LSU Health New Orleans
HEALTH SCIENCES CENTER
School of Medicine
Office of Medical Education

March 1, 2014

TO: All Incoming House Officers

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

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

RE: 2014-2015 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, 2014. The following health requirements must be provided with this page as a cover sheet.**

Name_____ DOB_____ SS#_____
Program_____ Start Date_____

1. PPD skin test 4-6 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 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.
7. Flu shot documentation or signed declination form (seasonal, accepted after September 1, 2013)

All Health Requirements documentation should be forwarded to your program coordinator.

If you have any questions, please contact the Student Health Office at 504-525-4839.

Louisiana State University Health Sciences Center • 2020 Gravier Street, Suite 602 • New Orleans, Louisiana 70112
phone 504.568.4006 • **fax** 504.599.1453 • **www**.lsuhsc.edu

LSU HEALTH SCIENCES CENTER – NEW ORLEANS BIOGRAPHICAL DATA FORM

1. Name _____ 2. SS# XXX-XX-_____ 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 _____

EDUCATION DATA

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

11. College/University Attended	Degree Received	Major	Date Received (Month/day/year)

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.

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

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 (2014)

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 2014 expires February 17, 2015. 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 $1,000 and includes more than $350 of unearned income (for example, interest and dividends).

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

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

The exceptions do not apply to supplemental wages greater than $1,000,000.

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 iincome, 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 2014. See Pub. 505, especially if your earnings exceed $130,000 (Single) or $180,000 (Married).

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

Personal Allowances Worksheet (Keep for your records.)

A	Enter "1" for **yourself** if no one else can claim you as a dependent	**A** _____
B	Enter "1" if: • You 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 $2,000 of **child or dependent care expenses** for which you plan to claim a credit . . . (**Note.** Do **not** include child support payments. See Pub. 503, Child and Dependent Care Expenses, for details.)	**F** _____
G	**Child Tax Credit** (including additional child tax credit). See Pub. 972, Child Tax Credit, for more information. • If your total income will be less than $65,000 ($95,000 if married), enter "2" for each eligible child; then **less** "1" if you have three to six eligible children or **less** "2" if you have seven or more eligible children. • If your total income will be between $65,000 and $84,000 ($95,000 and $119,000 if married), enter "1" for each eligible child . . .	**G** _____
H	Add lines A through G and enter total here. (**Note.** This may be different from the number of exemptions you claim on your tax return.) ►	**H** _____

For accuracy, complete all worksheets that apply.

- If you plan to **itemize** or **claim adjustments to income** and want to reduce your withholding, see the **Deductions and Adjustments Worksheet** on page 2.
- If you are **single and have more than one job** or are **married and you and your spouse both work** and the combined earnings from all jobs exceed $50,000 ($20,000 if married), see the **Two-Earners/Multiple Jobs Worksheet** on page 2 to avoid having too little tax withheld.
- If **neither** of the above situations applies, **stop here** and enter the number from line H on line 5 of Form W-4 below.

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

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

Employee's Withholding Allowance Certificate

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

OMB No. 1545-0074

2014

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 2014, 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 (4/11)

LDR
Contributing to a better quality of life

Employee Withholding Exemption Certificate (L-4)

Louisiana Department of Revenue

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

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

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

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

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

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

Block A

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

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.** Select one ☐ 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

Employment Eligibility Verification

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

USCIS
Form I-9
OMB No. 1615-0047
Expires 03/31/2016

►START HERE. 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 documentation presented has a future expiration date may also constitute illegal discrimination.

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

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

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

Date of Birth *(mm/dd/yyyy)*	U.S. Social Security Number	E-mail Address	Telephone Number
	___-___-____		

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

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

☐ A citizen of the United States

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

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

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

*For aliens authorized to work, provide your Alien Registration Number/USCIS Number **OR** Form I-94 Admission Number:*

1. Alien Registration Number/USCIS Number: _____

OR

2. Form I-94 Admission Number: _____

If you obtained your admission number from CBP in connection with your arrival in the United States, include the following:

Foreign Passport Number: _____

Country of Issuance: _____

Some aliens may write "N/A" on the Foreign Passport Number and Country of Issuance fields. (*See instructions*)

3-D Barcode
Do Not Write in This Space

Signature of Employee:	Date *(mm/dd/yyyy):*

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.

Signature of Preparer or Translator:			Date *(mm/dd/yyyy):*
Last Name *(Family Name)*	First Name *(Given Name)*		
Address *(Street Number and Name)*	City or Town	State	Zip Code

STOP ***Employer Completes Next Page*** STOP

Section 2. Employer or Authorized Representative Review and Verification

(Employers or their authorized representative must complete and sign Section 2 within 3 business days of the employee's first day of employment. You must physically examine one document from List A OR examine a combination of one document from List B and one document from List C as listed on the "Lists of Acceptable Documents" on the next page of this form. For each document you review, record the following information: document title, issuing authority, document number, and expiration date, if any.)

Employee Last Name, First Name and Middle Initial from Section 1:

List A Identity and Employment Authorization	OR	List B Identity	AND	List C Employment Authorization
Document Title:		Document Title:		Document Title:
Issuing Authority:		Issuing Authority:		Issuing Authority:
Document Number:		Document Number:		Document Number:
Expiration Date *(if any)(mm/dd/yyyy)*:		Expiration Date *(if any)(mm/dd/yyyy)*:		Expiration Date *(if any)(mm/dd/yyyy)*:
Document Title:				
Issuing Authority:				
Document Number:				
Expiration Date *(if any)(mm/dd/yyyy)*:				
Document Title:				
Issuing Authority:				
Document Number:				
Expiration Date *(if any)(mm/dd/yyyy)*:				

3-D Barcode
Do Not Write in This Space

Certification

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

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

Signature of Employer or Authorized Representative	Date *(mm/dd/yyyy)*	Title of Employer or Authorized Representative
Last Name *(Family Name)* First Name *(Given Name)*		Employer's Business or Organization Name
Employer's Business or Organization Address *(Street Number and Name)*	City or Town	State / Zip Code

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

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

C. If employee's previous grant of employment authorization has expired, provide the information for the document from List A or List C the employee presented that establishes current employment authorization in the space provided below.

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

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

Signature of Employer or Authorized Representative:	Date *(mm/dd/yyyy):*	Print Name of Employer or Authorized Representative:

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: _____

Last 4 digits of SS#: _____

Selective Service No.; if applicable _____

Signature: _____

Data Protection

IMPORTANT – Public Records Act 44

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

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

DATA PROTECTION DESIGNATION

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

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

Name (Please print)	Signature
Home Address	Home Telephone Number
Last 4 digits of SS#	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 ☐ U. S. Permanent Resident (must provide documentation;

☐ Other 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	2014						☐ 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
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

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_____

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: ________________________ Attention: **Program Director**
Address: ________________________ 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

Break Glass Policy

Scope

This policy establishes requirements for staff, faculty and students regarding access to LSU Healthcare Network information as well as the responsibilities for stewardship of LSU Healthcare Network information. LSU Healthcare Network information is all information generated or acquired, in printed or machine-readable form, by LSU Healthcare Network faculty, staff, students, contractors or others engaged on the LSU Healthcare Network's behalf, in the course of carrying out the LSU Healthcare Network's mission or conducting its patient care.

Policy Statement

LSU Healthcare Network shall be used only in appropriate purposes. Information is a resource analogous to Network financial and physical resources. All members of the Network community should be aware of their obligations to protect Network information. In particular:

- Network information may not be accessed by or disclosed to anyone who does not need the information to perform the activities and fulfill the responsibilities associated with his or her Network position.
- Those accessing Network information are responsible for giving a password and reason for entering a secured chart.
- Entering Network secured charts without entering the required information will be regarded with utmost seriousness. Alleged violations of this policy will be pursued in accordance with the appropriate disciplinary procedures for faculty, staff and students, and when indicated, sanctions up to and including dismissal will be imposed.

By signing this document, you are acknowledging that you have read and understand LSU Healthcare Network's Break Glass Policy.

Printed Name: _____

Signature: _____

Date: _____

LSU Health New Orleans
HEALTH SCIENCES CENTER
School of Medicine
Office of Medical Education

Pursuant to LAC 46XLV.422, a physician participating in postgraduate medical training in this state by way of registration, permit or license, shall report and shall request that the training program report to the Louisiana State Board of Medical Examiners (LSBME) in writing the suspension, termination, non-renewal, surrender, resignation or withdrawal of the physician's participation in training for any reason other than impairment by drugs or alcohol within thirty days of such action. To comply with this requirement, I, the undersigned, do hereby consent and give authority to LSU and its representatives to notify the LSBME in writing the suspension, termination, non-renewal, surrender, resignation or withdrawal of my participation in training in my GME program(s). Should I revoke this release at anytime LSU will notify the LSBME of such revocation.

_____ _____

Print Name Department

_____ _____ _____

Signature HO Level Date

Louisiana State University Health Sciences Center • 2020 Gravier Street, Suite 602 • New Orleans, Louisiana 70112
phone 504.568.4006 • **fax** 504.599.1453 • **www**.lsuhsc.edu

LSU Health New Orleans
HEALTH SCIENCES CENTER
School of Medicine
Office of Medical Education

Charles W. Hilton, MD
Associate Dean for Academic Affairs
Office of Graduate Medical Education
2020 Gravier Street, Suite 602
New Orleans, LA 70112

I hereby certify that I have received the mandatory 2014-15 House Officer Manual. I understand that I will be accountable for conducting duties in the workplace in accordance with the information contained in this manual. I understand that additional information is available through the LSUHSC-NO website; http://www.lsuhsc.edu/; http://www.lsuhsc.edu/no/administration/hrm; http://www.medschool.lsuhsc.edu/medical_education/graduate; LSU Bylaws and Regulations, LSU System Policies, LSUHSC Policies and GME Policies. I understand that these rules and policies are subject to change and the latest revision of this manual is at http://www.medschool.lsuhsc.edu/medical_education/graduate/HouseOfficerManual.aspx.

Print Name	AY 2014-2015 HO Level	Department
Signature	Date	SSN or EMPLID

Return this form to Program Coordinator