

Delta College Corporate Services BPSC (on assignment at Dow)

Payroll /Orientation Information

The following forms must be completed and returned to the Human Resources Office, J101, in order to be placed on payroll. A signed copy of this page must be submitted to Human Resources, by signing you have acknowledged receipt of the policies listed below. Questions should be directed to the department responsible for providing you with payroll packet, or Human Resources at (989)686-9107.

Employee Name:							
Home Phone #:			Date of Hire:				
Address:							
ETHNICITY: (please circle one) (1-Not Hispanic or Latino) (2-Hispanic or Latino)			GENDER: (please circle one) (1-Female) (2- Male)				
RACE: (please circle one or more): (African American) (American Indian or Alaskan Native) (Asian) (Caucasian) (Native Hawaiian or Other Pacific Island)							
<input type="checkbox"/>	Emergency Information	<input type="checkbox"/>	W-4 Form - Federal	<input type="checkbox"/>	W-4 Form - Michigan	<input type="checkbox"/>	SW-4 Form (City of Saginaw Residents Only)
Employment Eligibility Verification Form (I-9) (identification required - refer to form for options) Form must be completed within 3 business days of the date employment begins. Original documentation must be presented.							
Michigan Public School Employees Retirement System - New Employees will receive their Member ID in a personalized Welcome Letter. This letter will direct you to login to the miAccount where you can nominate a beneficiary. You should receive your Member ID personalized Welcome Letter approximately two weeks after your first pay period. MPSERS website							
Direct Deposit - OPTIONAL FORM – Employees not selecting direct deposit must pick up their checks at the Cashier’s Office.							
Drug Free Work Place Act							
Hepatitis B Vaccination Acknowledgement and Release Form – Required for Category A Employees only							
Health / Dental Enrollment Forms (Employee self pay option available) Benefits Summary and Health/Dental rates							
All new employees are required to review each of the items listed below							
Family Medical Leave Act – Employees Rights and Responsibilities							
HIPAA(Health Insurances Portability and Accountability Act)							
Notice Regarding Medicare and Your Prescription Drug Coverage							
Injury/Accident Reporting							
Regulations and Rules of Conduct							
Required Training Modules: Bloodborne Pathogens, Sexual Harassment, Diversity, FFERPA, Hazard Communications							
Additional Information							
Delta College’s Vision, Mission and Values							
Electronic Resources-For access to Delta's electronic resources go through the signup process at https://signup.delta.edu/default.aspx You must have completed and returned your payroll paperwork prior to sign up.							
Tax Sheltered Annuities Program Participation Details							
Payroll dates - employees are paid biweekly on Fridays for the previous 2 weeks (7 days in arrears)							

By signing this form, you are verifying that you have completed the payroll forms and have received information related to the topics listed above.

Employee Signature: _____ Date: _____

DELTA COLLEGE EMERGENCY INFORMATION

Name: _____

_____ Full-Time

_____ Part-Time

Position: _____

_____ Faculty

_____ Staff

IN CASE OF AN EMERGENCY NOTIFY

First Choice

Name: _____

Address: _____

Day Phone: _____

Evening Phone: _____

Relationship: _____

Second Choice

Name: _____

Address: _____

Day Phone: _____

Evening Phone: _____

Relationship: _____

Do you have any health and/or medication information you want the College to know in the event of emergency situations:

Additional Comments:

Form W-4 (2012)

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 2012 expires February 18, 2013. 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 \$950 and includes more than \$300 of unearned income (for example, interest and dividends).

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

income, see Pub. 505 to find out if you should adjust your withholding on Form W-4 or W-4P.

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

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

Check your withholding. After your Form W-4 takes effect, use Pub. 505 to see how the amount you are having withheld compares to your projected total tax for 2012. See Pub. 505, especially if your earnings exceed \$130,000 (Single) or \$180,000 (Married).

Future developments. The IRS has created a page on www.irs.gov for information about Form W-4, at www.irs.gov/w4. Information about any future developments affecting Form W-4 (such as legislation enacted after we release it) will be posted on that page.

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: <ul style="list-style-type: none"> • 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 \$1,900 of child or dependent care expenses for which you plan to claim a credit	F _____
G	Child Tax Credit (including additional child tax credit). See Pub. 972, Child Tax Credit, for more information. <ul style="list-style-type: none"> • If your total income will be less than \$61,000 (\$90,000 if married), enter "2" for each eligible child; then less "1" if you have three to seven eligible children or less "2" if you have eight or more eligible children. • If your total income will be between \$61,000 and \$84,000 (\$90,000 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. <ul style="list-style-type: none"> • 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 \$40,000 (\$10,000 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	<h2 style="margin: 0;">Employee's Withholding Allowance Certificate</h2> <p style="margin: 0;">▶ 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.</p>	OMB No. 1545-0074 <div style="font-size: 2em; font-weight: bold; text-align: center;">2012</div>
1 Your first name and middle initial	Last name	2 Your social security number
Home address (number and street or rural route)		3 <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> 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. ▶ <input type="checkbox"/>
5 Total number of allowances you are claiming (from line H above or from the applicable worksheet on page 2)	6 Additional amount, if any, you want withheld from each paycheck	5 _____ 6 \$ _____
7 I claim exemption from withholding for 2012, and I certify that I meet both of the following conditions for exemption. <ul style="list-style-type: none"> • 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 2012 itemized deductions. These include qualifying home mortgage interest, charitable contributions, state and local taxes, medical expenses in excess of 7.5% of your income, and miscellaneous deductions	1	\$ _____
2	Enter: $\left\{ \begin{array}{l} \$11,900 \text{ if married filing jointly or qualifying widow(er)} \\ \$8,700 \text{ if head of household} \\ \$5,950 \text{ if single or married filing separately} \end{array} \right\}$	2	\$ _____
3	Subtract line 2 from line 1. If zero or less, enter “-0-”	3	\$ _____
4	Enter an estimate of your 2012 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 <i>Converting Credits to Withholding Allowances for 2012 Form W-4</i> worksheet in Pub. 505.)	5	\$ _____
6	Enter an estimate of your 2012 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 \$3,800 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 2012. For example, divide by 26 if you are paid every two weeks and you complete this form in December 2011. 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

Table 2

Married Filing Jointly		All Others		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	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 - \$5,000	0	\$0 - \$8,000	0	\$0 - \$70,000	\$570	\$0 - \$35,000	\$570
5,001 - 12,000	1	8,001 - 15,000	1	70,001 - 125,000	950	35,001 - 90,000	950
12,001 - 22,000	2	15,001 - 25,000	2	125,001 - 190,000	1,060	90,001 - 170,000	1,060
22,001 - 25,000	3	25,001 - 30,000	3	190,001 - 340,000	1,250	170,001 - 375,000	1,250
25,001 - 30,000	4	30,001 - 40,000	4	340,001 and over	1,330	375,001 and over	1,330
30,001 - 40,000	5	40,001 - 50,000	5				
40,001 - 48,000	6	50,001 - 65,000	6				
48,001 - 55,000	7	65,001 - 80,000	7				
55,001 - 65,000	8	80,001 - 95,000	8				
65,001 - 72,000	9	95,001 - 120,000	9				
72,001 - 85,000	10	120,001 and over	10				
85,001 - 97,000	11						
97,001 - 110,000	12						
110,001 - 120,000	13						
120,001 - 135,000	14						
135,001 and over	15						

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.

MI-W4

(Rev. 08-11)

EMPLOYEE'S MICHIGAN WITHHOLDING EXEMPTION CERTIFICATE STATE OF MICHIGAN - DEPARTMENT OF TREASURY

This certificate is for Michigan income tax withholding purposes only. You must file a revised form within 10 days if your exemptions decrease or your residency status changes from nonresident to resident. Read instructions below before completing this form.

Issued under P.A. 281 of 1967.

▶ 1. Social Security Number		▶ 2. Date of Birth	
▶ 3. Type or Print Your First Name, Middle Initial and Last Name		4. Driver's License Number or State ID	
Home Address (No., Street, P.O. Box or Rural Route)		▶ 5. Are you a new employee?	
City or Town		<input type="checkbox"/> Yes If Yes, enter date of hire <input type="checkbox"/> No	
State		ZIP Code	
6. Enter the number of personal and dependent exemptions you are claiming		▶ 6. <input style="width:50px;" type="text"/>	
7. Additional amount you want deducted from each pay (if employer agrees)		7. \$ _____ .00	
8. I claim exemption from withholding because (does not apply to nonresident members of flow-through entities - see instructions): a. <input type="checkbox"/> A Michigan income tax liability is not expected this year. b. <input type="checkbox"/> Wages are exempt from withholding. Explain: _____ c. <input type="checkbox"/> Permanent home (domicile) is located in the following Renaissance Zone: _____			
EMPLOYEE: If you fail or refuse to file this form, your employer must withhold Michigan income tax from your wages without allowance for any exemptions. Keep a copy of this form for your records.		<i>Under penalty of perjury, I certify that the number of withholding exemptions claimed on this certificate does not exceed the number to which I am entitled. If claiming exemption from withholding, I certify that I anticipate that I will not incur a Michigan income tax liability for this year.</i>	
		9. Employee's Signature	
		▶ Date	
INSTRUCTIONS TO EMPLOYER: Employers must report all new hires to the State of Michigan. Keep a copy of this certificate with your records. If the employee claims 10 or more personal and dependent exemptions or claims a status exempting the employee from withholding, you must file their original MI-W4 form with the Michigan Department of Treasury. Mail to: New Hire Operations Center, P.O. Box 85010; Lansing, MI 48908-5010.		Employer: Complete lines 10 and 11 before sending to the Michigan Department of Treasury. 10. Employer's Name, Address, Phone No. and Name of Contact Person	
		▶ 11. Federal Employer Identification Number	
		<input style="width:150px; height:20px;" type="text"/>	

INSTRUCTIONS TO EMPLOYEE

You must submit a Michigan withholding exemption certificate (form MI-W4) to your employer on or before the date that employment begins. If you fail or refuse to submit this certificate, your employer must withhold tax from your compensation without allowance for any exemptions. Your employer is required to notify the Michigan Department of Treasury if you have claimed 10 or more personal and dependent exemptions or claimed a status which exempts you from withholding.

You MUST file a new MI-W4 within 10 days if your residency status changes or if your exemptions decrease because: a) your spouse, for whom you have been claiming an exemption, is divorced or legally separated from you or claims his/her own exemption(s) on a separate certificate, or b) a dependent must be dropped for federal purposes.

Line 5: If you check "Yes," enter your date of hire (mo/day/year).

Line 6: Personal and dependent exemptions. The total number of exemptions you claim on the MI-W4 may not exceed the number of exemptions you are entitled to claim when you file your Michigan individual income tax return.

If you are married and you and your spouse are both employed, you both may not claim the same exemptions with each of your employers.

If you hold more than one job, you may not claim the same exemptions with more than one employer. If you claim the same exemptions at more than one job, your tax will be under withheld.

Line 7: You may designate additional withholding if you expect to owe more than the amount withheld.

Line 8: You may claim exemption from Michigan income tax withholding ONLY if you do not anticipate a Michigan income tax liability for the current year because all of the following exist: a) your employment is less than full time, b) your personal and dependent exemption allowance exceeds your annual compensation, c) you claimed exemption from federal withholding, d) you did not incur a Michigan income tax liability for the previous year. You may also claim exemption if your permanent home (domicile) is located in a Renaissance Zone or you are a non-resident spouse of military personnel stationed in Michigan. Members of flow-through entities may not claim exemption from nonresident flow-through withholding. For more information on Renaissance Zones call (517) 636-4486. Full-time students that do not satisfy all of the above requirements cannot claim exempt status.

Visit the Treasury Web site at: www.michigan.gov/taxes

Form SW-4 Instructions - revised 1/05/10

Purpose: Complete form SW-4 so your employer can withhold the correct amount of city income taxes from your pay.

Dependents: To qualify as your dependent (line 4 below), a person

- (a) Must receive more than one-half of his or her support from you for the year, and
- (b) Must have less than \$750.00 gross income during the year (except your child who is a student or who is under 19 years of age, and
- (c) Must not be claimed as an exemption by such person's husband or wife, and
- (d) Must be a citizen or resident of the United States, and
- (e) Must have your home as his/her principal residence and be a member of your household for the entire year, or Must be related to you as follows: Your son or daughter, grandchild, step-son/daughter, son/daughter-in-law, father, mother, grandparent, step-father/mother, father/mother-in-law, brother, sister, stepbrother/sister, half brother/sister, brother/sister-in-law, uncle, aunt, nephew, or niece **(but only if related by blood)**.

Changes in exemptions: You **must** file a new certificate within 10 days if the number of exemptions previously claimed by you **decreases** for any of the following reasons:

- (a) Your wife/husband for whom you have been claiming exemption is divorced or legally separated, or claims her/his own exemption on a separate certificate.
- (b) The support of a dependent for whom you claimed exemption is taken over by someone else.
- (c) You find that a dependent for whom you claimed exemption will receive \$750.00 or more income of his/her own during the year (except your child who is a student and who is under 19 years of age).

Other Decreases: Such as the death of a wife, husband, or a dependent, do not affect your withholding until the next year, but require the filing of a new certificate by December 1 of the year in which they occur.

Change of Residence: You **must** file a new certificate within 10 days after you change your residence from or to a taxing city.

Employee: File this form with your employer. Otherwise your employer must withhold City of Saginaw income tax from your earnings without exemptions.

Employer: Keep this certificate with your record. If the information submitted by the employee is not believed to be true, correct and complete the **City of Saginaw** must be advised.

FORM SW-4		EMPLOYEE'S WITHHOLDING CERTIFICATE FOR CITY OF SAGINAW INCOME TAX		
<input type="checkbox"/> City Resident or <input type="checkbox"/> Non-City Resident		Your Social Security Number:		
Full Name: (First, Middle and Last Name)		Home Address: (Number & Street)		
City:		State:	Zip Code:	
Main place of employment: Print name of each city where you work for this employer and circle closest % of total earnings in each. This is for withholding purposes only.		City:	Under 25% <input type="checkbox"/> 40% <input type="checkbox"/> 60% <input type="checkbox"/> 80% <input type="checkbox"/> 100% <input type="checkbox"/>	
		City:	Under 25% <input type="checkbox"/> 40% <input type="checkbox"/> 60% <input type="checkbox"/> 80% <input type="checkbox"/> 100% <input type="checkbox"/>	
1. Exemptions for yourself: <input type="checkbox"/> Yourself <input type="checkbox"/> age 65 or over <input type="checkbox"/> Blind		2. Exemptions for your spouse: <input type="checkbox"/> Yourself <input type="checkbox"/> age 65 or over <input type="checkbox"/> Blind		3. Enter Total number of boxes checked in 1& 2:
4. Other Exemptions: Number of exemptions _____ for your children Number of exemptions _____ for your other dependents			5. Enter total number of Other Exemptions in box 4 below:	
6. Add the number of exemptions which you have claimed in box 3 & 5 and write the total below:		7. Write the additional amounts you want withheld from each paycheck, if any:		
Employer's Name and Address:				
I certify that the information submitted on this certificate is true, correct and complete to the best of my knowledge and belief.				
SIGNATURE:			DATE:	

Instructions**Read all instructions carefully before completing this form.**

Anti-Discrimination Notice. It is illegal to discriminate against any individual (other than an alien not authorized to work in the United States) in hiring, discharging, or recruiting or referring for a fee because of that individual's national origin or citizenship status. It is illegal to discriminate against work-authorized individuals. Employers **CANNOT** specify which document(s) they will accept from an employee. The refusal to hire an individual because the documents presented have a future expiration date may also constitute illegal discrimination. For more information, call the Office of Special Counsel for Immigration Related Unfair Employment Practices at 1-800-255-8155.

What Is the Purpose of This Form?

The purpose of this form is to document that each new employee (both citizen and noncitizen) hired after November 6, 1986, is authorized to work in the United States.

When Should Form I-9 Be Used?

All employees (citizens and noncitizens) hired after November 6, 1986, and working in the United States must complete Form I-9.

Filling Out Form I-9**Section 1, Employee**

This part of the form must be completed no later than the time of hire, which is the actual beginning of employment.

Providing the Social Security Number is voluntary, except for employees hired by employers participating in the USCIS Electronic Employment Eligibility Verification Program (E-Verify). **The employer is responsible for ensuring that Section 1 is timely and properly completed.**

Noncitizen nationals of the United States are persons born in American Samoa, certain former citizens of the former Trust Territory of the Pacific Islands, and certain children of noncitizen nationals born abroad.

Employers should note the work authorization expiration date (if any) shown in **Section 1**. For employees who indicate an employment authorization expiration date in **Section 1**, employers are required to reverify employment authorization for employment on or before the date shown. Note that some employees may leave the expiration date blank if they are aliens whose work authorization does not expire (e.g., asylees, refugees, certain citizens of the Federated States of Micronesia or the Republic of the Marshall Islands). For such employees, reverification does not apply unless they choose to present

in Section 2 evidence of employment authorization that contains an expiration date (e.g., Employment Authorization Document (Form I-766)).

Preparer/Translator Certification

The Preparer/Translator Certification must be completed if **Section 1** is prepared by a person other than the employee. A preparer/translator may be used only when the employee is unable to complete **Section 1** on his or her own. However, the employee must still sign **Section 1** personally.

Section 2, Employer

For the purpose of completing this form, the term "employer" means all employers including those recruiters and referrers for a fee who are agricultural associations, agricultural employers, or farm labor contractors. Employers must complete **Section 2** by examining evidence of identity and employment authorization within three business days of the date employment begins. However, if an employer hires an individual for less than three business days, **Section 2** must be completed at the time employment begins. Employers cannot specify which document(s) listed on the last page of Form I-9 employees present to establish identity and employment authorization. Employees may present any List A document **OR** a combination of a List B and a List C document.

If an employee is unable to present a required document (or documents), the employee must present an acceptable receipt in lieu of a document listed on the last page of this form. Receipts showing that a person has applied for an initial grant of employment authorization, or for renewal of employment authorization, are not acceptable. Employees must present receipts within three business days of the date employment begins and must present valid replacement documents within 90 days or other specified time.

Employers must record in Section 2:

1. Document title;
2. Issuing authority;
3. Document number;
4. Expiration date, if any; and
5. The date employment begins.

Employers must sign and date the certification in **Section 2**. Employees must present original documents. Employers may, but are not required to, photocopy the document(s) presented. If photocopies are made, they must be made for all new hires. Photocopies may only be used for the verification process and must be retained with Form I-9. **Employers are still responsible for completing and retaining Form I-9.**

For more detailed information, you may refer to the *USCIS Handbook for Employers (Form M-274)*. You may obtain the handbook using the contact information found under the header "USCIS Forms and Information."

Section 3, Updating and Reverification

Employers must complete **Section 3** when updating and/or reverifying Form I-9. Employers must reverify employment authorization of their employees on or before the work authorization expiration date recorded in **Section 1** (if any). Employers **CANNOT** specify which document(s) they will accept from an employee.

- A. If an employee's name has changed at the time this form is being updated/reverified, complete Block A.
- B. If an employee is rehired within three years of the date this form was originally completed and the employee is still authorized to be employed on the same basis as previously indicated on this form (updating), complete Block B and the signature block.
- C. If an employee is rehired within three years of the date this form was originally completed and the employee's work authorization has expired **or** if a current employee's work authorization is about to expire (reverification), complete Block B; and:

1. Examine any document that reflects the employee is authorized to work in the United States (see List A **or** C);
2. Record the document title, document number, and expiration date (if any) in Block C; and
3. Complete the signature block.

Note that for reverification purposes, employers have the option of completing a new Form I-9 instead of completing **Section 3**.

What Is the Filing Fee?

There is no associated filing fee for completing Form I-9. This form is not filed with USCIS or any government agency. Form I-9 must be retained by the employer and made available for inspection by U.S. Government officials as specified in the Privacy Act Notice below.

USCIS Forms and Information

To order USCIS forms, you can download them from our website at www.uscis.gov/forms or call our toll-free number at 1-800-870-3676. You can obtain information about Form I-9 from our website at www.uscis.gov or by calling 1-888-464-4218.

Information about E-Verify, a free and voluntary program that allows participating employers to electronically verify the employment eligibility of their newly hired employees, can be obtained from our website at www.uscis.gov/e-verify or by calling 1-888-464-4218.

General information on immigration laws, regulations, and procedures can be obtained by telephoning our National Customer Service Center at 1-800-375-5283 or visiting our Internet website at www.uscis.gov.

Photocopying and Retaining Form I-9

A blank Form I-9 may be reproduced, provided both sides are copied. The Instructions must be available to all employees completing this form. Employers must retain completed Form I-9s for three years after the date of hire or one year after the date employment ends, whichever is later.

Form I-9 may be signed and retained electronically, as authorized in Department of Homeland Security regulations at 8 CFR 274a.2.

Privacy Act Notice

The authority for collecting this information is the Immigration Reform and Control Act of 1986, Pub. L. 99-603 (8 USC 1324a).

This information is for employers to verify the eligibility of individuals for employment to preclude the unlawful hiring, or recruiting or referring for a fee, of aliens who are not authorized to work in the United States.

This information will be used by employers as a record of their basis for determining eligibility of an employee to work in the United States. The form will be kept by the employer and made available for inspection by authorized officials of the Department of Homeland Security, Department of Labor, and Office of Special Counsel for Immigration-Related Unfair Employment Practices.

Submission of the information required in this form is voluntary. However, an individual may not begin employment unless this form is completed, since employers are subject to civil or criminal penalties if they do not comply with the Immigration Reform and Control Act of 1986.

Read instructions carefully before completing this form. The instructions must be available during completion of this form.

ANTI-DISCRIMINATION NOTICE: It is illegal to discriminate against work-authorized individuals. Employers CANNOT specify which document(s) they will accept from an employee. The refusal to hire an individual because the documents have a future expiration date may also constitute illegal discrimination.

Section 1. Employee Information and Verification (To be completed and signed by employee at the time employment begins.)

Print Name: Last	First	Middle Initial	Maiden Name
Address (Street Name and Number)		Apt. #	Date of Birth (month/day/year)
City	State	Zip Code	Social Security #

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

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

- A citizen of the United States
- A noncitizen national of the United States (see instructions)
- A lawful permanent resident (Alien #) _____
- An alien authorized to work (Alien # or Admission #) _____ until (expiration date, if applicable - month/day/year)

Employee's Signature _____ Date (month/day/year) _____

Preparer and/or Translator Certification (To be completed and signed if Section 1 is prepared by a person other than the employee.) I attest, under penalty of perjury, that I have assisted in the completion of this form and that to the best of my knowledge the information is true and correct.

Preparer's/Translator's Signature	Print Name
Address (Street Name and Number, City, State, Zip Code)	
Date (month/day/year)	

Section 2. Employer Review and Verification (To be completed and signed by employer. Examine one document from List A OR examine one document from List B and one from List C, as listed on the reverse of this form, and record the title, number, and expiration date, if any, of the document(s).)

List A	OR	List B	AND	List C
Document title: _____		_____		_____
Issuing authority: _____		_____		_____
Document #: _____		_____		_____
Expiration Date (if any): _____		_____		_____
Document #: _____		_____		_____
Expiration Date (if any): _____		_____		_____

CERTIFICATION: I attest, under penalty of perjury, that I have examined the document(s) presented by the above-named employee, that the above-listed document(s) appear to be genuine and to relate to the employee named, that the employee began employment on (month/day/year) _____ and that to the best of my knowledge the employee is authorized to work in the United States. (State employment agencies may omit the date the employee began employment.)

Signature of Employer or Authorized Representative	Print Name	Title
Business or Organization Name and Address (Street Name and Number, City, State, Zip Code)		Date (month/day/year)

Section 3. Updating and Reverification (To be completed and signed by employer.)

A. New Name (if applicable)	B. Date of Rehire (month/day/year) (if applicable)	
C. If employee's previous grant of work authorization has expired, provide the information below for the document that establishes current employment authorization.		
Document Title: _____	Document #: _____	Expiration Date (if any): _____

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

Signature of Employer or Authorized Representative	Date (month/day/year)
--	-----------------------

LISTS OF ACCEPTABLE DOCUMENTS

All documents must be unexpired

LIST A

**Documents that Establish Both
Identity and Employment
Authorization**

LIST B

**Documents that Establish
Identity**

LIST C

**Documents that Establish
Employment Authorization**

OR

AND

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. Social Security Account Number card other than one that specifies on the face that the issuance of the card does not authorize employment in the United States
2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551)		2. Certification of Birth Abroad issued by the Department of State (Form FS-545)
3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa	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	3. Certification of Report of Birth issued by the Department of State (Form DS-1350)
4. Employment Authorization Document that contains a photograph (Form I-766)	3. School ID card with a photograph	4. 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. Voter's registration card	
5. In the case of a nonimmigrant alien authorized to work for a specific employer incident to status, a foreign passport with Form I-94 or Form I-94A bearing the same name as the passport and containing an endorsement of the alien's nonimmigrant status, as long as the 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	
	6. Military dependent's ID card	
	7. U.S. Coast Guard Merchant Mariner Card	
	8. Native American tribal document	
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	9. Driver's license issued by a Canadian government authority	6. U.S. Citizen ID Card (Form I-197)
	For persons under age 18 who are unable to present a document listed above:	7. Identification Card for Use of Resident Citizen in the United States (Form I-179)
	10. School record or report card	8. Employment authorization document issued by the Department of Homeland Security
	11. Clinic, doctor, or hospital record	
	12. Day-care or nursery school record	

Illustrations of many of these documents appear in Part 8 of the Handbook for Employers (M-274)



Delta College

DIRECT DEPOSIT

THIS PROCEDURE TAKES APPROXIMATELY ONE MONTH TO GO INTO EFFECT.

Direct deposit advices are delivered to employees online via MyDelta.

If you require a printed advice, please fill out the Opt-out form found on the Finance web page.

LIMIT – One direct deposit record PER bank/credit union with a maximum of two bank/credit unions in total.

Employee Name _____ Employee ID or Soc. Sec. No. _____
Employee Phone Number _____

NEW/ADDITIONAL DEPOSIT

Bank/Credit Union Name _____

(Payroll use only) Deposit code _____

Address _____ City, State _____

Bank Routing Number _____

Contact your Institution for this number

Type of account for Deposit _____ Checking _____ Savings

Account Number _____ Dollar Amount \$ _____

Enter 'Total Check' to have your entire check deposited or enter a specific dollar amount to have a portion of you check deposited

CHANGE

This is for changing the dollar amount or your account number only of an existing Direct Deposit at the same Institution. If you want to change to another Institution, you must cancel the existing Direct Deposit and fill out the New/Additional Deposit section of this form.

Bank/Credit Union Name _____

(Payroll use only) Deposit code _____

Type of account for Deposit _____ Checking _____ Savings

Change Account Number to _____

Change Dollar Amount to \$ _____

Enter 'Total Check' to have your entire check deposited or enter a specific dollar amount to have a portion of you check deposited

CANCEL

Cancellation requires five days notice.

Please cancel my existing Direct Deposit to _____

Institution Name

Account Number

AUTHORIZATION

I authorize Delta College and the financial institution listed to deposit my pay automatically to my account each payday. Adjusting entries to correct errors are also authorized. This authority will remain in effect until I have cancelled it in writing.

SIGNATURE _____

DATE _____

**DELTA COLLEGE POSITION STATEMENT
ON DRUG-FREE WORK PLACE ACT OF 1988**



By signing below, this indicates that I acknowledge receipt of the Delta College Position Statement on the Drug-Free Workplace Act of 1988.

Print Name

Human Resources Office

Employee Signature

Received by

Date

Date

INTRODUCTION

Under the Drug-Free Work Place Act of 1988 effective March 18, 1989, all Federal grant recipients are required to publish a statement, notifying employees that the unlawful manufacture, distributions, dispensation, possession, or use of a controlled substance is prohibited in the work place, specifying the sanctions that will take place against violators of their policy. The following is the position statement of Delta College pursuant to the requirements of such act.

DRUG-FREE WORK PLACE ACT OF 1988 STATEMENT

Senate Policy 2.035 (Regulations and Rules of Conduct) provides:

“No member of the college community shall manufacture, possess, distribute or use any prohibited drug in either the refined or crude form, except:

- (1) Controlled substance for personal usage must be under a current prescription of a licensed physician.
- (2) Those specifically authorized to Delta College by federal or state authorizing agencies for educational purposes, nor shall any member of the college community possess property, which is used, or intended for use, as a container for any controlled substances.

Such policy is specifically applicable to college employees during the course of their employment or at their work place. Employees who admit to violating such policy or are found to be in violation by a judicial process of the state or Delta College shall be suspended from employment.

Employees who are certified to medically dependent (hereafter dependent employees) by a licensed physician will be considered to have a health problem and eligible for medical leave

provided they participate in a recognized medically supervised program of treatment for chemical dependency under the following conditions:

- (a) Dependent employees will first obtain Delta's written consent to participate in a specified treatment program.
- (b) Dependent employees who voluntarily enroll in such a recognized program may use personal and/or vacation time, if medical leave is not available, or may apply to borrow sick leave. Otherwise, such employees will be considered to be on an approved leave of absence (without pay) for the period of the rehabilitation program.
- (c) During the period of enrollment in the program, such employees will comply with all medical decisions made by the treating or supervising physician of the program under the above conditions after being given the opportunity to participate, will be subject to disciplinary action including suspension for a stated period of time, or termination of employment
- (d) A dependent employee will be given only one opportunity for rehabilitation. If after returning to work it is determined by Delta that such employee has again violated any of Delta's rules and regulations related to possession or use of illegal drugs, or that such employee has been convicted of a drug related violation in the workplace, such employee will be subject to immediate discharge.
- (e) Dependent employees who do not participate in a rehabilitation program under the above conditions after being given the opportunity to participate, will be subject to disciplinary action including suspension for a stated period of time, or termination of employment.

All employees are notified that as a condition of employment each employee shall abide by the terms of this statement and must further notify Delta College of any criminal drug statute conviction for a violation occurring in the workplace no later than five (5) days after receiving such conviction.

Upon such notification, if funded under a Federal Grant, The Human Resources Office of the college must notify the granting agency within (10) days.

Delta College has established and is making a good faith effort to maintain a drug-free workplace through the implementation of a drug-free awareness program to inform and educate employees about:

- (1) The dangers of drug abuse in the workplace,
- (2) The policy of maintaining a drug-free workplace;
- (3) Any available drug counseling, rehabilitation, and employee assistance program; and
- (4) The penalties that may be imposed upon employees from drug violations occurring in the workplace.

Employees should make a copy of this policy for their own records.

DELTA COLLEGE EMPLOYEES ACKNOWLEDGEMENT AND RELEASE FORM HEPATITIS B VACCINATION

Only complete if you are a Category A Employee – Please check with your supervisor for clarification if you are unsure whether or not your position is considered Category A.

The following jobs have been identified as requiring procedures or tasks which involve exposure or reasonably anticipated exposure to blood or other potentially hazardous material:

• Public Safety	• Coaches
• Dental Assisting - Faculty, Staff & Students	• Dental Hygiene - Faculty, Staff & Students
• Exploratory Teaching - Faculty, Staff & Students	• Facilities Management Staff
• Fire Science Technology – Faculty, Staff & Students	• Multimedia Learning Lab (MLL) Technicians
• Nursing LPN - Faculty, Staff & Students	• Nursing RN - Faculty, Staff & Students
• Phlebotomy - Faculty, Staff & Students	• Designated Ctr Personnel -Planetarium, Saginaw & Midland
• Respiratory Care - Faculty, Staff & Students	• Surgical Technology - Faculty, Staff & Students
• Lifeguards	
• Science courses with microbiology components and/or involving human specimen collection - Faculty, Staff & Students involved in BIO 102 and BIO 203	

I understand that due to my occupational exposure to blood or other potentially infectious materials I may be at risk of acquiring hepatitis B virus (HBV) infection. I have been given the opportunity to be vaccinated with hepatitis B vaccine, at no charge to me.

IF YOU CHOOSE TO DECLINE....

If I decline the vaccination at this time, I understand that I continue to be at risk of acquiring hepatitis B, a serious disease. If in the future I still have occupational exposure risk and want to be vaccinated, I can receive the vaccine series at no charge to me.

MAKE YOUR DECISION, CHECK ONE OF THE FOLLOWING:

_____ I have ALREADY RECEIVED the hepatitis B vaccine and my verification is attached.

_____ I WOULD LIKE TO RECEIVE the hepatitis B vaccine series provided by Delta College.

_____ I DECLINE the vaccine and release Delta College from liability should I become infected.

EMPLOYEE'S NAME (print): _____

EMPLOYEE'S SIGNATURE: _____ DATE: _____

DEPARTMENT/DIVISION: _____ PHONE: _____

EMPLOYEE RIGHTS AND RESPONSIBILITIES UNDER THE FAMILY AND MEDICAL LEAVE ACT

Basic Leave Entitlement

FMLA requires covered employers to provide up to 12 weeks of unpaid, job-protected leave to eligible employees for the following reasons:

- For incapacity due to pregnancy, prenatal medical care or child birth;
- To care for the employee's child after birth, or placement for adoption or foster care;
- To care for the employee's spouse, son or daughter, or parent, who has a serious health condition; or
- For a serious health condition that makes the employee unable to perform the employee's job.

Military Family Leave Entitlements

Eligible employees with a spouse, son, daughter, or parent on active duty or call to active duty status in the National Guard or Reserves in support of a contingency operation may use their 12-week leave entitlement to address certain qualifying exigencies. Qualifying exigencies may include attending certain military events, arranging for alternative childcare, addressing certain financial and legal arrangements, attending certain counseling sessions, and attending post-deployment reintegration briefings.

FMLA also includes a special leave entitlement that permits eligible employees to take up to 26 weeks of leave to care for a covered servicemember during a single 12-month period. A covered servicemember is a current member of the Armed Forces, including a member of the National Guard or Reserves, who has a serious injury or illness incurred in the line of duty on active duty that may render the servicemember medically unfit to perform his or her duties for which the servicemember is undergoing medical treatment, recuperation, or therapy; or is in outpatient status; or is on the temporary disability retired list.

Benefits and Protections

During FMLA leave, the employer must maintain the employee's health coverage under any "group health plan" on the same terms as if the employee had continued to work. Upon return from FMLA leave, most employees must be restored to their original or equivalent positions with equivalent pay, benefits, and other employment terms.

Use of FMLA leave cannot result in the loss of any employment benefit that accrued prior to the start of an employee's leave.

Eligibility Requirements

Employees are eligible if they have worked for a covered employer for at least one year, for 1,250 hours over the previous 12 months, and if at least 50 employees are employed by the employer within 75 miles.

Definition of Serious Health Condition

A serious health condition is an illness, injury, impairment, or physical or mental condition that involves either an overnight stay in a medical care facility, or continuing treatment by a health care provider for a condition that either prevents the employee from performing the functions of the employee's job, or prevents the qualified family member from participating in school or other daily activities.

Subject to certain conditions, the continuing treatment requirement may be met by a period of incapacity of more than 3 consecutive calendar days combined with at least two visits to a health care provider or one visit and a regimen of continuing treatment, or incapacity due to pregnancy, or incapacity due to a chronic condition. Other conditions may meet the definition of continuing treatment.

Use of Leave

An employee does not need to use this leave entitlement in one block. Leave can be taken intermittently or on a reduced leave schedule when medically necessary. Employees must make reasonable efforts to schedule leave for planned medical treatment so as not to unduly disrupt the employer's operations. Leave due to qualifying exigencies may also be taken on an intermittent basis.

Substitution of Paid Leave for Unpaid Leave

Employees may choose or employers may require use of accrued paid leave while taking FMLA leave. In order to use paid leave for FMLA leave, employees must comply with the employer's normal paid leave policies.

Employee Responsibilities

Employees must provide 30 days advance notice of the need to take FMLA leave when the need is foreseeable. When 30 days notice is not possible, the employee must provide notice as soon as practicable and generally must comply with an employer's normal call-in procedures.

Employees must provide sufficient information for the employer to determine if the leave may qualify for FMLA protection and the anticipated timing and duration of the leave. Sufficient information may include that the employee is unable to perform job functions, the family member is unable to perform daily activities, the need for hospitalization or continuing treatment by a health care provider, or circumstances supporting the need for military family leave. Employees also must inform the employer if the requested leave is for a reason for which FMLA leave was previously taken or certified. Employees also may be required to provide a certification and periodic recertification supporting the need for leave.

Employer Responsibilities

Covered employers must inform employees requesting leave whether they are eligible under FMLA. If they are, the notice must specify any additional information required as well as the employees' rights and responsibilities. If they are not eligible, the employer must provide a reason for the ineligibility.

Covered employers must inform employees if leave will be designated as FMLA-protected and the amount of leave counted against the employee's leave entitlement. If the employer determines that the leave is not FMLA-protected, the employer must notify the employee.

Unlawful Acts by Employers

FMLA makes it unlawful for any employer to:

- Interfere with, restrain, or deny the exercise of any right provided under FMLA;
- Discharge or discriminate against any person for opposing any practice made unlawful by FMLA or for involvement in any proceeding under or relating to FMLA.

Enforcement

An employee may file a complaint with the U.S. Department of Labor or may bring a private lawsuit against an employer.

FMLA does not affect any Federal or State law prohibiting discrimination, or supersede any State or local law or collective bargaining agreement which provides greater family or medical leave rights.

FMLA section 109 (29 U.S.C. § 2619) requires FMLA covered employers to post the text of this notice. Regulations 29 C.F.R. § 825.300(a) may require additional disclosures.



For additional information:
1-866-4US-WAGE (1-866-487-9243) TTY: 1-877-889-5627
WWW.WAGEHOUR.DOL.GOV



HIPAA NOTICE

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

If you have any questions about this Notice, please contact:

Delta College
HIPAA Privacy Officer
1961 Delta Road
University Center, MI 48710
(989) 686-9106

Notice Effective Date: April 14, 2004

THIS NOTICE GIVES YOU INFORMATION REQUIRED BY LAW about the duties and privacy practices of the Delta College Group Health Plans (the "Plans") to protect the privacy of your medical information. The Delta College Group Health Plans consist of the following components:

- Blue Cross/Blue Shield Medical Plans
- Delta Dental Plan
- Vision/Hearing Allowance Reimbursement Plan
- Flexible Spending Plan Health Care Expense Reimbursement Account

The Plans provide health and/or dental benefits to you as described in your summary plan descriptions. The Plans receive and maintain your medical information in the course of providing these health benefits to you. The Plans may hire business associates to help provide these benefits to you. These business associates also receive and maintain your medical information in the course of assisting the Plans. The Plans are sponsored by Delta College (the "Plan Sponsor"). The Plans are all subject to the same federal privacy law, and are part of an Organized Health Care Arrangement ("OCHA") that follows the same privacy policies and procedures.

This notice applies to the Vision/Hearing Allowance Reimbursement Plan and the Flexible Spending Plan Health Care Expense Reimbursement Account. Blue Cross and Blue Shield of Michigan and Delta Dental each issued a Notice of Privacy Practices for their fully insured plans, which describes how they may use and disclose health information in connection with the coverage they provide for the Delta College Group Health Plans.

Our purpose for providing you with this notice is to tell you how the Plans and the third parties that assist in plan administration will use and disclose health information about you. The description of the uses and disclosures of medical information applies to the Plans and to the entities that perform services for the Plans or perform the functions of the Plans.

The Plans are required to follow the terms of this notice until it is replaced. The Plans reserve the right to change the terms of this notice at any time. If the Plans make changes to this notice, the Plans will revise it and send a new notice to all subscribers covered by the Plans at that time. The Plans reserve the right to make the new changes apply to all of your medical information maintained by the Plans before and after the effective date of the new notice.

For ease of reference, this Notice will use the word "Plan" to mean each of the Plans identified above.

Purposes for which the Plan May Use or Disclose Your Medical Information Without Your Consent or Authorization

The Plan may use and disclose your medical information for the following purposes:

Health Care Providers' Treatment Purposes. The Plan may disclose your medical information to your health care providers, at their request, for your treatment by them. For example, the Plan may disclose to your primary care physician the name of a specialist who is treating you so that they may coordinate your care.

Payment. The Plan may use or disclose your medical information to determine eligibility for plan benefits, to facilitate payment for the treatment and services you receive from health care providers, to determine benefit responsibility under the Plan, or to coordinate plan coverage. For example, the Plan may tell your health care provider about your medical history to determine whether a particular treatment is experimental, investigational, or medically necessary or to determine whether the Plan will cover the treatment.

Health Care Operations. The Plan may use or disclose your medical information as necessary to operate the Plan, including plan management and administrative activities. For example, the Plan may (i) conduct quality assessment and improvement activities, (ii) underwriting, premium rating, or other activities relating to the creation, renewal or replacement of a contract of health insurance, (iii) authorize business associates to perform data aggregation services, (iv) engage in care coordination or case management, and (v) manage, plan or develop the Plan's business.

As required by law. The Plan must allow the U.S. Department of Health and Human Services to audit the Plan's records. The Plan may also disclose your medical information as authorized by and to the extent necessary as required by federal, state or local law, including compliance with workers' compensation or other similar laws.

To Business Associates. The Plan may disclose your medical information to business associates the Plan hires to assist the Plan. Each business associate of the Plan must agree in writing to ensure the continuing confidentiality and security of your medical information.

To Plan Sponsor. The Plan may disclose to the Plan Sponsor, in summary form, claims history and other similar information. Such summary information does not disclose your name or other distinguishing characteristics. The Plan may also disclose to the Plan Sponsor the fact that you are enrolled in, or disenrolled from the Plan. The Plan may disclose your medical information to the Plan Sponsor for plan administrative functions that the Plan Sponsor provides to the Plan if the Plan Sponsor agrees in writing to ensure the continuing confidentiality and security of your medical information. The Plan Sponsor must also agree not to use or disclose your medical information for employment-related activities.

To Plans in the OHCA. Your medical information may be shared, used and disclosed among the Plans sponsored by Delta College and their business associates for purposes of facilitating and coordinating health care treatment, payments and operations, including the health care operations of the Organized Health Care Arrangement ("OHCA").

The Plan may also use and disclose your medical information as follows:

- To comply with legal proceedings, such as a court or administrative order or subpoena;
- To law enforcement officials for limited law enforcement purposes;
- To a family member, friend or other person, for the purpose of helping you with your health care or with payment for your health care, if you are in a situation such as a medical emergency and you cannot give your agreement to the Plan;
- To your personal representatives appointed by you or designated by applicable law;
- For research purposes in limited circumstances;
- To a coroner, medical examiner, or funeral director about a deceased person;

- To an organ procurement organization in limited circumstances;
- To avert a serious threat to your health or safety or the health or safety of others;
- To a governmental agency authorized to oversee the health care system or government programs;
- To federal officials for lawful intelligence, counterintelligence and other national security purposes;
- To public health authorities for public health purposes;
- To appropriate military authorities, if you are a member of the armed forces.

Uses and Disclosures with Your Permission

The Plan will not use or disclose your medical information for any other purposes unless you give the Plan your written authorization to do so. If you give the Plan written authorization to use or disclose your medical information for a purpose that is not described in this notice, then, in most cases, you may revoke it in writing at any time. Your revocation will be effective for all your medical information the Plan maintains, unless the Plan has taken action in reliance on your authorization.

Your Rights

You have certain rights with respect to your health information. To exercise these rights, you or your personal representative must make your request, in writing, directed to the Delta College HIPAA Privacy Officer. The HIPAA Privacy Officer will give you the necessary information and forms for you to complete and return to the HIPAA Privacy Officer. In some cases, the Plan may charge you a nominal, cost-based fee to carry out your request.

You have the right to:

- Request restrictions on certain uses and disclosures of your health information; however the Plan is not required to agree to a requested restriction;
- Receive confidential communications of your health information. You may request that the Plan communicates with you about your health information by alternative means or at an alternative location;
- Inspect and obtain a copy of your health information, except with regard to psychotherapy notes or information compiled in reasonable anticipation of certain civil, criminal or administrative proceedings;
- Request an amendment to your health information that the Plan has created, except with regard to those portions of your health information that you are precluded from inspecting and copying as set forth above.
- Obtain an accounting of certain disclosures of your health information; and
- Receive a paper copy of this notice in addition to any electronic copy you may receive.

Complaints

If you believe your privacy rights have been violated by the Plan, you have the right to complain to the Plan or to the Secretary of the U.S. Department of Health and Human Services. You may file a complaint to the Plan, in writing, directed to the Delta College HIPAA Privacy Officer. You will not be penalized or retaliated against if you choose to file a complaint.

Delta College
HIPAA Privacy Officer
1961 Delta Road
University Center, MI 48710
(989) 686-9106

INJURY/ACCIDENT REPORTING PROCEDURE

If an employee sustains a personal injury or occupational disease, which arises out of and in the course of employment, the employee must file a work-related claim of injury or illness.

1. All injuries/illnesses must be reported to Public Safety (Ext. 9111) within 24 hours of the injury/illness.
2. Injuries/illnesses requiring treatment must be done within ten days at Covenant Occupational Health Services located at 600 Irving Avenue, Saginaw, MI 48602. If treatment requires first aid only, the officer on duty shall administer first aid. If the employee needs to be transported to Covenant, Public Safety will make any decisions regarding transportation.
3. If at the time of the injury/illness you need to seek treatment, authorization must be given by Public Safety or the Human Resources Office (Ext. 9106) prior to receiving treatment. Employees electing to seek their own treatment will be responsible for all payments incurred.
4. If treatment is needed other than at the time of the injury, the employee must contact the Human Resources Office (9106 or 9107) for authorization to seek treatment at Covenant Occupational Health Services.
5. All employees seeking treatment due to a work related injury or illness will be drug and alcohol tested at the time of the visit.
6. The employee will be responsible for providing the Human Resources Office and their immediate supervisor with a copy of their physician's statement.

Human Resources will complete the appropriate forms to be forwarded to our Workers' Compensation Company, if necessary.

Any bills the employee receives as a result of the work-related injury/illness must be sent to the Human Resources Office.

Any lost time as a result of a work-related injury or illness will be reported as sick leave, if available.

Injuries/illnesses occurring off campus, which are work-related (i.e., at a College off campus facility or center, College sponsored trip, or approved off campus work assignment) shall be reported by phone as per instructions mentioned above.

REGULATIONS AND RULES OF CONDUCT

Delta College has adopted rules consistent with its goals and operations and enforces them with appropriate due process.

1. **General Responsibility:** Delta College has the responsibility to adopt and enforce rules which are consistent with Delta College goals and operations and to establish due process procedures in disciplinary cases.
2. **Authority to Establish Standards of Conduct:** Standards of conduct are established by rules of the College, as adopted by the Board of Trustees, and made known through College publications or by notices distributed or prominently posted on College Bulletin Boards; and by the law of the United States, State of Michigan, and County of Bay (public laws). Except in the case of interim or emergency type rules as granted by Michigan Public Act No. 26 of 1970, such regulations will be established and amended with the advice of the College Senate, but final authority is through either the Delta College Board of Trustees or the laws of the United States, State of Michigan, or County of Bay.
3. **Individual Responsibility:** An individual having an institutional relationship to Delta College (members of the Community College) is automatically placed under the rules of the College. "Institutional relationship to the College" means any connection of employment, enrollment, or service existing between any person and Delta College. As used herein, this phraseology is intended to prevent the application of these rules to purely personal or social relationships between or among students, faculty members, administration, or staff members, outside of the College proper. Therefore, it is important for all members of the College Community to familiarize themselves with the rules and regulations affecting them.
4. **Effect of Violating Rules:** A member of the College Community violating any of the rules of the College, or a public law, on campus, or off campus at a Delta College sponsored activity, is subject to disciplinary action by Delta College that is appropriate to the nature of the offense. Such disciplinary action will be taken in accordance with the procedures governing cases of violation as outlined in the Delta College Judicial Process.
5. **Reports of Violations:** Reporting of violations will be within the province of all members of the College Community, because they have a common responsibility to maintain an orderly and efficient community for their mutual benefit. Violations may fall in one of several categories: (1) Minor offenses which are dealt with by reprimand; (2) Violations by students which are to be reported to the Vice-President of Student Services; (3) Violations by faculty or staff members which are to be reported to the College President; and (4) Civil or criminal violations which are to be reported to the Office of Public Safety.
6. **Severance Provision:** If any of the foregoing rules or any part of such rule will be adjudged invalid by a court of competent jurisdiction, then such adjudication will not affect the validity of these rules as a whole or any provision or part of any such rule not so adjudged invalid.

Rules and Regulations:

1. **Physical Force:** No member of the College Community will use physical force, threaten physical force, or use intimidation against any person engaged in an activity properly undertaken as part of an institutional relationship of the College except as permitted under normal law enforcement procedures.
2. **Disruption:** No member of the College Community will interfere with a College function by depriving any person of needed safety, quiet or other physical conditions of work or study.
3. **Interference:** No member of the College Community will interfere with the free movement of any person engaged in an activity properly undertaken as part of an institutional relationship to the College.
4. **Compliance:** In keeping with the system of voluntary compliance that underlies the reasonable instructions given by an appropriate College official to cease specified conduct, if such conduct threatens disruption or interference with:
 - a. The rights of others
 - b. College discipline
 - c. College functions
 - d. Order in the College Community
5. **Identification:** No member of the College Community will refuse to provide identification when requested to do so by an identified employee of the College.

6. **Forbidden Occupation:** No member of the College Community will, subsequent to reasonable notice to leave given by the College President, or an authorized designee, continue occupation of any College facility or property which is under the direct control or responsibility of the College, especially if such occupation interferes with a College function or is a risk of injury to a person or property.
7. **Facility Entry and Usage:** No member of the College Community will gain or attempt to gain unauthorized entry to or make unauthorized use of the College facilities or property.
8. **Property:** No member of the College Community will damage, deface, destroy, steal, or misappropriate the property of the College or of any member of the College community or of any visitor to the College campus.
9. **Unauthorized Use of College Credit, Property, Etc.:** No unauthorized member of the College Community will use the College telephones, postal machines and meters, duplicating machines, motorized vehicles, computers, or other equipment where the unauthorized use of any such instrumentalities results in the incurring of charges by the College. This provision will be deemed to also include College billing, charging and credit card numbers utilized for communications or transportation purposes. Further it will be a violation of this section for any member of the College Community who has not been issued a key by the College to possess or use College keys for any purpose whatsoever.
10. **Counterfeiting, Altering and Copying:**
 - a. No member of the College Community, with intent to injure or defraud, will falsely make, forge, manufacture, print, reproduce, copy, tamper with, or alter any writing, document, record, or identification used or maintained by the College or by members of the College Community.
 - b. No member of the College Community will knowingly possess, display, or cause or permit to be displayed any writing, record, document, or identification form used or maintained by the College or by members of the College Community, knowing the same to be fictitious, altered, forged, counterfeited, or made without proper authority.
11. **Confidentiality of College Records:** No person will inspect, investigate, or use College files (i.e., Counseling, Financial Aid, Placement, Registrar) without proper College authorization.
12. **Firearms and Other Dangerous Material:** The possession or use of firearms, firecrackers, explosives, toxic or dangerous chemicals, or other lethal weapons, equipment or material is not permitted on College property at any time except:
 - a. When specifically authorized by the College for educational purposes, or
 - b. When firearms used for recreational purposes and transported through the campus meet the regulations of the Office of Public Safety.
13. **Alcoholic Beverages:** No member of the College Community will possess or consume beer, wine, or other alcoholic beverages on College property, or any property which is under the direct control or responsibility of the College, excluding college housing, in which case regulation of such will be the responsibility of Food and Conference Services. This rule may be suspended from time to time by authorization of the President's Office.
14. [Tobacco Free Campus Policy Philosophy](#). Effective August 1, 2007, Delta College became a tobacco free campus.
15. **Drugs:** No member of the College Community will possess, distribute, or use any prohibited drug in either the refined or crude form, nor will any member of the College community possess property which is used, or intended for use, as a container for any controlled substance except:
 - a. Controlled substances for personal usage, and these must be under a current prescription of a licensed physician;
 - b. Those specifically authorized to Delta College by Federal or State authorizing agencies for educational purposes.
16. **Selling, Soliciting, and Distributing:** Any person who wishes to distribute, solicit, or sell information, materials, goods, or services not within normal College activities and routine, must have the written permission of the Vice President of Student Services or Vice President of Finance and Business or their designee.
17. **Private Business Ventures:** Delta College facilities such as offices, computers, copiers, etc., are not to be used for private business ventures. Also, Delta College's name is not to be associated in any way (such as use of letterhead or return address) with private business ventures.
18. **Animals:** People may not bring animals on campus or into College buildings. Leader dogs and animals used for educational purposes are exceptions; however, all animals must remain under the control of their owners and be properly licensed and medically treated as required by law.
19. **Federal, State, Local Laws:** Violations of Federal, State, or local laws on campus, or off campus in connection with College sponsored activities, will constitute violations of College rules.

REQUIRED TRAINING MODULES

All employees are required to view the **Bloodborne Pathogens, Diversity, Sexual Harassment, FERPA and Hazard Communications** training modules.

All Delta College employees have access to the Global Compliance Network training modules at the following link: <http://www.gcn1.net/home.htm>

After you enter the site choose the “LOGIN” button and enter the Username: delta
Click the **Create New Account** button to create a User ID. Your User ID should simply be your First Name, Middle Initial and Last Name.

For detailed instructions on creating an account and logging in you can refer to the following link: <http://www.gcn1.net/forms/pdf/instructions.pdf>

After you review each module, **click the submit button at the bottom** and this will register you on the completion report that Human Resources will run to verify all modules were reviewed.

If you have any questions or difficulties accessing these resources, please contact Jeanette O’Boyle in the Human Resources Office at 686-9106.

Notice of Employee Eligibility to Participate in 403(b) Retirement Plan

All employees, excluding student workers, are eligible to participate in the Delta College 403(b) Retirement Plan immediately upon hire. Eligible employees may elect to make pre-tax salary reduction contributions to the 403(b) plan up to the maximum allowed by the IRS each tax year. Each participating employee chooses among the available investment options offered by the approved investment vendors under the plan. Employee contributions and the related investment earnings are tax deferred until withdrawn from the plan.

Employees may enroll in the 403(b) plan by contacting one or more of the Delta College approved 403(b) vendors at any time throughout the year to speak to a representative. A list of approved vendors and representatives is available at <http://www.delta.edu/humres/annuities.aspx>.

After establishing a 403(b) account and making investment and beneficiary choices with a vendor representative, a completed Salary Reduction Agreement must be submitted to the Delta College Finance Office to begin making bi-weekly payroll deduction contributions to a 403(b) account. The Salary Reduction Agreement is available. <http://www.delta.edu/files/Human%20Resources/403bSalaryReductionAgt.pdf>. This form may also be used to stop deductions or to make changes to the deduction amount. We ask that employees limit making changes to their salary reduction to 4 times per year.

Links to the Plan Document and Adoption Agreement for the Delta College 403(b) Retirement Plan as amended 01/01/09 are as follows:

Plan Document: <http://www.delta.edu/files/Human%20Resources/403bRetirementPlanDocument.pdf>

Adoption Agreement: <http://www.delta.edu/files/Human%20Resources/403bAdoptionAgreement.pdf>

Please contact Jeanne Doyle at extension 9390 or jpdoyle@delta.edu with any questions.