Aliquippa School District

Lorraine DiGiovine *Payroll/Benefits Coordinator*

Required Hiring Information

There are mandatory clearances/forms that must be obtained prior to working in the Aliquippa School District. Certain volunteers are also required to get clearances. The needed information and necessary steps to obtain it are available here:

Act 34-PA Criminal Record History - $8.00 (free for volunteer)

This clearance can be obtained online if you go to epatch.state.pa.us . You may apply online or download the form for submission. ***Volunteers: Please indicate "VOLUNTEER" in the Reason for Request section.***

Act 151 PA Child Abuse History - $8.00 (free for volunteer)

This clearance may be obtained online at www.compass.state.pa.us/CWIS . You may apply online or download the form for submission. ***Volunteers: Please indicate "SCHOOL" in the Purpose of Clearance section.***

Act 114 FBI Federal Criminal History (Fingerprints) - $22.60 (Employment) $21.35 (Volunteer)

This clearance must be obtained through an approved provider. The Beaver Valley Intermediate Unit (BVIU) is one such entity. Individuals may go to www.identogo.com. To register, applicants can click on the blue "Get Fingerprinted" button at the top right-hand corner of the page. Enter Code - 1KG6S7 or for Volunteers enter Code 1KG6Y3 Applicants may also phone in a registration by calling 844-321-2101 or 855-845-7434. . Please make sure you register under **"Pennsylvania Department of Education-PDE"**, not "*Pennsylvania Department of Public Welfare-DPW"* or "*Pennsylvania Department of Banking-DOB" or "Pennsylvania Department of Transportation"*. You will receive a receipt with the PAE number. The PAE number must be submitted to Lorraine DiGiovine, Payroll Coordinator, for processing. Instructions are included.

Act 126-Mandated Reporter Training-Free

This training must be completed by all employees of the District. Access this training at www.reportabusepa.pitt.edu.

Act 24 Arrest and Conviction Report-Free

This form is available on the District website at www.quipsd.org

Form W-4 (2018)

Future developments. For the latest information about any future developments related to Form W-4, such as legislation enacted after it was published, go to *www.irs.gov/FormW4*.

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. You may claim exemption from withholding for 2018 if **both** of the following apply.

- For 2017 you had a right to a refund of **all** federal income tax withheld because you had **no** tax liability, **and**
- For 2018 you expect a refund of **all** federal income tax withheld because you expect to have **no** tax liability.

If you're exempt, complete **only** lines 1, 2, 3, 4, and 7 and sign the form to validate it. Your exemption for 2018 expires February 15, 2019. See Pub. 505, Tax Withholding and Estimated Tax, to learn more about whether you qualify for exemption from withholding.

General Instructions

If you aren't exempt, follow the rest of these instructions to determine the number of withholding allowances you should claim for withholding for 2018 and any additional amount of tax to have withheld. For regular wages, withholding must be based on allowances you claimed and may not be a flat amount or percentage of wages.

You can also use the calculator at ***www.irs.gov/W4App*** to determine your tax withholding more accurately. Consider using this calculator if you have a more complicated tax situation, such as if you have a working spouse, more than one job, or a large amount of nonwage income outside of your job. After your Form W-4 takes effect, you can also use this calculator to see how the amount of tax you're having withheld compares to your projected total tax for 2018. If you use the calculator, you don't need to complete any of the worksheets for Form W-4.

Note that if you have too much tax withheld, you will receive a refund when you file your tax return. If you have too little tax withheld, you will owe tax when you file your tax return, and you might owe a penalty.

Filers with multiple jobs or working spouses. If you have more than one job at a time, or if you're married and your spouse is also working, read all of the instructions including the instructions for the Two-Earners/Multiple Jobs Worksheet before beginning.

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 might owe additional tax. Or, you can use the Deductions, Adjustments, and Other Income Worksheet on page 3 or the calculator at *www.irs.gov/W4App* to make sure you have enough tax withheld from your paycheck. If you have pension or annuity income, see Pub. 505 or use the calculator at *www.irs.gov/W4App* to find out if you should adjust your withholding on Form W-4 or W-4P.

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

Specific Instructions

Personal Allowances Worksheet

Complete this worksheet on page 3 first to determine the number of withholding allowances to claim.

Line C. *Head of household please note:* Generally, you can claim head of household filing status on your tax return only if you're unmarried and pay more than 50% of the costs of keeping up a home for yourself and a qualifying individual. See Pub. 501 for more information about filing status.

Line E. Child tax credit. When you file your tax return, you might be eligible to claim a credit for each of your qualifying children. To qualify, the child must be under age 17 as of December 31 and must be your dependent who lives with you for more than half the year. To learn more about this credit, see Pub. 972, Child Tax Credit. To reduce the tax withheld from your pay by taking this credit into account, follow the instructions on line E of the worksheet. On the worksheet you will be asked about your total income. For this purpose, total income includes all of your wages and other income, including income earned by a spouse, during the year.

Line F. Credit for other dependents. When you file your tax return, you might be eligible to claim a credit for each of your dependents that don't qualify for the child tax credit, such as any dependent children age 17 and older. To learn more about this credit, see Pub. 505. To reduce the tax withheld from your pay by taking this credit into account, follow the instructions on line F of the worksheet. On the worksheet, you will be asked about your total income. For this purpose, total income includes all of

---

Separate here and give Form W-4 to your employer. Keep the worksheet(s) for your records.

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

Employee's Withholding Allowance Certificate

▶ **Whether you're 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

2018

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 filing separately, check "Married, but withhold at higher Single rate."	
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 800-772-1213 for a replacement card.** ▶ ☐	

5	Total number of allowances you're claiming (from the applicable worksheet on the following pages) . . .	5	
6	Additional amount, if any, you want withheld from each paycheck	6	$
7	I claim exemption from withholding for 2018, 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 boxes 8 and 10 if sending to IRS and complete boxes 8, 9, and 10 if sending to State Directory of New Hires.)	9 First date of employment	10 Employer identification number (EIN)

H511.340 (8/2011) Position _____

COMMONWEALTH OF PENNSYLVANIA
PENNSYLVANIA DEPARTMENT OF HEALTH

SCHOOL PERSONNEL HEALTH RECORD

I. Patient Information

Last Name | First | MI | Sex | Date of Birth

Social Security Number | Home Telephone | Work Telephone

Mailing Address | Street | City | State | Zip

Usual Source of Medical Care | Physician's Name | Address | Telephone

Emergency Contact – Name | Relationship | Address | Telephone

II. Immunization History

VACCINE	Enter Month, Day, and Year Each Immunization was Given DOSES			BOOSTERS & DATES	
Diphtheria and Tetanus*	1.	2.	3.	4.	5.
Hepatitis B	1.	2.	3.		
Measles, Mumps, Rubella	1.	2.			
Other _____	1.	Other _____		1.	

* Tetanus and Diphtheria are usually received in combined vaccines such as DTP, DtaP, DT, or Td

III. Required Tuberculosis Test Results (as per Regulations of the Department of Health

DATE APPLIED	ARM	METHOD	ANTIGEN	MANUFACTURER	SIGNATURE
DATE READ	**RESULTS (mm)**		**SIGNATURE**		

For previously known/new positive reactors: _____

Chest X-ray: Date: _____ Results: _____ (Attach a copy of the report.)

Other: Date: _____ Results: _____ (Attach a copy of the report.)

Preventive Anti-Tuberculosis Chemotherapy ordered: ☐ No ☐ Yes Date: _____

IF SIGNIFICANT REACTION WAS REPORTED, THE PHYSICIAN REPORT MUST STATE THAT THE APPLICANT IS FREE FROM CURRENT TUBERCULOSIS DISEASE OR IS UNDER ADEQUATE CHEMOTHERAPY FOR TUBERCULOSIS DISEASE:

_____

_____

_____

IV. Significant Medical Conditions (✓)

	Yes	No	If Yes, Explain:
Allergies	☐	☐	
Asthma	☐	☐	
Cardiac	☐	☐	
Chemical Dependency	☐	☐	
Drugs	☐	☐	
Alcohol	☐	☐	
Diabetes Mellitus	☐	☐	
Gastrointestinal Disorder	☐	☐	
Hearing Disorder	☐	☐	
Hypertension	☐	☐	
Neuromuscular Disorder	☐	☐	
Orthopedic Condition	☐	☐	
Respiratory Illness	☐	☐	
Seizure Disorder	☐	☐	
Skin Disorder	☐	☐	
Vision Disorder	☐	☐	
Other (Specify)	☐	☐	

V. Report of Physical Examination (✓)

	NORMAL	ABNORMAL	NOT EXAMINED	COMMENTS
Height (inches) _____				
Weight (pounds) _____				
Pulse _____				
Blood Pressure _____				
Hair/Scalp				
Skin				
Eyes – Visual Acuity: R _____ L _____				
Eyes – Color Vision				
Ears – Hearing (dB) R _____ L _____				
Nose and Throat				
Teeth and Gingiva				
Lymph Glands				
Heart – Murmur, etc…				
Lungs – Adventitous Findings				
Abdomen				
Genitourinary				
Neuromuscular System				
Extremities				

Are there any special medical problems or chronic diseases which require restriction of activity, medication or which might affect his/her work role? If so, specify _____

_____ Physician Name (Print)

_____ Signature of Examiner

_____ Date

_____ Physician Address

The statements and answers as recorded above are full, complete and true to the best of my knowledge and belief. I understand that any false or misleading statements may cause termination of my employment.

I authorize the physician or other person to disclose any knowledge or information pertaining to my health to the employing authority for whom this examination is performed.

_____ Signature of Employee

_____ Date

CLGS-3Z-6 (5-11)

RESIDENCY CERTIFICATION FORM
Local Earned Income Tax Withholding

TO EMPLOYERS/TAXPAYERS:

This form is to be used by employers and/or taxpayers to report essential information for the collection and distribution of Local Earned Income Taxes. This form must be utilized by employers when a new employee is hired or when a current employee notifies employer of a name and/or address change.

EMPLOYEE INFORMATION - RESIDENCE LOCATION

NAME (Last Name, First Name, Middle Initial)			SOCIAL SECURITY NUMBER
STREET ADDRESS (No PO Box, RD or RR)			
SECOND LINE OF ADDRESS			
CITY	STATE	ZIP CODE	DAYTIME PHONE NUMBER
MUNICIPALITY (City, Borough or Township)			
COUNTY	RESIDENT PSD CODE		TOTAL RESIDENT EIT RATE

EMPLOYER INFORMATION - EMPLOYMENT LOCATION

EMPLOYER BUSINESS NAME (Use Federal ID Name)			EMPLOYER FEIN
Aliquippa School District			256000016
STREET ADDRESS WHERE ABOVE EMPLOYEE REPORTS TO WORK (No PO Box, RD or RR)			
800 21st St			
SECOND LINE OF ADDRESS			
CITY	STATE	ZIP CODE	PHONE NUMBER
Aliquippa	PA	15001	724-857-7500
MUNICIPALITY (City, Borough or Township)			
Aliquippa City/Aliquippa S D			
COUNTY	WORK LOCATION PSD CODE		WORK LOCATION NON-RESIDENT EIT RATE
Beaver	040101		1.5000

CERTIFICATION

Under penalties of perjury, I (we) declare that I (we) have examined this information, including all accompanying schedules and statements and to the best of my (our) belief, they are true, correct and complete.

SIGNATURE OF EMPLOYEE	DATE (MM/DD/YYYY)
PHONE NUMBER	EMAIL ADDRESS

For information on obtaining the appropriate MUNICIPALITY (City, Borough, Township), PSD CODES and EIT (Earned Income Tax) RATES, please refer to the Pennsylvania Department of Community & Economic Development website:

www.newPA.com

ARREST/CONVICTION REPORT AND CERTIFICATION FORM
(under Act 24 of 2011 and Act 82 of 2012)

Section 1. Personal Information

Full Legal Name: _____

Date of Birth: ____/____/_____

Other names by which you have been identified: _____

Section 2. Arrest or Conviction

☐ By checking this box, I state that I have NOT been arrested for or convicted of any Reportable Offense.

☐ By checking this box, I report that I have been arrested for or convicted of an offense or offenses enumerated under 24 P.S. §§1-111(e) or (f.1) ("Reportable Offense(s)"). See Page 3 of this Form for a list of Reportable Offenses.

Details of Arrests or Convictions

For each arrest for or conviction of any Reportable Offense, specify in the space below (or on additional attachments if necessary) the offense for which you have been arrested or convicted, the date and location of arrest and/or conviction, docket number, and the applicable court.

_____

_____

Section 3. Child Abuse

☐ By checking this box, I state that I have NOT been named as a perpetrator of a founded report of child abuse within the past five (5) years as defined by the Child Protective Services Law.

☐ By checking this box, I report that I have been named as a perpetrator of a founded report of child abuse within the past five (5) years as defined by the Child Protective Services Law.

Section 4. Certification

By signing this form, I certify under penalty of law that the statements made in this form are true, correct and complete. I understand that false statements herein, including, without limitation, any failure to accurately report any arrest or conviction for a Reportable Offense, shall subject me to criminal prosecution under 18 Pa.C.S. §4904, relating to unsworn falsification to authorities.

_____

Signature *Date*

INSTRUCTIONS

Pursuant to 24 P.S. §1-111(c.4) and (j), the Pennsylvania Department of Education developed this standardized form (PDE-6004) to be used by current and prospective employees of public and private schools, intermediate units, and area vocational-technical schools.

As required by subsection (c.4) and (j)(2) of 24 P.S. §1-111, this form shall be completed and submitted by all current and prospective employees of said institutions to provide written reporting of any arrest or conviction for an offense enumerated under 24 P.S. §§1-111(e) and (f.1) and to provide notification of having been named as a perpetrator of a founded report of child abuse within the past five (5) years as defined by the Child Protective Services Law.

As required by subsection (j)(4) of 24 P.S. §1-111, this form also shall be utilized by current and prospective employees to provide written notice within seventy-two (72) hours after a subsequent arrest or conviction for an offense enumerated under 24 P.S. §§1-111(e) or (f.1).

In accordance with 24 P.S. §1-111, employees completing this form are required to submit the form to the administrator or other person responsible for employment decisions in a school entity. Please contact a supervisor or the school entity administration office with any questions regarding the PDE 6004, including to whom the form should be sent.

PROVIDE ALL INFORMATION REQUIRED BY THIS FORM LEGIBLY IN INK.

LIST OF REPORTABLE OFFENSES

- **A reportable offense enumerated under 24 P.S. §1-111(e) consists of any of the following:**

(1) An offense under one or more of the following provisions of Title 18 of the Pennsylvania Consolidated Statutes:

- Chapter 25 (relating to criminal homicide)
- Section 2702 (relating to aggravated assault)
- Section 2709.1 (relating to stalking)
- Section 2901 (relating to kidnapping)
- Section 2902 (relating to unlawful restraint)
- Section 2910 (relating to luring a child into a motor vehicle or structure)
- Section 3121 (relating to rape)
- Section 3122.1 (relating to statutory sexual assault)
- Section 3123 (relating to involuntary deviate sexual intercourse)
- Section 3124.1 (relating to sexual assault)
- Section 3124.2 (relating to institutional sexual assault)
- Section 3125(relating to aggravated indecent assault)
- Section 3126 (relating to indecent assault)
- Section 3127 (relating to indecent exposure)
- Section 3129 (relating to sexual intercourse with animal)
- Section 4302 (relating to incest)
- Section 4303 (relating to concealing death of child)
- Section 4304 (relating to endangering welfare of children)
- Section 4305 (relating to dealing in infant children)
- A felony offense under section 5902(b) (relating to prostitution and related offenses)
- Section 5903(c) or (d) (relating to obscene and other sexual materials and performances)
- Section 6301(a)(1) (relating to corruption of minors)
- Section 6312 (relating to sexual abuse of children)
- Section 6318 (relating to unlawful contact with minor)
- Section 6319 (relating to solicitation of minors to traffic drugs)
- Section 6320 (relating to sexual exploitation of children)

(2) An offense designated as a felony under the act of April 14, 1972 (P.L. 233, No. 64), known as "The Controlled Substance, Drug, Device and Cosmetic Act."

(3) An offense SIMILAR IN NATURE to those crimes listed above in clauses (1) and (2) under the laws or former laws of:

- the United States; or
- one of its territories or possessions; or
- another state; or
- the District of Columbia; or
- the Commonwealth of Puerto Rico; or
- a foreign nation; or
- under a former law of this Commonwealth.

- **A reportable offense enumerated under 24 P.S. §1-111(f.1) consists of any of the following:**

(1) An offense graded as a felony offense of the first, second or third degree, other than one of the offenses enumerated under 24 P.S. §1-111(e), if less than (10) ten years has elapsed from the date of expiration of the sentence for the offense.

(2) An offense graded as a misdemeanor of the first degree, other than one of the offenses enumerated under 24 P.S. §1-111(e), if less than (5) five years has elapsed from the date of expiration of the sentence for the offense.

(3) An offense under *75 Pa.C.S. § 3802(a)*, (b), (c) or (d)(relating to driving under influence of alcohol or controlled substance) graded as a misdemeanor of the first degree under *75 Pa.C.S. § 3803* (relating to grading), if the person has been previously convicted of such an offense and less than (3) three years has elapsed from the date of expiration of the sentence for the most recent offense.

Employment Eligibility Verification

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

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

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

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

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

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

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

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

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

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

☐ 1. A citizen of the United States

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

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

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

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

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

QR Code - Section 1
Do Not Write In This Space

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

Preparer and/or Translator Certification (check one):

☐ I did not use a preparer or translator. ☐ A preparer(s) and/or translator(s) assisted the employee in completing Section 1.

(Fields below must be completed and signed when preparers and/or translators assist an employee in completing Section 1.)

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

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

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

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

STOP *Employer Completes Next Page* STOP

Section 2. Employer or Authorized Representative Review and Verification

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

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

List A Identity and Employment Authorization	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)*				

Additional Information

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

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

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

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

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

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

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

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

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

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

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

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

LISTS OF ACCEPTABLE DOCUMENTS
All documents must be UNEXPIRED

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

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

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

Refer to the instructions for more information about acceptable receipts.

New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 11-30-2013)

PART A: General Information

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by your employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October,2013 for coverage starting as early as January 1, 2014.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.[1]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution -as well as your employee contribution to employer-offered coverage- is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact Lorraine DiGiovine - Payroll/Benefit Coordinator 724-857-7500 X 1103.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit **HealthCare.gov** for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

[1] An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer name		4. Employer Identification Number (EIN)
Aliquippa School District		25-6000016
5. Employer address		6. Employer phone number
800 21st St		724-857-7500
7. City	8. State	9. ZIP code
Aliquippa	PA	15001

10. Who can we contact about employee health coverage at this job?	
Lorraine DiGiovine, Payroll/Benefits Coordinator	
11. Phone number (if different from above)	12. Email address
724-857-7500 x 1103	ldigiovine@quipsd.org

Here is some basic information about health coverage offered by this employer:

- As your employer, we offer a health plan to:
  - ☐ All employees.
  - ☑ Some employees. Eligible employees are:

    Full Time - Administrators, Secretaries and all Bargaining Unit Employees.

- With respect to dependents:
  - ☑ We do offer coverage. Eligible dependents are:

    Spouses and children up to age 26.

  - ☐ We do not offer coverage.

☑ If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, **HealthCare.gov** will guide you through the process. Here's the employer information you'll enter when you visit **HealthCare.gov** to find out if you can get a tax credit to lower your monthly premiums.

ACT 29 FORM

The State of Pennsylvania requires that Public School Employees be categorized into two categories. One category is for employees who worked for any public school entity in Pennsylvania in any capacity prior to July 1, 1994. The second category is for those who never worked for any public school entity in any capacity prior to July 1, 1994. We need you to fill in the required information, check the appropriate box, and sign and return the form to the Business Office

Name_____

Social Security Number_____

Check one of the boxes below:

☐ I was employed by a Public School in Pennsylvania prior to July 1, 1994.

☐ I was <u>not</u> employed by a Public School in Pennsylvania prior to July 1, 1994.

_____ _____

Signature Date

BrickStreet

Aliquippa Borough School District - Aliquippa 15001

Your Workers' Compensation Insurance Carrier is:

BrickStreet Insurance

PO Box 3151 Charleston, WV 25332

Phone: 1-866-452-7425

NOTICE TO EMPLOYEES IN CASE OF WORK-RELATED INJURIES

If you suffer a work-related injury, your employer or its insurance company must pay for reasonable surgical and medical services and supplies, orthopedic appliances and prosthesis, including training in their use.

In order to insure that your medical treatment will be paid for by your employer or the insurance company, you must select from one of the following health care providers. You must continue to visit one of the providers listed below, if you need treatment, for ninety (90) days from the date of your first visit.

If one of the providers below refers you to another licensed specialist, your employer or their insurer will pay the bill for these services.

After this ninety- (90) day period, if you still need treatment and your employer has provided a list as set forth above, you may choose to go to another health care provider for treatment. You should notify your employer of this action within five days of your visit to said provider.

If a physician on the list prescribes invasive surgery, you may obtain a second opinion from any physician of your choice. If the second opinion is different than the listed physician's opinion, you may determine which course of treatment to follow; however, the second opinion must contain a specific and detailed treatment plan. If you choose the second opinion, the procedures in that opinion must be performed by one of the physicians on the list for the first ninety- (90) days. Therefore, in this situation, the employee may be required to treat with an employer designated provider for up to 180 days.

If you are faced with a medical emergency, you may secure assistance from a hospital, physician, or health care provider of your choice for your work related injury. However, when the emergency is resolved, you must seek treatment from a provider listed below.

Name	Address	Phone	Area of Specialty
dExpress ultiple Locations)	3944 Brodhead Road, Suite 7B Monaca, PA 15061	724-773-0777	Occupational Medicine / Urgent Care
rnal Medicine Specialist (SVMG)	2360 Hospital Drive Aliquippa, PA 15001	724-378-0830	Occupational Medicine
itage Valley Signature BusinessCare	5000 Industrial Blvd. Aliquippa, PA 15001	724-773-6464	Occupational Medicine
ociation of Specialty Physicians Inc. - hopedic ultiple Locations)	Beaver Medical Commons, 1030 Beaner Hollow Road Beaver, PA 15009	724-775-4242	Orthopedics
itage Valley Surgical Services	93 Boundry Lane Bridgewater, PA 15009	724-728-8300	General Surgery
gheny Neurological Associates ltiple Locations)	701 Broad Street, 4th Floor, Section D Sewickley, PA 15143	412-359-8850	Neurology
vickley Eye Group ltiple Locations)	95 Golfview Drive, Suite A Monaca, PA 15061	724-770-9000	Ophthalmology
Chiropractic	200 Ninth Street Monaca, PA 15061	724-774-8068	Chiropractic

CONVENIENT NETWORK LOCATIONS LISTED BELOW

mier Comp PT Network	Call Toll Free for Closest Location	1-888-594-4001	Physical Therapy
mier Comp MRI Network	Call Toll Free for Closest Location	1-888-594-4001	MRIs
ventry DME Plus	Call Toll Free	1-877-203-9899	DME
tum Pharmacy Network	Call Toll Free for Closest Location or go to www.cypresscare.com	1-800-419-7191	Pharmacy

Panel Date: 2/1/2017

Brickstreet INSURANCE

NOTICE: MEDICAL TREATMENT FOR YOUR WORK INJURY OR OCCUPATIONAL ILLNESS

Your employer has selected a list of 6 or more physicians and other health care providers who are available to treat your work-related injuries and illnesses during the first 90 days of treatment. This list is posted at _____ for you to view. Also, you may get a copy of this list from _____.

If you are injured at work or suffer an occupational illness, you have certain legal RIGHTS and DUTIES under Section 306(f.l)(1)(i) of the Workers' Compensation Act regarding your medical treatment. These rights and duties are summarized below.

MEDICAL TREATMENT: DURING THE FIRST 90 DAYS

- You have the RIGHT to receive reasonable and necessary medical treatment for your work injury or occupational illness. Your employer must pay for the treatment, as long as the treatment is by one of the listed providers.
- You have the RIGHT to choose which of the listed providers will treat you for your work injury or illness.
- You have the RIGHT to switch among any of the listed providers when you receive treatment; and if a listed provider refers you to a provider not on your employer's list, you have the RIGHT to receive treatment from the referral provider.
- You have the RIGHT to receive emergency medical treatment from any provider. However, non-emergency treatment must be given by a listed provider.
- If a listed provider prescribes surgery for you, you have the RIGHT to receive a second opinion from any provider of your choice. If that opinion is different from the opinion of the listed provider, you have the RIGHT to choose which course of treatment to follow. If you choose the treatment prescribed in the second opinion, you must receive the treatment from a listed provider for a period of 90 days after the date of your visit to the provider of the second opinion.
- You have the DUTY to visit one or more of the listed providers for the first 90 days of treatment for your work injury or illness if you expect your employer to pay for the medical treatment you receive.
- If you seek treatment for your work injury or illness from a provider who is not on the list, your employer may not have to pay for this medical treatment during this 90-day period. Therefore, you should talk to your employer before seeking treatment from a provider who is not on the list.

IMPORTANT: The requirements your employer must meet to have a valid list of at least 6 providers are shown on the reverse side of this form. If the list does not meet these requirements, it is not a valid list, and you have the right to seek medical treatment for your work injury or occupational illness from any health care provider of your choice.

MEDICAL TREATMENT: AFTER THE FIRST 90 DAYS

- You have the RIGHT to receive treatment from any physician or other health care provider of your choice, whether or not they are listed by your employer. Your employer must pay for this treatment, as long as it is reasonable and necessary for your work injury or occupational illness and has been properly documented by the physician or other health care provider.
- You have the DUTY to notify your employer if you receive treatment from a physician or other health care provider who is not listed by your employer. You must notify your employer within five days of the first visit to any provider who is not on your employer's list. The employer may not be required to pay for treatment received until you have given this notice.

Your signature on this form indicates that you have been informed of and you understand these rights and duties. If you have questions, be sure you have your rights and duties explained to you before signing this form.

I HAVE BEEN INFORMED OF MY MEDICAL TREATMENT RIGHTS AND DUTIES WITH REGARD TO WORK-RELATED INJURIES AND OCCUPATIONAL ILLNESSES. THIS NOTICE WAS PRESENTED TO ME AT (check one):

☐ TIME OF HIRE ☐ WHEN I WAS INJURED ☐ OTHER

EMPLOYEE: _____ DATE: _____

EMPLOYER REPRESENTATIVE: _____ DATE: _____

(OVER)

Brickstreet®

REQUIREMENTS FOR EMPLOYER'S LIST OF HEALTH CARE PROVIDERS

1. There must be at least 6 health care providers on the list, but there may be more than 6 listed.

2. At least 3 of the health care providers on the list must be physicians.

3. No more than 4 of the health care providers on the list may be coordinated care organizations (CCOs).

4. The names, addresses, phone numbers and areas of medical specialties of all health care providers must be included on the list.

5. The health care providers on the list must be geographically accessible and must have specialties that are appropriate based on the anticipated work-related medical problems of the employees.

6. Your employer must specify on the list if any of the health care providers on the list are employed, owned or controlled by your employer or its workers' compensation insurance company.

NOTE: Your employer's list of health care providers must meet all of the above requirements. If the list does not meet all of these requirements, you do not have to choose a provider from the list. Instead, you have the right to seek medical treatment with any health care provider of your choice.

BUREAU OF WORKERS' COMPENSATION
HELPLINE INFORMATION CENTER
1-800-482-2383 (long-distance calls inside PA)
1-717-772-4447 (local and calls outside PA)

pennsylvania

Notification to Employees of Their Rights and Duties Under the PA Workers' Compensation Act Section 306 (f.1)(1)(i)

The Pennsylvania Workers' Compensation Act requires that employees be given written notice of their rights and duties under Sec. 306 (f.1)(1)(i) of the Act if a list of designated health care providers is established by the employer. The text of this section is provided on the next page.

If you are viewing this electronically, your electronic signature will be your acknowledgement that you have been provided with your rights and duties; otherwise, you must acknowledge this with your signature and return it to your employer. You may keep a copy for your records.

Rights and Duties

As an employee of the commonwealth working at a location where a list of designated health care providers has been established and posted, you have the right to seek emergency medical treatment from any provider; for post-emergency and other injuries, you must obtain treatment for work-related injuries and illnesses from a designated health care provider for 90 days. The penalty for not using a designated health care provider is that the commonwealth is not liable for the medical bills incurred. Specific rights and duties are:

- The duty to obtain treatment for work-related injuries and illnesses from one or more of the designated health care providers for 90 days from the date of the first visit to a designated provider.
- The right to seek emergency medical treatment from any provider, but subsequent non-emergency treatment shall be by a designated provider for the remainder of the 90-day period.
- The right to have all reasonable medical supplies and treatment related to the injury paid for by your employer as long as treatment is obtained from a designated provider during the 90-day period.
- The right, during this 90-day period, to switch from one designated health care provider to another designated provider.
- The right to seek treatment from a provider if you are referred to that provider by a designated provider.
- The right to an additional opinion from a provider of your choice when invasive surgery is prescribed by the designated provider.
- The right to seek treatment or medical consultation from a non designated provider during the 90-day period, but the services shall be **at your expense** for the applicable 90 days.
- The right to seek treatment from any health care provider after the 90-day period has ended.
- The duty to **notify your employer of treatment by a non designated provider (after the 90 day period) within 5 days of the first visit to that provider.** The employer may not be required to pay for treatment rendered by a non designated provider prior to receiving this notification.

I acknowledge that I have been informed of my rights and duties under Sec. 306 (f.1)(1)(i) and that I understand them to the extent they are explained above.

Employee's Printed Name	Employee's Signature	Date

If you have any questions, ask your human resources office or call the Bureau of Workers' Compensation at 800.482.2383

Revision 5.16.12

Text of Section 306 (f.1)(1)(i): The employer shall provide payment in accordance with this section for reasonable surgical and medical services, services rendered by physicians or other health care providers, including an additional opinion when invasive surgery may be necessary, medicines and supplies, as and when needed. Provided an employer establishes a list of at least six designated health care providers, no more than four of whom may be a coordinated care organization and no fewer than three of whom shall be physicians, the employee shall be required to visit one of the physicians or other health care providers so designated and shall continue to visit the same or another designated physician or health care provider for a period of ninety (90) days from the date of the first visit: provided, however, that the employer shall not include on the list a physician or other health care provider who is employed, owned or controlled by the employer or the employer's insurer unless employment, ownership or control is disclosed on the list. Should invasive surgery for an employee be prescribed by a physician or other health care provider so designated by the employer, the employee shall be permitted to receive an additional opinion from any health care provider of the employee's own choice. If the additional opinion differs from the opinion provided by the physician or health care provider so designated by the employer, the employee shall determine which course of treatment to follow: provided, that the second opinion provides a specific and detailed course of treatment. If the employee chooses to follow the procedures designated in the second opinion, such procedures shall be performed by one of the physicians or other health care providers so designated by the employer for a period of ninety (90) days from the date of the visit to the physician or other health care provider of the employee's own choice. Should the employee not comply with the foregoing, the employer will be relieved from liability for the payment for the services rendered during such applicable period. It shall be the duty of the employer to provide a clearly written notification of the employee's rights and duties under this section to the employee. The employer shall further ensure that the employee has been informed and that he understands these rights and duties. This duty shall be evidenced only by the employee's written acknowledgment of having been informed and having understood his rights and duties. Any failure of the employer to provide and evidence such notification shall relieve the employee from any notification duty owed, notwithstanding any provision of this act to the contrary, and the employer shall remain liable for all rendered treatment. Subsequent treatment may be provided by any health care provider of the employee's own choice. Any employee who, next following termination of the applicable period, is provided treatment from a nondesignated health care provider shall notify the employer within five (5) days of the first visit to said health care provider. Failure to so notify the employer will relieve the employer from liability for the payment for the services rendered prior to appropriate notice if such services are determined pursuant to paragraph (6) to have been unreasonable or unnecessary.

Acceptable Use Policy

For the Use of Technology Equipment and/or the Internet

Common Sense Acceptable Use Policy for Aliquippa School District Technology Users

iduction

Children's Internet Protection Act (CIPA) requires schools to establish Internet Safety guidelines for the appropriate use of computer networks. The Aliquippa School District makes able to trained staff and students the global resources of the Internet, as well as the computer resources of our local area network. Through technology resources, educators and nts can communicate with others, share resources, search databases, and retrieve useful information. User accounts are provided at no charge to students and staff of the School ct for Internet use and are bound by the Acceptable Use Policy.

onsible Usage

nternet is to be used for **educational purposes only.** All users should treat this usage with respect and recognize that access to the Internet is *a privilege not a right.* We exercise control over content of information through our systems, but cannot guarantee all unacceptable sites are blocked. You, the employee, must comply with whatever rules are itable for the system to access. If the information appears to be offensive, you should avoid it completely. You must take responsibility for statements you make in email, chat t, discussion forums, and newsgroups. If you act irresponsibly or your actions endanger our system through misuse or vandalism, we may suspend or revoke your privilege.

urce Usage

stem has unlimited resources. Chat rooms, instant messenger, and social networking sites should not be used on school time, but rather reserved for our personal use at home. serve the right to limit individual login sessions so that everyone can gain equal access to the limited resources available. If you use excessive Internet time we may suspend your s at any time without notice. You must log off when leaving the Internet.

ful Use

t information may not be used for unlawful purposes. Transmission of any material in violation of any federal or state regulation is prohibited (Title 18). Penalty of unauthorized ay result in a fine of up to $30,000, up to seven years in jail and/or expulsion from school. This transmission includes copyrighted material, material legally judged to be threatening cene or material protected by trade secret.

norized Usage

empt to access or modify unauthorized computer system information or to interfere with normal system operations will result in **suspension of your access privileges.** orized activities include guessing or using passwords other than accessing your own information that does not have public permission, and accessing any system on which you welcome. **A user's privilege of access to remote electronic information resources shall be temporarily, or permanently, revoked for inappropriate use or violation of the s policy.** Violations shall be documented. Documented violations and repeated violations by a user shall be presented to the superintendent for appropriate action.

Internet Acceptable Use Agreement Form

Staff Member:

I have read and understand the Aliquippa School District's (ASD) Acceptable Use Policy (AUP). Should I misuse this privilege, as indicated in the AUP, I understand that the ASD reserves the right to revoke access to the Internet. **I understand that access to and use of the network is designed for educational purposes and that the ASD has taken precautions to control access to controversial material, but there are limitations to this control. This is my RESPONSIBILITY.**

○ **I agree to adhere to the guidelines of the ASD Acceptable Use Policy.**

_____

Name (please print)

_____ _____

Signature Date

Accounts will be terminated immediately upon resignation, dismissal or retirement.

Please file with personnel records.

Accepted by: _____ Date: _____

ALIQUIPPA SCHOOL DISTRICT

Direct Deposit Authorization

$$$

☐ **Start** ☐ **Stop** ☐ **Change** ☐ **Reactivate**

Name Of Financial Institution

[ ]

Transit Routing Number

[ ]

Direct Deposit Account Number

[ ]

☐ **Checking** ☐ **Savings**

Name ***(please print)***____

Employee Social Security # _____ - _____- _________

Note: A Voided check should be attached to this form, if applicable. Please sign and date at bottom of form

Signed__________________________________ Date:_______________

I understand that by signing this form I authorize the Aliquippa School District to make the payments indicated above via direct deposit to my account in the financial institution named. I authorize the financial institution to accept any credit entries to the above account initiated by the Aliquippa School District. If funds to which I am not entitled are deposited to my account, I authorize the Aliquippa School District to direct the financial institution to return said funds.

I understand that three weeks may pass before this authorization takes effect. I understand that it is my responsibility to verify that payments have been credited to my account and that the Aliquippa School District assumes no liability for overdrafts for any reason. I understand that in the event my financial institution is not able to deposit any transfer into my account due to any action I take, the School District cannot issue the funds to me until the funds are returned to the School District by my financial institution.

I understand that this authorization will override any previous authorization and will remain in effect until revoked by my written request.

ALIQUIPPA SCHOOL DISTRICT

EMPLOYEE INFORMATION SHEET

NAME _____

ADDRESS _____

_____

PHONE ( ) - _____

CELL ( ) - _____

DOB _____

EMERGENCY CONTACT NAME & PHONE NUMBER

_____

_____

PLEASE LIST ALL DEPENDENT INFORMATION (INCLUDING BIRTH DATES)

NAME **DOB** _____

_____

_____

_____

PLEASE LIST CURRENT CERTIFICATIONS

_____

TOWNSHIP _____
(FOR WAGE TAX PURPOSES)

BUILDING _____

SUBJECTS TAUGHT _____

_____

PLEASE FORWARD TO THE SUPERINTENDENT'S OFFICE.

Acknowledgement of Receipt of School District Property & Financial Obligation Form

Date:_____

I hereby acknowledge receipt and assignment of the following School District property:

- ☐ Office/Building Key (No:)_____
- ☐ Identification/Security Access Card (No:)_____
- ☐ Cellular Phone (Inventory/Serial No:)_____
- ☐ Lap-top computer (Inventory/Serial No:)_____
- ☐ Uniform (List:)_____
- ☐ Safety Equipment (List:)_____
- ☐ Other Equipment:_____
- ☐ Other:_____

Return of Property: In the event of my termination/separation from employment, I will return all tools, and company property (specified above or on attached sheet), upon my last day of work (or as specified by my supervisor). If any property is not returned, I authorize a reasonable value for such items to be deducted from my final paycheck (and if applicable any final reimbursement owed to me). In addition, if I no longer need any of the items, I will report this information to my supervisor. I agree to notify the company if any of the items are damaged, destroyed, or lost.

Employee Signature_____

Print Employee's Name:_____Date_____

Building / Dept._____

Original copy – Personnel File
Copy – Employee and Employee's supervisor

PSERS Communications

When you become a new member of PSERS, PSERS will mail you a *Welcome Packet*. The *Welcome Packet* will include reference to an *Active Member Handbook*, a *Nomination of Beneficiaries* (PSRS-187) form, and an *Application for Multiple Service Membership* (PSRS-1259). You may print the handbook from the PSERS website or call PSERS to request a copy of the handbook. If applicable, you will also receive a *Class T-F Election Packet*. If you are an active member of PSERS, you may be eligible to apply to purchase service credit. Certain types of service credit purchases have time restrictions. Please refer to your member handbook or PSERS website for additional details.

Naming a Beneficiary

After you are enrolled as a member of PSERS, you should designate a beneficiary(ies) to receive any benefits you have accrued if you die prior to retirement. You will receive a *Nomination of Beneficiaries* form (PSRS-187) with your *Welcome Packet* from PSERS. A new *Nomination of Beneficiaries* (PSRS-187) must be filed with PSERS anytime you change your beneficiary.

Multiple Service - 365 Day Election Deadline

If you have former service credited with the Pennsylvania State Employees' Retirement System (SERS) for work performed for the Commonwealth of Pennsylvania (for example, Department of Public Welfare, Labor & Industry, Transportation, etc.), you may elect multiple service, which combines state and school service. You will receive an election form with the PSERS *Welcome Packet*. **You have only 365 days from the date of your enrollment letter to make your multiple service election.**

Keeping Your Address Current

Throughout the year, PSERS sends you important publications and notifications pertaining to your retirement account. For you to receive this information, you must keep your address current. You should notify your employer whenever your name and/or address changes.

Contacting PSERS

If you have any questions, please contact the PSERS Member Service Center by calling toll-free, 1.888.773.7748 (1.888.PSERS4U). Harrisburg local callers, please use 717.787.8540. The Member Service Center is staffed each business day from 8:00 a.m. to 5:00 p.m.

To contact PSERS by email, use the following address: *ContactPSERS@pa.gov*

For your convenience, PSERS also has eight regional field offices to serve you. For more general information or to find the regional office serving your area, you may visit PSERS online at *www.psers.pa.gov*

5 N 5th Street
Harrisburg PA 17101-1905

Phone: 888.773.7748

Website: *www.psers.pa.gov*

Email: *ContactPSERS@pa.gov*

PSERS

Information for New School Employees

Welcome to the Public School Employees' Retirement System

Publication # 9800 1/2015

About PSERS...

PSERS Membership

PSERS is a Defined Benefit retirement plan, which means your retirement benefit is determined by a defined formula. PSERS' basic formula to calculate retirement benefits is based on a pension multiplier, your credited years of service, and your final average salary.

All full-time employees must become members of PSERS and must make retirement contributions. "Full-time," for retirement purposes, is defined as employees who work 5 or more hours a day, 5 days a week or its equivalent (25 or more hours a week), even if your employer considers you to be part-time.

Part-time salaried employees qualify for PSERS membership as of their first day of employment and must have retirement contributions withheld.

Part-time hourly and part-time per diem employees must meet minimum service requirements to qualify for PSERS membership (500 hours or 80 days). Once you meet membership requirements, subsequent service is qualified service unless there is a break in membership.

Employers may opt to withhold retirement contributions for part-time hourly and per diem employees beginning with the first day of employment. Once you meet PSERS membership eligibility requirements, your employer must withhold PSERS retirement contributions.

All part-time employees may waive membership in PSERS. To qualify for the waiver, the part-time employee must have an Individual Retirement Account and request a waiver within the first school year they qualify for PSERS membership. When you waive membership in PSERS, you forfeit all future rights to benefits for that waived school year.

NOTE: If you are currently a PSERS retiree, your monthly benefit will stop upon re-employment unless you are hired under emergency or extracurricular employment (the provisions of Act 2004-63).

Membership Class of Service

The law governing PSERS sets the terms of membership classes. Your membership class is determined by the date you become a member of PSERS and the class election you make.

For school employees who become new members of PSERS on or after July 1, 2011, there are two membership classes: Class T-E and Class T-F. New members automatically become Class T-E members, but have a one-time opportunity to elect Class T-F membership. PSERS will mail information and an election ballot to your home address. To elect Class T-F, you must return the ballot within 45 days of the date of notification.

If you previously were a Class T-C or Class T-D member, and had a 90-day or longer break in service, in your new period of employment you will be a Class T-D member.

Employee Contribution Rate

Employee contribution rates are based on a member's date of hire and class of service and are set by law.

The contribution rate for Class T-E members is 7.50% (base) with "shared risk" provision that could cause the total contribution levels to fluctuate between 7.50% and 9.50%. The contribution rate for Class T-F members is 10.30% (base rate) with "shared risk" provision that could cause the total contribution levels to fluctuate between 10.30% and 12.30%. With a "shared risk" program, you benefit when investments of the fund perform well and share some of the risk when investments underperform. The employee contribution rate may not go below the base rate of 7.50% for Class T-E and 10.30% for Class T-F members.

The contribution rate is set at 7.50% for Class T-D members enrolled on or after July 1, 2001.

Contributions are not included as part of your gross income for federal tax purposes; they are federally tax-deferred.

Benefit Eligibility upon Termination of Employment - Class T-E and Class T-F

Benefit	Requirement
Refund of Contributions and Interest	Under age 65 with fewer than 10 years of service
Disability Retirement	5 years of service and medical eligibility
Vesting (deferring retirement)	10 or more years of service
Early Retirement	10 or more years of service at any age
Normal Retirement (Superannuation)	Age 65 with 3 years of service; or attain a total combination of age and service that is equal to or greater than 92 with a minimum of 35 years of service.

Benefit Eligibility upon Termination of Employment - Class T-D

Benefit	Requirement
Refund of Contributions and Interest	Under age 62 with fewer than 5 years of service
Disability Retirement	5 years of service and medical eligibility
Vesting (deferring retirement)	5 or more years of service
Early Retirement	5 or more years of service at any age
Normal Retirement (Superannuation)	35 years of service at any age; age 60 with 30 years of service; or age 62 with 1 year of service.

PART TIME EMPLOYEES: Consider this notice of your right to waive membership.

Waiving Membership

New part-time salaried, part-time hourly, and part-time per diem employees have the option of waiving membership with PSERS. That is, choose not to participate and contribute to PSERS. To qualify to waive PSERS membership, you must have an individual retirement account such as a Traditional IRA, Roth IRA, Simplified Employee Pension (SEP), or a Savings Incentive match Plan for Employees of Small Employers (Simple) IRA.

You must contact your employer to request waiving your PSERS membership. You have until the end of the school year in which you wish to waive membership to exercise this option. PSERS recommends that this process take place within the first 30 days of being hired in order to avoid unnecessary withholding of retirement contributions. Your employer will submit your request to PSERS. Your employer will also ask to see verification of your individual retirement plan.

After your employer notifies PSERS of your request to waive membership, PSERS will send you a letter advising you that waiving membership in PSERS is not automatic, along with a PSERS Field Services Division form. This letter will advise you that waiving membership must be approved by PSERS and that you need to contact your PSERS Regional Office to review the waiver process and obtain the PSERS Membership Waiver (PSRS-51).

For the membership waiver to be binding, complete and return the Membership Waiver (PSRS-51) form by the due date stated on the form. If you do not return the Membership Waiver (PSRS-51) form by the date stated in the letter, you will be ineligible to waive membership.

WAIVED SERVICE MAY NEVER BE PURCHASED.

I wish to waive membership in PSERS. I have produced proof as indicated above, that I am eligible for waiver.

Signature _____ Date _____

Aliquippa School District

Peter M. Carbone
Superintendent of Schools

Deborah Engelman
Business Administrator

403(b) UNIVERSAL AVAILABILITY NOTICE

September 2, 2016

The Opportunity.
You have the opportunity to save for retirement by participating in your Employer's 403(b) retirement plan. If there are any questions, you may contact the Plan's administrator, The OMNI Group at 877-544-6664.

We recommend that all employees view a brief, 3-minute video presentation called, '403(b). Why me?' explaining a 403(b) plan, and how to contribute. The video can be viewed on OMNI's website at www.omni403b.com.

How Can I Participate?

You can participate in the Plan with pre-tax contributions by submitting a Salary Reduction Agreement ("SRA") online via OMNI's website or by submitting a completed SRA form, found on the same website, to OMNI either by facsimile to (585) 672-6194 or by mail to 1099 Jay St., Bldg F, Rochester, NY, 14611. Additionally, prior to contributing you must open an account with an investment provider participating in the Plan. A list of the Plan's participating investment providers may be viewed on OMNI's website after submitting your Employer's name and state.

How Much Can I Contribute Annually?

You may contribute up to $18,000 in 2015; this amount is subject to change annually. If you have at least 15 years of service with your employer or you are at least 50 years old, you may be entitled to make additional contributions. For appropriate limits for your particular circumstances, please contact OMNI's Customer Care Center at 877-544-6664.

What If I Already Have An Account?

If you are already contributing to the Plan, and you want to change your contribution amount or investment provider, simply complete and submit a new SRA. See directions above for on-line and paper submission options.

What If I Do Not Want To Contribute?

If you do not want to take advantage of this program, simply submit an SRA with the option "I do not wish to participate at this time" selected. See directions above for on-line and paper submission options.

How can I get more information?

You can access further information at www.omni403b.com.

COMMONWEALTH OF PENNSYLVANIA
SEXUAL MISCONDUCT/ABUSE DISCLOSURE RELEASE
(Pursuant to Act 168 of 2014)

Instructions

This standardized form has been developed by the Pennsylvania Department of Education, pursuant to Act 168 of 2014, to be used by school entities and independent contractors of school entities and by applicants who would be employed by or in a school entity in a position involving direct contact with children to satisfy the Act's requirement of providing information related to abuse or sexual misconduct. As required by Act 168, in addition to fulfilling the requirements under section 111 of the School Code and the Child Protective Services Law ("CPSL"), an applicant who would be employed by or in a school entity in a position having direct contact with children, must provide the information requested in SECTION 1 of this form and complete a written authorization that consents to and authorizes the disclosure by the applicant's current and former employers of the information requested in SECTION 2 of this form. The applicant shall complete one form for the applicant's current employer(s) and one for each of the applicant's former employers that were school entities or where the applicant was employed in a position having direct contact with children (therefore, the applicant may have to complete more than one form). Upon completion by the applicant, the hiring school entity or independent contractor shall submit the form to the applicant's current and former employers to complete SECTION 2. **A school entity or independent contractor may not hire an applicant who does not provide the required information for a position involving direct contact with children.**

Relevant Definitions:

Direct Contact with Children is defined as: "the possibility of care, supervision, guidance or control of children or routine interaction with children."

Sexual Misconduct is defined as: "any act, including, but not limited to, any verbal, nonverbal, written or electronic communication or physical activity, directed toward or with a child or a student regardless of the age of the child or student that is designated to establish a romantic or sexual relationship with the child or student. Such acts include, but are not limited to: (1) sexual or romantic invitation; (2) dating or soliciting dates; (3) engaging in sexualized or romantic dialogue; (4) making sexually suggestive comments; (5) self-disclosure or physical exposure of a sexual, romantic or erotic nature; or (6) any sexual, indecent, romantic or erotic contact with the child or student."

Abuse is defined as "conduct that falls under the purview and reporting requirements of the CPSL, 23 Pa.C.S. Ch. 63, is directed toward or against a child or a student, regardless of the age of the child or student."

Please Note

A prospective employer that receives any requested information regarding an applicant may use the information for the purpose of evaluating the applicant's fitness to be hired or for continued employment and shall report the information as appropriate to the Department of Education, a state licensing agency, law enforcement agency, child protective services agency, another school entity or to a prospective employer.

If the prospective employer decides to further consider an applicant after receiving an affirmative response to any of the questions listed in SECTIONS 1 and 2 of this form, the prospective employer shall request that former employers responding affirmatively to the questions provide additional information about the matters disclosed and include any related records. The **Commonwealth of Pennsylvania Sexual Misconduct/Abuse Disclosure Information Request** can be used to request this follow-up information. Former employers shall provide the additional information and records within 60 calendar days of the prospective employer's request.

The completed form and any information or records received shall not be considered public records for the purposes of the Act of February 14, 2008 (P.L. 6, No. 3) known as the "Right to Know Law."

The Department of Education shall have jurisdiction to determine willful violations of Act 168 and may, following a hearing, assess a civil penalty not to exceed $10,000. School entities shall be barred from entering into a contract with an independent contractor who is found to have willfully violated the provisions of Act 168.

COMMONWEALTH OF PENNSYLVANIA
SEXUAL MISCONDUCT/ABUSE DISCLOSURE RELEASE
(under Act 168 of 2014)

(Hiring school entity or independent contractor submits this form to ALL current employer(s) and to former employer(s) that were school entities and/or where the applicant had direct contact with children)

Name of Current or Former Employer:		☐ No applicable employment
Street Address:		
City, State, Zip:		
Telephone Number:	Fax Number:	Email:
Contact Person:		Title:

The named applicant is under consideration for a position with our entity. The Pennsylvania General Assembly has determined that additional safeguards are necessary in the hiring of school employees to ensure the safety of the Commonwealth's students. The individual whose name appears below has reported previous employment with your entity. We request you provide the information requested in SECTION 2 of this form within **20 calendar days** as required by Act 168 of 2014.

SECTION 1: APPLICANT CERTIFICATION AND RELEASE (TO BE COMPLETED BY THE APPLICANT EVEN IF THE APPLICANT HAS NO CURRENT OR PRIOR EMPLOYMENT TO DISCLOSE)

Applicant's Name (First, Middle, Last):	
Any former names by which the Applicant has been identified:	
DOB:	
Last 4 digits of Applicant's Social Security Number:	PPID (if applicable):
Approximate dates of employment with the entity listed above:	
Position(s) held with the entity:	

Pursuant to Act 168, an employer, school entity, administrator, and/or independent contractor that provides information or records about a current or former employee or applicant shall be immune from criminal liability under the CPSL, the Educator Discipline Act, and from civil liability for the disclosure of the information, unless the information or records provided were knowingly false. Such immunity shall be in addition to and not in limitation of any other immunity provided by law or any absolute or conditional privileges applicable to such disclosure by the virtue of the circumstances of the applicant's consent thereto. Under Act 168, the willful failure to respond to or provide the information and records as requested may result in civil penalties and/or professional discipline, where applicable.

Have you (Applicant) ever:

Yes ◯ No ◯ Been the subject of an abuse or sexual misconduct investigation by any employer, state licensing agency, law enforcement agency or child protective services agency (unless the investigation resulted in a finding that the allegations were false)?

Yes ◯ No ◯ Been disciplined, discharged, non-renewed, asked to resign from employment, resigned from or otherwise separated from employment while allegations of abuse or sexual misconduct were pending or under investigation or due to adjudication or findings of abuse or sexual misconduct?

Yes ◯ No ◯ Had a license, professional license or certificate suspended, surrendered or revoked while allegations of abuse or sexual misconduct were pending or under investigation or due to an adjudication or findings of abuse or sexual misconduct?

By signing this form, I certify under penalty of law that the statements made in this form are correct, complete, and true to the best of my knowledge. I understand that false statements herein, including, without limitation, any willful failure to disclose the information required, shall subject me to criminal prosecution under 18 Pa.C.S. § 4904 (relating to unsworn falsification to authorities) and to discipline up to, and including, termination or denial of employment, and may subject me to civil penalties and disciplinary action under the Educator Discipline Act. I also hereby authorize the above-named employer to release to the entity listed on page 3, the information requested in SECTION 2 of this form and any related records. I hereby release, waive, and discharge the above-named employer from any and all liability of any kind that may arise from such disclosure or release of records. I understand that third party vendors may be used to process this Act 168 pre-employment history review.

Signature of Applicant _____ Date _____

SECTION 2: CURRENT/FORMER EMPLOYER VERIFICATION (TO BE COMPLETED BY THE APPLICANT'S CURRENT EMPLOYER(S) AND ALL FORMER EMPLOYERS THAT WERE SCHOOL ENTITIES AND/OR WHERE THE APPLICANT HAD DIRECT CONTACT WITH CHILDREN)

Dates of employment of Applicant: _____ Contact telephone #: _____

To the best of your knowledge, has Applicant ever:

Yes ◯ No ◯ Been the subject of an abuse or sexual misconduct investigation by any employer, state licensing agency, law enforcement agency or child protective services agency (unless the investigation resulted in a finding that the allegations were false)?

Yes ◯ No ◯ Been disciplined, discharged, non-renewed, asked to resign from employment, resigned from or otherwise separated from employment while allegations of abuse or sexual misconduct were pending or under investigation or due to adjudication or findings of abuse or sexual misconduct?

Yes ◯ No ◯ Had a license, professional license or certificate suspended, surrendered or revoked while allegations of abuse or sexual misconduct were pending or under investigation or due to an adjudication or findings of abuse or sexual misconduct?

☐ No records or other evidence currently exists regarding the above questions. I have no knowledge of information pertaining to the applicant that would disqualify the applicant from employment.

Former Employer Representative Signature and Title _____ Date _____

Return all completed information to:

School Entity/Independent Contractor: Aliquippa School District				
Address: 800 21st St			Phone: 724-857-7500	
City: Aliquippa	State: PA	Zip: 15001	Fax: 724-857-3404	Email: ldigiovine@quipsd.org
Contact Person: Lorraine DiGiovine			Title: Payroll/Benefits Coordinator	

Date Form Received: _____ Received by: _____

COMMONWEALTH OF PENNSYLVANIA
SEXUAL MISCONDUCT/ABUSE DISCLOSURE RELEASE
(Pursuant to Act 168 of 2014)

Instructions

This standardized form has been developed by the Pennsylvania Department of Education, pursuant to Act 168 of 2014, to be used by school entities and independent contractors of school entities and by applicants who would be employed by or in a school entity in a position involving direct contact with children to satisfy the Act's requirement of providing information related to abuse or sexual misconduct. As required by Act 168, in addition to fulfilling the requirements under section 111 of the School Code and the Child Protective Services Law ("CPSL"), an applicant who would be employed by or in a school entity in a position having direct contact with children, must provide the information requested in SECTION 1 of this form and complete a written authorization that consents to and authorizes the disclosure by the applicant's current and former employers of the information requested in SECTION 2 of this form. The applicant shall complete one form for the applicant's current employer(s) and one for each of the applicant's former employers that were school entities or where the applicant was employed in a position having direct contact with children (therefore, the applicant may have to complete more than one form). Upon completion by the applicant, the hiring school entity or independent contractor shall submit the form to the applicant's current and former employers to complete SECTION 2. **A school entity or independent contractor may not hire an applicant who does not provide the required information for a position involving direct contact with children.**

Relevant Definitions:

Direct Contact with Children is defined as: "the possibility of care, supervision, guidance or control of children or routine interaction with children."

Sexual Misconduct is defined as: "any act, including, but not limited to, any verbal, nonverbal, written or electronic communication or physical activity, directed toward or with a child or a student regardless of the age of the child or student that is designated to establish a romantic or sexual relationship with the child or student. Such acts include, but are not limited to: (1) sexual or romantic invitation; (2) dating or soliciting dates; (3) engaging in sexualized or romantic dialogue; (4) making sexually suggestive comments; (5) self-disclosure or physical exposure of a sexual, romantic or erotic nature; or (6) any sexual, indecent, romantic or erotic contact with the child or student."

Abuse is defined as "conduct that falls under the purview and reporting requirements of the CPSL, 23 Pa.C.S. Ch. 63, is directed toward or against a child or a student, regardless of the age of the child or student."

Please Note

A prospective employer that receives any requested information regarding an applicant may use the information for the purpose of evaluating the applicant's fitness to be hired or for continued employment and shall report the information as appropriate to the Department of Education, a state licensing agency, law enforcement agency, child protective services agency, another school entity or to a prospective employer.

If the prospective employer decides to further consider an applicant after receiving an affirmative response to any of the questions listed in SECTIONS 1 and 2 of this form, the prospective employer shall request that former employers responding affirmatively to the questions provide additional information about the matters disclosed and include any related records. The **Commonwealth of Pennsylvania Sexual Misconduct/Abuse Disclosure Information Request** can be used to request this follow-up information. Former employers shall provide the additional information and records within 60 calendar days of the prospective employer's request.

The completed form and any information or records received shall not be considered public records for the purposes of the Act of February 14, 2008 (P.L. 6, No. 3) known as the "Right to Know Law."

The Department of Education shall have jurisdiction to determine willful violations of Act 168 and may, following a hearing, assess a civil penalty not to exceed $10,000. School entities shall be barred from entering into a contract with an independent contractor who is found to have willfully violated the provisions of Act 168.

COMMONWEALTH OF PENNSYLVANIA
SEXUAL MISCONDUCT/ABUSE DISCLOSURE RELEASE
(under Act 168 of 2014)

(Hiring school entity or independent contractor submits this form to ALL current employer(s) and to former employer(s) that were school entities and/or where the applicant had direct contact with children)

o:

Name of Current or Former Employer:		☐ No applicable employment
Street Address:		
City, State, Zip:		
Telephone Number:	Fax Number:	Email:
Contact Person:		Title:

The named applicant is under consideration for a position with our entity. The Pennsylvania General Assembly has determined that additional safeguards are necessary in the hiring of school employees to ensure the safety of the Commonwealth's students. The individual whose name appears below has reported previous employment with your entity. We request you provide the information requested in SECTION 2 of this form within **20 calendar days** as required by Act 168 of 2014.

SECTION 1: APPLICANT CERTIFICATION AND RELEASE (TO BE COMPLETED BY THE APPLICANT EVEN IF THE APPLICANT HAS NO CURRENT OR PRIOR EMPLOYMENT TO DISCLOSE)

Applicant's Name (First, Middle, Last):	
Any former names by which the Applicant has been identified:	
DOB:	
Last 4 digits of Applicant's Social Security Number:	PPID (if applicable):
Approximate dates of employment with the entity listed above:	
Position(s) held with the entity:	

Pursuant to Act 168, an employer, school entity, administrator, and/or independent contractor that provides information or records about a current or former employee or applicant shall be immune from criminal liability under the CPSL, the Educator Discipline Act, and from civil liability for the disclosure of the information, unless the information or records provided were knowingly false. Such immunity shall be in addition to and not in limitation of any other immunity provided by law or any absolute or conditional privileges applicable to such disclosure by the virtue of the circumstances of the applicant's consent thereto. Under Act 168, the willful failure to respond to or provide the information and records as requested may result in civil penalties and/or professional discipline, where applicable.

Have you (Applicant) ever:

Yes ◯ No ◯ Been the subject of an abuse or sexual misconduct investigation by any employer, state licensing agency, law enforcement agency or child protective services agency (unless the investigation resulted in a finding that the allegations were false)?

Yes ◯ No ◯ Been disciplined, discharged, non-renewed, asked to resign from employment, resigned from or otherwise separated from employment while allegations of abuse or sexual misconduct were pending or under investigation or due to adjudication or findings of abuse or sexual misconduct?

Yes ◯ No ◯ Had a license, professional license or certificate suspended, surrendered or revoked while allegations of abuse or sexual misconduct were pending or under investigation or due to an adjudication or findings of abuse or sexual misconduct?

By signing this form, I certify under penalty of law that the statements made in this form are correct, complete, and true to the best of my knowledge. I understand that false statements herein, including, without limitation, any willful failure to disclose the information required, shall subject me to criminal prosecution under 18 Pa.C.S. § 4904 (relating to unsworn falsification to authorities) and to discipline up to, and including, termination or denial of employment, and may subject me to civil penalties and disciplinary action under the Educator Discipline Act. I also hereby authorize the above-named employer to release to the entity listed on page 3, the information requested in SECTION 2 of this form and any related records. I hereby release, waive, and discharge the above-named employer from any and all liability of any kind that may arise from such disclosure or release of records. I understand that third party vendors may be used to process this Act 168 pre-employment history review.

Signature of Applicant _____ Date _____

SECTION 2: CURRENT/FORMER EMPLOYER VERIFICATION (TO BE COMPLETED BY THE APPLICANT'S CURRENT EMPLOYER(S) AND ALL FORMER EMPLOYERS THAT WERE SCHOOL ENTITIES AND/OR WHERE THE APPLICANT HAD DIRECT CONTACT WITH CHILDREN)

Dates of employment of Applicant: _____ Contact telephone #: _____

To the best of your knowledge, has Applicant ever:

Yes ◯ No ◯ Been the subject of an abuse or sexual misconduct investigation by any employer, state licensing agency, law enforcement agency or child protective services agency (unless the investigation resulted in a finding that the allegations were false)?

Yes ◯ No ◯ Been disciplined, discharged, non-renewed, asked to resign from employment, resigned from or otherwise separated from employment while allegations of abuse or sexual misconduct were pending or under investigation or due to adjudication or findings of abuse or sexual misconduct?

Yes ◯ No ◯ Had a license, professional license or certificate suspended, surrendered or revoked while allegations of abuse or sexual misconduct were pending or under investigation or due to an adjudication or findings of abuse or sexual misconduct?

☐ No records or other evidence currently exists regarding the above questions. I have no knowledge of information pertaining to the applicant that would disqualify the applicant from employment.

Former Employer Representative Signature and Title _____ Date _____

Return all completed information to:

School Entity/Independent Contractor: Aliquippa School District				
Address: 800 21st St			Phone: 724-857-7500	
City: Aliquippa	State: PA	Zip: 15001	Fax: 724-857-3404	Email: ldigiovine@quipsd.org
Contact Person: Lorraine DiGiovine			Title: Payroll/Benefits Coordinator	

Date Form Received: _____ Received by: _____