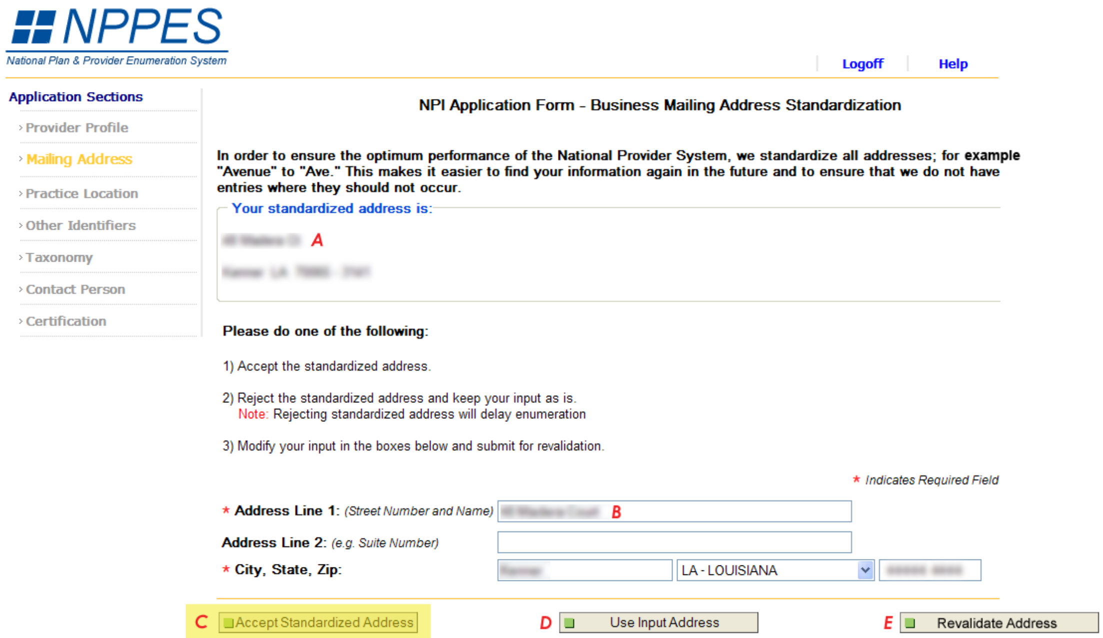
8.



Enter your current home mailing address (A). If you will be moving prior to beginning your residency, you should update this address after completing your move. Also, some residency programs may require you to use a specific mailing address, so you may need to update this information to satisfy their requirements.

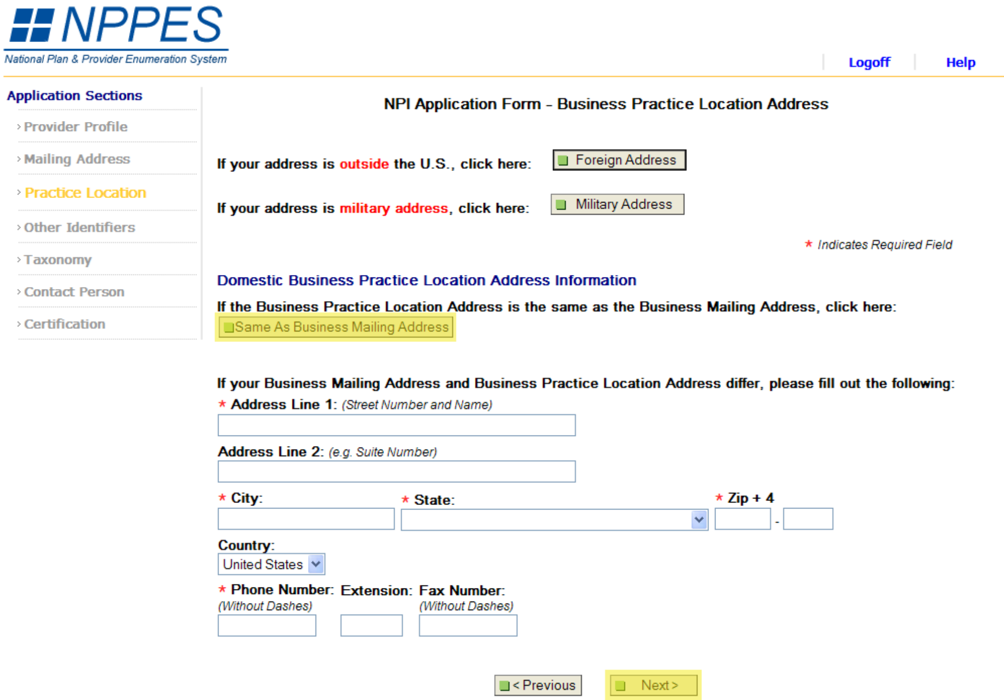
While not required, it is recommended that you enter a *Phone Number* (B). If there is a problem with your NPI application, they will attempt to contact you by phone to resolve the problem.

9.



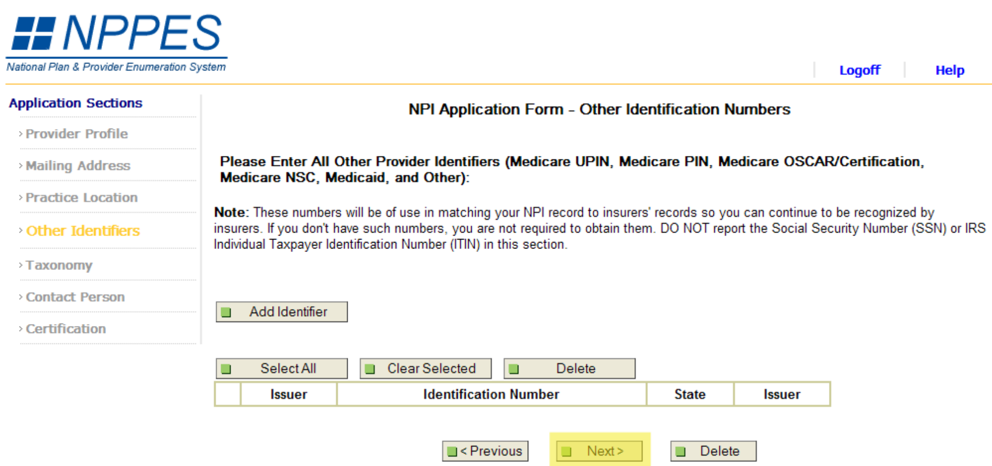
If the *Standardized Address* (A) is correct, click the **Accept Standardized Address** button (C). If the *Standardized Address* is NOT correct, make corrections to the address (B) and click the **Revalidate Address** (E) button. If the new *Standardized Address* still isn't correct, make any necessary changes to the address (A) and click the **Use Input Address** button (D).

10.



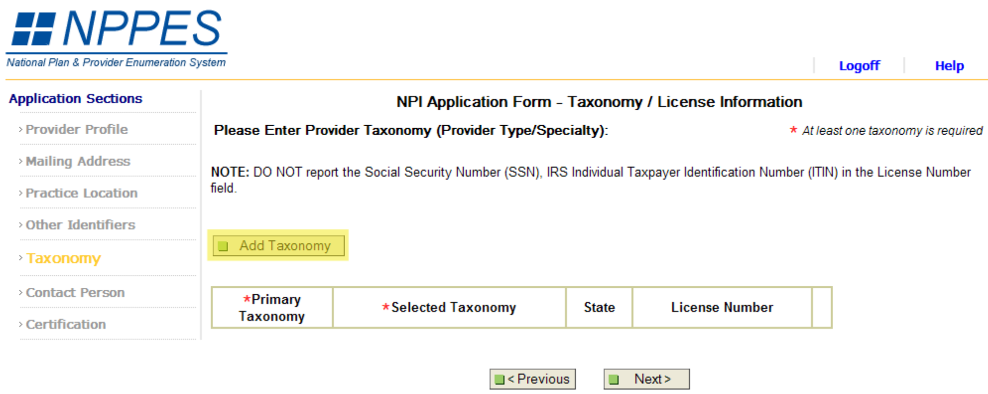
Click the **Same as Business Mailing Address** button, and then click the **Next** > button. Once you begin your residency, you will need to update this address to the location where you are practicing the most.

11.



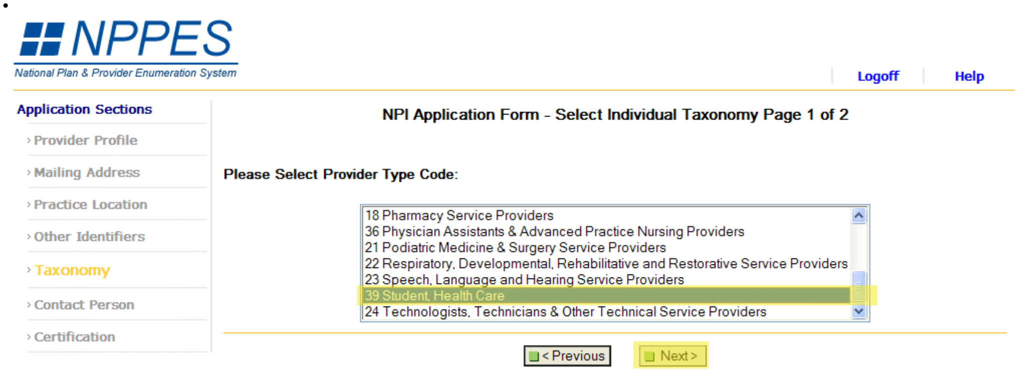
Click the **Next** > button. You do not currently have any other identification numbers. Once you begin your residency, you will begin to be assigned other identification numbers, such as a Medicaid Provider Number. You will need to update your NPI registration with those numbers as they are issued to you.

12.



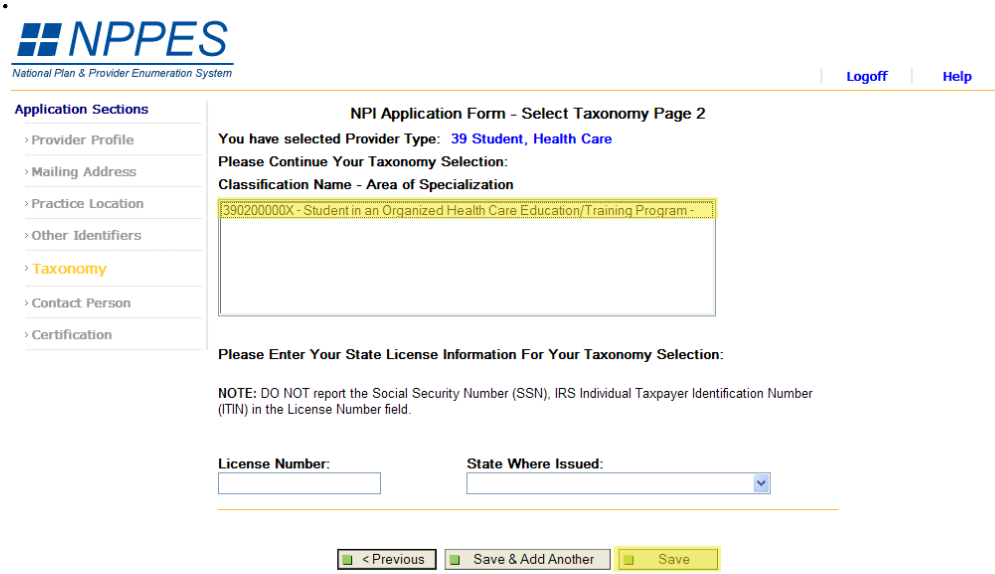
Click the **Add Taxonomy** button.

13.



Choose **39 Student, Health Care** from the list and then click the **Next >** button.

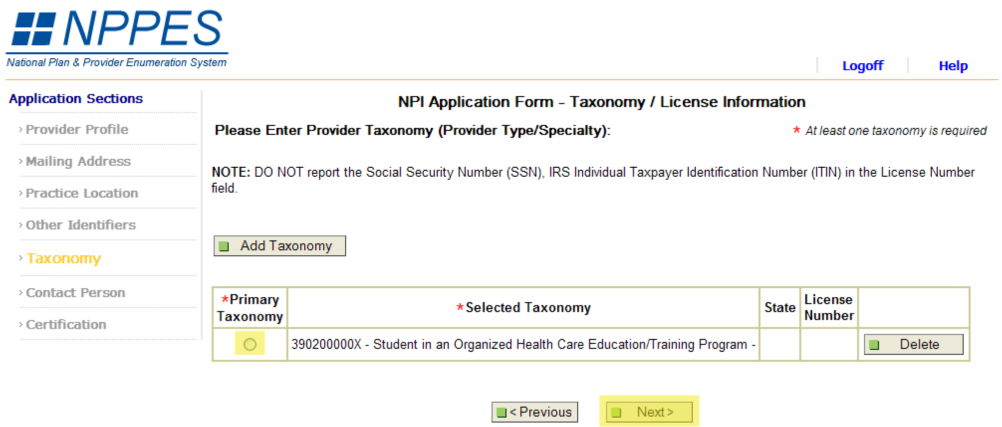
14.



Choose **390200000X – Student in an Organized Health Care Education / Training Program**. Leave the *License Number* and *State Where Issued* fields blank. Click the **Save** button.

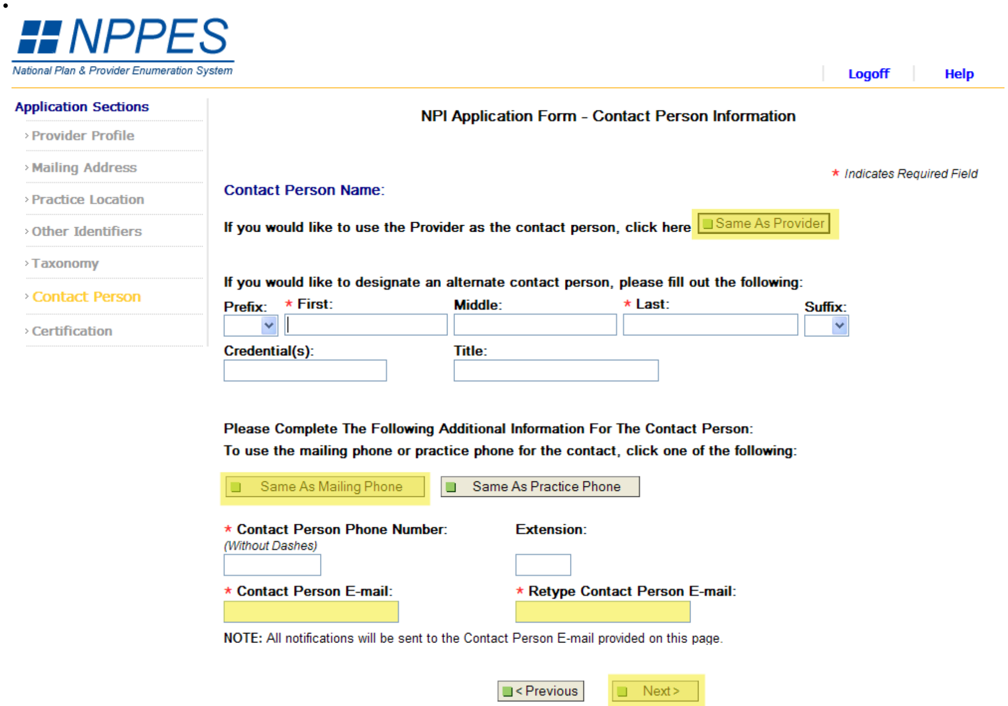
Note: LSU's current understanding of the NPPES regulations is that a resident should use the Student taxonomy code until a full, unrestricted medical license has been granted. Some non-LSU residency programs may ask that you choose a different taxonomy code. Use whatever instructions your residency program dictates.

15.



Select the radio button next to the student taxonomy and then click the **Next** > button.

16.



Click the **Same as Provider** button to use yourself as the contact for this NPI registration. Click the **Same as Mailing Phone** button to use your phone number as the contact phone number. Enter your email address in the *Contact Person E-Mail* fields, and then click the **Next** > button.

17.

NPPES
National Plan & Provider Enumeration System

Logoff | Help

Application Sections
- Provider Profile
- Mailing Address
- Practice Location
- Other Identifiers
- Taxonomy
- Contact Person
- Certification

NPI Application Form - Certification Statement

☐ **Check this box to indicate that you certify to the following:**

I have read the contents of the application and the information contained herein is true, correct and complete. If I become aware that any information in this application is not true, correct, or complete, I agree to notify the NPI Enumerator of this fact immediately.

I authorize the NPI Enumerator to verify the information contained herein. I agree to keep the NPPES updated with any changes to data listed on this application form within 30 days of the effective date of the change.

I have read and understand the Privacy Act Statement.

I have read and understand the **Penalties for Falsifying Information** on the NPI Application / Update Form as stated in this application. I am aware that falsifying information will result in fines and/or imprisonment.

Penalties for Falsifying Information

18 U.S.C. 1001 authorizes criminal penalties against an individual who in any matter within the jurisdiction of any department or agency of the United States knowingly or willfully falsifies, conceals, or covers up by any trick, scheme or device a material fact, or makes any false, fictitious or fraudulent statements or representations, or makes any false writing or document knowing the same to contain any false, fictitious or fraudulent statement or entry. Individual offenders are subject to fines of up to $250,000 and imprisonment for up to five years. Offenders that are organizations are subject to fines of up to $500,000. 18 U.S.C. 3571(d) also authorizes fines of up to twice the gross gain derived by the offender if it is greater than the amount specifically authorized by the sentencing statute.

< Previous | Submit

Click the checkbox and then click the Submit button to complete and submit your NPI Application.

NOTE: Please read the certification statement carefully. There can be serious repercussions for willingly submitting false information.

18.

Thank you. Your application will be processed.

Application processing times may vary based on current inventories. If you have any questions regarding this application or if the designated contact person does not receive the provider's NPI via email within 15 working days, please contact the NPI Enumerator at 1-800-465-3203 (NPI Toll-Free).

Provider Name:
Your tracking number is:

Please provide this tracking number on all correspondence.

Please print this page for your records.

View Printer Friendly Application

Clicking this button will allow you to view and print the information furnished on your application.
Please Note: This page/printout may contain sensitive information.

NPI Enumerator Contact Information

By phone: 1-800-465-3203 (NPI Toll-Free)
1-800-692-2326 (NPI TTY)

By e-mail at: customerservice@npienumerator.com

By mail at: NPI Enumerator
PO Box 6059
Fargo, ND 58108-6059

When your application is complete, you will be issued a tracking number. This number is NOT your NPI number. You will receive your NPI number via email in several days. If you do not receive your NPI number after 15 days, you can contact the NPI Enumerator with the contact info provided on the page. It is recommended that you print a copy of the confirmation page, as well as a copy of your completed application (by clicking the **View Printer Friendly Application** button).