CENTRAL LOUISIANA TECHNICAL COMMUNITY COLLEGE

New Hire Payroll Documents

Employee Name: _____ **Date of Hire:** _____

Required for Student Workers (Federal Work Study Program)

- ☐ Application for Student Employment
- ☐ Statement of Agreement and Understanding
- ☐ Wallace Investigations Background Check Form
- ☐ FERPA Confidentiality Statement
- ☐ Driver's License
- ☐ Social Security Card
- ☐ W-4 Employee's Withholding Allowance Certificate
- ☐ L-4 Louisiana Department of Revenue Withholding Exemption
- ☐ I-9 Employment Eligibility Verification
- ☐ E-2 Louisiana Second Injury Form
- ☐ Direct Deposit Authorization (Recommended but not required)
- ☐ LCTCS Recoupment of Overpayment Policy
- ☐ SF-13 Appointment Affidavits
- ☐ Confidentiality of Home Address and Phone Number
- ☐ Employee Personal Data Form

SF 10D

Rev. 4/03

APPLICATION FOR STUDENT EMPLOYMENT

PLEASE PRINT OR TYPE

File form with employing agency.

An Equal Opportunity Employer

PERSONAL

Name of Applicant	Position Applied For	Telephone No. ( ) -

Address	City	State	Zip Code	Date of Birth	Social Security No.

YES	NO	In the section below, if the answer to items 1,2, or 3 is YES, you are required to answer the accompanying questions. A YES answer to these questions will not automatically bar you from employment.	
☐	☐	1. In the past five (5) years, have you been removed from a position as a result of misconduct or resigned to avoid such removal?	1.If yes, give name and address of employer(s) and reason(s) for separation.
☐	☐	2. Within the past five (5) years, have you been convicted of any law violation? (Exclude minor traffic violations.)	2. & 3. If yes, give law enforcement authority (city police, sheriff, FBI, etc.) offense, date of offense, place and sentence.
☐	☐	3. Have you ever been convicted of a felony?	

EDUCATION

4.Are you now a full time regular student? ☐ YES ☐ NO	5. School, college or university you are now attending. NAME ADDRESS	
6. Current Grade/Classification High School College Graduate School _____1st yr_____2nd yr	Other School	7. If you are not presently attending school A. When were you last registered? MO YEAR B. When do you plan to return to school?

8. LIST PREVIOUS WORK EXPERIENCE ON PART 2

AUTHORIZATIONON

I have completed this application with the knowledge and understanding that any or all items contained herein may be subject to investigation prescribed by law and I consent to the release of information concerning my capacity and fitness by employers, educational institutions, law enforcement agencies, hospitals and other individuals and agencies to duly accredited investigators, personnel technicians and other authorized employees of the state government for that purpose.

I certify that the answers I have given to all questions in this application are true to the best of my knowledge. If I am appointed, I agree to promptly notify the proper agency official of any change in my status as a student, including any reduction in courses taken, termination of student status, or scholastic probation.

Signature of Applicant	Date

REPORT OF SCHOOL OFFICIAL

Yes	No	THE RECORDS OF THIS SCHOOL INDICATE THAT THE APPLICANT NAMED HEREIN
☐	☐	A. Is classified as a full-time regular student of this school under its criteria D. Current Grade/ Classification
☐	☐	B. Has completed his course and received a diploma or certificate or has graduated
☐	☐	C. Has applied for enrollment in this school effective (give date)
☐	☐	Is your school accredited?
☐	☐	Is your school approved by the state in which it is located?

Name of School	Address

Signature of School Official	Title	Date

AGENCY REVIEW OF STUDENT STATUS

Date Reviewed 1.	Initials	Date Reviewed 2.	Initials	Date Reviewed 3.	Initials	Date Reviewed 4.	Initials	Date Reviewed 5.	Initials	Date Reviewed 6.	Initials

The following information is collected to compile equal opportunity reports, as required by law. You ARE NOT legally obligated to provide this information.

Racial Group

☐ White ☐ Black or African American ☐ American Indian/Alaskan Native ☐ Asian ☐ Hispanic or Latino ☐ Native Hawaiian or other Pacific Islander ☐ Other

SEX

☐ Male ☐ Female

Ethnic Group

☐ Hispanic or Latino ☐ Non-Hispanic or Non-Latino

PART 2

EMPLOYMENT HISTORY

PRESENT AND PREVIOUS EMPLOYMENT –Start with Present or Most Recent Position			
DATE (Month/ Year) From	DATE (Month/ Year) To	NAME AND ADDRESS OF EMPLOYER	POSITION
Have you worked under another name? ☐ YES ☐ NO If yes, give name(s).			May inquiry be made of your present employer? ☐YES☐ NO May inquiry be made of your former employers? ☐ YES ☐ NO Do you have a legal right to work In the United States? ☐ YES ☐ NO

MAY PUT ADDITIONAL WORK EXPERIENCE BELOW.

Louisiana SCS State Civil Service

STATEMENT OF AGREEMENT AND UNDERSTANDING
Employment in a Non-Permanent Job Appointment Position

8/4/2014

Name:	Agency/Section/Unit:

In accordance with Civil Service Rules, agencies may establish temporary, non-permanent appointments of a limited duration to assist with work of a temporary nature or work overloads. Your signature below indicates that you agree and accept the conditions of this temporary, non-permanent appointment.

I, _____ understand that I am accepting a temporary, non-permanent appointment. I understand that the agency has the discretion to extend this appointment under certain conditions or may terminate this appointment at any time for any reason.

I understand that I **may not** be eligible for or entitled to state benefits, leave earning or paid holidays. I understand that in the event the appointing authority determines that a layoff is necessary I do not have rights to offers of relocation to another position and this appointment may be terminated.

I have read the above and agree to accept this temporary, non-permanent appointment. I further understand that as long as I remain employed in such a temporary, non-permanent capacity, the aforementioned conditions apply.

Employee Printed or Typed Name: _____

Employee Signature: _____ **Date** _____

HR Representative: _____ **Date** _____

NOTE: If you have any questions concerning these terms, please consult with your Human Resources Office.

Lance S. Wallace
Licensed Private Investigator

Office/Fax: 337.562.1579
Mobile: 337.802.9569
Email: wallaceinv@suddenlink.net

Central Louisiana Technical Community College

Select your campus location below.

Alexandria Main Campus ____ Oakdale Campus _____

Ferriday Campus _____ Rod Brady (Jena) Campus _____

Huey P. Long (Winnfield) Campus _____ WHN Avoyelles (Cottonport) Campus ____

Lamar Salter (Leesville) Campus _____

Please type or print clearly and legibly.

Full Name:_____
(Last) (First) (Middle) (Maiden)

Current Address:_____

City, State and Zip Code:_____

Seven-Year Address History (include City, State and Zip Code):

_____

_____

_____

Date of Birth: _____ Race: _____ Gender: _____

Social Security Number: _____ Driver's License or I.D. Number: _____

State where Driver's License/I.D. Issued:_____

WITH MY SIGNATURE BELOW, I AUTHORIZE WALLACE INVESTIGATIONS, LLC TO RELEASE MY COMPLETE ARREST RECORD TO CLTCC. I WAIVE SUCH LEGAL RIGHTS THAT MAY ARISE AND I DO RELEASE ALL PERSONS AND LAW ENFORCEMENT AGENCY FROM LIABILITY IN CONNECTION WITH FURNISHING OF SUCH INFORMATION. I UNDERSTAND THAT A PROCESSING FEE WILL BE CHARGED FOR THIS REPORT.

Position/Department:_____

Signature of Applicant: _____Date:_____

Lance S. Wallace
Licensed Private Investigator

Office/Fax: 337.562.1579
Mobile: 337.802.9569
Email: wallaceinv@suddenlink.net

Central Louisiana Technical Community College

Employment Reference Authorization Form to
Obtain Reference Information from
Wallace Investigations, LLC
4934 Westridge Park East, Lake Charles, LA 70605

Please type or print clearly and legibly.

Name of Applicant: _____

List your three most recent places of employment.

1) Name of Employer: _____

Supervisor: _____

Dates of Employment: From: _____ To: _____

Employer Address/City and State: _____

Employer Phone Number: _____

2) Name of Employer: _____

Supervisor: _____

Dates of Employment: From: _____ To: _____

Employer Address: _____

Employer Phone Number: _____

3) Name of Employer: _____

Supervisor: _____

Dates of Employment: From: _____ To: _____

Employer Address: _____

Lance S. Wallace
Licensed Private Investigator

Office/Fax: 337.562.1579
Mobile: 337.802.9569
Email: wallaceinv@suddenlink.net

Arrest/Self-Disclosure Form

Please type or print clearly and legibly.

Full Name:_____
(Last) (First) (Middle) (Maiden)

Have you ever been arrested, indicted, or summoned into court as a defendant in a criminal proceeding, and/or convicted, fined, imprisoned and/or placed on probation and/or ordered to deposit bail for the violation of any law, police regulation, or ordinance, except for minor traffic violations?

YES _____ NO _____

If yes, provide the following information for each event:

1) Date of arrest
2) City, Parish/County and State of Arrest/Conviction
3) Penalty (fines, jail time, etc). Attach additional sheet if necessary.

_____

_____

_____

_____

_____

Rev. 5/19/15

CENTRAL LOUISIANA TECHNICAL COMMUNITY COLLEGE

Please read the following prior to completing the form:

By signing this form, I acknowledge that I have received and understand Central Louisiana Technical Community College's (CLTCC) FERPA policy as it pertains to student records.

FERPA (Confidentiality Statement)

Along with the right to access the records of students at CLTCC comes the responsibility to maintain the rights of students particularly as outlined in the Family Educational Rights and Privacy Act (FERPA). Student Records are open to members of the faculty and staff who have a legitimate need to know their contents; however, you do have a responsibility to maintain confidentiality.

Under the terms of FERPA, Central Louisiana Technical Community College (CLTCC) has established the following as directory information: Student's Name, Degrees and Awards Received and Dates, Dates of Attendance (Current and Past) and Full or Part-time Enrollment Status.

All other information may not be released without written consent of the student. Grades, Social Security Numbers, Ethnicity, and Student Schedules should not be released to anyone other than the student under discussion and not over the phone.

I acknowledge that I fully understand that the intentional disclosure by me of this information to any unauthorized person could subject me to criminal and civil penalties imposed by law.

I further acknowledge that such willful or unauthorized disclosure also violates Central Louisiana Technical Community College's (CLTCC) policy and could constitute just cause for disciplinary action including termination of my employment, regardless of whether criminal or civil penalties are imposed.

I have read the above and agree to maintain the confidentiality of student records.

Printed Name: _____ Position: _____

Signature: _____ Date: _____

Form W-4 (2017)

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 2017 expires February 15, 2018. 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 can't claim exemption from withholding if your total income exceeds $1,050 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 don't apply to supplemental wages greater than $1,000,000.

Basic instructions. If you aren't exempt, complete the **Personal Allowances Worksheet** below. The worksheets on page 2 further adjust your withholding allowances based on itemized deductions, certain credits, adjustments to income, or two-earners/multiple jobs situations.

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

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

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

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

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

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

Check your withholding. After your Form W-4 takes effect, use Pub. 505 to see how the amount you are having withheld compares to your projected total tax for 2017. 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're single and have only one job; or • You're married, have only one job, and your spouse doesn't 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 $70,000 ($100,000 if married), enter "2" for each eligible child; then **less** "1" if you have two to four eligible children or **less** "2" if you have five or more eligible children. • If your total income will be between $70,000 and $84,000 ($100,000 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

2017

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 2017, 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 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

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

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

Name: _____ Date_____

Agency/Department: _____ Position: _____

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

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

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

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

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

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

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

_____

_____

_____

_____

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

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

☐ YES ☐ NO

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

_____

_____

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

☐ YES ☐ NO If yes, please explain:

_____

_____

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

☐ YES ☐ NO

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

_____

_____

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

☐ YES ☐ NO

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

_____

_____

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

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

_____

_____

_____

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

☐ YES ☐ NO

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

_____

_____

_____

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

_____

_____

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

☐ YES ☐ NO

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

_____

_____

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

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

SIGNATURE: _____ DATE: _____

WITNESS: _____ DATE: _____

Revision Date: 12/2005

LCTCSPR05_Ed052112.DirectDepositMainBank

LCTCS Centralized Payroll
Direct Deposit Enrollment Authorization – Main Bank (Primary Account)

Employee ID VPDI/Institution Code

Action Type (one)
/ /NEW / /CHANGE / /TERMINATE THIS OPTION

PRIMARY ACCOUNT INFORMATION – MAIN BANK
DEPOSIT AMOUNT TO THIS ACCOUNT WILL BE EQUAL TO NET PAY LESS ANY DEPOSITS TO SECONDARY ACCOUNTS

FINANCIAL INSTITUTION NAME	***FINANCIAL INSTITUTION ROUTING (ABA) NUMBER (Bank Key)***
BANK ACCOUNT NUMBER	***ACCOUNT NAME (Ex: Mr. and Mrs. John Doe, John or Jane Doe, John Doe)***
ACCOUNT TYPE (one) (Bank Control Key) / / *CHECKING ***(provide voided check or account verification)*** / / *SAVINGS ***(obtain account # & ABA # from financial institution)***	* Account verification or completion of enrollment form by financial institution will assure the accuracy of account data: Signature from Institution: _____ Phone Number: _____

(Print full name)

I, _____, authorize and request the Louisiana Community & Technical College centralized payroll to direct my net pay check to the account at the financial institution I designated above.

For any funds paid to me which are not due and owing to me, through a pre-note paper check or through direct deposit, I hereby agree and authorize my appointing authority (employer) to adjust the amount next due to me to correct the overpayment, or to recover amount overpaid by reducing my future payroll checks so that the overpayment will be repaid or recouped within a reasonable number of months [not to exceed 12 months].

It is my responsibility to notify Human Resources, as appropriate, should any changes occur to account specified. Considering all above conditions are met, this authorization remains in full effect until a written, signed notification to terminate, or another signed form (LCTCSPR20) indicating termination of this option is received from me and the
Louisiana Community & Technical College System Centralized Payroll has had reasonable opportunity to act on the termination.

_____ _____ _____
Signature Date Phone where you can be reached between 8:00 a.m. and 4:30p.m.

***Institution requirements may vary. Contact your human resources representative if you have questions.**

/ / CHECK HERE IF SECONDARY ACCOUNT FORMS ARE ATTACHED.

STATEMENT OF UNDERSTANDING
LCTCS RECOUPMENT OF OVERPAYMENTS POLICY

My signature below indicates understanding of the LCTCS Recoupment of Overpayments Policy. I understand that if overpaid, the overpayment may be recouped in a future pay period after notification from the agency, in according with the LCTCS policy.

I understand that should there be an outstanding overpayment from a prior state agency, t I must disclose this outstanding overpayment to the LCTCS at time of employment by the LCTCS and that, upon notification of such outstanding overpayment, the LCTCS is required to work with such prior state agency in recoupment of such outstanding overpayment.

I understand that I am required to work with the LCTCS on the recoupment of any overpayment while in active employment. I understand that should there be an outstanding overpayment by the LCTCS at time of future termination of employment, that I am required to work with the LCTCS, and any future state agency with which I am employed, in recoupment of any outstanding overpayment.

_____ _____

Print Name Date

_____

Signature

Print Form

SF-13 (R 5-03)

APPOINTMENT AFFIDAVITS

IMPORTANT: Please read the following appointment affidavits. Before swearing to these affidavits, make sure you understand the fully. It is the responsibility of the employing agency to determine any change in employment status since the applicant filed the original pre-employment application.

APPOINTEE	AGENCY /DIVISION
PRESENT STREET ADDRESS	PLACE OF EMPLOYMENT
CITY/ STATE/ZIP	DATE OF BIRTH

A. SINCE YOU FILED THE APPLICATION RESULTING IN YOUR APPOINTMENT, HAVE YOU BEEN INDICTED OR CONVICTED OF ANY LAW VIOLATION (excludes minor traffic violations)? ☐ YES ☐ NO

IF YES, GIVE DETAILS:

DATE	LOCATION	CHARGE

DISPOSITION

B. SINCE YOU FILED THE APPLICATION RESULTING IN YOUR APPOINTMENT, HAVE YOU RESIGNED OR BEEN DISCHARGED AS A RESULT OF MISCONDUCT? ☐ YES ☐ NO

IF YES, GIVE DETAILS:

C. DO YOU NOW HOLD OR ARE YOU A CANDIDATE FOR AN ELECTIVE PUBLIC OFFICE? ☐ YES ☐ NO

D. AS REQUIRED BY LOUISIANA REVISED STATUE 42:52

Do you solemnly swear (or affirm) to support the Constitution and laws of the United States and Constitution and laws of this State, and faithfully and impartially discharge and perform all of the duties incumbent upon you as a State employee according to the best of your ability and understanding? ☐ YES ☐ NO

DATE	SIGNATURE OF APPOINTEE	SOCIAL SECURITY NO.

CONFIDENTIALITY OF HOME ADDRESS AND PHONE NUMBER

In accordance with R.S. 44:11 the following items in the personnel records of a public employee of any body shall be confidential:

1. The home telephone number of the public employee where such employee has chosen to have a private or unlisted home telephone number because of the nature of his occupation with such body.

2. The home telephone number of the public employee where such employee has requested that the number be confidential.

3. The home address of the public employee where such employee has requested that the address be confidential.

Please indicate below if you wish your home telephone and home address to be confidential.

_____Yes
_____No — I want my home telephone number to be regarded as confidential in accordance with R.S.44:11.

_____Yes
_____No — I want my home address to be regarded as confidential in accordance with R.S.44:11.

I understand that, if at any time I want to change the above information, I must submit a revised copy of this form to Employee Administration.

_____ _____
Employee Name (Printed) Social Security Number

_____ _____
Employee Signature Date

CENTRAL LOUISIANA TECHNICAL COMMUNITY COLLEGE

EMPLOYEE PERSONAL DATA FORM

Employee Name: _____

Home Address: _____

Mailing Address: _____

Home Telephone: _____ **Cell:** _____

Email Address: _____

Date of Birth: _____

Married: _____ **Single:** _____ **(Y in correct category)**

Emergency Contact Information:

Name: _____ **Relationship:** _____

Telephone: _____ **Cell:** _____