DREXEL UNIVERSITY
COLLEGE OF MEDICINE

Hello and congratulations on your appointment with Drexel University College of Medicine! We are excited to have you join our team! Please review the following information carefully so we can complete your new employee accounts in our systems as quickly as possible.

Enclosed in this packet you will find the documents required to be completed for employment at the College of Medicine. All documents *must be completed in their entirety* or as noted below.

- **Self-Identification** form must be submitted even if you choose not to fill out your race, gender and veteran status information. Simply check the "I Do Not Wish to Disclose" box, and then submit the form. Please note that completion/non-completion of this form does not affect your employment status in any way.

- **Direct Deposit form** is optional. If you do not complete the form, your check will be physically mailed to you each pay period. A voided check is not required.

- **Consent and Release for Background Reports form** must be completed in its entirety. Employment is contingent upon successful completion of the background check. Drexel's background screening vendor will contact you via the provided email address to complete the process.

- **Guidelines for Occupational Health Services form** must be completed in its entirety. If you are not sure what category your position falls under, please contact your supervisor for clarification. Also, be sure to list your supervisor's name and phone number (use Drexel's Search site) on this form and then sign the bottom. Your supervisor will sign the form at a later date.

- **Employee's Statement of Non-Residence in PA form** is an optional form intended only for residents of NJ, WV, VA, OH, MD and IN. Complete this form only if you wish to have your home state's taxes withheld from your pay. Residents of other states can disregard this form.

- **International Tax Notification form:** If you are NOT a *citizen* or *permanent resident alien* of the U.S., print the International Tax Notification form, complete it, and submit it along with the enclosed documents.

- **I-9 Form:** As a legal requirement of employment, you must complete an I-9 form **no later than 3 days** after your *official start date*. Please note that your *official start date* may not match your *first day of classes.* We encourage you to complete this as early as possible, even prior to your start date if possible.

  - If your appointment is for a course for which you *will not* have access to the Drexel campuses with an HR office (below), you are required to complete an I-9 form with the assistance of a Notary Public in your area. (You must pay a minimal fee for their service.) Click on this I-9 form link to access the correct form to be used. Print the Notary Instruction Form for the Notary to review. You will complete Section 1, then have the Notary complete Sections 2 & 3 and photocopy your identification used to complete the form (click on this acceptable documents link to see which documents you can use). You must then *physically mail* the original notarized I-9 form AND the photocopies of your identification to your Talent Acquisition Consultant. Federal law requires we have the original signed documents; we cannot accept faxed/scanned versions. Your other new hire documents in this packet may be faxed or scanned.

  - If you *will* have access to one of the campuses listed below, you will be required to visit the HR department to complete an I-9 form, which they will provide. You will need to bring identification to satisfy the I-9 requirements. Click on this acceptable documents link to see which documents you can use.

After completing these documents, you may hand them in at an HR office below, or fax/scan them to your Talent Acquisition Consultant by the date in the attached email. If you have any questions, please contact your Talent Acquisition Consultant, or call our main number at 215-895-2850. We thank you in advance for your prompt response and we wish you the best!

Sincerely,

Drexel University Human Resources Team

University City Campus: 3201 Arch St, Suite 430, Philadelphia, PA 19104 T: 215-895-2850
Center City Campus: 1505 Race St, 1st Floor, Philadelphia, PA 19102 T: 215-762-6880
Academy of Natural Sciences Campus: 1900 Ben Franklin Pkwy, Philadelphia, PA 19103 T: 215-299-1083

DREXEL UNIVERSITY
COLLEGE OF MEDICINE

Faculty New Employee Form

EMPLOYEE INFORMATION

SSN | Last Name | First Name | Middle Initial | Date of Birth

Prefix ☐ Dr. ☐ Mr. ☐ Miss ☐ Ms. ☐ Mrs.

Suffix ☐ Sr. ☐ Jr. ☐ MD ☐ PhD ☐ Other

Home Address | Apt | City | State | Zip Code

Home Telephone | Cell Phone

EMERGENCY CONTACT INFORMATION

Name | Relationship | Telephone

Address | Apt | City | State | Zip Code

WORK LOCATION INFORMATION

Address | City | State | Zip Code

Telephone | Fax

BIOGRAPHICAL INFORMATION

Gender
- ☐ Male
- ☐ Female

Citizenship
- ☐ Citizen
- ☐ Non-Citizen

Residency Status
- ☐ US Citizen
- ☐ Permanent Resident
- ☐ Non-Resident Alien
- ☐ Resident Alien
- ☐ Unknown

Marital Status
- ☐ Single
- ☐ Married

VISA INFORMATION

- ☐ F-1
- ☐ J-1
- ☐ H-1
- ☐ B-1
- ☐ Other

Visa Expiration Date

Birth Country

Citizenship Country

Employment Authorization Expiration Date

POSITION INFORMATION

Start Date

Department

- ☐ New Hire
- ☐ Rehire (if you had a position with DUCOM within the past year)

SIGNATURES

Employee Signature _____ Date _____

Human Resources _____ Date _____

HRIS _____ Date _____

Last revised: 4/16/12

DREXEL UNIVERSITY
COLLEGE OF MEDICINE

Self Identification Form

☐ New ☐ Update University ID (required for Updates) _____

Last Name _____ First Name _____ Middle Initial _____

Drexel University is an equal opportunity employer committed to providing a diverse working environment where all qualified individuals are treated and considered for employment without regard to race, color, national origin, religion, gender, age, disability, sexual orientation, identity or expression or veteran's status.

As a federal contractor receiving funds in the form of financial aid and research grants, Drexel University is required to report to the federal government summary data about the gender, ethnicity, race, and veteran status of its employees and its efforts to achieve equal opportunity through affirmative action for minorities, women, persons with disabilities, and veterans.

Drexel University asks and encourages its employees to self-identify their status in order to make our Affirmative Action Plan and governmental reporting as accurate as possible. However, employees are not required to provide this information and refusing to do so will not subject you to any adverse action. The information collected by the University will be kept confidential and will only be used to report in summary fashion for compliance purposes. When reported, data will not identify any specific individual.

Please indicate the categories in which you should be reported.

ETHNICITY (Select all that apply.)

☐	Hispanic or Latino	A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race.

- ☐ Hispanic
- ☐ Cuban American
- ☐ Puerto Rican American - Mainland
- ☐ Puerto Rican American - Commonwealth
- ☐ Mexican American

☐ Not Hispanic or Latino

☐ I do not wish to disclose

RACE (Select all that apply.)

☐	American Indian or Alaska Native	A person having origins in any of the original peoples of North and South America (including Central America), and who maintains tribal affiliation or community attachment.
☐	Asian	A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.

- ☐ Asian
- ☐ Chinese
- ☐ Filipino
- ☐ Indian
- ☐ Japanese
- ☐ Korean
- ☐ Pakistani
- ☐ Vietnamese

☐	Black or African American	A person having origins in any of the black racial groups of Africa.
☐	Native Hawaiian or Other Pacific Islander	A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.
☐	White	A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.

☐ I do not wish to disclose

VETERAN STATUS

☐ I am not a veteran.

☐ I am a veteran. If you are a veteran who served on active duty in the U.S. military, ground, naval or air service and have been discharged or released, please indicate your discharge date: _____

☐ I do not wish to disclose

If you are a veteran, please select one or more categories below that apply to you:

☐	Veteran with a Disability	1. A veteran of the U.S. military, ground, naval or air service who is entitled to compensation (or who but for the receipt of military retired pay would be entitled to compensation) under laws administered by the Secretary of Veterans Affairs, or 2. Was discharged or released from active duty because of a service-connected disability.
☐	Other Protected Veteran	A veteran who served on active duty in the U.S. military, ground, naval or air service during a war or in a campaign or expedition for which a campaign badge has been authorized under the laws administered by the Department of Defense. For a list of officially recognized campaigns, please see www.opm.gov/veterans/html/vgmedal2.asp.
☐	Armed Forces Service Medal Veteran	A veteran who, while serving on active duty in the U.S. military, ground, naval or air service, participated in a United States military operation for which an Armed Forces service medal was awarded pursuant to Executive Order 12985 (61 FR 1209, 3 CFR, 1996 Comp., p.159).
☐	Recently Separated Veteran	Veterans within 36 months from discharge or release from active duty.

DISABILITY STATUS (Select One.)

☐	Not an Individual with a Disability	
☐	Individual with a Disability	The Americans with Disabilities Act ("ADA") Amendment Act guides Drexel in defining a person with a disability who is entitled to a reasonable accommodation as a person who: 1. Has a physical or mental impairment which substantially limits one or more of such person's major life activities, or 2. Has a record of such impairment. *If you are requesting an accommodation, please visit the Office of Disability Resources website (www.drexel.edu/oed/disabilityResources) for more information.*

☐ I do not wish to disclose

The information I have provided to Drexel University is true and complete to the best of my knowledge.

_____
Signature

_____
Date

DREXEL UNIVERSITY COLLEGE OF MEDICINE

Drexel University College of Medicine Faculty Application

It is the policy of Drexel University College of Medicine to provide a working and learning environment in which employees and students are able to realized their full potential as productive members of the Drexel University College of Medicine Community.

Drexel University College of Medicine values diversity and seeks talented students, faculty and staff from diverse backgrounds. Drexel University College of Medicine does not discriminate in hiring or employment on the basis of race, sex, sexual orientation, religion, color, national or ethnic origin, age, disability, status as a Vietnam Era Veteran or disabled veteran, or gender identity or expression in the administration of educational policies, program or activities; admissions policies, scholarship and load awards; athletic, or other College of Medicine administered programs or employment. Any questions on this application or other employment documents relating to any of the foregoing enumerated categories is intended to secure information for use only in conjunction with the College of Medicine's affirmative action plan required by federal law. Submission of such information is voluntary.

Employment resulting from this application is terminable "at will" by either the employee or Drexel University College of Medicine. Employment is contingent upon the applicant providing the necessary proof of US citizenship or legal authorization to work in the United States.

Note: Please complete all sections of this Application for Employment even when attaching a resume.

PERSONAL DATA

Last Name _____ First Name _____ Middle Initial _____

Street Address & Apt Number _____

City _____ State _____ Zip Code _____ Email _____

Telephone _____ Secondary Telephone _____

Are you 18 years of age or older? ☐ Yes ☐ No

Other names under which you have been known for employment, educational records or references: _____

Position (w/Position #) for which you are applying _____

Date Available _____

Have you ever been employed by Drexel? ☐ Yes ☐ No If Yes, reason for leaving _____

How did you learn about this position?

☐ Employee Referral Name of Employee _____

☐ Posting Name of Website _____

☐ Print Ad Name of Newspaper/Journal _____

☐ Agency Name of Agency _____

Are you legally eligible to work in the US?* ☐ Yes Alien Registration # _____ ☐ No

**Under the Immigration Reform Control Act of 1986, any new employee (whether US citizen, resident alien or non-immigrant) must provide proof of identity and/or work authorization at time of employment. If unable to do so, the individual cannot be employed.*

As an applicant for employment with Drexel University College of Medicine, I understand the following:

☐ Any misrepresentation or falsification of information or significant omissions will be cause for rejection of my application or for subsequent discipline up to and including my dismissal from employment.

☐ I understand that my employment is contingent upon the successful completion of a background investigation, including reference checks.

☐ I authorize Drexel University College of Medicine and any agent acting on its behalf, to conduct such investigation and authorize all previous employers to furnish the College of Medicine with my reason for leaving, my employment dates and position title(s) and other information regarding my job duties and responsibilities. I release Drexel University College of Medicine and my previous employers from all liability that may arise from such investigation.

☐ Neither this form nor statements by representatives of Drexel University College of Medicine constitutes an employment contract. Employment with the College of Medicine is not guaranteed for any term, and the employer or the employee may terminate employment at any time for any reason. No management or academic official is authorized to make any oral assurance or promise of continued employment.

☐ Upon employment, I must submit appropriate documentation to satisfy the requirement for completing INS Form I-9.

☐ Upon employment, I also agree to abide by all rules, policies and procedures and performance standards established by Drexel University College of Medicine, Management and my immediate supervisor.

☐ Drexel University's annual security report includes statistics for the previous three years concerning reported crimes that occurred on campus, in certain off-campus buildings owned or controlled by Drexel University, and on public property within, or immediately adjacent to and accessible from campus. The report also includes institutional policies concerning campus security, such as policies on alcohol and drug use, crime prevention, reporting of crimes, sexual assault, and other matters. You can obtain a copy of this report through Public Safety by calling 215-895-1550.

Signature _____ Date _____

Form W-4 (2014)

Purpose. Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay. Consider completing a new Form W-4 each year and when your personal or financial situation changes.

Exemption from withholding. If you are exempt, complete **only** lines 1, 2, 3, 4, and 7 and sign the form to validate it. Your exemption for 2014 expires February 17, 2015. See Pub. 505, Tax Withholding and Estimated Tax.

Note. If another person can claim you as a dependent on his or her tax return, you cannot claim exemption from withholding if your income exceeds $1,000 and includes more than $350 of unearned income (for example, interest and dividends).

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

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

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

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

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

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

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

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

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

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

Check your withholding. After your Form W-4 takes effect, use Pub. 505 to see how the amount you are having withheld compares to your projected total tax for 2014. See Pub. 505, especially if your earnings exceed $130,000 (Single) or $180,000 (Married).

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

Personal Allowances Worksheet (Keep for your records.)

A	Enter "1" for **yourself** if no one else can claim you as a dependent	A
B	Enter "1" if: • You are single and have only one job; or • You are married, have only one job, and your spouse does not work; or • Your wages from a second job or your spouse's wages (or the total of both) are $1,500 or less.	B
C	Enter "1" for your **spouse.** But, you may choose to enter "-0-" if you are married and have either a working spouse or more than one job. (Entering "-0-" may help you avoid having too little tax withheld.)	C
D	Enter number of **dependents** (other than your spouse or yourself) you will claim on your tax return	D
E	Enter "1" if you will file as **head of household** on your tax return (see conditions under **Head of household** above)	E
F	Enter "1" if you have at least $2,000 of **child or dependent care expenses** for which you plan to claim a credit (**Note.** Do **not** include child support payments. See Pub. 503, Child and Dependent Care Expenses, for details.)	F
G	**Child Tax Credit** (including additional child tax credit). See Pub. 972, Child Tax Credit, for more information. • If your total income will be less than $65,000 ($95,000 if married), enter "2" for each eligible child; then **less** "1" if you have three to six eligible children or **less** "2" if you have seven or more eligible children. • If your total income will be between $65,000 and $84,000 ($95,000 and $119,000 if married), enter "1" for each eligible child	G
H	Add lines A through G and enter total here. (**Note.** This may be different from the number of exemptions you claim on your tax return.) ►	H

For accuracy, complete all worksheets that apply.

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

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

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

Employee's Withholding Allowance Certificate

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

OMB No. 1545-0074
2014

1 Your first name and middle initial	Last name	2 **Your social security number**
Home address (number and street or rural route)		3 ☐ Single ☐ Married ☐ Married, but withhold at higher Single rate. **Note.** If married, but legally separated, or spouse is a nonresident alien, check the "Single" box.
City or town, state, and ZIP code		4 **If your last name differs from that shown on your social security card, check here. You must call 1-800-772-1213 for a replacement card.** ► ☐
5 Total number of allowances you are claiming (from line **H** above **or** from the applicable worksheet on page 2)		5
6 Additional amount, if any, you want withheld from each paycheck		6 $
7 I claim exemption from withholding for 2014, and I certify that I meet **both** of the following conditions for exemption. • Last year I had a right to a refund of **all** federal income tax withheld because I had **no** tax liability, **and** • This year I expect a refund of **all** federal income tax withheld because I expect to have **no** tax liability. If you meet both conditions, write "Exempt" here ►		7

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

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

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

Deductions and Adjustments Worksheet

Note. Use this worksheet *only* if you plan to itemize deductions or claim certain credits or adjustments to income.

1	Enter an estimate of your 2014 itemized deductions. These include qualifying home mortgage interest, charitable contributions, state and local taxes, medical expenses in excess of 10% (7.5% if either you or your spouse was born before January 2, 1950) of your income, and miscellaneous deductions. For 2014, you may have to reduce your itemized deductions if your income is over $305,050 and you are married filing jointly or are a qualifying widow(er); $279,650 if you are head of household; $254,200 if you are single and not head of household or a qualifying widow(er); or $152,525 if you are married filing separately. See Pub. 505 for details	1	$
2	Enter: { $12,400 if married filing jointly or qualifying widow(er); $9,100 if head of household; $6,200 if single or married filing separately }	2	$
3	**Subtract** line 2 from line 1. If zero or less, enter "-0-"	3	$
4	Enter an estimate of your 2014 adjustments to income and any additional standard deduction (see Pub. 505)	4	$
5	**Add** lines 3 and 4 and enter the total. (Include any amount for credits from the *Converting Credits to Withholding Allowances for 2014 Form W-4* worksheet in Pub. 505.)	5	$
6	Enter an estimate of your 2014 nonwage income (such as dividends or interest)	6	$
7	**Subtract** line 6 from line 5. If zero or less, enter "-0-"	7	$
8	**Divide** the amount on line 7 by $3,950 and enter the result here. Drop any fraction	8	
9	Enter the number from the **Personal Allowances Worksheet,** line H, page 1	9	
10	**Add** lines 8 and 9 and enter the total here. If you plan to use the **Two-Earners/Multiple Jobs Worksheet,** also enter this total on line 1 below. Otherwise, **stop here** and enter this total on Form W-4, line 5, page 1	10	

Two-Earners/Multiple Jobs Worksheet (See *Two earners or multiple jobs* on page 1.)

Note. Use this worksheet *only* if the instructions under line H on page 1 direct you here.

1	Enter the number from line H, page 1 (or from line 10 above if you used the **Deductions and Adjustments Worksheet**)	1	
2	Find the number in **Table 1** below that applies to the **LOWEST** paying job and enter it here. **However,** if you are married filing jointly and wages from the highest paying job are $65,000 or less, do not enter more than "3"	2	
3	If line 1 is **more than or equal to** line 2, subtract line 2 from line 1. Enter the result here (if zero, enter "-0-") and on Form W-4, line 5, page 1. **Do not** use the rest of this worksheet	3	

Note. If line 1 is **less than** line 2, enter "-0-" on Form W-4, line 5, page 1. Complete lines 4 through 9 below to figure the additional withholding amount necessary to avoid a year-end tax bill.

4	Enter the number from line 2 of this worksheet	4	
5	Enter the number from line 1 of this worksheet	5	
6	**Subtract** line 5 from line 4	6	
7	Find the amount in **Table 2** below that applies to the **HIGHEST** paying job and enter it here	7	$
8	**Multiply** line 7 by line 6 and enter the result here. This is the additional annual withholding needed	8	$
9	Divide line 8 by the number of pay periods remaining in 2014. For example, divide by 25 if you are paid every two weeks and you complete this form on a date in January when there are 25 pay periods remaining in 2014. Enter the result here and on Form W-4, line 6, page 1. This is the additional amount to be withheld from each paycheck	9	$

Table 1

Married Filing Jointly		All Others	
If wages from **LOWEST** paying job are—	Enter on line 2 above	If wages from **LOWEST** paying job are—	Enter on line 2 above
$0 - $6,000	0	$0 - $6,000	0
6,001 - 13,000	1	6,001 - 16,000	1
13,001 - 24,000	2	16,001 - 25,000	2
24,001 - 26,000	3	25,001 - 34,000	3
26,001 - 33,000	4	34,001 - 43,000	4
33,001 - 43,000	5	43,001 - 70,000	5
43,001 - 49,000	6	70,001 - 85,000	6
49,001 - 60,000	7	85,001 - 110,000	7
60,001 - 75,000	8	110,001 - 125,000	8
75,001 - 80,000	9	125,001 - 140,000	9
80,001 - 100,000	10	140,001 and over	10
100,001 - 115,000	11		
115,001 - 130,000	12		
130,001 - 140,000	13		
140,001 - 150,000	14		
150,001 and over	15		

Table 2

Married Filing Jointly		All Others	
If wages from **HIGHEST** paying job are—	Enter on line 7 above	If wages from **HIGHEST** paying job are—	Enter on line 7 above
$0 - $74,000	$590	$0 - $37,000	$590
74,001 - 130,000	990	37,001 - 80,000	990
130,001 - 200,000	1,110	80,001 - 175,000	1,110
200,001 - 355,000	1,300	175,001 - 385,000	1,300
355,001 - 400,000	1,380	385,001 and over	1,560
400,001 and over	1,560		

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 who claims no withholding allowances; 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 possessions 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.

DREXEL UNIVERSITY
COLLEGE OF MEDICINE

DIRECT DEPOSIT AUTHORIZATION

For Payroll and Employee Expense Reimbursements

Reset Form

Submit this form to:

Payroll Department
3201 Arch Street, Suite 400
Tel (215) 895-2885
Fax (215) 895-1615 or (215) 895-1753

I am an Employee of: ☐ **Drexel University** ☐ **Drexel College of Medicine** ☐ **Academy of Natural Sciences of Drexel University**

Employee Name: _____ **University ID Number:** _____

Election for direct deposit requires full net pay to be distributed between the checking and savings accounts listed below. All direct deposit information will be verified with your bank before becoming active. You will receive paper checks until your accounts become active, which may take two or more pay periods. The primary account will also be used for direct deposit of employee expense reimbursements. Please note that student billing account eRefunds will continue to be deposited to the account you have designated for that purpose, which may be different from the primary account designated below. A copy of a check or a direct deposit form from the bank must be provided for each account listed below.

Primary Account - Required for Payroll and Employee Expense Reimbursements

Bank Transit/ Routing Number: (9 digits)	**Bank Name and Phone #**
Account Number:	**Net payroll, after the partial deposits listed below, will be deposited to this account. This account will also receive all employee expense reimbursements.**
Type of Account: ☐ Checking ☐ Savings	**Check One:** ☐ Start ☐ Stop

Secondary Account #1 - Optional partial deposit for Payroll only

Bank Transit/ Routing Number: (9 digits)	**Bank Name and Phone #**
Account Number:	**Dollar Amount to be Deposited:**
Type of Account: ☐ Checking ☐ Savings	**Check One:** ☐ Start ☐ Stop ☐ Change Amount

Secondary Account #2 - Optional partial deposit for Payroll only

Bank Transit/ Routing Number: (9 digits)	**Bank Name and Phone #**
Account Number:	**Dollar Amount to be Deposited:**
Type of Account: ☐ Checking ☐ Savings	**Check One:** ☐ Start ☐ Stop ☐ Change Amount

I hereby authorize the University to initiate direct deposit into the account(s) and financial institution(s) listed above. Payroll direct deposits and direct deposits of employee expense reimbursements will me made to the accounts listed above until I choose to terminate or change this agreement by submission of a new Direct Deposit Authorization form.

Should funds be erroneously deposited into my account(s), I authorize the University to debit my account for an amount not to exceed the amount of the credit.

I further authorize the University to provide me with an electronic pay statement and I understand that I will be notified by e-mail to my official University e-mail address for any employee expense reimbursements made to my primary account.

Employee Signature: _____ **Date:** _____ **Phone:** _____

DREXEL UNIVERSITY
COLLEGE OF MEDICINE

Confidential Consent and Release for Background Reports

I hereby request and authorize DREXEL UNIVERSITY COLLEGE OF MEDICINE and/or HIRERIGHT, to conduct a background investigation on myself. I provide this authorization of my own free will to allow Drexel University College of Medicine to evaluate my application for employment and/or to maintain reports on my qualifications as an employee.

I understand and agree that the background investigation will consist of the following checked items, and only the items checked:

- ☒ Verification of Professional Licenses
- ☒ Criminal History
- ☒ Social Security Trace
- ☐ PA Child Abuse History Clearance
- ☒ Verification of Educational History
- ☒ National Sex Offender Registry
- ☒ Reference Checks
- ☐ FBI Fingerprint Check
- ☐ Credit Check (for specific finance-related positions)
- ☐ Driving Record (for positions that involve driving a vehicle for University business)
- ☐ PA State Police Request for Criminal Records Check

I authorize DREXEL UNIVERSITY COLLEGE OF MEDICINE and/or HIRERIGHT, to contact government agencies, past employers, educational institutions and listed references in the course of conducting an investigation into my background.

I authorize DREXEL UNIVERSITY COLLEGE OF MEDICINE and/or HIRERIGHT, to release all data gathered during the background investigation to hiring officials at Drexel University College of Medicine for use in evaluating my application for employment.

I understand and acknowledge that the information DREXEL UNIVERSITY COLLEGE OF MEDICINE and/or HIRERIGHT, gathers and provides to hiring officials at Drexel University College of Medicine may be unfavorable to my application for employment.

In order to verify my identity for purposes of the background check, I am voluntarily releasing my date of birth for my own benefit and fully understand that age is not a consideration of employment.

I acknowledge and declare that I have received "A Summary of Your Rights Under the Fair Credit Reporting Act," the federal law which controls how the information (as marked above) can be used and my privacy rights concerning it.

In order to complete the verification, you will be asked to complete a secure online form; you will receive an email from HireRight to initiate the verification process. You must access the online form within 2 business days of receiving this email. To ensure that your information verification proceeds efficiently, please complete all sections of the form that are applicable.

I hereby consent to this investigation and authorize DREXEL UNIVERSITY COLLEGE OF MEDICINE to procure the reports as marked above (and only the reports marked), in order to evaluate my application for employment and/or maintain records on my status as an employee of Drexel University College of Medicine.

First Name

Last Name

Date of Birth (MM/DD/YY)

Email address _____

By providing this information, I acknowledge that HireRight will contact me at the email address listed above to initiate the online background verification process.

Signature _____ Date _____

California, Minnesota, & Oklahoma applicants only: Please contact HIRERIGHT at 1-800-426-2761 to have a copy of your consumer report sent directly to you at the current address listed above.

Para información en español, visite www.consumerfinance.gov/learnmore o escribe a la Consumer Financial Protection Bureau, 1700 G Street N.W., Washington DC 20552.

A Summary of Your Rights Under the Fair Credit Reporting Act

The federal Fair Credit Reporting Act (FCRA) promotes the accuracy, fairness, and privacy of information in the files of consumer reporting agencies. There are many types of consumer reporting agencies, including credit bureaus and specialty agencies (such as agencies that sell information about check writing histories, medical records, and rental history records). Here is a summary of your major rights under the FCRA. **For more information, including information about additional rights, go to www.consumerfinance.gov/learnmore or write to: Consumer Financial Protection Bureau, 1700 G Street N.W., Washington, DC 20552.**

- **You must be told if information in your file has been used against you.** Anyone who uses a credit report or another type of consumer report to deny your application for credit, insurance, or employment - or to take another adverse action against you - must tell you, and must give you the name, address, and phone number of the agency that provided the information.

- **You have the right to know what is in your file.** You may request and obtain all the information about you in the files of a consumer reporting agency (your "file disclosure"). You will be required to provide proper identification, which may include your Social Security number. In many cases, the disclosure will be free. You are entitled to a free file disclosure if:
  - a person has taken adverse action against you because of information in your credit report;
  - you are the victim of identity theft and place a fraud alert in your file;
  - your file contains inaccurate information as a result of fraud;
  - you are on public assistance;
  - you are unemployed but expect to apply for employment within 60 days.

- In addition, all consumers are entitled to one free disclosure every 12 months upon request from each nationwide credit bureau and from nationwide specialty consumer reporting agencies. See www.consumerfinance.gov/learnmore for additional information.

- **You have the right to ask for a credit score.** Credit scores are numerical summaries of your credit-worthiness based on information from credit bureaus. You may request a credit score from consumer reporting agencies that create scores or distribute scores used in residential real property loans, but you will have to pay for it. In some mortgage transactions, you will receive credit score information for free from the mortgage lender.

- **You have the right to dispute incomplete or inaccurate information.** If you identify information in your file that is incomplete or inaccurate, and report it to the consumer reporting agency, the agency must investigate unless your dispute is frivolous. See www.consumerfinance.gov/learnmore for an explanation of dispute procedures.

- **Consumer reporting agencies must correct or delete inaccurate, incomplete, or unverifiable information.** Inaccurate, incomplete or unverifiable information must be removed or corrected, usually within 30 days. However, a consumer reporting agency may continue to report information it has verified as accurate.

- **Consumer reporting agencies may not report outdated negative information.** In most cases, a consumer reporting agency may not report negative information that is more than seven years old, or bankruptcies that are more than 10 years old.

- **Access to your file is limited.** A consumer reporting agency may provide information about you only to people with a valid need -- usually to consider an application with a creditor, insurer, employer, landlord, or other business. The FCRA specifies those with a valid need for access.

- **You must give your consent for reports to be provided to employers.** A consumer reporting agency may not give out information about you to your employer, or a potential employer, without your written consent given to the employer. Written consent generally is not required in the trucking industry. For more information, go to www.consumerfinance.gov/learnmore.

- **You may limit "prescreened" offers of credit and insurance you get based on information in your credit report.** Unsolicited "prescreened" offers for credit and insurance must include a toll-free phone number you can call if you choose to remove your name and address from the lists these offers are based on. You may opt-out with the nationwide credit bureaus at 1-888-567-8688.

- **You may seek damages from violators.** If a consumer reporting agency, or, in some cases, a user of consumer reports or a furnisher of information to a consumer reporting agency violates the FCRA, you may be able to sue in state or federal court.

- **Identity theft victims and active duty military personnel have additional rights.** For more information, visit www.consumerfinance.gov/learnmore.

States may enforce the FCRA, and many states have their own consumer reporting laws. In some cases, you may have more rights under state law. For more information, contact your state or local consumer protection agency or your state Attorney General. For Information about your Federal rights contact:

TYPE OF BUSINESS:	CONTACT:
1. a. Banks, savings associations, and credit unions with total assets of over $10 billion and their affiliates. b. Such affiliates that are not banks, savings associations, or credit unions also should list, in addition to the CFPB:	a. Consumer Financial Protection Bureau 1700 G Street NW Washington, DC 20552 b. Federal Trade Commission: Consumer Response Center – FCRA Washington, DC 20580 (877) 382-4357
2. To the extent not included in item 1 above: a. National banks, federal savings associations and federal branches and federal agencies of foreign banks b. State member banks, branches and agencies of foreign banks (other than federal branches, federal agencies and Insured State Branches of Foreign Banks), commercial lending companies owned or controlled by foreign banks, and organizations operating under section 25 or 25A of the Federal Reserve Act c. Nonmember Insured Banks, Insured State Branches of Foreign Banks, and insured state savings associations d. Federal Credit Unions	 a. Office of the Comptroller of the Currency Customer Assistance Group 1301 McKinney Street, Suite 3450 Houston, TX 77010-9050 b. Federal Reserve Consumer Help Center PO Box 1200 Minneapolis, MN 55480 c. FDIC Consumer Response Center 1100 Walnut St., Box #11 Kansas City, MO 64106 d. National Credit Union Administration Office of Consumer Protection (OCP) Division of Consumer Compliance and Outreach (DCCO) 1775 Duke Street Alexandria, VA 22314
3. Air carriers	Asst. General Counsel for Aviation Enforcement & Proceedings Aviation Consumer Protection Division Department of Transportation 1200 New Jersey Avenue, S.E. Washington, DC 20590
4. Creditors Subject to Surface Transportation Board	Office of Proceedings, Surface Transportation Board Department of Transportation 395 E Street, S.W. Washington, DC 20423
5. Creditors Subject to Packers and Stockyards Act, 1921	Nearest Packers and Stockyards Administration area Supervisor
6. Small Business Investment Companies	Associate Deputy Administrator for Capital Access United States Small Business Administration 409 Third Street, SW, 8th Floor Washington, DC 20416
7. Brokers and Dealers	Securities and Exchange Commission 100 F Street, N.E. Washington, DC 20549
8. Federal Land Banks, Federal Land Bank Associations, Federal Intermediate Credit Banks and Production Credit Associations	Farm Credit Administration 1501 Farm Credit Drive McLean, VA 22102-5090
9. Retailers, Finance Companies, and All Other Creditors Not Listed Above	FTC Regional Office for region in which the creditor operates or Federal Trade Commission: Consumer Response Center - FCRA Washington, DC 20580 (877) 382-4357

DREXEL UNIVERSITY
COLLEGE OF MEDICINE

Sanction Check Request

Applicant requests and authorizes Drexel University College of Medicine (DUCOM) and/or Compliance Concepts Inc. (CCI) to conduct a Sanction Check. I authorize DUCOM to use the information it obtains to evaluate my application for employment and if I am hired, to evaluate my qualifications as an employee.

Applicant hereby certifies that he/she (i) has never been excluded, suspended, debarred or otherwise deemed ineligible to participate in Federal and/or State healthcare programs; and (ii) has never been convicted of a criminal offense related to the provision of healthcare items or services and (iii) has not been reinstated in the healthcare programs after a period of exclusion, suspension, debarment, or ineligibility.

Applicant further acknowledges that he/she (i) has never been excluded, suspended, debarred or otherwise deemed ineligible to participate in any and all Federal procurement programs; and (ii) hereby authorizes the Drexel University College of Medicine to review, on an ongoing basis while an employee of DUCOM pertinent government databases to ensure the eligibility status of employee as required by relevant governmental regulations or to comply with applicable contractual requirements.

Signature of Applicant _____ Date _____

PLEASE COMPLETE SECTION BELOW

First Name

Last Name

Maiden Name or Other Names Used

Middle Name/Initial

Date of Birth (mm/dd/yy)

Current Address

City

State

Zip Code

TO BE COMPLETED BY HUMAN RESOURCES

Requestor's Name

Telephone (Area Code + 7 digit phone number)

Requestor's Title

Fax (Area Code + 7 digit phone number)

Company Name

DREXEL UNIVERSITY
COLLEGE OF MEDICINE

Guidelines for Occupational Health Services

Name _____ Date of Hire _____

Department _____ Supervisor/Contact _____

Position Title _____ Supervisor Telephone _____

Telephone _____ Fax _____

Have you ever been employed by Drexel University or Drexel University College of Medicine or an associated Hospital (HUH, MCP, EPPI)?

◯ Yes ◯ No

Check each appropriate category.

(You are required to obtain health screening services, if applicable, in order to continue in your position with DU or DUCOM. This screening must be done within ten days of your date of hire.)

☐ **Research Activity 1** (Do not work with animals, human subjects/human blood or bodily fluids or exotic etiologic agents.)

☐ **Research Activity 2** (Work with human blood, bodily fluids, tissues or cell lines.)

☐ **Research Activity 3** (Work with human subjects.)

☐ **Research Activity 4** (Work with potentially pathogenic botanical agents.)

☐ **Research Activity 5** (Work with animals.)

☐ **Research Activity 6** (Work with biological agents known to be infectious, animals exposed to infectious/exotic agents or human subjects, blood or bodily fluids known to be exposed to or contain/carry infectious/exotic agents.)
List known agents below and have your Department Head/Supervisor sign and **fax to Safety & Health at 215.895.5926.**

_____

☐ **Research Activity 7** (Work with anesthetic gasses or chemical agents known to be carcinogenic, teratogenic or mutagenic.)
List known agents below**.**

_____

☐ **Clinical Activity 1** (Direct contact with patients.)

☐ **Clinical Activity 2** (Work with non-fixed human cadavers or tissues, human blood or bodily fluids or work in a health care environment or doctor's office.)

☐ **Clinical Activity 3** (Work with anesthetic gasses.)

☐ **Administrative 1** (Located within a clinical area (hospital or doctor's office) where human subjects/patients are present.)

☐ **Administrative 2** (Located within a hospital building, but in an area where no patients are present.)

☐ **Administrative 3** (Located in a separate, non-hospital building where no patients or human subjects are present.)

☐ **Other** (Please describe below.)

_____

Have you ever worked in a research or health care facility? ◯ Yes ◯ No

Please list and describe any vaccinations or immunization shots. _____

Employee Signature _____ Date _____

Supervisor Signature _____ Date _____

Return completed forms to Safety & Health: 215.895.5926 (fax)

DREXEL UNIVERSITY
COLLEGE OF MEDICINE

New Jersey Residents

If you are a resident of New Jersey, you may claim exemption from Pennsylvania Personal Income Tax withholding by completing the attached form Employee's Statement of Non-Residence in Pennsylvania and Authorization to Withhold Other State's Income Tax **(Form REV-420 AS)**.

Generally, Drexel University will not withhold New Jersey income tax from your paychecks, since the credit for income taxes paid for Philadelphia city wage tax, will offset any New Jersey tax liability on your earnings from Drexel. However, if you have income from other sources in New Jersey, you may still have a tax liability. If you still wish to have New Jersey income tax withheld from your pay, you must complete a Form NJ-W4 (which can be found at www.state.nj.us/treasury/taxation/pdf/other_forms/git-er/njw4.pdf).

REV-420 AS (06-07)

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF REVENUE
BUREAU OF BUSINESS TRUST FUND TAXES
PO BOX 280904
HARRISBURG, PA 17128-0904

EMPLOYEE'S STATEMENT OF NONRESIDENCE IN PENNSYLVANIA AND AUTHORIZATION TO WITHHOLD OTHER STATE'S INCOME TAX

PLEASE PRINT OR TYPE

Employer Instructions: You must keep a copy of this form on file for each employee who claims exemption from withholding of Pennsylvania Personal Income Tax on compensation received in Pennsylvania and who authorizes withholding of income tax for another state for remittance to that state. Send the bottom portion of this form to the PA Department of Revenue, Bureau of Business Trust Fund Taxes, PO BOX 280904, Harrisburg, PA 17128-0904. Photocopies of this form are acceptable. Unless the state of residence changes, it is not necessary to refile this statement each year.

Employee Instructions: You must complete both portions of this form to claim an exemption from withholding of Pennsylvania Personal Income Tax and to authorize withholding of your state's income tax. Only residents of the states listed on this form are eligible for exemption of withholding from Pennsylvania since they are the only states with which there is a reciprocal agreement. If you change your residence from the state specified on this form, you must notify your employer and complete a new form within 10 days of that change of residence.

CUT HERE

EMPLOYER COPY (EMPLOYEE COMPLETES INFORMATION BELOW AND SIGNS)

Employee name: First, Middle Initial, Last	Social Security Number
Home Address	
City	State Zip Code

I hereby declare that, under penalties of perjury, I am a resident of the state checked below:

☐ INDIANA ☐ MARYLAND ☐ OHIO ☒ NEW JERSEY ☐ VIRGINIA ☐ WEST VIRGINIA

and that pursuant to the reciprocal agreement between those states, I claim an exemption from withholding of Pennsylvania 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.

Employee's Signature	Date

(EMPLOYER COMPLETES INFORMATION BELOW)

Employer Name: PHEC d/b/a Drexel University College of Medicine	Federal Employer Identification Number (EIN) 23-2979433
Business Address Payroll Dept, 3201 Arch St, Ste 400	Telephone Number (215) 895-1423
City Philadelphia	State PA Zip Code 19104

CUT HERE

COPY TO BE SENT TO THE COMMONWEALTH OF PENNSYLVANIA (EMPLOYEE COMPLETES INFORMATION BELOW AND SIGNS)

Employee name: First, Middle Initial, Last	Social Security Number
Home Address	
City	State Zip Code

I hereby declare that, under penalties of perjury, I am a resident of the state checked below:

☐ INDIANA ☐ MARYLAND ☐ OHIO ☒ NEW JERSEY ☐ VIRGINIA ☐ WEST VIRGINIA

and that pursuant to the reciprocal agreement between those states, I claim an exemption from withholding of Pennsylvania 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.

Employee's Signature	Date

(EMPLOYER COMPLETES INFORMATION BELOW)

Employer Name: PHEC d/b/a Drexel University College of Medicine	Federal Employer Identification Number (EIN) 23-2979433
Business Address Payroll Dept, 3201 Arch St, Ste 400	Telephone Number (215) 895-1423
City Philadelphia	State PA Zip Code 19104

DREXEL UNIVERSITY
COLLEGE OF MEDICINE

University Policy Acknowledgement

Acknowledgement of Responsibility to Read and Comply with all University Policies including Conflict of Interest and Commitment, Confidentiality, and Code of Conduct.

This is to acknowledge that I have been advised of the web-based Drexel University Human Resources Policies and Procedures, which can be accessed at www.drexel.edu/admin/hr_hs/policies/index.html. I understand that this section outlines my privileges and obligations as an employee of Drexel University. I further understand that I am governed by the contents of the Policies and Procedures and that it is my responsibility to familiarize myself with all the information in the Policies and Procedures section of the website.

I further understand that as a member of the Drexel University community, it is my obligation to read, comply with, and act in accordance to the principles and standards as stated in the Conflict of Interest and Commitment Policy (http://www.drexel.edu/generalcounsel/medpolicies/OGC-1/), the Confidentiality Policy (http://www.drexel.edu/hr/resources/policies/ducompolicies/hr50/), and the Code of Conduct (http://www.drexel.edu/generalcounsel/medpolicies/OGC-5/).

Since information, policies and benefits described in the Policies and Procedures are subject to change, I understand and agree that such changes can be made by the University in its sole and absolute discretion, and I agree to observe those changes in all respects.

If I have any questions about any of the material in the Policies and Procedures, I will direct my questions to my supervisor and/or the Human Resources Department.

Employee Name _____ Date _____

Employee Signature _____

Department _____

DREXEL UNIVERSITY
COLLEGE OF MEDICINE

Acknowledgement of DrexelOne Portal for Employee Services

Upon being granted access to the DrexelOne Portal (http://one.drexel.edu), I acknowledge that I may obtain my personnel and payroll information. Human Resources has informed me of this valuable option.

The DrexelOne Portal contains specific real-time facts and figures for your student and/or employee records. By signing below, you certify that you have been made aware of the Employee Services section within DrexelOne.

Information available online through the DrexelOne Portal for each active employee includes:

-Benefits and Deductions
-Payroll Information (history included)
-Tax Forms
-Current and Past Jobs
-Time Reporting and Leave Balances
-Timesheet/Leave Report

Employee Name _____ Date _____

Employee Signature _____

Department _____

DREXEL UNIVERSITY COLLEGE OF MEDICINE

Compliance Hotlines

Drexel University College of Medicine (DUCOM) is committed to conducting its affairs in full compliance with the law and its own policies and procedures. Such adherence strengthens and promotes ethical and fair practices and treatment of all members of the College and those who conduct business with it.

While we have developed and implemented internal controls and procedures that we hope will deter and prevent improper conduct, there is an easy and confidential way for members of the University community to bring instances of suspected improper conduct to the attention of someone who can be counted upon to investigate the problem promptly and fairly, without any fear of retaliation.

The following hotline may be used to report any improper conduct to the College's Chief Compliance Officer:

866.936.1010 or https://secure.ethicspoint.com/domain/en/report_custom.asp?clientid=13963

This hotline was created at the specific direction of the Board of Trustees. Every report is kept completely confidential. No information likely to reveal your identity will be shared with anyone else without your permission. Reporters will be completely protected from retaliation for having made good faith reports. The Chief Compliance Officer is required to report quarterly to the Audit Committee of the Board of Trustees on all matters reported to the hotline and the actions taken in response.

If you are aware of any conduct--act or omission--which you think violates College policy, rule or regulation, you are encouraged to report them to your supervisor or teacher, your Department Head, your Dean, or a Vice President; or to use the hotline. We owe it to ourselves to make this the best place it can be.

Questions about the hotline may be addressed to the Chief Compliance Officer:

Ed Longazel, Edward.Longazel@drexelmed.edu

The University/College policies governing the hotline may be found at: www.drexel.edu/generalcounsel/medpolicies/OGC-7/

DREXEL UNIVERSITY
COLLEGE OF MEDICINE

TO: All New Employees
FROM: Michele M. Rovinsky, JD, Associate Vice President, Equality and Diversity
Office of Equality and Diversity
RE: Equal Opportunity and Non-Discrimination at Drexel University

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Welcome to the Drexel University community.

Drexel is committed to providing to all qualified individuals an equal employment opportunity in a welcoming, inclusive, respectful, engaging, and diverse work environment free from unlawful discrimination. The University specifically prohibits discrimination based on race, color, religion, national origin, gender, pregnancy, sexual orientation, gender identity and expression, age, disability, veteran status, and any other prohibited characteristic.

Information on the University's equality and diversity programs and related University policies and applicable federal, state and local laws can be found on the Office of Equality and Diversity's website at http://www.drexel.edu/oed.

The University's WIRED for Success Guide is intended as a resource for supporting our welcoming, inclusive, respectful, engaging, and diverse ("WIRED") community and for preparing our students to be leaders in the workforces of the future. The WIRED for Success Guide includes links to University resources and tips for best practices for understanding and respecting our differences and creating a WIRED community to support all members of our diverse and global community. Please take a moment to review this Guide at http://www.drexel.edu/intercultural/.

MANDATORY ONLINE PROGRAM: As a new full or part-time faculty or professional staff member, you are required to complete an online discrimination, harassment, and retaliation prevention program. This program, entitled Preventing Workplace Harassment must be completed within the first 90 days of your start date. The link for the program can be found on the Office of Equality and Diversity's website (under "Training and Education" located in the top navigation bar).

If you have any questions or concerns related to equal opportunity, discrimination, harassment, or retaliation, please contact the Office of Equality and Diversity at (215) 895-1405 or by e-mail at mrovinsky@drexel.edu.

I wish you a successful and rewarding work experience at Drexel.

DREXEL UNIVERSITY
COLLEGE OF MEDICINE

Workers' Compensation Information

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.

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.

You should report immediately any injury or work-related illness to your employer.

Your benefits could be delayed or denied if you do not notify your employer immediately.

If your claim is denied by your employer, you have the right to request a hearing before a workers' compensation judge.

The Bureau of Workers' Compensation cannot provide legal advice. However, you may contact the Bureau of Workers' Compensation for additional general information at: 1171 South Cameron St, 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.

I hereby acknowledge receipt of the "WORKERS' COMPENSATION INFORMATION" form.

Employee Signature _____ Date _____

DREXEL UNIVERSITY
COLLEGE OF MEDICINE

Notice to Employee and Employee Acknowledgement of Rights and Responsibilities for Work Related Injuries

If you suffer a work related injury or illness, your employer or its workers' compensation insurance company must pay for medical and surgical services, services rendered by physicians or other health care providers, medicines and supplies, which are reasonable, necessary and related to the work related injury.

Your employer has posted in the work place at least six designated health care providers. In order to ensure that your reasonable and necessary medical treatment and supplies will be paid for by your employer or its workers' compensation insurance company during the first 90 days of treatment, you must select and visit one of the listed health care providers, and continue to visit that health care provider or another of the listed health care providers for a period of ninety (90) days from the date of the first visit. As required by law, this list will include no more than four (4) coordinated care organization (as approved by the state), and no fewer than three (3) physicians. You are permitted to switch from one health provider on the list to another health care provider on the list during the ninety (90) day period.

The employer is not permitted to include on this list a physician or health care provider who is employed, owned or controlled by your employer or its workers' compensation carrier unless that employment, ownership or control is disclosed on the list.

You have the right to seek treatment from a provider not appearing on the list (referral provider) if you **are referred** to such provider by one of the designated providers appearing on the list: Your employer shall pay for the reasonable and necessary treatment rendered by a designated provider for the remainder of the ninety (90) day period.

You have the right to seek emergency medical treatment from any provider, but subsequent non-emergency treatment shall be rendered by a designated provider for the remainder of the ninety (90) day period.

If one of the designated providers prescribes or recommends invasive surgery, you may seek and receive an additional option from any health care provider of your own choice. The charge for this consultation will be paid by your employer or its workers' compensation insurance carrier. If the additional opinion differs from the opinion provided by the designated provider, you may choose which course of treatment to follow: provided, however, that the second opinion includes a specific and detailed course of treatment. If you choose to follow the providers designated in the additional or second opinion, such procedures shall be performed by one of the designated providers for a period of ninety (90) days from the date of your visit to the physician rendering the second additional opinion.

With regard to, all other treatment (i.e. that not involving invasive surgery) you have the right to seek treatment or medical consultation from a non-designated provider during the ninety (90) day period, but such services shall be at your own expense during the applicable period of ninety (90) days.

Following the first ninety (90) days of treatment with the designated physician or other health care provider, subsequent treatment may be provided by any health care practitioner of your own choice. You must notify your employer that your care has been transferred to a non-designated provider within five (5) days of your first visit to the non-designated provider of your choice. Your employer may not be required to pay for treatment rendered by a non-designated provider prior to receiving this notification. However, the employer shall pay for these services once notified, unless the treatment is found to be unreasonable by a Utilization Review Organization.

I, _____ hereby acknowledge that I have received this notice, and that I understand my rights and responsibilities as set forth by Drexel University College of Medicine.

Employee Signature _____ Date _____

University ID _____

DREXEL UNIVERSITY COLLEGE OF MEDICINE

Designated Health Care Providers

THE FOLLOWING PROCEDURE MUST BE FOLLOWED IN CASE OF WORK RELATED INJURY OR ILLNESS:

A. IMMEDIATELY REPORT THE INJURY TO YOUR SUPERVISOR.

Any injury you sustain at work must be reported immediately to your supervisor. **Failure to do so may delay your benefits or cause you to lose your rights to benefits**. Supervisors must promptly report injuries to the OFFICE OF RISK MANAGEMENT by calling (215)255-7838 or faxing incident report to (215)255-7856.

B. OBTAIN MEDICAL CARE FROM A MEDICAL HEALTH CARE PROVIDER LISTED BELOW.

Provider	Address/Phone Number	Specialty
WORKNET OCCUPATIONAL HEALTH ***TREATMENT AVAILABLE :*** ***ALL NON LIFE-THREATENING INJURIES***	HAHNEMANN UNIVERSITY HOSPITAL BROAD & VINE STREETS PHILADELPHIA, PA 19102 PHONE (215)762-8525	PRIMARY CARE ***FREE TRANSPORTATION,*** ***HOSPITAL ACCESSIBILITY***
NOVACARE OCCUPATIONAL HEALTH	MANY LOCATIONS AVAILABLE THROUGHOUT PHILA PHONE (800)770-NOVA	PHYSICAL THERAPY
ROBERT T. SATALOFF, MD, DMA, SACS**	1721 PINE ST, PHILA, PA 19103 219 N. BROAD ST, PHILA, PA 19102 PHONE (215)545-3322	EAR, NOSE AND THROAT HEAD AND NECK SURGERY
HAHNEMANN ORTHOPEDICS	HAHNEMANN UNIVERSITY HOSPITAL BROAD & VINE STS, PHILA, PA 19102 PHONE (215)762-2663	ALL ORTHOPEDIC CARE
GEORGE AMROM, MD** MICHAEL MARCUCCI, MD**	219 N. BROAD ST, 8TH FL, PHILA, PA 19107 PHONE (215)762-3430	GENERAL SURGERY
DREXEL UNIVERSITY COLLEGE OF MEDICINE DEPT. OF NEUROLOGY**	219 N. BROAD ST, 7TH FL, PHILA, PA 19107 PHONE (215)762-6915	NEUROLOGY
ABHAY J. DHOND, MD, MPH	219 N. BROAD ST, 8TH FL, PHILA, PA 19107 PHONE (215)762-6900	INTERNAL MEDICINE
DREXEL EYE ASSOCIATES**	219 N. BROAD ST, 3RD FL, PHILA PA 19107 PHONE (215)762-3937	OPHTHALMOLOGY
PHILADELPHIA HAND CENTER	834 CHESTNUT ST,PHILA, PA 19107 1-800-971-4263	HAND/WRIST
PENNSYLVANIA ORTHOPEDIC FOOT AND ANKLE SURGEONS	230 W. WASHINGTON SQ, 5TH FL,PHILA, PA 19106 PHONE (215)829-3668	FOOT & ANKLE SURGERY
DREXEL DERMATOLOGY ASSOCIATES**	219 N. BROAD ST, 4TH FL, PHILA, PA 19102 PHONE (215)762-5550	DERMATOLOGY
NABIL ABAZA, DMD, Ph.D.**	207 N. BROAD ST, 8TH FL, PHILA, PA 19107 (215)561-0562	ORAL SURGEON/ MAXILLOFACIAL SURGEON

** INDICATES THAT THE PROVIDER IS EMPLOYED AND/OR OPERATED BY DREXEL UNIVERSITY COLLEGE OF MEDICINE

C. MEDICAL EMERGENCY:

If you are faced with a medical emergency, **you may secure initial emergency treatment from any emergency facility.** However,any follow-up care to the emergency treatment must be with a designated health care provider.

D. FOR MEDICAL TREATMENT TO BE PAID BY YOUR EMPLOYER:

1. **You must select one of the providers listed above**. If you choose to seek treatment from a provider not listed above within the first ninety (90) days of treatment **you will be held responsible for costs incurred.**
2. **You must continue** to visit one of the providers listed above or any specialist to which that provider refers you, if you need treatment, for **ninety (90) days from the date of your first visit.** This requirement is in conformance with the Pennsylvania Workers' Compensation Act, Section 306 (F) (1) (i).
3. **After Ninety (90) days,** if you still need treatment, you may continue with the same provider or you may choose to go to another provider for treatment. **If you decide to go to another provider, you must notify your employer of this action within five (5)days of your visit.**
4. You have the right to seek an additional opinion form any health care provider of your choice when a designated provider prescribes invasive surgery. If the additional opinion differs from the opinion of the designated provider, you shall determine what course of treatment to follow.

DREXEL UNIVERSITY
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Requirement to Review Policy OCG 7.01 within 30 days of hire

Policy OGC 7.01: Federal and State False Claims Statues

The Deficit Reduction Act of 2005 requires that The Drexel University College of Medicine develop policies regarding Federal and State False Claims Statues and that all employees of the providers be educated about the policy. Please read Policy OGC - 7.01 at www.drexel.edu/admin/hr_hs/policies/DU-OGC-7_01.htm.

Drexel Med takes compliance with the federal and state false claims laws seriously. Any employee who becomes aware of a violation or potential violation of such laws, or any fraudulent or potentially fraudulent conduct for that matter, is expected to report the same immediately. Employees, including Drexel Med management, contractors, and agents, shall review, understand, and follow Policy OGC - 7, Reporting Allegations, and Policy OGC - 7.01, Federal and False Claim Statues found on the Human Resources policy page which sets forth general procedures for reporting and investigating suspected fraud. Employees may direct questions regarding the policy to their immediate supervisors or to Drexel Med's Chief Compliance and Privacy Officer.

Drexel Med encourages employees initially to report compliance concerns to their immediate supervisors, when appropriate. In the alternative, reports may be made to Drexel Med's Compliance Hotline (at 866-936-1010 or on the web at www.drexelmed.edu/ComplianceHotline) or directly to the Chief Compliance Officer at 215-255-7819. Any information that employees provide in good faith to their supervisors, or any member of the administration or the Chief Compliance Officer, will be kept in confidence to the extent feasible and legal. In the event of a government investigation or lawsuit, or if the need otherwise arises for Drexel Med to disclose the information, such information may be disclosed at the direction of legal counsel.

Drexel Med will not take adverse action against an employee for reasonably requesting assistance from, or reporting potential violations of law or Drexel Med policy in good faith to, a supervisor, the Compliance Hotline, or the Chief Compliance Officer. By reporting his or her own misconduct, however, an employee will not insulate himself or herself from potential disciplinary action for such a violation. Employees should report concerns about possible retaliation or harassment to the Chief Compliance Officer.

Drexel Med will not tolerate abuse of the reporting process. Any employee who makes an intentionally false statement, or makes a report of alleged misconduct in bad faith, shall be subject to appropriate disciplinary action. Signature below denotes agreement to review policy OGC-7.01.

Employee Signature _____ Date _____

Employee Name _____

Department _____

Office of the General Counsel
Three Parkway, 1601 Cherry Street, Mail Stop 11622, Philadelphia, PA 19102-1192 TEL 215.255.7818 FAX 215.255-7816

DREXEL UNIVERSITY
COLLEGE OF MEDICINE

Acknowledgment of Responsibility to Read and Comply with HIPAA Privacy and Security Awareness and Training

Required within 30 Days of Hire

HIPAA Security regulations require the College of Medicine to ensure the confidentiality, integrity and availability of all electronic protected health information also known as "e- P H I." We meet our responsibility by educating the entire workforce of the School as appropriate for the position or role held by each individual while at work. Non-clinical faculty and staff and those not directly involved in human subject research (e.g. Basic Science faculty and staff) need only read this to meet the training requirements for the nature of the work performed for the School. A signed copy of this form should be retained as proof of training for the supervisor.

Note that if one is employed in clinically active role (involved with patients as a clinician and/or employed in a clinical department in any job/role/function) or involved in human subject's research specific different training requirements apply and must be completed within 30 days of hire.

Once "Clinically active" all faculty and staff must complete web training at: http://webcampus.drexelmed.edu/hipaa/

Once involved in Human Subjects research all faculty and staff must also complete the web training at: https://apps.research.drexel.edu/train/login.asp

The goal of the Privacy Program is to protect all electronic protected health information including information created, received, stored or maintained and/or transmitted electronically using any electronic media whether `storage media" or "transmission media". Included for example are desktop computers, laptops, PDAs, tapes, diskettes, CD ROM, DVD, and USB stick type memory resources. Penalties for HIPAA Security violations escalate according to severity of the e-PHI breach. Basic violations are calculated at the rate of $ 100 per person per violation and not more than $ 25,000. Penalties for "Knowing misuse of e-PHI" escalate according to the purpose of the misuse. No more than $ 50,000 and not more than one year imprisonment may be assigned for knowing misuse without misrepresentation, profit or malicious intent. Misuse under false pretenses carries a fine of not more than $ 100,000 and not more than five years in prison. Misuse with intent to sell, for personal gain or with malicious intent renders a fine of not more than $ 250,000 and/or imprisonment of not more than 10 years.

HIPPA Security violations will be investigated by the HIPAA Security Officer and the HIPAA Privacy Officer in consultation with department administration and the appropriate Dean or Vice-President. If you have any questions concerning information or network security please contact the Privacy Officer at 215-255-7819 or call the Confidential HOTLINE at 866-936-1010. Report any unusual e-mail activity immediately to 215-762-1999.

Name _____

Department _____

Signature _____ Date _____

Office of the General Counsel
Three Parkway, 1601 Cherry Street, Mail Stop 11622, Philadelphia, PA 19102-1192 **TEL** 215.255.7818 **FAX** 215.255-7816