



Student Employment Documents Checklist

Dear Student - Please use this checklist as a guide to ensure that you've completed all necessary paperwork and steps as part of the hiring process.

PLEASE PRINT ALL FORMS ONE-SIDED, COMPLETE ALL FORMS IN BLUE OR BLACK INK, AND WRITE NEATLY TO ENSURE THE ACCURACY OF YOUR DATA.

- ____ Apply to position via Handshake (undergraduate student worker positions)
- ____ Work Authorization Form - Student Employee section (undergraduate student worker positions)
- ____ Student Employee Data Sheet
- ____ Form W-4, Employee's Withholding Certificate*
- ____ Local Earned Income Tax Residency Certification Form
- ____ Employee's Nonwithholding Application Certificate* (for residents of MD, NJ, OH, VA, WV)
- ____ Local Services Tax - Exemption Certificate (optional)
- ____ Form I-9, Employment Eligibility Verification (Section 1 only)
- ____ Form I-9, Preparer and/or Translator Certification (only if applicable)
- ____ Form I-9 Documentation**
- ____ Social Security Card **REQUIRED**
- ____ Direct Deposit Authorization Form **REQUIRED** (voided check recommended)
- ____ Confidentiality Statement
- ____ Workers' Compensation Employee Notification***
- ____ Workers' Compensation Information***
- ____ SU Information Release Authorization
- ____ SU Background Clearance Certification
- ____ SU FBI Fingerprint Questionnaire

International Students - Additional Requirements

- ____ Proof of application for Social Security Card
- ____ Form I-20, Certificate of Eligibility for Nonimmigrant Student Status
- ____ Form I-94, U.S. Customs & Border Protection, Arrival/Departure Record
- ____ Passport – Required to copy **all** marked pages

****Further instructions available at end of packet***

*****Please refer to List of Acceptable Documents at end of packet***

******List of Designated Health Care Providers available at end of packet***



Student Employment Work Authorization Form

Student Employee Responsibilities: If you are a new student employee (not previously employed at Shippensburg University) you will have to complete a student payroll packet and submit all the paperwork to Human Resources/Payroll BEFORE you begin working. Students cannot work until all paperwork and required documents are submitted and approved by the HR/Payroll office. Students are not permitted to work during times they are scheduled to be in class. There are no exceptions to this rule. Students should only enter hours in eTime for dates and times they have worked. If you need assistance with eTime, please work with your department's timekeeper. Student employees are expected to appear on time for their scheduled work hours or provide advance notice if absent or delayed. My signature below indicates that I agree and understand these requirements. This offer of employment is contingent upon available resources; if budgetary adjustments are made, this offer of employment may be withdrawn.

| | |
|---|--|
| Name (Last, First, Middle): | |
| SU Student ID: | SU email: _____@ship.edu |
| Are you a current employee of the University? YES or NO | Are you a previous employee of the University? YES or NO |
| Signature: | Date: |

Hiring Department Responsibilities: Department representatives are responsible to notify Human Resources/Payroll of any changes in the student's employment status. This includes, but is not limited to, changes to start and end dates. Departments are responsible to ensure that student employees remain within their budget amounts of hours and earnings. Departments should make every effort to accommodate the constraints that academics impose on students when developing work schedules. Department timekeepers must only approve hours that the student employee actually worked and are responsible to ensure the student employee's time is accurate. Students cannot work until all paperwork and required documents are submitted and approved by the HR/Payroll office.

| | |
|---|---|
| Student Position Title: | Employment Start Date: |
| Hourly Rate of Pay: | Is this position a Graduate Assistantship or SPP? (circle one) GA SPP N/A |
| New hire of the department: <input type="checkbox"/> Rehire of the department: <input type="checkbox"/> | |
| Do you expect the student to be paid from Federal Work Study funds: YES or NO | |
| Department: | Cost Center Number: |
| Timekeeper: | |
| Timekeeper's email: | Timekeeper's extension: |
| Department Signature: | Date: |

HR Office Use Only: M _____ S _____ Wage Type _____ Position # _____

0554 _____ Assign. M _____ S _____ Wage Type _____ Position # _____

Financial Aid Office Use Only:

| | | |
|--------------------------|-------------|-------------------|
| Credits Enrolled: | SAP: | Wage Type: |
| FAO Signature: | | Date: |



Student Employee Data Sheet

Name _____ (as it appears on Social Security Card)

*Legal Address (this is your home address--the address used to pay your federal taxes)

Street _____

City _____ State _____ Zip Code _____

County _____ Township/Borough _____

Date of Birth _____ SU Campus Email _____

Cell Phone _____ Home Phone _____

Gender: (check one)

_____ Male

_____ Female

_____ Other

_____ Prefer not to answer

Marital Status: (check one)

_____ Single

_____ Married

_____ Widowed

_____ Divorced

_____ Separated

_____ Other

_____ Prefer not to answer

Ethnicity: (check one)

_____ Hispanic/Latino

_____ Not Hispanic/Latino

Race: (check the ones which best describe you)

_____ American Indian or Alaskan Native

_____ Asian

_____ Black or African American

_____ Native Hawaiian or Other Pacific Islander

_____ White

Employee's Withholding Certificate

Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay.

Give Form W-4 to your employer.

Your withholding is subject to review by the IRS.

2024**Step 1:**
Enter
Personal
Information

| | | |
|---|-----------|---|
| (a) First name and middle initial | Last name | (b) Social security number |
| Address | | Does your name match the name on your social security card? If not, to ensure you get credit for your earnings, contact SSA at 800-772-1213 or go to www.ssa.gov . |
| City or town, state, and ZIP code | | |
| (c) <input type="checkbox"/> Single or Married filing separately | | |
| <input type="checkbox"/> Married filing jointly or Qualifying surviving spouse | | |
| <input type="checkbox"/> Head of household (Check only if you're unmarried and pay more than half the costs of keeping up a home for yourself and a qualifying individual.) | | |

Complete Steps 2–4 ONLY if they apply to you; otherwise, skip to Step 5. See page 2 for more information on each step, who can claim exemption from withholding, and when to use the estimator at www.irs.gov/W4App.

Step 2:
Multiple Jobs
or Spouse
Works

Complete this step if you (1) hold more than one job at a time, or (2) are married filing jointly and your spouse also works. The correct amount of withholding depends on income earned from all of these jobs.

Do **only one** of the following.

- (a) Use the estimator at www.irs.gov/W4App for most accurate withholding for this step (and Steps 3–4). If you or your spouse have self-employment income, use this option; **or**
- (b) Use the Multiple Jobs Worksheet on page 3 and enter the result in Step 4(c) below; **or**
- (c) If there are only two jobs total, you may check this box. Do the same on Form W-4 for the other job. This option is generally more accurate than (b) if pay at the lower paying job is more than half of the pay at the higher paying job. Otherwise, (b) is more accurate ☐

Complete Steps 3–4(b) on Form W-4 for only **ONE** of these jobs. Leave those steps blank for the other jobs. (Your withholding will be most accurate if you complete Steps 3–4(b) on the Form W-4 for the highest paying job.)

| | | | |
|--|---|-------------|----------|
| Step 3: Claim Dependent and Other Credits | If your total income will be \$200,000 or less (\$400,000 or less if married filing jointly): | | |
| | Multiply the number of qualifying children under age 17 by \$2,000 \$ _____ | | |
| | Multiply the number of other dependents by \$500 \$ _____ | | |
| | Add the amounts above for qualifying children and other dependents. You may add to this the amount of any other credits. Enter the total here | 3 | \$ _____ |
| Step 4 (optional): Other Adjustments | (a) Other income (not from jobs). If you want tax withheld for other income you expect this year that won't have withholding, enter the amount of other income here. This may include interest, dividends, and retirement income | 4(a) | \$ _____ |
| | (b) Deductions. If you expect to claim deductions other than the standard deduction and want to reduce your withholding, use the Deductions Worksheet on page 3 and enter the result here | 4(b) | \$ _____ |
| | (c) Extra withholding. Enter any additional tax you want withheld each pay period . . | 4(c) | \$ _____ |

Step 5:
Sign
Here

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

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

Employer's name and address

First date of
employmentEmployer identification
number (EIN)



LOCAL EARNED INCOME TAX RESIDENCY CERTIFICATION FORM

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, First, Middle Initial) | | | SOCIAL SECURITY NUMBER |
| FIRST LINE OF ADDRESS (If PO Box, please include actual street address) | | | |
| SECOND LINE OF ADDRESS | | | |
| CITY | STATE | ZIP CODE | DAYTIME PHONE NUMBER |
| MUNICIPALITY (City, Borough, Township) | | | |
| COUNTY | PSD CODE <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> | | TOTAL RESIDENT EIT RATE |

| EMPLOYER INFORMATION - EMPLOYMENT LOCATION | | | |
|---|---|----------|---------------------------------|
| EMPLOYER NAME (Use Federal ID Name) | | | EMPLOYER FEIN |
| Shippensburg University | | | |
| FIRST LINE OF ADDRESS (If PO Box, please include actual street address) | | | |
| 1871 Old Main Drive | | | |
| SECOND LINE OF ADDRESS | | | |
| CITY | STATE | ZIP CODE | PHONE NUMBER |
| Shippensburg | PA | 17257 | |
| MUNICIPALITY (City, Borough, Township) | | | |
| COUNTY | PSD CODE <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> | | MUNICIPAL NON-RESIDENT EIT RATE |

| CERTIFICATION | |
|-----------------------|---------------|
| SIGNATURE OF EMPLOYEE | DATE |
| 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
 Select Get Local Gov Support, >Municipal Statistics

REV-419

**EMPLOYEE'S NONWITHHOLDING
APPLICATION CERTIFICATE**

20 _____

Please print or type. A fill-in form may be obtained from www.revenue.pa.gov.

SECTION I **EMPLOYEE INFORMATION**

| | | | | | |
|--|------|-------|----------|--|------------------|
| Employee Name: first, middle initial, last | | | | Social Security Number | Telephone Number |
| Street Address | City | State | Zip Code | Tax Year (not necessary if checking Box b below) | |

SECTION II **EXEMPTION INFORMATION**

I claim exception from withholding because:

- ☐ a. I qualified for Tax Forgiveness of my PA personal income tax liability last year, and had a right to a full refund of all income tax withheld and/or I expect to qualify for Tax Forgiveness of my PA personal income tax liability this year and expect to have a right to a full refund of all income tax withheld.
- ☐ b. I declare I am a resident of the reciprocal state checked below:
☐ INDIANA ☐ MARYLAND ☐ NEW JERSEY ☐ OHIO ☐ VIRGINIA ☐ WEST VIRGINIA
and that pursuant to the reciprocal tax agreement between that state and PA, I claim an exemption from withholding of PA personal income tax and authorize my employer to withhold income tax for my resident state on compensation paid to me in the Commonwealth of Pennsylvania.
- ☐ c. I certify I am a legal resident of the state of _____ and am not subject to Pennsylvania withholding because I meet the requirements set forth under the Servicemembers Civil Relief Act, as amended, and as set forth in revised Personal Income Tax Bulletin 2010-01.

SECTION III **CERTIFICATION**

Under penalties of perjury, I certify that I did not incur any Pennsylvania personal income tax liability during the preceding tax year and/or I do not expect to incur any liability during the current tax year based on the reason(s) indicated above.

| | | | | |
|----------------------|--|---|------------------|--|
| Employee Signature | | | Date | |
| Employer Name | | Federal Employer Identification Number | | |
| Business Address | | | Telephone Number | |
| City | | State | Zip Code | |
| Employer's Signature | | Employee's Quarterly Compensation (not required for applicants checking Box b or c above) \$ | | |

LOCAL SERVICES TAX – EXEMPTION CERTIFICATE

2024

Tax Year

APPLICATION FOR EXEMPTION FROM LOCAL SERVICES TAX

- A copy of this application for exemption from the Local Services Tax (LST), and all necessary supporting documents, must be completed and presented to your employer AND to the political subdivision levying the Local Services Tax where you are principally employed.
- This application for exemption from the Local Services Tax must be signed and dated.
- **No exemption will be approved until proper documentation has been received.**

Name: _____

Soc Sec #: _____

Address: _____

Phone #: _____

City/State: _____

Zip: _____

REASON FOR EXEMPTION

1. _____ MULTIPLE EMPLOYERS: Attach a copy of a current pay statement from your principal employer that shows the name of the employer, the length of the payroll period and the amount of Local Services Tax withheld. List all employers on the reverse side of this form. **You must notify your other employers of a change in principal place of employment within two weeks of the change.**
2. _____ EXPECTED TOTAL EARNED INCOME AND NET PROFITS FROM ALL SOURCES WITHIN Shippensburg Township (municipality or school district) WILL BE LESS THAN \$ 12,000 : Attach copies of your last pay statements or your W-2 for the year prior.

If you are self-employed, please attach a copy of your PA Schedule C, F, or RK-1 for the prior year.
3. _____ ACTIVE DUTY MILITARY EXEMPTION: Please attach a copy of your orders directing you to active duty status. Annual training is not eligible for exemption. You are required to advise the tax office when you are discharged from active duty status.
4. _____ MILITARY DISABILITY EXEMPTION: Please attach copy of your discharge orders and a statement from the United States Veterans Administrator documenting your disability. Only 100% permanent disabilities are recognized for this exemption.

EMPLOYER: Once you receive this Exemption Certificate, you shall not withhold the Local Services Tax for the portion of the calendar year for which this certificate applies, unless you are otherwise notified or instructed by the tax collector to withhold the tax.

Tax Office: Cumberland County Tax Bureau

Address: 21 Waterford Drive, Suite 201

City/State: Mechanicsburg, PA

Phone #: 717-590-7997

Zip: 17050

IMPORTANT NOTE TO EMPLOYERS

1. The municipality is required by law to exempt from the LST employees whose earned income from all sources (employers and self-employment) in their municipality is less than \$12,000 when the levied rate exceeds \$10.00.
2. The school district for the municipality in which your worksite(s) is located may or may not levy an LST. If it does, the income exemption provided may differ from the municipality and can be anywhere from \$0 to \$11,999.
3. Contact the tax office where your business worksites are located to obtain this information.

Employment Information: List all places of employment for the applicable tax year. Please list your PRIMARY EMPLOYER under #1 below and your secondary employers under the other columns. If self employed, write SELF under Employer Name column.

1. PRIMARY EMPLOYER 2.

3.

| | | | |
|--------------------------|--|--|--|
| Employer Name | | | |
| Address | | | |
| Address 2 | | | |
| City, State Zip | | | |
| Municipality | | | |
| Phone | | | |
| Start Date | | | |
| End Date | | | |
| Status (FT or PT) | | | |
| Gross Earnings | | | |

4.

5.

6.

| | | | |
|--------------------------|--|--|--|
| Employer Name | | | |
| Address | | | |
| Address 2 | | | |
| City, State Zip | | | |
| Municipality | | | |
| Phone | | | |
| Start Date | | | |
| End Date | | | |
| Status (FT or PT) | | | |
| Gross Earnings | | | |

PLEASE NOTE:

All information received by the Tax Collector is considered to be CONFIDENTIAL and is only used for official purposes relating to the collection, administration and enforcement of the LOCAL SERVICES TAX.

I DECLARE UNDER PENALTY OF LAW THAT THE INFORMATION STATED ON AND ATTACHED TO THIS FORM IS TRUE AND CORRECT:

SIGNATURE: _____ **DATE:** _____



Employment Eligibility Verification

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

USCIS
Form I-9

OMB No.1615-0047

Expires 07/31/2026

START HERE: Employers must ensure the form instructions are available to employees when completing this form. Employers are liable for failing to comply with the requirements for completing this form. See below and the [Instructions](#).

ANTI-DISCRIMINATION NOTICE: All employees can choose which acceptable documentation to present for Form I-9. Employers cannot ask employees for documentation to verify information in **Section 1**, or specify which acceptable documentation employees must present for **Section 2** or Supplement B, Reverification and Rehire. Treating employees differently based on their citizenship, immigration status, or national origin may be illegal.

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 (if any) | Other Last Names Used (if any) | | |
| Address (Street Number and Name) | | | Apt. Number (if any) | City or Town | | State | ZIP Code |
| Date of Birth (mm/dd/yyyy) | U.S. Social Security Number | | Employee's Email Address | | | Employee's Telephone Number | |
| I am aware that federal law provides for imprisonment and/or fines for false statements, or the use of false documents, in connection with the completion of this form. I attest, under penalty of perjury, that this information, including my selection of the box attesting to my citizenship or immigration status, is true and correct. | | Check one of the following boxes to attest to your citizenship or immigration status (See page 2 and 3 of the instructions.): | | | | | |
| | | <input type="checkbox"/> 1. A citizen of the United States | | | | | |
| | | <input type="checkbox"/> 2. A noncitizen national of the United States (See Instructions.) | | | | | |
| | | <input type="checkbox"/> 3. A lawful permanent resident (Enter USCIS or A-Number.) | | | | | |
| | | <input type="checkbox"/> 4. A noncitizen (other than Item Numbers 2. and 3. above) authorized to work until (exp. date, if any) | | | | | |
| | | If you check Item Number 4. , enter one of these: | | | | | |
| | | USCIS A-Number | OR | Form I-94 Admission Number | OR | Foreign Passport Number and Country of Issuance | |
| Signature of Employee | | | | | Today's Date (mm/dd/yyyy) | | |

If a preparer and/or translator assisted you in completing Section 1, that person **MUST** complete the [Preparer and/or Translator Certification](#) on Page 3.

Section 2. Employer Review and Verification: Employers or their authorized representative must complete and sign **Section 2** within three business days after the employee's first day of employment, and must physically examine, or examine consistent with an alternative procedure authorized by the Secretary of DHS, documentation from List A OR a combination of documentation from List B and List C. Enter any additional documentation in the Additional Information box; see Instructions.

| List A | | OR | List B | AND | List C |
|---|--|---|--|-----|---------------------------------------|
| Document Title 1 | | | | | |
| Issuing Authority | | | | | |
| Document Number (if any) | | | | | |
| Expiration Date (if any) | | | | | |
| Document Title 2 (if any) | | Additional Information | | | |
| Issuing Authority | | | | | |
| Document Number (if any) | | | | | |
| Expiration Date (if any) | | | | | |
| Document Title 3 (if any) | | | | | |
| Issuing Authority | | Check here if you used an alternative procedure authorized by DHS to examine documents. | | | |
| Document Number (if any) | | | | | |
| Expiration Date (if any) | | | | | |
| Certification: I attest, under penalty of perjury, that (1) I have examined the documentation presented by the above-named employee, (2) the above-listed documentation appears 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. | | | | | First Day of Employment (mm/dd/yyyy): |
| Last Name, First Name and Title of Employer or Authorized Representative | | | Signature of Employer or Authorized Representative | | Today's Date (mm/dd/yyyy) |
| Employer's Business or Organization Name | | | Employer's Business or Organization Address, City or Town, State, ZIP Code | | |

For reverification or rehire, complete [Supplement B, Reverification and Rehire](#) on Page 4.



Supplement A, Preparer and/or Translator Certification for Section 1

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

USCIS
Form I-9
Supplement A
OMB No. 1615-0047
Expires 07/31/2026

| | | |
|--|--|---|
| Last Name (<i>Family Name</i>) from Section 1 . | First Name (<i>Given Name</i>) from Section 1 . | Middle initial (if any) from Section 1 . |
|--|--|---|

Instructions: This supplement must be completed by any preparer and/or translator who assists an employee in completing Section 1 of Form I-9. The preparer and/or translator must enter the employee's name in the spaces provided above. Each preparer or translator must complete, sign, and date a separate certification area. Employers must retain completed supplement sheets with the employee's completed Form I-9.

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 | | Date (<i>mm/dd/yyyy</i>) | |
| Last Name (<i>Family Name</i>) | First Name (<i>Given Name</i>) | | Middle Initial (<i>if any</i>) |
| Address (<i>Street Number and Name</i>) | City or Town | State | ZIP Code |

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 | | Date (<i>mm/dd/yyyy</i>) | |
| Last Name (<i>Family Name</i>) | First Name (<i>Given Name</i>) | | Middle Initial (<i>if any</i>) |
| Address (<i>Street Number and Name</i>) | City or Town | State | ZIP Code |

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 | | Date (<i>mm/dd/yyyy</i>) | |
| Last Name (<i>Family Name</i>) | First Name (<i>Given Name</i>) | | Middle Initial (<i>if any</i>) |
| Address (<i>Street Number and Name</i>) | City or Town | State | ZIP Code |

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 | | Date (<i>mm/dd/yyyy</i>) | |
| Last Name (<i>Family Name</i>) | First Name (<i>Given Name</i>) | | Middle Initial (<i>if any</i>) |
| Address (<i>Street Number and Name</i>) | City or Town | State | ZIP Code |



DIRECT DEPOSIT AUTHORIZATION FORM

How Direct Deposit works –

The Pennsylvania State System of Higher Education notifies your financial institution electronically of the funds to be deposited on your behalf. Your financial institution records this transaction into an account of your choice, creating immediate access on the day of deposit. You receive an earnings statement documenting this payment. If you desire to make a direct deposit into more than one institution, you must complete a form for each institution. Only one deposit can be made to one account at each institution.

- ✓ **It's convenient** – saves you a trip to the bank.
- ✓ **It's faster** – most banks post the funds to your account at the beginning of the day's business on payday allowing immediate access.
- ✓ **It's safer** – Direct Deposit eliminates the worry of a lost or stolen paycheck.
- ✓ **It's confidential** – funds are automatically processed and you can instruct your bank to apply them to your savings or checking account.

Name _____ Personnel Number _____
(may be found on pay statement)

I hereby authorize the Pennsylvania State System of Higher Education to **(circle one) Start / Change / Stop** total biweekly payroll deduction to the Financial Institution shown below. You may designate any bank, savings and loan association, or credit union in the U.S. that (1) is a member of the Federal Reserve System and (2) accepts electronic funds transfer. Payroll will notify you if the institution you choose does not qualify.

Financial Institution Name _____
Transit Routing Number _____
Account Number _____
Account Type (Savings/Checking) _____
Deduction Amount (\$ Amount) _____
Effective with pay date of _____

I have an established account at the Financial Institution indicated above and authorize the Pennsylvania State System of Higher Education to initiate credit entries and to initiate debit entries and adjustments for any credit entries in error to my (our) account(s) listed above. **I have provided a copy of a voided check** (see attached) solely for the purpose of verifying my account number and the Financial Institution's routing number. My authorization will remain in effect until revoked by me in writing or until I terminate my employment with the Pennsylvania State System of Higher Education.

Signature _____ Date _____

Co-Signature (**Required if Joint Account**) _____

Confidentiality Statement

As an employee/student employee/graduate assistant/volunteer/contractor of Shippensburg University of Pennsylvania, I understand that I may have access to confidential, personal data and/or records of University employees, students, customers and other related constituents. I agree that I will access, use, discuss, release and/or divulge only the data that is needed to perform my job. I understand that I am prohibited from accessing, using, discussing, releasing and/or divulging this data unless doing so is a requirement of my job.

I further understand that unauthorized disclosure of confidential information and records applies to all information on the University computing/networking systems, all printed information, as well as formal and informal verbal conversations.

I understand that any release of this information will be done only through authorized protocols. Breaches in confidentiality of such data may result in disciplinary action up to and including separation from employment and in the case of student employees and graduate assistants, possible University judicial action. A violation of this agreement also may result in legal action if it is determined that any local, state, or federal laws have been violated.

I have reviewed this statement and understand that if I have questions, or would like to discuss this responsibility with a representative of the University I can make that request by contacting the Human Resources office at 717-477-1124 or hr@ship.edu.

By my signature below, I certify that I have read, understand, and agree to abide by the provisions of this statement.

Name (print) _____

Signature

Date

For Use Beginning August 23, 1996

WORKERS' COMPENSATION EMPLOYEE NOTIFICATION

The Workers' Compensation Act is designed to provide reimbursement for reasonable medical care for someone who suffers an injury arising in the course of his employment and causally related thereto. Pursuant to the Act, your employer will provide payment for reasonable surgical and medical services, services rendered by physicians or other health care providers, medicines and supplies, as and when needed.

If you require emergency medical treatment, you may seek it from any provider, however, any subsequent non-emergency treatment shall be obtained from one of the designated health care providers whose names appear on the list posted on your employer's premises. You must obtain treatment from one of these providers for ninety (90) days from the date of your first visit to that provider; otherwise, your employer shall not be responsible for payment of your non-emergency medical bills for that first ninety (90) days.

During the initial ninety (90) days from the date of your first visit, you have the right to switch from one health care provider on the list to another and that treatment will be paid for by your employer.

If a designated health care provider refers you for treatment to another health care provider whose name is not on the list, your employer will pay for treatment rendered by the provider whom you were referred.

Naturally, you have the right to seek treatment or medical consultation from a non-designated health care provider during the initial ninety (90) day period following the first visit, but you are personally responsible for payment for those services.

You have the right to seek treatment from any health care provider at the expiration of the ninety (90) day period from the date of first visit. This treatment will be paid for by your employer unless the treatment is found to be unreasonable or unnecessary by a utilization review organization pursuant to the utilization review process contained in the Pennsylvania Workers' Compensation Act.

Your employer will be responsible for the cost of that treatment after the initial ninety (90) day period has ended but only if you notify the employer that you are receiving treatment from a non-designated health care provider and only if that notice is provided to your employer within five (5) days after the first visit to that provider. If you provide notice to your employer of treatment by a non-designated provider more than five (5) days after the first visit to that provider, the employer will not be responsible to pay for treatment rendered by that non-designated provider until it receives notification from you that you are receiving such treatment.

Should invasive surgery be prescribed by a designated health care provider, your employer will pay for an additional opinion from a health care provider of your choice. If the additional opinion differs from the opinion of the designated health care provider and if the additional opinion provides a specific and detailed course of treatment, you will then determine which course of treatment to follow. If you choose to follow the procedures recommended in the additional opinion, your employer will pay to have such procedures performed by one of its designated health care providers and will not be responsible for payment for treatment provided by a non-designated provider for a period of ninety (90) days from the date of your visit to the health care provider from whom you obtained the additional opinion.

I HEREBY ACKNOWLEDGE THAT I HAVE BEEN INFORMED OF AND UNDERSTAND MY RIGHTS AND DUTIES UNDER THE WORKER'S COMPENSATION ACT AS SET FORTH HEREIN.

DATE: _____
Employee

EMPLOYEE RE-NOTIFICATION

I hereby acknowledge that I have been informed again and that I understand my rights and duties under the Worker's Compensation Act. I have received a copy of this Worker's Compensation employee notification form.

DATE: _____
Employee

Workers' Compensation Information

The following information is being provided to you in compliance with 34 Pa.Code § 121.3b.

- 1) The workers' compensation law provides wage loss and medical benefits to employees who cannot work, or who need medical care, because of a work-related injury.
- 2) Benefits are required to be paid by your employer when self-insured, or through insurance provided by your employer. Your employer is required to post the name of the company responsible for paying workers' compensation benefits at its primary place of business and at its sites of employment in a prominent and easily accessible place, including, without limitation, areas used for the treatment of injured employees or for the administration of first aid.
- 3) You should report immediately any injury or work-related illness to your employer.
- 4) Your benefits could be delayed or denied if you do not notify your employer immediately.
- 5) If your claim is denied by your employer, you have the right to request a hearing before a workers' compensation judge.
- 6) The Bureau of Workers' Compensation cannot provide legal advice. However, you may contact the Bureau of Workers' Compensation for additional general information at: Bureau of Workers' Compensation, 1171 South Cameron Street, Room 103, Harrisburg, Pennsylvania 17104-2501; telephone number within Pennsylvania (800) 482-2383; telephone number outside of this Commonwealth (717) 772-4447; TTY (800) 362-4228 (for hearing and speech impaired only); www.state.pa.us, PA Keyword: workers comp.

Employee's Signature: _____

Date: _____

SHIPPENSBURG UNIVERSITY

INFORMATION RELEASE AUTHORIZATION Employee

PLEASE PRINT ALL INFORMATION CLEARLY AS REQUESTED

I, _____, hereby authorize any educational institution, any past or present employer (including any branch of the armed services), any local, state, or federal government agency (including any laws enforcement or security agencies) to release to Shippensburg University through its authorized representative(s) bearing this authorization, all information concerning me.

I voluntarily agree to this investigation of my background with the knowledge and understanding that whatever information is obtained is for the official use of Shippensburg University and will not be released to any other parties.

I further understand any information obtained during such investigation may only be used to determine my fitness, competence, and ability for the purpose of working at Shippensburg University.

I release Shippensburg University from any liability which may result from making this investigation. Furthermore, I hereby forever release anyone who has knowledge or information concerning my employment history and criminal history from any claims or demands from liability or damages for disclosure of true and accurate information provided by this investigation. This authorization shall supersede and countername any prior request or authorizations to the contrary.

I further authorize the use of photocopies of this authorization and agree to provide copies of search results if they are sent directly to me.

PLEASE PRINT CLEARLY BELOW

Name: *Last* _____ *First* _____ M.I. _____

Home/Cell/Work Phone: _____ Email Address: _____

Current Address: _____

City/State/Zip Code: _____

Hiring Department: _____

Signature: _____ Date: _____

DO NOT WRITE BELOW THIS LINE: FOR UNIVERSITY USE ONLY

Date of Birth: _____ Previously Employed? YES or NO

Timekeeper: _____ Timekeeper's Email: _____



Shippensburg University
Background Clearance Certification
for Provisional Employment or Volunteering
(Under the Child Protective Services Law)

Please read this entire form carefully before completing it. This form is to be used by prospective employees/volunteers to meet the written certification requirement to be considered as a provisional hire or volunteer assignment. In certain limited circumstances, current employees/volunteers may need to complete this form.

Section 1. Personal Information

Full Legal Name: _____

Any former names or aliases by which you have been identified: _____

Section 2. Instructions

Please submit this form to Human Resources. [To be completed by the university.]

If you have any question about whether to report an offense, you should report it. Failure to report may result in disqualification for employment.

List of Reportable Offenses

A Reportable Offense enumerated under Pennsylvania's Child Protective Services Law, 23 Pa.C.S. §6344(c), consists of one or more of the following:

1. Provisions of Title 18 of the Pennsylvania Consolidated Statutes (relating to crimes and offenses) or an equivalent crime under the laws or former laws of the United States or one of its territories or possessions, another state, the District of Columbia, the Commonwealth of Puerto Rico or a foreign nation, or under a former law of the Commonwealth of Pennsylvania:
 - 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 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 3125 relating to aggravated indecent assault
 - Section 3126 relating to indecent assault
 - Section 3127 relating to indecent exposure
 - Section 4302 relating to incest
 - Section 4303 relating to concealing death of a 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 relating to corruption of minors
 - Section 6312 relating to sexual abuse 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," committed within the preceding five-year period.
3. A founded report of child abuse within the preceding five-year period in the statewide database maintained by the Department of Human Services.

Section 3. No Conviction

- ☐ By checking this box, I certify that I have **not** been convicted of any Reportable Offense or an offense similar in nature to a Reportable Offense under the laws or former laws of the United States or one of its territories or possessions, another state, the District of Columbia, the Commonwealth of Puerto Rico or a foreign nation, or under a former law of the Commonwealth of Pennsylvania. (See Section 2 for a list of Reportable Offenses.)

Section 4. Application for Background Checks

I certify that I have applied or will apply for the following required background clearance checks:

- ☐ A report of criminal history record from the Pennsylvania State Police (PSP) or statement from the PSP that no criminal record exists.
- ☐ Certification from the Pennsylvania Department of Human Services as to whether I am named in the statewide database as a perpetrator in a pending child abuse investigation or in a founded report or indicated report of child abuse.
- ☐ A report of federal criminal history record information. *I understand that I must submit a full set of fingerprints to the PSP to obtain this report if I have not been a resident of Pennsylvania for the entirety of at least the last 10 consecutive years prior to the date of this application.*
- ☐ I further certify that I have provided or will provide copies of the completed request forms and results for these background clearance checks to Shippensburg University. (Appropriate forms may be attached to this Certification Form.)

Section 5. Certification

By signing this form, I swear and affirm 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

Shippensburg University
FBI Fingerprint Questionnaire
Applicant Information for Act 114 FBI Criminal Search With Fingerprints

Name: _____
Last First MI

Alias: _____
Including Maiden Names

Phone: _____
Home/Cell/Work

Address: _____
Home/Permanent Campus, if different

City/State/Zip

City/State/Zip

Email: _____
Ship.edu Personal

Place of Birth: _____
City and State

Country of Citizenship: _____
Country

Gender: ☐ Male
☐ Female

Ethnicity: ☐ Hispanic
☐ Non-Hispanic

Hair Color: _____

Eye Color: _____

Height: _____
Feet/Inches

Weight: _____
Pounds

Race: ☐ Asian ☐ Caucasian/Latino
☐ Black ☐ Unknown
☐ Native American

Signature

Date

General Instructions

Section references are to the Internal Revenue Code.

Future Developments

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

Purpose of Form

Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay. If too little is withheld, you will generally owe tax when you file your tax return and may owe a penalty. If too much is withheld, you will generally be due a refund. Complete a new Form W-4 when changes to your personal or financial situation would change the entries on the form. For more information on withholding and when you must furnish a new Form W-4, see Pub. 505, Tax Withholding and Estimated Tax.

Exemption from withholding. You may claim exemption from withholding for 2024 if you meet both of the following conditions: you had no federal income tax liability in 2023 **and** you expect to have no federal income tax liability in 2024. You had no federal income tax liability in 2023 if (1) your total tax on line 24 on your 2023 Form 1040 or 1040-SR is zero (or less than the sum of lines 27, 28, and 29), or (2) you were not required to file a return because your income was below the filing threshold for your correct filing status. If you claim exemption, you will have no income tax withheld from your paycheck and may owe taxes and penalties when you file your 2024 tax return. To claim exemption from withholding, certify that you meet both of the conditions above by writing "Exempt" on Form W-4 in the space below Step 4(c). Then, complete Steps 1(a), 1(b), and 5. Do not complete any other steps. You will need to submit a new Form W-4 by February 15, 2025.

Your privacy. Steps 2(c) and 4(a) ask for information regarding income you received from sources other than the job associated with this Form W-4. If you have concerns with providing the information asked for in Step 2(c), you may choose Step 2(b) as an alternative; if you have concerns with providing the information asked for in Step 4(a), you may enter an additional amount you want withheld per pay period in Step 4(c) as an alternative.

When to use the estimator. Consider using the estimator at www.irs.gov/W4App if you:

1. Expect to work only part of the year;
2. Receive dividends, capital gains, social security, bonuses, or business income, or are subject to the Additional Medicare Tax or Net Investment Income Tax; or
3. Prefer the most accurate withholding for multiple job situations.

Self-employment. Generally, you will owe both income and self-employment taxes on any self-employment income you receive separate from the wages you receive as an employee. If you want to pay these taxes through withholding from your wages, use the estimator at www.irs.gov/W4App to figure the amount to have withheld.

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

Step 1(c). Check your anticipated filing status. This will determine the standard deduction and tax rates used to compute your withholding.

Step 2. Use this step if you (1) have more than one job at the same time, or (2) are married filing jointly and you and your spouse both work.

Option **(a)** most accurately calculates the additional tax you need to have withheld, while option **(b)** does so with a little less accuracy.

Instead, if you (and your spouse) have a total of only two jobs, you may check the box in option **(c)**. The box must also be checked on the Form W-4 for the other job. If the box is checked, the standard deduction and tax brackets will be cut in half for each job to calculate withholding. This option is accurate for jobs with similar pay; otherwise, more tax than necessary may be withheld, and this extra amount will be larger the greater the difference in pay is between the two jobs.



Multiple jobs. Complete Steps 3 through 4(b) on only one Form W-4. Withholding will be most accurate if you do this on the Form W-4 for the highest paying job.

Step 3. This step provides instructions for determining the amount of the child tax credit and the credit for other dependents that you may be able to claim when you file your tax return. To qualify for the child tax credit, the child must be under age 17 as of December 31, must be your dependent who generally lives with you for more than half the year, and must have the required social security number. You may be able to claim a credit for other dependents for whom a child tax credit can't be claimed, such as an older child or a qualifying relative. For additional eligibility requirements for these credits, see Pub. 501, Dependents, Standard Deduction, and Filing Information. You can also include **other tax credits** for which you are eligible in this step, such as the foreign tax credit and the education tax credits. To do so, add an estimate of the amount for the year to your credits for dependents and enter the total amount in Step 3. Including these credits will increase your paycheck and reduce the amount of any refund you may receive when you file your tax return.

Step 4 (optional).

Step 4(a). Enter in this step the total of your other estimated income for the year, if any. You shouldn't include income from any jobs or self-employment. If you complete Step 4(a), you likely won't have to make estimated tax payments for that income. If you prefer to pay estimated tax rather than having tax on other income withheld from your paycheck, see Form 1040-ES, Estimated Tax for Individuals.

Step 4(b). Enter in this step the amount from the Deductions Worksheet, line 5, if you expect to claim deductions other than the basic standard deduction on your 2024 tax return and want to reduce your withholding to account for these deductions. This includes both itemized deductions and other deductions such as for student loan interest and IRAs.

Step 4(c). Enter in this step any additional tax you want withheld from your pay **each pay period**, including any amounts from the Multiple Jobs Worksheet, line 4. Entering an amount here will reduce your paycheck and will either increase your refund or reduce any amount of tax that you owe.

Step 2(b)—Multiple Jobs Worksheet (Keep for your records.)

If you choose the option in Step 2(b) on Form W-4, complete this worksheet (which calculates the total extra tax for all jobs) on **only ONE** Form W-4. Withholding will be most accurate if you complete the worksheet and enter the result on the Form W-4 for the highest paying job. To be accurate, submit a new Form W-4 for all other jobs if you have not updated your withholding since 2019.

Note: If more than one job has annual wages of more than \$120,000 or there are more than three jobs, see Pub. 505 for additional tables; or, you can use the online withholding estimator at www.irs.gov/W4App.

- 1 Two jobs.** If you have two jobs or you're married filing jointly and you and your spouse each have one job, find the amount from the appropriate table on page 4. Using the "Higher Paying Job" row and the "Lower Paying Job" column, find the value at the intersection of the two household salaries and enter that value on line 1. Then, **skip** to line 3 **1** \$ _____
- 2 Three jobs.** If you and/or your spouse have three jobs at the same time, complete lines 2a, 2b, and 2c below. Otherwise, skip to line 3.
 - a** Find the amount from the appropriate table on page 4 using the annual wages from the highest paying job in the "Higher Paying Job" row and the annual wages for your next highest paying job in the "Lower Paying Job" column. Find the value at the intersection of the two household salaries and enter that value on line 2a **2a** \$ _____
 - b** Add the annual wages of the two highest paying jobs from line 2a together and use the total as the wages in the "Higher Paying Job" row and use the annual wages for your third job in the "Lower Paying Job" column to find the amount from the appropriate table on page 4 and enter this amount on line 2b **2b** \$ _____
 - c** Add the amounts from lines 2a and 2b and enter the result on line 2c **2c** \$ _____
- 3** Enter the number of pay periods per year for the highest paying job. For example, if that job pays weekly, enter 52; if it pays every other week, enter 26; if it pays monthly, enter 12, etc. **3** _____
- 4 Divide** the annual amount on line 1 or line 2c by the number of pay periods on line 3. Enter this amount here and in **Step 4(c)** of Form W-4 for the highest paying job (along with any other additional amount you want withheld) **4** \$ _____

Step 4(b)—Deductions Worksheet (Keep for your records.)

- 1** Enter an estimate of your 2024 itemized deductions (from Schedule A (Form 1040)). Such deductions may include qualifying home mortgage interest, charitable contributions, state and local taxes (up to \$10,000), and medical expenses in excess of 7.5% of your income **1** \$ _____
- 2** Enter:

| | | |
|--|---|-----------|
| <ul style="list-style-type: none"> • \$29,200 if you're married filing jointly or a qualifying surviving spouse • \$21,900 if you're head of household • \$14,600 if you're single or married filing separately | } | |
|--|---|-----------|

2 \$ _____
- 3** If line 1 is greater than line 2, subtract line 2 from line 1 and enter the result here. If line 2 is greater than line 1, enter "-0-" **3** \$ _____
- 4** Enter an estimate of your student loan interest, deductible IRA contributions, and certain other adjustments (from Part II of Schedule 1 (Form 1040)). See Pub. 505 for more information **4** \$ _____
- 5 Add** lines 3 and 4. Enter the result here and in **Step 4(b)** of Form W-4 **5** \$ _____

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

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

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

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

Married Filing Jointly or Qualifying Surviving Spouse

| Higher Paying Job Annual Taxable Wage & Salary | Lower Paying Job Annual Taxable Wage & Salary | | | | | | | | | | | |
|--|---|----------------------|----------------------|----------------------|----------------------|----------------------|----------------------|----------------------|----------------------|----------------------|------------------------|------------------------|
| | \$0 - 9,999 | \$10,000 - 19,999 | \$20,000 - 29,999 | \$30,000 - 39,999 | \$40,000 - 49,999 | \$50,000 - 59,999 | \$60,000 - 69,999 | \$70,000 - 79,999 | \$80,000 - 89,999 | \$90,000 - 99,999 | \$100,000 - 109,999 | \$110,000 - 120,000 |
| \$0 - 9,999 | \$0 | \$0 | \$780 | \$850 | \$940 | \$1,020 | \$1,020 | \$1,020 | \$1,020 | \$1,020 | \$1,020 | \$1,370 |
| \$10,000 - 19,999 | 0 | 780 | 1,780 | 1,940 | 2,140 | 2,220 | 2,220 | 2,220 | 2,220 | 2,220 | 2,570 | 3,570 |
| \$20,000 - 29,999 | 780 | 1,780 | 2,870 | 3,140 | 3,340 | 3,420 | 3,420 | 3,420 | 3,420 | 3,770 | 4,770 | 5,770 |
| \$30,000 - 39,999 | 850 | 1,940 | 3,140 | 3,410 | 3,610 | 3,690 | 3,690 | 3,690 | 4,040 | 5,040 | 6,040 | 7,040 |
| \$40,000 - 49,999 | 940 | 2,140 | 3,340 | 3,610 | 3,810 | 3,890 | 3,890 | 4,240 | 5,240 | 6,240 | 7,240 | 8,240 |
| \$50,000 - 59,999 | 1,020 | 2,220 | 3,420 | 3,690 | 3,890 | 3,970 | 4,320 | 5,320 | 6,320 | 7,320 | 8,320 | 9,320 |
| \$60,000 - 69,999 | 1,020 | 2,220 | 3,420 | 3,690 | 3,890 | 4,320 | 5,320 | 6,320 | 7,320 | 8,320 | 9,320 | 10,320 |
| \$70,000 - 79,999 | 1,020 | 2,220 | 3,420 | 3,690 | 4,240 | 5,320 | 6,320 | 7,320 | 8,320 | 9,320 | 10,320 | 11,320 |
| \$80,000 - 99,999 | 1,020 | 2,220 | 3,620 | 4,890 | 6,090 | 7,170 | 8,170 | 9,170 | 10,170 | 11,170 | 12,170 | 13,170 |
| \$100,000 - 149,999 | 1,870 | 4,070 | 6,270 | 7,540 | 8,740 | 9,820 | 10,820 | 11,820 | 12,830 | 14,030 | 15,230 | 16,430 |
| \$150,000 - 239,999 | 1,960 | 4,360 | 6,760 | 8,230 | 9,630 | 10,910 | 12,110 | 13,310 | 14,510 | 15,710 | 16,910 | 18,110 |
| \$240,000 - 259,999 | 2,040 | 4,440 | 6,840 | 8,310 | 9,710 | 10,990 | 12,190 | 13,390 | 14,590 | 15,790 | 16,990 | 18,190 |
| \$260,000 - 279,999 | 2,040 | 4,440 | 6,840 | 8,310 | 9,710 | 10,990 | 12,190 | 13,390 | 14,590 | 15,790 | 16,990 | 18,190 |
| \$280,000 - 299,999 | 2,040 | 4,440 | 6,840 | 8,310 | 9,710 | 10,990 | 12,190 | 13,390 | 14,590 | 15,790 | 16,990 | 18,380 |
| \$300,000 - 319,999 | 2,040 | 4,440 | 6,840 | 8,310 | 9,710 | 10,990 | 12,190 | 13,390 | 14,590 | 15,980 | 17,980 | 19,980 |
| \$320,000 - 364,999 | 2,040 | 4,440 | 6,840 | 8,310 | 9,710 | 11,280 | 13,280 | 15,280 | 17,280 | 19,280 | 21,280 | 23,280 |
| \$365,000 - 524,999 | 2,720 | 6,010 | 9,510 | 12,080 | 14,580 | 16,950 | 19,250 | 21,550 | 23,850 | 26,150 | 28,450 | 30,750 |
| \$525,000 and over | 3,140 | 6,840 | 10,540 | 13,310 | 16,010 | 18,590 | 21,090 | 23,590 | 26,090 | 28,590 | 31,090 | 33,590 |

Single or Married Filing Separately

| Higher Paying Job Annual Taxable Wage & Salary | Lower Paying Job Annual Taxable Wage & Salary | | | | | | | | | | | |
|--|---|----------------------|----------------------|----------------------|----------------------|----------------------|----------------------|----------------------|----------------------|----------------------|------------------------|------------------------|
| | \$0 - 9,999 | \$10,000 - 19,999 | \$20,000 - 29,999 | \$30,000 - 39,999 | \$40,000 - 49,999 | \$50,000 - 59,999 | \$60,000 - 69,999 | \$70,000 - 79,999 | \$80,000 - 89,999 | \$90,000 - 99,999 | \$100,000 - 109,999 | \$110,000 - 120,000 |
| \$0 - 9,999 | \$240 | \$870 | \$1,020 | \$1,020 | \$1,020 | \$1,540 | \$1,870 | \$1,870 | \$1,870 | \$1,870 | \$1,910 | \$2,040 |
| \$10,000 - 19,999 | 870 | 1,680 | 1,830 | 1,830 | 2,350 | 3,350 | 3,680 | 3,680 | 3,680 | 3,720 | 3,920 | 4,050 |
| \$20,000 - 29,999 | 1,020 | 1,830 | 1,980 | 2,510 | 3,510 | 4,510 | 4,830 | 4,830 | 4,870 | 5,070 | 5,270 | 5,400 |
| \$30,000 - 39,999 | 1,020 | 1,830 | 2,510 | 3,510 | 4,510 | 5,510 | 5,830 | 5,870 | 6,070 | 6,270 | 6,470 | 6,600 |
| \$40,000 - 59,999 | 1,390 | 3,200 | 4,360 | 5,360 | 6,360 | 7,370 | 7,890 | 8,090 | 8,290 | 8,490 | 8,690 | 8,820 |
| \$60,000 - 79,999 | 1,870 | 3,680 | 4,830 | 5,840 | 7,040 | 8,240 | 8,770 | 8,970 | 9,170 | 9,370 | 9,570 | 9,700 |
| \$80,000 - 99,999 | 1,870 | 3,690 | 5,040 | 6,240 | 7,440 | 8,640 | 9,170 | 9,370 | 9,570 | 9,770 | 9,970 | 10,810 |
| \$100,000 - 124,999 | 2,040 | 4,050 | 5,400 | 6,600 | 7,800 | 9,000 | 9,530 | 9,730 | 10,180 | 11,180 | 12,180 | 13,120 |
| \$125,000 - 149,999 | 2,040 | 4,050 | 5,400 | 6,600 | 7,800 | 9,000 | 10,180 | 11,180 | 12,180 | 13,180 | 14,180 | 15,310 |
| \$150,000 - 174,999 | 2,040 | 4,050 | 5,400 | 6,860 | 8,860 | 10,860 | 12,180 | 13,180 | 14,230 | 15,530 | 16,830 | 18,060 |
| \$175,000 - 199,999 | 2,040 | 4,710 | 6,860 | 8,860 | 10,860 | 12,860 | 14,380 | 15,680 | 16,980 | 18,280 | 19,580 | 20,810 |
| \$200,000 - 249,999 | 2,720 | 5,610 | 8,060 | 10,360 | 12,660 | 14,960 | 16,590 | 17,890 | 19,190 | 20,490 | 21,790 | 23,020 |
| \$250,000 - 399,999 | 2,970 | 6,080 | 8,540 | 10,840 | 13,140 | 15,440 | 17,060 | 18,360 | 19,660 | 20,960 | 22,260 | 23,500 |
| \$400,000 - 449,999 | 2,970 | 6,080 | 8,540 | 10,840 | 13,140 | 15,440 | 17,060 | 18,360 | 19,660 | 20,960 | 22,260 | 23,500 |
| \$450,000 and over | 3,140 | 6,450 | 9,110 | 11,610 | 14,110 | 16,610 | 18,430 | 19,930 | 21,430 | 22,930 | 24,430 | 25,870 |

Head of Household

| Higher Paying Job Annual Taxable Wage & Salary | Lower Paying Job Annual Taxable Wage & Salary | | | | | | | | | | | |
|--|---|----------------------|----------------------|----------------------|----------------------|----------------------|----------------------|----------------------|----------------------|----------------------|------------------------|------------------------|
| | \$0 - 9,999 | \$10,000 - 19,999 | \$20,000 - 29,999 | \$30,000 - 39,999 | \$40,000 - 49,999 | \$50,000 - 59,999 | \$60,000 - 69,999 | \$70,000 - 79,999 | \$80,000 - 89,999 | \$90,000 - 99,999 | \$100,000 - 109,999 | \$110,000 - 120,000 |
| \$0 - 9,999 | \$0 | \$510 | \$850 | \$1,020 | \$1,020 | \$1,020 | \$1,020 | \$1,220 | \$1,870 | \$1,870 | \$1,870 | \$1,960 |
| \$10,000 - 19,999 | 510 | 1,510 | 2,020 | 2,220 | 2,220 | 2,220 | 2,420 | 3,420 | 4,070 | 4,070 | 4,160 | 4,360 |
| \$20,000 - 29,999 | 850 | 2,020 | 2,560 | 2,760 | 2,760 | 2,960 | 3,960 | 4,960 | 5,610 | 5,700 | 5,900 | 6,100 |
| \$30,000 - 39,999 | 1,020 | 2,220 | 2,760 | 2,960 | 3,160 | 4,160 | 5,160 | 6,160 | 6,900 | 7,100 | 7,300 | 7,500 |
| \$40,000 - 59,999 | 1,020 | 2,220 | 2,810 | 4,010 | 5,010 | 6,010 | 7,070 | 8,270 | 9,120 | 9,320 | 9,520 | 9,720 |
| \$60,000 - 79,999 | 1,070 | 3,270 | 4,810 | 6,010 | 7,070 | 8,270 | 9,470 | 10,670 | 11,520 | 11,720 | 11,920 | 12,120 |
| \$80,000 - 99,999 | 1,870 | 4,070 | 5,670 | 7,070 | 8,270 | 9,470 | 10,670 | 11,870 | 12,720 | 12,920 | 13,120 | 13,450 |
| \$100,000 - 124,999 | 2,020 | 4,420 | 6,160 | 7,560 | 8,760 | 9,960 | 11,160 | 12,360 | 13,210 | 13,880 | 14,880 | 15,880 |
| \$125,000 - 149,999 | 2,040 | 4,440 | 6,180 | 7,580 | 8,780 | 9,980 | 11,250 | 13,250 | 14,900 | 15,900 | 16,900 | 17,900 |
| \$150,000 - 174,999 | 2,040 | 4,440 | 6,180 | 7,580 | 9,250 | 11,250 | 13,250 | 15,250 | 16,900 | 18,030 | 19,330 | 20,630 |
| \$175,000 - 199,999 | 2,040 | 4,510 | 7,050 | 9,250 | 11,250 | 13,250 | 15,250 | 17,530 | 19,480 | 20,780 | 22,080 | 23,380 |
| \$200,000 - 249,999 | 2,720 | 5,920 | 8,620 | 11,120 | 13,420 | 15,720 | 18,020 | 20,320 | 22,270 | 23,570 | 24,870 | 26,170 |
| \$250,000 - 449,999 | 2,970 | 6,470 | 9,310 | 11,810 | 14,110 | 16,410 | 18,710 | 21,010 | 22,960 | 24,260 | 25,560 | 26,860 |
| \$450,000 and over | 3,140 | 6,840 | 9,880 | 12,580 | 15,080 | 17,580 | 20,080 | 22,580 | 24,730 | 26,230 | 27,730 | 29,230 |

Instructions for REV-419

Employee's Nonwithholding Application Certificate


WHAT'S NEW

The form has been redesigned to meet the branding, formatting and instructions standards used for all department forms. The instructions and form have also been updated as a result of recent amendments to the federal Servicemembers Civil Relief Act.

GENERAL INFORMATION

PURPOSE OF FORM

Complete Form REV-419 so that your employer can withhold the correct Pennsylvania personal income tax from your pay. Complete a new Form REV-419 every year or when your personal or financial situation changes. Photocopies of this form are acceptable.

 **NOTE:** Unless the state of residence changes, residents of the reciprocal states listed in the next paragraph do not need to refile this application every year.

GENERAL INSTRUCTIONS

WHO IS ELIGIBLE FOR NONWITHHOLDING?

You may be entitled to nonwithholding of PA personal income tax if you incurred no liability for income tax the preceding tax year and/or you anticipate that you will incur no liability for income tax during the current tax year, according to the Special Tax Provisions of section 304 of the Tax Reform Code, as a resident of the reciprocal state of Indiana, Maryland, New Jersey, Ohio, Virginia or West Virginia and your employer agrees to withhold the income tax from that state or as the spouse of an active duty service member under the Servicemembers Civil Relief Act (SCRA), as amended.

WHEN TO CLAIM?

File this certificate with your employer as soon as you determine you are entitled to claim nonwithholding. You must file a certificate each year you are eligible (see Note above for an exception). If you are employed by more than one employer you must file a separate REV-419 with each employer.

RESPONSIBILITIES OF EMPLOYEES

You must revoke this certification within 10 days from the day you anticipate you will incur PA personal income tax liability for the current tax year. To discontinue or revoke this certification, submit notification in writing to your employer. Claimants who qualify for complete Tax Forgiveness under section 304 of the Tax Reform Code must file a PA-40,

Pennsylvania Personal Income Tax Return, and Schedule SP to claim Tax Forgiveness even if they are eligible for non-withholding.

Under the SCRA, as amended, you may be exempt from PA personal income tax on your wages if (i) your spouse is a member of the armed forces present in PA in compliance with military orders; (ii) you are present in PA solely to be with your spouse; and (iii) you and your spouse both maintain domicile (state residency) in another state. If you claim exemption under the SCRA, enter your state of domicile (legal residence) on Line d below and attach a copy of your spousal military identification card and your spouse's current military orders to form REV-419. See **Personal Income Tax Bulletin 2010-01** for additional information.

RESPONSIBILITIES OF EMPLOYER

If you agree not to withhold PA tax because your employee is a resident of a reciprocal state, you must withhold the other state's tax.

Retain Form REV-419 with your records. You are required to submit a copy of this certificate and accompanying attachments to the **PA DEPARTMENT OF REVENUE, BUREAU OF INDIVIDUAL TAXES, PO BOX 280507, HARRISBURG, PA 17128-0507**, when:

1. You have reason to believe this certificate is incorrect;
2. The PA taxable gross compensation of any employee who claimed exemption from nonwithholding on the form under Section II, Line a, exceeds \$1,625 for any quarter;
3. The employee claims an exemption from withholding on the basis of residence in a reciprocal state (Indiana, Maryland, New Jersey, Ohio, Virginia or West Virginia) and therefore, you agree to withhold income tax of the employee's state of residence; or
4. The employee claims an exemption from withholding under the SCRA, as amended.

DEPARTMENT'S RESPONSIBILITY

Upon receipt of any exemption application, the department will make a determination and notify the employer if a change is required. If the department disapproves the application, the employer must immediately commence withholding at the regular rate. Once a certificate is revoked by the department, the employer must send any new application received from the employee to the department for approval before implementing the nonwithholding.

LISTS OF ACCEPTABLE DOCUMENTS

All documents containing an expiration date must be unexpired.

* Documents extended by the issuing authority are considered unexpired.

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

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

| LIST A | | LIST B | LIST C |
|--|----|---|--|
| Documents that Establish Both Identity and Employment Authorization | OR | Documents that Establish Identity | AND 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 an individual temporarily authorized to work for a specific employer because of his or her status or parole: 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 individual's status or parole 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 For examples, see Section 7 and Section 13 of the M-274 on uscis.gov/i-9-central . The Form I-766, Employment Authorization Document, is a List A, Item Number 4. document, not a List C document. |
| | | 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: | | | |
| 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 | | 10. School record or report card | |
| | | 11. Clinic, doctor, or hospital record | |
| | | 12. Day-care or nursery school record | |
| Acceptable Receipts | | | |
| May be presented in lieu of a document listed above for a temporary period. | | | |
| For receipt validity dates, see the M-274. | | | |
| • Receipt for a replacement of a lost, stolen, or damaged List A document. • Form I-94 issued to a lawful permanent resident that contains an I-551 stamp and a photograph of the individual. • Form I-94 with "RE" notation or refugee stamp issued to a refugee. | OR | Receipt for a replacement of a lost, stolen, or damaged List B document. | Receipt for a replacement of a lost, stolen, or damaged List C document. |

*Refer to the Employment Authorization Extensions page on [I-9 Central](#) for more information.

INSERVCO INSURANCE SERVICES, INC.

Workers' Compensation Program: Designated Health Care Providers

NOTICE TO EMPLOYEES IN CASE OF WORK-RELATED INJURIES

If you suffer a work-related injury, immediately report the injury to your supervisor. Failure to do so may delay your benefits or may cause you to lose your rights to benefits. For necessary medical treatment and supplies to be paid by your employer:

- All treatment must be obtained from one of the healthcare providers listed below.
- You must continue to visit one of the healthcare providers listed below if you need treatment for 90 days from the date of your first visit. If one of the providers listed below refers you to another licensed specialist, those services will be paid.
- After this 90-day period, if you still need treatment, you may go to another healthcare provider for treatment as long as you notify your claims adjuster within five (5) days of your visit to a new provider.
- If a listed physician prescribes invasive surgery, you have the right to obtain a second opinion from a physician of your choice. If a second opinion differs from that of the listed physician's opinion, you may determine which course of treatment to follow; however, the second opinion must contain a detailed treatment plan. 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.

If you are faced with a medical emergency, you may secure initial emergency treatment from any emergency facility. However, when the emergency is resolved, follow-up treatment must be obtained from one of the following healthcare providers. If you choose to treat with an out-of-state provider, you may be subject to balance billing.

| NAME OF PROVIDER | STREET | CITY, STATE, ZIP | PHONE | SPECIALTY |
|--------------------------------------|-----------------------------------|-------------------------|--------------|--------------------|
| Scott Mueller, MD | 1900 Bridge Street | New Cumberland, PA | 717.774.7041 | Family Practice |
| PinnacleHealth Neurology | 2005 Technology Parkway, Ste. 400 | Mechanicsburg, PA 17050 | 717.791.2520 | Neurology |
| UPMC Urgent Care | 1175 Walnut Bottom Road | Carlisle, PA 17015 | 717.258.9355 | Occ. Medicine |
| UPMC Urgent Care | 6481 Carlisle Pike | Mechanicsburg, PA | 717.796.9355 | Occ. Medicine |
| Patient First | 107 S. Sporting Hill Rd. | Mechanicsburg, PA | 717.943.1781 | Occ. Medicine |
| Premier Eye Care Group | 3903 Hartzdale Drive | Camp Hill, PA 17011 | 717.761.3077 | Ophthalmology |
| Stoken Wagner Ophthalmic Assoc. | 338 Alexander Spring Road | Carlisle, PA 17015 | 717.249.6337 | Ophthalmology |
| Orthopedic Institute of PA | 3399 Trindle Road | Camp Hill, PA 17011 | 717.761.5530 | Orthopedics |
| Orthopedic Institute of PA | 99 November Drive | Camp Hill, PA 17011 | 717.761.5530 | Orthopedics |
| Orthopedic Institute of PA | 429 N. 21st Street | Camp Hill, PA 17011 | 717.761.5530 | Orthopedics |
| UPMC West Shore Orthopaedics | 19 Sprint Drive | Carlisle, PA 17015 | 717.988.8135 | Orthopedics |
| Orthopedic Institute of PA | 250 Alexander Spring Road | Carlisle, PA 17015 | 717.761.5530 | Orthopedics |
| Penn Hand Specialists | 2015 Technology Parkway | Mechanicsburg, PA 17050 | 717.791.2474 | Orthopedics |
| UPMC West Shore Orthopaedics | 1830 Good Hope Road | Enola, PA 17025 | 717.988.8135 | Orthopedics |
| CPRS | 3916 Trindle Road | Camp Hill, PA 17011 | 866.446.2848 | Physical Therapy |
| Drayer Physical Therapy | 3 Jennifer Ct., Ste. A | Carlisle, PA 17015 | 866.446.2848 | Physical Therapy |
| Inspired Physical Therapy | 21 Waterford Drive, Ste. 202 | Mechanicsburg, PA 17050 | 866.446.2848 | Physical Therapy |
| Orthopedic Institute of PA | 3399 Trindle Road | Camp Hill, PA 17011 | 855.682.4647 | Ortho. Urgent Care |
| PennState Health - Susq. Urgent Care | 431 N. 21st Street, Ste. 100 | Camp Hill, PA 17011 | 717.763.3730 | Urgent Care |
| UPMC Urgent Care | 1175 Walnut Bottom Rd. | Carlisle, PA 17015 | 717.258.9355 | Urgent Care |

FOR PRESCRIPTION MEDICATIONS AND DURABLE MEDICAL EQUIPMENT OR TO SCHEDULE PHYSICAL THERAPY, CHIROPRACTIC AND DIAGNOSTIC IMAGING APPOINTMENTS, AND LOCATIONS CLOSE TO YOU, PLEASE CALL KEYSERSCRIPTS AT 1.866.446.2848.

All of your healthcare provider bills and reports need to be sent to the following address for review and payment in accordance with the Pennsylvania Workers' Compensation Act:

Inservco Insurance Services, Inc. P.O. Box 3899, Harrisburg, PA 17105-3899

Phone: 1.800.356.0438 - Fax: 1.866.356.0438

INSERVCO INSURANCE SERVICES, INC.

Workers' Compensation Program: Designated Health Care Providers

NOTICE TO EMPLOYEES IN CASE OF WORK-RELATED INJURIES

If you suffer a work-related injury, immediately report the injury to your supervisor. Failure to do so may delay your benefits or may cause you to lose your rights to benefits. For necessary medical treatment and supplies to be paid by your employer:

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| NAME OF PROVIDER | STREET | CITY, STATE, ZIP | PHONE | SPECIALTY |
|-------------------------------------|--------------------------|-------------------------|--------------|--------------|
| UPMC Urgent Care | 6481 Carlisle Pike | Mechanicsburg, PA | 717.796.9355 | Urgent Care |
| Patient First | 107 S. Sporting Hill Rd. | Mechanicsburg, PA | 717.943.1781 | Urgent Care |
| Warner Chiropractic Care Center, PC | 5315 E. Trindle Road | Mechanicsburg, PA 17050 | 866.446.2848 | Chiropractic |

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| NAME OF PROVIDER | STREET | CITY, STATE, ZIP | PHONE | SPECIALTY |
|--------------------------------------|--------------------------------------|------------------------|--------------|------------------|
| Waynesboro Family Medical Associates | 1051 East Main Street | Waynesboro, PA 17268 | 717.762.9118 | Family Practice |
| WellSpan Neurology | 22 St. Paul Drive, Bldg. 1, Ste. 101 | Chambersburg, PA 17201 | 717.262.2665 | Neurology |
| WellSpan Occupational Health | 1610 Orchard Drive | Chambersburg, PA | 717.261.0929 | Occ. Medicine |
| Ludwick Eye Center | 825 Fifth Ave., Ste. 102 | Chambersburg, PA | 717.262.9700 | Ophthalmology |
| Orthopedic Institute of PA | 250 Alexander Spring Road | Carlisle, PA 17015 | 717.761.5530 | Orthopedics |
| WellSpan Orthopedics | 120 N. 7th St., Ste. 101 | Chambersburg, PA | 717.263.1220 | Orthopedics |
| WellSpan Orthopedics | 601 E. Main Street, Level 1 | Waynesboro, PA 17268 | 717.263.1220 | Orthopedics |
| Drayer Physical Therapy | 432 Gateway Avenue | Chambersburg, PA 17201 | 866.446.2848 | Physical Therapy |
| Fyzical Therapy & Balance Center | 11050 Buchanan Trail East | Waynesboro, PA 17268 | 866.446.2848 | Physical Therapy |
| MedExpress | 1048 Lincoln Way East, Ste. 101 | Chambersburg, PA | 717.267.2273 | Urgent Care |
| WellSpan Urgent Care | 46 Walnut Bottom Road | Shippensburg, PA 17257 | 717.477.2764 | Urgent Care |
| Chambersburg Chiropractic | 1461 Lincoln Way East | Chambersburg, PA | 866.446.2848 | Chiropractic |

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