LSUHSC-NO INCOMING HOUSE OFFICER HEALTH REQUIREMENTS

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 IMMUNIZATIONS.

1. PPD skin test within 4 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 and Mumps 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.

ALL DOCUMENTS MUST BE SUBMITTED TO YOUR PROGRAM OFFICE BEFORE MAY 1, 2012.

IF YOU HAVE ANY QUESTIONS, PLEASE CONTACT THE STUDENT HEALTH OFFICE AT 504-525-4839.

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

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 _____

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

Form W-4 (2012)

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 2012 expires February 18, 2013. See Pub. 505, Tax Withholding and Estimated Tax.

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

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-earners/multiple jobs situations.

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

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

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

Nonwage income. If you have a large amount of nonwage income, such as interest or dividends, consider making estimated tax payments using Form 1040-ES, Estimated Tax for Individuals. Otherwise, you may owe additional tax. If you have pension or annuity income, see Pub. 505 to find out if you should adjust your withholding on Form W-4 or W-4P.

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

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

Check your withholding. After your Form W-4 takes effect, use Pub. 505 to see how the amount you are having withheld compares to your projected total tax for 2012. See Pub. 505, especially if your earnings exceed $130,000 (Single) or $180,000 (Married).

Future developments. The IRS has created a page on IRS.gov for information about Form W-4, at *www.irs.gov/w4*. Information about any future developments affecting Form W-4 (such as legislation enacted after we release it) will be posted on that page.

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 $1,900 of **child or dependent care expenses** for which you plan to claim a credit (**Note.** Do **not** include child support payments. See Pub. 503, Child and Dependent Care Expenses, for details.)	**F** _____
G	**Child Tax Credit** (including additional child tax credit). See Pub. 972, Child Tax Credit, for more information. • If your total income will be less than $61,000 ($90,000 if married), enter "2" for each eligible child; then **less** "1" if you have three to seven eligible children or **less** "2" if you have eight 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	**G** _____
H	Add lines A through G and enter total here. (**Note.** This may be different from the number of exemptions you claim on your tax return.) ►	**H** _____

For accuracy, complete all worksheets that apply.

- If you plan to **itemize** or **claim adjustments to income** and want to reduce your withholding, see the **Deductions and Adjustments Worksheet** on page 2.
- If you are **single and have more than one job** or are **married and you and your spouse both work** and the combined earnings from all jobs exceed $40,000 ($10,000 if married), see the **Two-Earners/Multiple Jobs Worksheet** on page 2 to avoid having too little tax withheld.
- If **neither** of the above situations applies, **stop here** and enter the number from line H on line 5 of Form W-4 below.

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

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

Employee's Withholding Allowance Certificate

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

OMB No. 1545-0074

2012

1	Your first name and middle initial	Last name	**2** **Your social security number**
	Home address (number and street or rural route)	**3** ☐ Single ☐ Married ☐ Married, but withhold at higher Single rate. **Note.** If married, but legally separated, or spouse is a nonresident alien, check the "Single" box.	
	City or town, state, and ZIP code	**4** **If your last name differs from that shown on your social security card, check here. You must call 1-800-772-1213 for a replacement card.** ► ☐	
5	Total number of allowances you are claiming (from line **H** above **or** from the applicable worksheet on page 2)		**5**
6	Additional amount, if any, you want withheld from each paycheck		**6** $
7	I claim exemption from withholding for 2012, and I certify that I meet **both** of the following conditions for exemption. • Last year I had a right to a refund of **all** federal income tax withheld because I had **no** tax liability, **and** • This year I expect a refund of **all** federal income tax withheld because I expect to have **no** tax liability. If you meet both conditions, write "Exempt" here ►		**7**

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

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

8	Employer's name and address (Employer: Complete lines 8 and 10 only if sending to the IRS.)	**9** Office code (optional)	**10** Employer identification number (EIN)

R-1300 (10/08)

LDR
Contributing to a better quality of life

Employee Withholding Exemption Certificate (L-4)

Louisiana Department of Revenue

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

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

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

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

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

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

Block A

- Enter "0" to claim neither yourself nor your spouse. You may enter "0" if you are married, and have a working spouse or more than one job to avoid having too little tax withheld.
- Enter "1" to claim yourself if you did not claim this exemption in connection with other employment, or if your spouse has not claimed your exemption. Enter "1" to claim one personal exemption if you will file as head of household.
- Enter "2" to claim yourself and your spouse.

A.

Block B

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

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 claimed in Block A	**6.**
7. Total number of dependents claimed in Block B	**7.**
8. Increase or decrease in the amount to be withheld each pay period. Decreases should be indicated as a negative amount.	**8.**

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

Employee's signature	Date

The following is to be completed by employer.

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

OMB No. 1615-0047; Expires 08/31/12

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

Form I-9, Employment Eligibility Verification

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-authorized 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 of the United States
- ☐ A noncitizen national of the United States (see instructions)
- ☐ A lawful permanent resident (Alien #) _____
- ☐ An alien authorized to work (Alien # or Admission #) _____ until (expiration date, if applicable - *month/day/year*)

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 authorized 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 authorization.

Document Title: _____ Document #: _____ Expiration Date *(if any)*: _____

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

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

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: _____

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
NEW ORLEANS

VETERANS SELF-IDENTIFICATION FORM

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 disabled veterans, special disabled veterans, and veterans of the Vietnam era.

If you are 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 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.

Veteran Status (41CFR60-250 and 41CFR60-300) please check all of the following categories that apply to you.

I further attest, by checking the appropriate space and signing below, that I am:

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

☐ **Special disabled veteran** means: 1. A veteran of the U.S. military, ground, naval or air service who is entitled to compensation (or who but for the receipt of military retired pay would be entitled to compensation) under laws administered by the Department of Veterans' Affairs for a disability (A) rated at 30 percent or more, or (B) rated at 10 or 20 percent in the case of a veteran who has been determined under Section 38 U.S.C. 3106 to have a serious employment handicap.

2. A person who was discharged or released from active duty because of a service-connected disability.

☐ **Veteran of the Vietnam era** means 1. Served on active duty in the U.S. military, ground, naval or air service for a period of more than 180 days and who was discharged or released with other than a dishonorable discharge, if any part of such active duty was performed: (A) In the Republic of Vietnam between February 28, 1961, and May 7, 1975; or (B) Between August 5, 1964, and May 7, 1975, in all other cases.

2. Was discharged or released from active duty in the U.S. military, ground, naval or air service for a service-connected disability if any part of such active duty was performed: (A) In the Republic of Vietnam between February 28, 1961, and May 7, 1975; or (B) Between August 5, 1964, and May 7, 1975, in any other location

☐ **Other protected veteran means:** Veterans who served on active duty in the U.S. military, ground, naval or air service during a war or in a campaign or expedition for which a campaign badge has been authorized

☐ **Recently separated veteran means:** Any veteran who served on active duty in the U.S. military, ground, naval or air service during the **one-year period** beginning on the date of such veteran's discharge or release from active duty (41CFR 60-250)

Date of Discharge _____

LSU Health Sciences Center
NEW ORLEANS

VETERANS SELF-IDENTIFICATION FORM

☐ **Recently separated veteran means:** Any veteran who served on active duty in the U.S. military, ground, naval or air service during the **three-year period** beginning on the date of such veteran's discharge or release from active duty (41CFR 60-300)

Date of Discharge _____

☐ **Armed forces service medal veteran** means a veteran who, while serving on active duty in the U.S. military, ground, naval or air service, participated in a U.S. military operation for which an Armed Forces service medal was awarded pursuant to Executive Order 12985 (61 FR 1209, 3 CFR, 1996 Comp., p. 159).

☐ **Active Reserve**

☐ **Inactive Reserve**

☐ **Retired Military**

☐ **No Military Service**

☐ **I do not wish to Self Identify**

I certify that I have read the above "Veterans Self Identification Form" and that I understand its terms.

Name	_____	Signature	_____
Employee ID	_____	Military Branch	_____
School/Division	_____	Department	_____
Contact Phone	_____	Email Address	_____

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) ☐ Other INS classification (list status): _____

- ☐ Short-term scholar
- ☐ Professor
- ☐ Research Scholar
- ☐ Other

☐ 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	2012						☐ 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

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

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

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

Revision Date: 12/2005

☐	☐	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 t he body operated on, the ty pe 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, phy sical 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:** _____

DATA SHEET
LSU SCHOOL OF MEDICINE – GME OFFICE

PLEASE PRINT LEGIBLY OR TYPE

(Check 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 Number ___ ___ ___ - ___ ___ - ___ ___ ___ ___ 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:

College:_____ City, State: _____

Dates Attended: _____ Degree: _____

Medical School:_____City,State:_____

Dates Attended:_____Degree:_____

Dental School:_____City,State_____

Dates Attended:_____Degree:_____

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

Complete Page 2

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: _____

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

Explain any gaps in the above longer than 1 month—use additional pages if necessary.

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 Library

Patron Registration Form

SECTION ONE --PERSONAL INFORMATION: *(Please Print Clearly)* DATE:_____

Full Name:_____ Social Security #:_____ EmplID #:_____
Last First Middle

Local/Home Address:_____

(City, State, Zip Code) _____ Email Address:_____

Home Phone #:_____ Pager/Other Phone #:_____
Area Code Area Code

Department:_____ Campus Building/Box #:_____

Campus Phone #:_____ Office/Business Phone #:_____

Office or Business Address:_____

SECTION TWO --AFFILIATION INFORMATION:

☐ **LSUHSC:**

☐ School of Allied Health ☐ School of Dentistry ☐ School of Graduate Studies
☐ School of Medicine ☐ School of Nursing ☐ School of Public Health
☐ Other _____

Status: ☐ Faculty *(check one, if faculty:* ☐ *Full-Time* ☐ *Part-Time* ☐ *Clinical* ☐ *Gratis)*
☐ Resident
☐ Fellow
☐ Staff
☐ Proxy Staff/Student Worker checking out for _____/_____ (Faculty /Dept.)
☐ Student -- *Please circle your program:*
Allied Health: CPSC CLS OT PT RC COMD MHS OMT
Medicine: L1 L2 L3 L4
Graduate Studies: _____ (Dept)
Dental: D1 D2 D3 D4 DH DLT
Nursing: BSN GN IGRO CRNA
Public Health: _____ (Dept)

☐ **Tulane Medical Center:**

☐ School of Graduate Studies ☐ School of Medicine ☐ School of Public Health

Status: ☐ Faculty ☐ Fellow ☐ Resident ☐ Student ☐ Staff Tulane Library barcode:_____

☐ **Other:**

☐ Licensed Health Professional: License Type:_____ License #:_____
☐ Outside LALINC Patron
☐ Courtesy Patron (approval required)

SECTION THREE -- PATRON RESPONSIBILITY STATEMENT:

I agree to observe all library regulations; to be responsible for all library materials checked out with this card; to pay charges for all lost or damaged materials; to immediately report loss of card or incur liability for its misuse. I understand that any abuse of library regulations may result in suspension of privileges.

Signature:_____ Date:_____

Library Staff Use Only:

Library Staff Initials_____ Ptype____ Pcode____ Pcode2____ Pcode3____

Expiration Date_____ Barcode_____

updated 06/09

FCVS RELEASE FORM

For you to obtain initial licensure in the state, the Louisiana State Board of Medical Examiners (LSBME) uses a service of the Federation of State Medical Boards (FSMB) called Federation Credentials Verification Service (FCVS). As you move to full licensure, the LSBME will use reports from FCVS. To have the information to prepare those reports, FCVS requires us to update their files each year on your progress by filling out the below form which is the same one filled out for initial licensure. By copy of this release you consent to allow us to release all of the below requested information to FCVS on an annual basis during your training including a summary report if requested by FCVS. For those not pursuing full licensure, we will still prepare and submit these same reports to FCVS. A benefit to you is that throughout your practice years as you switch hospitals and health plans your training information will be available through FCVS which will significantly speed your credentialing process. This release is valid for activities occurring during your training program.

Resident name: (print)________________________Program Name:_____________________________

Resident signature: ________________________________Date:_____________________________

Federation of STATE MEDICAL BOARDS

Federation Credentials Verification Service (FCVS)
Federation Place, P.O. Box 619850, Dallas, TX 75261-9850
Tel: (817) 868-5000 Fax: (817) 868-5099

Verification of Postgraduate Medical Education

Institution: ____________________
Address: ____________________
____

Attention: **Program Director**
Affiliated University: ____________________

Verification For:

Name: ____________________
SSN: ____________________
DOB: ____________________
Individual's Name on Record (If different from above): ____________________

Program Participation:
Important:
Report incomplete postgraduate years (PGY) separate from those that were successfully completed.

If the postgraduate year is currently in progress report the expected completion date in the "To" field.

Report Internships, Residencies and Fellowships separately.

Use one section per Department/Specialty. If the Department/Specialty is rotating or transitional, please provide a schedule of rotations.

PGY: ___ **Specialty/Subspecialty:** ____________________
☐ Internship ☐ Residency ☐ Chief Residency ☐ Fellowship ☐ Research
From: __________ **To:** __________
Successfully Completed?: Yes ☐ No ☐ In Progress ☐
Accredited by: ACGME ☐ AOA ☐ LCGME ☐ RSC ☐ CFPC ☐ RCPSC ☐ APPAP ☐ FMRAC ☐ None of these ☐

PGY: ___ **Specialty/Subspecialty:** ____________________
☐ Internship ☐ Residency ☐ Chief Residency ☐ Fellowship ☐ Research
From: __________ **To:** __________
Successfully Completed?: Yes ☐ No ☐ In Progress ☐
Accredited by: ACGME ☐ AOA ☐ LCGME ☐ RSC ☐ CFPC ☐ RCPSC ☐ APPAP ☐ FMRAC ☐ None of these ☐

PGY: ___ **Specialty/Subspecialty:** ____________________
☐ Internship ☐ Residency ☐ Chief Residency ☐ Fellowship ☐ Research
From: __________ **To:** __________
Successfully Completed?: Yes ☐ No ☐ In Progress ☐
Accredited by: ACGME ☐ AOA ☐ LCGME ☐ RSC ☐ CFPC ☐ RCPSC ☐ APPAP ☐ FMRAC ☐ None of these ☐

Unusual Circumstances:
Check the correct response. Omitted responses require written explanation.

If necessary, you may continue your explanation on a separate sheet of paper.

1. Did this individual ever take a leave of absence or break from his/her training? .... ☐Yes ☐No
2. Was this individual ever placed on probation? .... ☐Yes ☐No
3. Was this individual ever disciplined or placed under investigation? .... ☐Yes ☐No
4. Were any negative reports for behavioral reasons ever filed by instructors? .... ☐Yes ☐No
5. Were any limitations or special requirements placed upon this individual because of questions of academic incompetence, disciplinary problems or any other reason? .... ☐Yes ☐No

Please explain any "Yes" response from above: (attach an additional sheet if necessary)

Certification:

Affix your institutional seal in this space. If no seal is available, you must have this form notarized.

Completion of the following is certification that the information above is an accurate account of this individual's records and is true and correct. This section must be signed by the Program Director (M.D./D.O. only), or if appropriate, the Director of GME.

Name: ____________________ Signature: ____________________
Title: ____________________ **Date of Signature:** ____________________
Tel: __________ **Fax:** __________ **E-Mail:** ____________________

Rev. 09/07/05 Packet ID: __________ Request ID: __________ __________

Rev2/11