Please complete all the enclosed employment forms and return all forms to Human Resources.

Please provide a copy of a document from List A or a copy of documents from List B and List C of the I-9 form within three (3) days from the date of hire. These documents are needed in order to verify employment eligibility.

Our office will be unable to process payment for services until these forms are received.

Please return to:

Delta State University
Human Resource Management
Kent Wyatt Hall 247
Cleveland, MS 38733

Should you have any questions, please contact us at 662-846-4035.
DELTA STATE UNIVERSITY

Human Resources Employee Information Form

Instructions: This information is required to prepare various reports (including affirmative action), and to serve staff benefits, emergency and public information needs of the university. Use this form to add information for a new employee or to change existing employee information. Please print or type. Return this form to the Human Resources Department, Kent Wyatt Hall 247 or 662-846-4035.

Check All That Apply:
- □ New Employee
- □ Home Address Change
- □ Campus Address Change
- □ Marital Status Change
- □ Name Change
- □ Home Phone Change
- □ Campus Phone Change

REQUIRED EMPLOYEE INFORMATION:
Social Security Number (Will not be published) __________________________ Date of Birth: __________________________
Employee's Name: __________________________
First Middle Last
Campus Address: __________________________ Campus Phone: __________________________

REQUIRED RESIDENCE AND PERSONAL INFORMATION:
Permanent Address: __________________________ Home Telephone #: __________________________
City: __________________________ State: __________________________ Zip: __________________________

Gender: □ Male □ Female
Marital Status: □ Single □ Divorced □ Widowed
Military Service: □ Active □ Inactive
Branch: __________________________ Citizenship: □ Native USA □ Non-Citizen □ Naturalized

ETHNIC CLASSIFICATION
What is your ethnicity? □ Hispanic or Latino □ Not Hispanic or Latino (A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race.)
What is your race? Mark one or more races to indicate what race you consider yourself to be.
- □ WHITE (origins of Europe, North Africa, or Middle East).
- □ BLACK or AFRICAN AMERICAN (origins of any of the Black Racial Groups of Africa).
- □ ASIAN (Origins in any of the original peoples of the Far East, SE Asia, the Indian Sub-Continent, for example, Cambodia, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.)
- □ AMERICAN INDIAN OR ALASKAN NATIVE (Origins in any of the original peoples of North and South America (including Central America) who maintains cultural identification through tribal or community attachment).
- □ NATIVE HAWAIIAN or OTHER PACIFIC ISLANDER (Origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.)

Notify in Case of Emergency: (Required)
Name: __________________________
Address: __________________________
Relation: __________________________ Telephone #: __________________________
City, State, Zip: __________________________

OPTIONAL INFORMATION:
If married, please give name of spouse: __________________________
First Middle Last
Religion Preference: __________________________
Do you have a physical or mental disability affecting your employment: □ Yes □ No Specify: __________________________
Name and Birthdates of Children: __________________________

Employee Signature: __________________________ Date: __________________________

The above address information in the Required Employee Information is considered to be departmental directory information. This information will be published in the Employee Directory and will be made available on the campus computer network. Permanent address information is considered personal information. Do you wish to have your permanent address information published in the campus directory? □ Yes □ No.
**Employment Eligibility Verification**

**Section 1. Employee Information and Attestation**

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

<table>
<thead>
<tr>
<th>Last Name (Family Name)</th>
<th>First Name (Given Name)</th>
<th>Middle Initial</th>
<th>Other Names Used (If any)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Address (Street Number and Name)</th>
<th>Apt. Number</th>
<th>City or Town</th>
<th>State</th>
<th>Zip Code</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Date of Birth (mm/dd/yyyy)</th>
<th>U.S. Social Security Number</th>
<th>E-mail Address</th>
<th>Telephone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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 Registration Number/USCIS Number): ______________________

- [ ] An alien authorized to work until (expiration date, if applicable, mm/dd/yyyy) _____________. Some aliens may write "N/A" in this field. (See instructions)

For aliens authorized to work, provide your Alien Registration Number/USCIS Number OR Form I-94 Admission Number:

1. Alien Registration Number/USCIS Number: ______________________

OR

2. Form I-94 Admission Number: ______________________

If you obtained your admission number from CBP in connection with your arrival in the United States, include the following:

<table>
<thead>
<tr>
<th>Foreign Passport Number</th>
<th>Country of Issuance</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Some aliens may write "N/A" on the Foreign Passport Number and Country of Issuance fields. (See instructions)

<table>
<thead>
<tr>
<th>Signature of Employee:</th>
<th>Date (mm/dd/yyyy):</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**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.

<table>
<thead>
<tr>
<th>Signature of Preparer or Translator:</th>
<th>Date (mm/dd/yyyy):</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Last Name (Family Name)</th>
<th>First Name (Given Name)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Address (Street Number and Name)</th>
<th>City or Town</th>
<th>State</th>
<th>Zip Code</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Section 2. Employer or Authorized Representative Review and Verification

(Owners or their authorized representatives must complete and sign Section 2 within 3 business days of the employee's first day of employment. You must physically examine one document from List A OR examine a combination of one document from List B and one document from List C as listed on the "Lists of Acceptable Documents" on the next page of this form. For each document you review, record the following information: document title, issuing authority, document number, and expiration date, if any.)

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Document Title:</td>
<td></td>
<td>Document Title:</td>
<td></td>
<td>Document Title:</td>
</tr>
<tr>
<td>Issuing Authority:</td>
<td></td>
<td>Issuing Authority:</td>
<td></td>
<td>Issuing Authority:</td>
</tr>
<tr>
<td>Document Number:</td>
<td></td>
<td>Document Number:</td>
<td></td>
<td>Document Number:</td>
</tr>
<tr>
<td>Expiration Date (if any) (mm/dd/yyyy):</td>
<td></td>
<td>Expiration Date (if any) (mm/dd/yyyy):</td>
<td></td>
<td>Expiration Date (if any) (mm/dd/yyyy):</td>
</tr>
<tr>
<td>Document Title:</td>
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<td>Document Title:</td>
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<td>Document Title:</td>
</tr>
<tr>
<td>Issuing Authority:</td>
<td></td>
<td>Issuing Authority:</td>
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<td>Issuing Authority:</td>
</tr>
<tr>
<td>Document Number:</td>
<td></td>
<td>Document Number:</td>
<td></td>
<td>Document Number:</td>
</tr>
<tr>
<td>Expiration Date (if any) (mm/dd/yyyy):</td>
<td></td>
<td>Expiration Date (if any) (mm/dd/yyyy):</td>
<td></td>
<td>Expiration Date (if any) (mm/dd/yyyy):</td>
</tr>
</tbody>
</table>

Certification

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

The employee's first day of employment (mm/dd/yyyy): ____________

(See instructions for exemptions.)

<table>
<thead>
<tr>
<th>Signature of Employer or Authorized Representative</th>
<th>Date (mm/dd/yyyy)</th>
<th>Title of Employer or Authorized Representative</th>
</tr>
</thead>
<tbody>
<tr>
<td>Last Name (Family Name)</td>
<td></td>
<td>Employer's Business or Organization Name</td>
</tr>
<tr>
<td>First Name (Given Name)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employer's Business or Organization Address (Street Number and Name)</td>
<td>City or Town</td>
<td>State</td>
</tr>
</tbody>
</table>

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

A. New Name (if applicable) Last Name (Family Name) First Name (Given Name) Middle Initial

B. Date of Rehire (if applicable) (mm/dd/yyyy):

C. If employee's previous grant of employment authorization has expired, provide the information for the document from List A or List C the employee presented that establishes current employment authorization in the space provided below.

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

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

| Signature of Employer or Authorized Representative: | Date (mm/dd/yyyy): | Print Name of Employer or Authorized Representative: |
LISTS OF ACCEPTABLE DOCUMENTS
All documents must be UNEXPIRED

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

<table>
<thead>
<tr>
<th>LIST A</th>
<th>LIST B</th>
<th>LIST C</th>
</tr>
</thead>
<tbody>
<tr>
<td>Documents that Establish Both Identity and Employment Authorization</td>
<td>Documents that Establish Identity</td>
<td>Documents that Establish Employment Authorization</td>
</tr>
<tr>
<td>1. U.S. Passport or U.S. Passport Card</td>
<td>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</td>
<td>1. A Social Security Account Number card, unless the card includes one of the following restrictions:</td>
</tr>
<tr>
<td>2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551)</td>
<td>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</td>
<td>(1) NOT VALID FOR EMPLOYMENT</td>
</tr>
<tr>
<td>3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa</td>
<td>3. School ID card with a photograph</td>
<td>(2) VALID FOR WORK ONLY WITH INS AUTHORIZATION</td>
</tr>
<tr>
<td>4. Employment Authorization Document that contains a photograph (Form I-766)</td>
<td>4. Voter’s registration card</td>
<td>(3) VALID FOR WORK ONLY WITH DHS AUTHORIZATION</td>
</tr>
</tbody>
</table>

For nonimmigrant alien authorized to work for a specific employer because of his or her status:

a. Foreign passport; and
b. Form I-94 or Form I-94A that has the following:
   (1) The same name as the passport; and
   (2) An endorsement of the alien’s nonimmigrant status as long as that period of endorsement has not yet expired and the proposed employment is not in conflict with any restrictions or limitations identified on the form.

5. For persons under age 18 who are unable to present a document listed above:
   10. School record or report card
   11. Clinic, doctor, or hospital record
   12. Day-care or nursery school record

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

Refer to Section 2 of the instructions, titled "Employer or Authorized Representative Review and Verification," for more information about acceptable receipts.
DELTA STATE UNIVERSITY
APPLICATION FOR EMPLOYMENT

INSTRUCTIONS: Please answer all questions, where applicable, completely and truthfully to the best of your knowledge and belief. Type or print in ink as carefully as possible. Omit any information that discloses race, age, ethnic origin, religious or political affiliation.

PERSONAL INFORMATION
Position Applied For: ____________________________ Email address: ____________________________

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First</th>
<th>Middle</th>
<th>Social Security No.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Present Address: Street No.</th>
<th>City</th>
<th>State</th>
<th>Zip</th>
<th>Telephone:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Working conditions you will accept:</th>
</tr>
</thead>
<tbody>
<tr>
<td>[ ] Full-time</td>
</tr>
<tr>
<td>[ ] Part-time</td>
</tr>
<tr>
<td>[ ] Temporary</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>When can you begin work?</th>
<th>Home:</th>
</tr>
</thead>
</table>

EDUCATION
<table>
<thead>
<tr>
<th>School/Institution</th>
<th>City</th>
<th>State</th>
<th>Dates Attended</th>
<th>Did you Graduate/Complete?</th>
<th>List Type of Certificate, Courses or Major Diploma, Degree</th>
<th>Courses or Major</th>
</tr>
</thead>
<tbody>
<tr>
<td>High School or GED</td>
<td>To</td>
<td></td>
<td>To</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vocational/Technical School</td>
<td>To</td>
<td></td>
<td>To</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Community College</td>
<td>To</td>
<td></td>
<td>To</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Undergraduate School</td>
<td>To</td>
<td></td>
<td>To</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Graduate School</td>
<td>To</td>
<td></td>
<td>To</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>To</td>
<td></td>
<td>To</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

List of scholastic honors, membership in professional societies, etc.

OTHER REQUIRED INFORMATION
If you are offered employment, can you submit proof of your legal right to work in the United States within three days of your hire? [ ] Yes  [ ] No

Are you currently enrolled as a student at Delta State University? [ ] Yes  [ ] No

Have you been previously employed by the University? [ ] Yes  [ ] No

If yes, give department and dates: ____________________________

Have you ever been convicted of a felony? [ ] Yes  [ ] No

If yes, please explain. (A record of conviction will not necessarily bar you from employment).

Mississippi law prohibits any individual from being employed in a department or unit under the supervision of a relative who has or may have direct effect on the individual’s progress, performance or welfare. If you have any relative(s) employed at Delta State University, give their name(s), relationship, and department where employed:

Active Military Service: Service and Branch: ____________________________ Date Entered: ____________________________ Date Separated: ____________________________

If you are applying for a position which requires you to drive, please complete this section:

Type of License: [ ] Not Applicable

[ ] Operator

Driver’s License No: ____________________________ State: ____________________________


Has your license ever been restricted, revoked, or suspended? [ ] Yes  [ ] No

If yes, please explain. [ ] Yes  [ ] No

Do you type? [ ] Yes  [ ] No

List equipment you can operate (copier, lawnmower etc.):

Computer Systems/Software with which you are experienced (Word, Excel, etc.):

List other job-related skills you have ( shorthand, dictation, etc.):
**EMPLOYMENT**

<table>
<thead>
<tr>
<th>From:</th>
<th>Month</th>
<th>Year</th>
<th>Employer’s Name</th>
<th>Reason for Leaving:</th>
</tr>
</thead>
<tbody>
<tr>
<td>To:</td>
<td>Month</td>
<td>Year</td>
<td>Supervisor’s Name/Title</td>
<td></td>
</tr>
</tbody>
</table>

Check One: [ ] Full-time [ ] Part-time [ ] Temporary

Street Address

Your Title: City State Zip Phone Number:

Duties:

---

**EMPLOYMENT**

<table>
<thead>
<tr>
<th>From:</th>
<th>Month</th>
<th>Year</th>
<th>Employer’s Name</th>
<th>Reason for Leaving:</th>
</tr>
</thead>
<tbody>
<tr>
<td>To:</td>
<td>Month</td>
<td>Year</td>
<td>Supervisor’s Name/Title</td>
<td></td>
</tr>
</tbody>
</table>

Check One: [ ] Full-time [ ] Part-time [ ] Temporary

Street Address

Your Title: City State Zip Phone Number:

Duties:

---

**EMPLOYMENT**

<table>
<thead>
<tr>
<th>From:</th>
<th>Month</th>
<th>Year</th>
<th>Employer’s Name</th>
<th>Reason for Leaving:</th>
</tr>
</thead>
<tbody>
<tr>
<td>To:</td>
<td>Month</td>
<td>Year</td>
<td>Supervisor’s Name/Title</td>
<td></td>
</tr>
</tbody>
</table>

Check One: [ ] Full-time [ ] Part-time [ ] Temporary

Street Address

Your Title: City State Zip Phone Number:

Duties:

---

**REFERENCES** (List three persons, other than relatives or personal friends, who have knowledge of your experience and/or education)

<table>
<thead>
<tr>
<th>Name</th>
<th>Address</th>
<th>Relationship</th>
<th>Telephone Number</th>
</tr>
</thead>
</table>

---

**ACKNOWLEDGEMENT OF TERMS AND CONDITIONS OF APPLICATION AND AUTHORIZATION**

This application is not to be interpreted as a contract of employment or as a promise of continued employment. I acknowledge that Delta State University retains the right to establish and enforce with full discretion any and all rules, regulations, and policies. I agree to abide by all applicable rules, regulations, and policies upon my acceptance of employment. I certify that all the information submitted by me on this application is true and accurate. I understand that if any false information, misrepresentation of facts, or omissions are discovered, my application may be rejected and, if I am employed, my employment may be terminated.

I authorize Delta State University to contact any educational institution, organization, business, or individual that I have listed on my employment application, resume, or mentioned in job interviews and obtain from them any relevant information about my job qualifications, including my performance, experience, skills, credentials, and other factors affecting my suitability for employment. I understand that I am consenting to the release of any reference-related information about me held or known by my former employers, department heads, supervisors, and co-workers. In addition, I consent to the release of any information about my educational, performance, experience, credentials, abilities, or work-related characteristics or titles held or known by other organizations or individuals, including schools and educational institutions, professional or business associations, friends, and acquaintances that Delta State University might consider in the course of conducting a reference check or background investigation of my suitability for employment.

In exchange for Delta State University’s consideration of my employment application, I agree not to file or pursue any complaints, claims, or legal actions of any kind against Delta State University or any of its employees or agents arising out of their efforts to obtain work-related information about me. I also agree not to file or pursue any complaints, claims, or legal actions of any kind against any organization, business corporation, educational institution, or individual that provides work-related information about me to Delta State University or any of its employees or agents in accordance with the terms and intent of this release.

Print Name: ____________________________ Signature: ____________________________

Social Security Number: ____________________________ Date: ____________________________
EMPLOYEE CERTIFICATION AND AUTHORIZATION

I have been notified that as an employee of the State of Mississippi I cannot have been convicted of or pled guilty in any court of this state, another state, or in federal court of any felony in which public funds were unlawfully taken, obtained or misappropriated in the abuse or misuse of my office or employment or money coming into my hands by virtue of my office or employment. I understand that any conviction or guilty plea of embezzlement will disqualify me from employment with the State of Mississippi and result in my termination.

I swear or affirm that I have never been convicted or pled guilty in any court of this state, another state, or in federal court of any felony in which public funds were unlawfully taken, obtained or misappropriated by the abuse or misuse of any office or employment or money coming into my hands by virtue of my office or employment.

I hereby authorize Delta State University ("DSU") to conduct a background check of my criminal history at any time as a condition of and/or subsequent to my employment. I understand and acknowledge that I may revoke my permission for such background check. In such case, no background check investigation will be done and my employment may be terminated.

I further understand and acknowledge that should the criminal background check occur and it establishes that I have been convicted or pled guilty to misuse of public funds in violation of Section 25-1-113 my employment with DSU will terminate, and I will have no recourse against Delta State University.

I certify that my responses to this requirement are accurate and true to the best of my knowledge and ability.

Employee:

Signature of Employee __________ Date __________

Employee’s Name – Printed __________

Social Security Number __________

Date of Birth __________

Witness:

Signature of Witness __________ Date __________

Name of Witness - Printed __________
Form W-4 (2016)

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 2016 expires February 15, 2017. 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 $1,050 and includes more than $250 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. 561, Dependents, 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 are the child tax credit 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 how 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 1303, 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 2016. See Pub. 505, especially if your earnings exceed $150,000 (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/taxforms.

---

Personal Allowances Worksheet (Keep for your records)

A Enter "1" for yourself if no one else can claim you as a dependent.

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.

C Enter "1" for your spouse. But, you may choose to enter "0-2" if you are married and have either a working spouse or more than one job. (Filing "0-2" may help you avoid having too little tax withheld.)

D Enter number of dependents (other than your spouse or yourself) you will claim on your tax return.

E Enter "1" if you will file as head of household on your tax return (see conditions under Head of household above).

F Enter "1" if you have at least $2,000 of child or dependent care expenses for which you plan to claim a credit.

G Child Tax Credit (including additional child tax credit). See Pub. 972, Child Tax Credit, for more information.

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.)

For accuracy, complete all worksheets that apply.

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

---

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.

1 Your first name and middle initial

2 Last name

3 Single □ Married □ Married, but withheld at higher Single rate.

Note: If married, but legally separated, or spouse is a nonresident alien, check the "Single" box.

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)

6 Additional amount, if any, you want withheld from each paycheck

7 I claim exemption from withholding for 2016, and I certify that I meet both of the following conditions for exemption.

   a. Last year I had a right to a refund of all federal income tax withheld because I had no tax liability, and

   b. 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.

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

Date

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For Privacy Act and Paperwork Reduction Act Notice, see page 2.

Cat. No. 1020202

Form W-4 (2016)
**Deductions and Adjustments Worksheet**

**Note:** Use this worksheet only if you plan to itemize deductions or claim certain credits or adjustments to income. Enter an estimate of your 2016 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, 1952) of your income, and miscellaneous deductions. For 2016, you may have to reduce your itemized deductions if your income is over $311,300 and you are married filing jointly or if you are qualifying widow(er); $285,550 if you are head of household; $259,400 if you are single and not head of household; or a qualifying widow(er); or $175,650 if you are married filing separately. See Pub. 505 for details.

1. $12,600 if married filing jointly or qualifying widow(er) .......................................................... 1 $

2. Enter: $9,300 if head of household .......................................................... 2 $

3. Subtract line 2 from line 1. If zero or less, enter "-0-" ..................................................... 3 $

4. Enter an estimate of your 2016 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 2016 Form W-4 worksheet in Pub. 505) ............ 5 $

6. Enter an estimate of your 2016 nonwage income (such as dividends or interest) ...................... 6 $

7. Subtract line 5 from line 4. If zero or less, enter "-0-" ..................................................... 7 $

8. Divide the amount on line 7 by $4,050 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.)

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 $55,000 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 2016. 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 2016. 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>
<thead>
<tr>
<th>Married Filing Jointly</th>
<th>All Others</th>
</tr>
</thead>
<tbody>
<tr>
<td>If wages from LOWEST paying job are—</td>
<td>Enter on line 2 above</td>
</tr>
<tr>
<td>$0 - $6,000</td>
<td>0</td>
</tr>
<tr>
<td>6,001 - 14,000</td>
<td>1</td>
</tr>
<tr>
<td>14,001 - 25,000</td>
<td>2</td>
</tr>
<tr>
<td>25,001 - 35,000</td>
<td>3</td>
</tr>
<tr>
<td>35,001 - 50,000</td>
<td>4</td>
</tr>
<tr>
<td>50,001 - 65,000</td>
<td>5</td>
</tr>
<tr>
<td>65,001 - 75,000</td>
<td>6</td>
</tr>
<tr>
<td>75,001 - 90,000</td>
<td>7</td>
</tr>
<tr>
<td>90,001 - 115,000</td>
<td>8</td>
</tr>
<tr>
<td>115,001 - 130,000</td>
<td>9</td>
</tr>
<tr>
<td>130,001 - 150,000</td>
<td>10</td>
</tr>
<tr>
<td>150,000 and over</td>
<td>11</td>
</tr>
</tbody>
</table>

**Table 2**

<table>
<thead>
<tr>
<th>Married Filing Jointly</th>
<th>All Others</th>
</tr>
</thead>
<tbody>
<tr>
<td>If wages from HIGHEST paying job are—</td>
<td>Enter on line 7 above</td>
</tr>
<tr>
<td>$0 - $75,000</td>
<td>$0</td>
</tr>
<tr>
<td>75,001 - 135,000</td>
<td>1</td>
</tr>
<tr>
<td>135,001 - 205,000</td>
<td>2</td>
</tr>
<tr>
<td>205,001 - 300,000</td>
<td>3</td>
</tr>
<tr>
<td>300,001 - 405,000</td>
<td>4</td>
</tr>
<tr>
<td>405,001 and over</td>
<td>5</td>
</tr>
<tr>
<td>$0 - $36,000</td>
<td>$0</td>
</tr>
<tr>
<td>36,001 - 85,000</td>
<td>1</td>
</tr>
<tr>
<td>85,001 - 165,000</td>
<td>2</td>
</tr>
<tr>
<td>165,001 - 340,000</td>
<td>3</td>
</tr>
<tr>
<td>340,001 and over</td>
<td>4</td>
</tr>
</tbody>
</table>

**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(d)(2) and 6109 and their regulations require you to provide this information; your employer uses it to determine your federal income tax withholding. Failure to provide a properly completed form will result in your being treated as a single person with no 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 creditors, 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 non-tax 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 tax. 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.
**MISSISSIPPI EMPLOYEE'S WITHHOLDING EXEMPTION CERTIFICATE**

**Department of Revenue**
P.O. Box 960
Jackson Mississippi 39205

**Employee's Name:**

**Employee's Residence Address:**

<table>
<thead>
<tr>
<th>Number and Street</th>
<th>City or Town</th>
<th>State</th>
<th>Zip Code</th>
</tr>
</thead>
</table>

**Marital Status**

1. Single
2. Married (Check One)
   - [ ] Spouse NOT employed: Enter $12,000.
   - [ ] Spouse IS employed: Enter that part of $12,000 claimed by you, in multiples of $500. See instructions 2(c) & 2(d) below.
3. Head of Family
   - [ ] Enter $9,500 as exemption. To qualify as head of family, you must be single and have a dependent living in the home with you. See instructions 2(e) & 2(f) below.

**Employer:**

Keep this certificate with your records. If the employee is believed to have claimed excess exemptions, the Department of Revenue should be advised.

**Dependents**

You may claim $1,500 for each dependent, other than for taxpayer and spouse, who receives basic support from you and who qualifies as a dependent for Federal income tax purposes. A head of family may claim $3,000 for each dependent excluding the one which qualifies you as head of family. Multiply number of dependents claimed by you by $1,500. Enter amount claimed.

<table>
<thead>
<tr>
<th>Number Claimed</th>
<th>Amount Claimed</th>
</tr>
</thead>
</table>

**Age and Blindness Exemption**

- Age 65 or older
- [ ] Husband
- [ ] Wife
- [ ] Single Blind
- [ ] Husband Blind
- [ ] Wife Blind

Multiply number of blocks checked by $1,500. Enter amount claimed.

**Effective only for pay periods in 2000 and after**

6. TOTAL AMOUNT OF EXEMPTION CLAIMED - Lines 1 through 5.

7. Additional dollar amount withholding per pay period if agreed to by your employer.

**Military Spouses Residency Relief Act Exception from Mississippi Withholding**

8. If you meet the conditions set forth under the Service Member Civil Relief Act, as amended by the Military Spouses Residency Relief Act and have no Mississippi tax liability, write "EXEMPT" on line 8. You must attach a copy of the Federal Form DD-2058 and a copy of your Military Spouse ID Card to this form so your employer can validate the exemption claimed.

I declare under the penalties imposed for filing false reports that the amount of exemption claimed on this certificate does not exceed the amount to which I am entitled or I am entitled to claim exempt status.

**Employee's Signature:**

**Date:**

---

**INSTRUCTIONS**

1. **The Personal Exemptions Allowed Are:**
   - (a) Single individuals - $5,000
   - (b) Married individuals (jointly) - $12,000
   - (c) Head of family - $9,500
   - (d) Dependents - $3,000
   - (e) Age 65 and blindness - $1,500

2. **Claiming Personal Exemptions:**
   - (a) Single individuals enter $5,000 on Line 1.
   - (b) Married individuals are allowed a joint exemption of $12,000. If the spouse is not employed, enter $12,000 on Line 2(a). If the spouse is employed, the exemption of $12,000 may be divided between the taxpayer and spouse in any manner they choose - in multiples of $500. For example - taxpayer may claim $5,500 and spouse claims $6,500, or taxpayer may claim $6,000 and spouse claims $6,000. The total claimed by taxpayer and spouse may not exceed $12,000. Enter amount claimed by you on Line 2(b).
   - (c) A Head of Family is a single individual who maintains a home which is the principal place of habitation for himself and at least one dependent. Single individuals maintaining a head of family are allowed a head of family exemption in the manner specified above. If the taxpayer has more than one dependent, additional exemptions are applicable. See item (d).
   - (d) An additional exemption of $1,500 may generally be claimed for each dependent of the taxpayer. A dependent is any relative who receives financial support from the taxpayer and who qualifies as a dependent for Federal income tax purposes. Head of family individuals may claim an additional exemption for each dependent excluding the one which is required for head of family status. For example, a head of family taxpayer has 2 dependent children and his dependent mother living with him. The taxpayer may claim 2 additional exemptions. Married or single individuals may claim an additional exemption for each dependent, but should not include themselves or their spouse. Married taxpayers may divide the number of their dependents between them in any manner they choose, for example, a married couple has 3 children who qualify as dependents. The taxpayer may claim 2 dependents and the spouse 1, or the taxpayer 3 and the spouse none. Enter the amount of dependent exemption as line 4.
   - (e) An additional exemption of $1,500 may be claimed by either taxpayer or spouse or both if either or both have reached the age of 65 before the close of the taxable year. No additional exemption is authorized for dependents by reason of age. Check applicable blocks on Line 5.
   - (f) An additional exemption of $1,500 may be claimed by either taxpayer or spouse or both if either or both are blind. No additional exemption is authorized for dependents by reason of blindness. Check applicable blocks on Line 5. Multiply number of blocks checked on Line 5 by $1,500 and enter amount of exemption claimed.

3. **Total Exemption Claimed:**

Add the amount of exemptions claimed in each category and enter the total on Line 6. This amount will be used as a basis for withholding income tax under the appropriate withholding tables.

4. **A New Exemption Certificate Must Be Filed With Your Employer Within 30 Days After Any Change In Your Exemption Status.**

5. **Penalties Are Imposed For Willfully Supplying False Information Or Willfully Failure To Supply Information Which Would Reduce The Withholding Exemption.**

6. **If The Employee Fails To File An Exemption Certificate With His Employer, Income Tax Must Be Withheld By The Employer On Total Wages Without The Benefit Of Exemption.**

7. **Important: Use This Form Only For Pay Periods In 2000 And After.**

8. **To Comply With The Military Spouses Residency Relief Act (PL 111-97) Signed into law November 11, 2009.**
SELECTIVE SERVICE ELIGIBILITY AND VERIFICATION

As of January 01, 2000, all new male employees must complete this form regarding their eligibility for Selective Service registration. Males age 18 through 26 who are required to register for Selective Service must provide verification of registration or exemption as a condition of employment. It applies to all employees of Delta State University, including faculty, staff, and students regardless of title or source of funds. If the new employee is unable to provide verification of registration or exemption, they cannot work. For assistance, contact the Human Resources department at 846-4035.

INSTRUCTIONS: To be completed immediately by all new male employees on or before first day of employment.

Name: (Please Print)

Last
First
Middle

Social Security Number: __________ / __________ / __________

Section 1 – Registration Based on Age

1. Are you a male age 18 through 26?  (Circle One)  YES  NO

If YES, go to Section 2.

If NO, return this form to the Human Resources department. The Human Resource department will keep this information in your employment records file.

Section 2 – Registration Based on Status

1. As a male age 18 through 26, are you required to register for Selective Service? (Circle One)

   YES  You are required to register if you are a male U.S. citizen or immigrant alien male.

   NO  You are not required to register if you are a lawful non-immigrant alien on a student, visitor, tourist, or diplomatic visa; on active duty in the U.S. Armed Forces; or attending certain service academies.

If YES, go to Section 3.

If NO, return this form to the Human Resources department. The Human Resource department will keep this information in your employment records file.

Section 3 – Verification of Registration or Exemption

1. The Selective Service card issued upon registration. (Attach a copy of the card to this form)

2. Telephone verification. Call 847-688-6888 to obtain telephone verification of registration.


Selective Service Number: ________________________________

If you have not yet registered, you must register IMMEDIATELY or you will not be able to be employed at Delta State University. You may register either on-line at http://www.sss.gov or at the nearest post office. The supervisor or department head will initiate termination to any employee who does not provide appropriate documentation to the Human Resources department within three weeks of their employment date.

Verification of Exemption

Please state the reason you are exempt: ________________________________. Exemptions are extremely rare and only include children of diplomats assigned to embassies in the United States, and individuals who are part of trade commissions or embassies of foreign countries. Exemptions do not include student deferments or conscientious objectors. The Human Resource department will contact you for further information and documentation.

I certify that all the information, including attachments, is true and complete, and I understand that any misstatement, falsification, or omission of information shall be grounds for refusal to hire, or if hired, termination.

Employee Signature ________________________________  Date Signed ______ / _____ / ______
State of Mississippi
State Directory of New Hires

http://www.MS-NewHire.com

Effective October 1, 1997, all Mississippi employers (or independent contractors) are required to report certain information about personnel who have been newly hired, rehired, or have returned to work. Employers must either (1) complete this form, or (2) submit a copy of the worker's IRS W-4 form with the "other information section" completed on this form, or (3) submit the information by magnetic tape or floppy diskette. Call 800-241-1330 to obtain information on submitting new hire reports electronically. This form may be reproduced as necessary. Reports must be made within 15 calendar days from date of hire.

PLEASE PRINT (or TYPE) NEATLY IN UPPER-CASE LETTERS AND NUMBERS, USING A DARK, BALLPOINT PEN

- COMPLETE ALL FIELDS -

WORKER INFORMATION

Social Security Number: _______ _______ _______

Male (M) or Female (F): ____

Worker State of Hire: _______

First Name: __________________________

Middle Initial: _______

Last Name: __________________________

Suffix: _______

Address: ____________________________

City: ____________________________

State: _______ Zip Code: _______ _______

Date of Hire: _______ _______ _______

Worker's Date of Birth: _______ _______ _______

EMPLOYER INFORMATION

Employer Federal EIN: _______ _______ _______

Employer State EIN: _______ _______ _______

Employer Name: __________________________

Payroll Address: __________________________

City: ____________________________

State: _______ Zip Code: _______ _______

Employer contact in case of questions: __________________________

Phone: _______

Send Reports to:
Mississippi New Hire Reporting Program
P.O. Box 800008
Raleigh, NC 27675-9008
Fax: 800-937-8668

To report electronically or for more information, go to http://www.MS-NewHire.com

Date: _______ _______ _______

MDHS-DOSE-6700
Revised: Jan 2008
Employee Signature Acknowledgement

The Health Insurance Portability and Accountability Act (HIPAA) offers protection for millions of American workers that improve portability and continuity of health insurance coverage. By signing below, I acknowledge that I have received information regarding the HIPAA Act.

Signature ___________________________ Date ________________

---

Employee Signature Acknowledgement

In accordance with the IHL Best Practices for Human Resources all employees are required to receive the Computer/Technology Security and Use, Drug Free Workplace and Sexual Harassment policies and notices.

By signing below, I acknowledge receiving and reading the policies and procedure statements for each of the items listed below. I agree to abide by the provisions and understand that violation of the policy(ies) may result in disciplinary action.

- Computer/Technology Security and Use
- Drug Free Workplace Policy
- Harassment Policy

For more information regarding these policies, please refer to the Employment Section II and Technology Section IX under the University Policies website. (http://www.deltastate.edu/pages/2457.asp)

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DELTA STATE UNIVERSITY – STATEMENT OF UNIVERSITY POLICIES AND PROCEDURES

The official policies and procedures of Delta State University are located on the University Policies website at http://www.deltastate.edu/pages/2457.asp. By signing below, I acknowledge that it is my responsibility as DSU employee to become well informed and understand DSU's employment practices, benefits, facilities, advantages offered, and the related responsibilities I accept as an employee. The University reserves the right to amend or alter the conditions and terms as it deems necessary.

Signature ___________________________ Date ________________

February 2015
AMERICANS WITH DISABILITIES ACT (ADA)  
ACCOMMODATIONS REQUEST FORM

Delta State University is committed to equal employment opportunity and affirmative action for the disabled. As a government contractor, the IHL Executive Office is subject to The Americans with Disabilities Act of 1990 (ADA), and therefore must comply with governmental recordkeeping, reporting, and other requirements.

A disabled person is defined as:

1. An individual who has a physical or mental impairment that substantially limits a major life activity;
2. An individual who has a record of a substantially limiting impairment; and
3. An individual who is regarded as having substantially limiting impairment.

Those who believe themselves covered by the Act and who wish to benefit under Delta State University’s Affirmative Action Plan are asked to identify themselves. All information will be considered confidential except (1) supervisors may be informed regarding work restrictions or accommodations; (2) emergency response workers may be informed for first aid purposes; (3) governmental officials investigating compliance of the Act will be informed. Choosing not to provide this information will not result in adverse treatment or disciplinary action.

☐ I choose not to provide ADA status information.

Signature                                      Date

DATE:______________________________________

NAME:______________________________________ SEX: M  F (Circle One)

SOCIAL SECURITY NUMBER:____________________  BIRTH DATE:________

POSITION TITLE:____________________________

DEPARTMENT/OFFICE:_________________________

BRIEFLY DESCRIBE YOUR DISABILITY:

Please describe any reasonable accommodations that you request Delta State University to make to enable you to perform your job in a proper and safe manner.
VIETNAM ERA AND SPECIAL DISABLED VETERANS IDENTIFICATION INVITATION

Delta State University is committed to equal employment opportunity and affirmative action for Vietnam Era and Special Disabled Veterans. As a government contractor, Delta State University is subject to Sections 503 and 504 of the Rehabilitation Act of 1973, The Americans with Disabilities Act of 1990 (ADA), and Section 402 of the Vietnam Era Veterans Readjustment Assistance Act of 1974; and therefore must comply with governmental record keeping, reporting, and other requirements.

A "Veteran of the Vietnam Era" is defined as (1) an individual who served more than 180 days of active military, naval, or air service, any part of which was during the period August 5, 1964 through May 7, 1975, and was honorably discharged or released; or (2) was discharged or released because of a service-connected disability.

A "Special Disabled Veteran" is defined as (1) an individual who is entitled to compensation (including those receiving military retirement pay but who would otherwise be entitled to compensation) under laws administered by the Veterans Administration for disability rated at 30 percent or more or rated at 10 or 20 percent in the case of those determined to have a serious employment disability; or (2) an individual discharged or released from active duty because of a service-connected disability.

Veterans, as defined above, are asked to identify themselves by providing the requested information. All information will be considered confidential and will be used only in accordance with meeting the requirements and obligations of the Acts previously mentioned. Choosing not to provide this information will not result in adverse treatment or disciplinary action.

☐ I choose not to provide Veteran status information.

__________________________  __________________________
Signature                                      Date

DATE: __________________________________________
NAME: __________________________________________
SOCIAL SECURITY NUMBER: _________________________
POSITION TITLE: _________________________________
DEPARTMENT/OFFICE: _____________________________

VETERAN'S STATUS (CHECK ONLY ONE PLEASE):

________ VIETNAM ERA     ________ DISABLED VETERAN

8/2/2013
Effective July 1, 1999, all Public Employees' Retirement System (PERS) agencies must verify dual employment status. Regulation 36 states that if an employee has dual employment with another PERS agency, and at least one position is classified as a covered position, they MUST be reported by both agencies.

Please mark the box that applies to you:

☐ Currently employed with a state agency and participate in the Public Employees' Retirement System (PERS).

☐ Currently employed with a state agency and participate in the Optional Retirement Plan (ORP).

☐ Retired from the Public Employees' Retirement System (PERS).

☐ Do not participate in the Public Employees' Retirement System (PERS).

______________________________  ______________________________
Employee's Name (Please print)  Employee's Signature

______________________________  ______________________________
Social Security Number  Date
Non-Covered Employment Acknowledgment

Form 4A - Revised 8/1/2012

Complete only if employee is not receiving PERS service retirement benefits and is not contributing to PERS through another employer. Please print or type in black ink. Completed form should be mailed or faxed to PERS. See bottom of form for contact information.

1 Employee Information

First Name: ___________________________ MI: ___________________________ Last Name: ___________________________ Gender: ☐ M ☐ F

Social Security No.: ___________________________ Birth Date mm/dd/yyyy: ___________________________ E-Mail: ___________________________

Mailing Address: ___________________________ City: ___________________________ State: ____ Zip: __________ ___________

Phone: ___________________________ ☐ Cellular ☐ Home ☐ Work Phone: ___________________________ ☐ Cellular ☐ Home ☐ Work

2 Employee Acknowledgment

I hereby acknowledge that I am not receiving service retirement benefits from PERS and am not employed in a position working a total of 80 hours or more per month or in a position working more than four and a half months or in a position working one-half or more of the normal working load and receiving one-half or more of the normal compensation for the school academic year, and that I, therefore, am not eligible for coverage for such service under the provisions of PERS. ☐ ☐ If an authorized representative signs this form, attach a copy of the durable power of attorney, conservatorship or guardianship papers, or other legal documents as proof of authority to sign this form.

Employee's Signature: ___________________________ Date mm/dd/yyyy: ___________________________

3 Employer Certification - This section must be completed by an authorized employer representative, not the employee.

Employee's Position Held/Job Title: ___________________________

Employee's Hire Date mm/dd/yyyy: ___________________________ Employee's Termination Date mm/dd/yyyy: ___________________________

Employer Name: ___________________________ Employer No.: __________

Employer Representative's Name: ___________________________ Employer Representative's Title: ___________________________

Employer Representative's Phone: ___________________________ Fax: ___________________________ E-Mail: ___________________________

As an employer representative, I understand that wages earned and paid to the above named individual during this period of employment will not be subject to withholding for state retirement. I further understand that any person who makes a false statement or shall falsely or permit to be falsified any record of a retirement plan administered by PERS in an attempt to defraud the plan may be subject to criminal prosecution. With that understanding, I certify that the above information is true and correct and that employment in this position does not meet the eligibility requirements of PERS Board of Trustees Regulation 26, Eligibility of Part-time Employees for State Retirement Annuity Service Credit, and PERS Board of Trustees Regulation 36, Eligibility for Membership in the Public Employees' Retirement System of Mississippi (PERS).

Employer Representative's Signature: ___________________________ Date mm/dd/yyyy: ___________________________

Public Employees’ Retirement System of Mississippi
429 Mississippi Street, Jackson, MS 39201-1005  601.359.3589  601.359.5262, fax  www.pers.state.ms.us
Millions of employees enjoy the benefits of direct deposit and it is one of the most confidential methods of processing your check. In fact, many employees enjoy the convenience of knowing their earnings are deposited into their accounts. Your money is available in your account on payday.

Your monthly statement from your financial institution will provide a record of all direct deposits. You may also verify your deposit through several services (i.e., telephone info-line, ATM machine, etc.) your financial institution provides. You will receive your pay stub showing your gross earnings, deductions, and net pay at the same time paychecks are available to those that are not participating in direct deposit. Please remember to notify our office of changed or closed accounts. This may delay the receipt of payments.

Instructions:
- Complete all information listed below including name and account number at financial institution and whether deposit to a checking or savings account is requested.
- Checking Account – Attach a voided check
- Savings Account – Attach a letter or statement from your financial institution which includes the financial institution’s routing number and your account number.
- Sign and return form to the Human Resource Department, Kent Wyatt Hall 247. If you have a joint account, both signatures are required to initiate a direct deposit. Should you have any questions, please contact us at 662-846-4035.

EMPLOYEE’S AUTHORIZATION: I (we) hereby authorize DELTA STATE UNIVERSITY and the financial institution listed below to initiate credit entries, and to initiate, if necessary, debit entries and adjustments for any credit entries in error to my account listed below. This authority will remain in effect until I have cancelled in writing with sufficient notice to allow the financial institution and Delta State University adequate time to act on it.

This is an authorization to: ☐ Establish New Account  ☐ Change Existing Account

☐ Checking account – A voided check is required to process this authorization.
☐ Savings Account – A letter from your financial institution that includes the routing number and your account number is required to process this authorization.

<table>
<thead>
<tr>
<th>Financial Institution</th>
<th>Employee’s Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>City, State, Zip</td>
<td>Social Security Number</td>
</tr>
<tr>
<td>Account Number</td>
<td>Employee’s Signature</td>
</tr>
<tr>
<td>Routing Number</td>
<td>Joint Account’s Signature (If applicable)</td>
</tr>
</tbody>
</table>

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

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

Can I Save Money on my Health Insurance Premiums in the Marketplace?
You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn’t meet certain standards. The savings on your premium that you’re eligible for depends on your household income.

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

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

How Can I Get More Information?
For more information about your coverage offered by your employer, place check your summary plan description which can be accessed at http://knowyourbenefits.dfa.state.ms.us/ or contact:

Delta State University
Department of Human Resources
Kent Wyatt Hall 247
Cleveland, MS 38733

Phone: (662) 846-4035

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

1An employer-sponsored health plan meets the "minimum value standard" if the plan’s share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.
PART B: Information About Health Coverage Offered by Your Employer

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

3. Employer name: Delta State University
4. Employer identification Number (EIN): 646026565
5. Employer Address: Kent Wyatt Hall, Suite 247
6. Employer Phone Number: (662) 846-4035
7. City: Cleveland
8. State: MS
9. Zip Code: 38733
10. Who can we contact about employee health coverage at this job?:
Department of Human Resources
11. Phone number (If different from above): 
12. Email address: DSUhr@delta.edu

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

- As your employer, we offer a health plan to:
  - [ ] All Employees.
  - [x] Some Employees. Eligible employees are:
    A faculty or staff member employed at least fifty percent (50%) time for an anticipated four and one half (4 1/2) months who receives compensation directly from Delta State University and is making contributions to a retirement plan approved by the Mississippi Public Employees' Retirement System.

- With respect to dependents:
  - [x] We do offer coverage. Eligible dependents are:
    The employee's legal spouse as defined by Mississippi law, unless the spouse also appears as an eligible employee under the Plan. The employee's natural child, stepchild, legally adopted child, foster child, child placed in the employee's home in anticipation of adoption, child for whom the employee is legal guardian, child for whom the employee has legal custody, or child of the employee who is required to be covered by reason of Qualified Medical Child Support Order up to age 26.

  - [ ] We do not offer coverage.

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

The State and School Employees' Health Insurance Plan does meet the minimum value standard, and the cost of this coverage (based on employee only premiums) is intended to be affordable.

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

If you decide to shop for coverage in the Marketplace, HealthCare.gov will guide you through the process.
PLEASE KEEP
THE
FOLLOWING
NOTICES
The Health Insurance Portability and Accountability Act (HIPAA)

The Health Insurance Portability and Accountability Act (HIPAA) offers protections for millions of American workers that improve portability and continuity of health insurance coverage.

HIPAA Protects Workers and Their Families By

- Limiting exclusions for preexisting medical conditions (known as preexisting conditions)
- Providing credit against maximum preexisting condition exclusion periods for prior health coverage and a process for providing certificates showing periods of prior coverage to a new group health plan or health insurance issuer
- Providing new rights that allow individuals to enroll for health coverage when they lose other health coverage, get married or add a new dependent
- Prohibiting discrimination in enrollment and in premiums charged to employees and their dependents based on health status-related factors
- Guaranteeing availability of health insurance coverage for small employers and renewability of health insurance coverage for both small and large employers
- Preserving the states’ role in regulating health insurance, including the states’ authority to provide greater protections than those available under federal law

Preexisting Condition Exclusions

- The law defines a preexisting condition as one for which medical advice, diagnosis, care, or treatment was recommended or received during the 6-month period prior to an individual’s enrollment date (which is the earlier of the first day of health coverage or the first day of any waiting period for coverage)
- Group health plans and issuers may not exclude an individual’s preexisting medical condition from coverage for more than 12 months (18 months for late enrollees) after an individual’s enrollment date
- Under HIPAA, a new employer’s plan must give individuals credit for the length of time they had prior continuous health coverage, without a break in coverage of 63 days or more, thereby reducing or eliminating the 12-month exclusion period (18 months for late enrollees)

Creditable Coverage

- Includes prior coverage under a group health plan, an individual health insurance policy, COBRA, Medicaid, Medicare, CHAMPUS, the Indian Health Service, a state health benefits risk pool, FEHBP, the Peace Corps Act, or a public health plan
Certificates of Creditable Coverage

- Certificates of creditable coverage must be provided automatically and free of charge by the plan or issuer when an individual loses coverage under the plan, becomes entitled to elect COBRA continuation coverage or exhausts COBRA continuation coverage. A certificate must also be provided free of charge upon request while you have health coverage or anytime within 24 months after your coverage ends.

- Certificates of creditable coverage should contain information about the length of time you or your dependents had coverage as well as the length of any waiting period for coverage that applied to you or your dependents.

- For plan years beginning on or after July 1, 2005, certificates of creditable coverage should also include and educational statement that describes individuals’ HIPAA portability rights. A new model certificate is available on EBIA’s Web site.

- If a certificate is not received, or the information on the certificate is wrong, you should contact your prior plan or issuer. You have a right to show prior creditable coverage with other evidence – like pay stubs, explanation of benefits, letters from a doctor – if you cannot get a certificate.

Special Enrollment Rights

- Are provided for individuals who lose their coverage in certain situations, including on separation, divorce, death, termination of employment and reduction in hours. Special enrollment rights also are provided if employer contributions toward the other coverage terminates.

- Are provided for employees, their spouses and new dependents upon marriage, birth, adoption or placement for adoption.

Discrimination Prohibitions

- Ensure that individuals are not excluded from coverage, denied benefits, or charged more for coverage offered by a plan or issuer, based on health status-related factors.
Harassment

POLICY STATEMENT

It is the policy of Delta State University that all employees, students, customers, contractors, and visitors to our campus enjoy a positive, respectful and productive work environment free from behavior, actions or language constituting workplace harassment.

DEFINITIONS

Harassment: Delta State University follows the Equal Employment Opportunity Commission’s definition of harassment as its guideline for defining harassment.

Harassment, as defined by the Equal Employment Opportunity Commission (EEOC), "is a form of employment discrimination that violates Title VII of the Civil Rights Act of 1964, the Age Discrimination in Employment Act of 1967, (ADEA), and the Americans with Disabilities Act of 1990, (ADA). Harassment is unwelcome conduct that is based on race, color, sex, religion, national origin, disability, and/or age. Harassment becomes unlawful where (1) enduring the offensive conduct becomes a condition of continued employment, or (2) the conduct is severe or pervasive enough to create a work environment that a reasonable person would consider intimidating, hostile, or abusive" (http://www.eeoc.gov/types/harassment.html).

Harassment based upon race, color, religion, sex, national origin, age, or disability is a form of discrimination and is prohibited by federal laws. Harassment based on sexual orientation or group affiliation is prohibited by DSU policy. The University, in its efforts to foster an environment of respect for the dignity and worth of all members of the university community, is committed to maintaining a work-learning environment free of harassment. Supervisors have a responsibility to ensure compliance with all applicable laws and regulations and to create a safe and pleasant workplace environment for their employees. Therefore, supervisors must be familiar with anti harassment laws and regulations and possible consequences of violations.

Hostile Environment: A hostile environment is determined by looking at all of the circumstances including:

- the nature of the alleged hostility
- the frequency of the allegedly harassing conduct,
- its severity,
- whether it is physically threatening or humiliating, and
- whether it unreasonably interferes with an employee’s work or student’s academic performance

Quid Pro Quo: Unwelcome sexual advances, requests for sexual favors, and other verbal and physical conduct of a sexual nature by one in a position of power or influence constitutes “quid pro quo sexual harassment” when:

- submission by an individual is made either an explicit or implicit term or condition of employment or of academic standing, or
- submission to or rejection of such conduct is used as the basis for academic or employment decisions affecting that employee or student
As defined, "quid pro quo" normally arises in the context of an authority relationship. This relationship may be direct as in the case of a supervisor and subordinate or teacher and student or it may be indirect when the harasser has the power to influence others who have authority over the victim. Same sex sexual harassment is included in the definition of this policy and the offender and victim can be either male or female.

**Student:** Any individual enrolled either full-time or part-time in Delta State University on or off-campus courses.

**Employee:** This generally includes faculty and staff employees on University paid appointments. It generally excludes students or temporary employees. For specific information on who is considered an employee, contact the Human Resources Department.

**Supervisor:** An employee designated by management who exercises major supervisory functions over another employee or employees. These functions include hiring, evaluating, assigning work, and disciplining employees.

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**PROCEDURES and RESPONSIBILITIES**

Delta State University is committed to providing and promoting an atmosphere in which faculty and staff can realize their maximum potential in the workplace and students can engage fully in the learning process. Toward this end, all members of the university community (including faculty, staff and students) must understand that harassment will not be tolerated, and that they are required to abide by university policy. Harassment violates federal civil rights laws and the university’s nondiscrimination policy.

The purpose of this policy includes:
1. to serve as notice of the types of behavior which are unacceptable and will not be tolerated by DSU and
2. to advise those who feel they have been the object of harassment of the resources available to them.

It is incumbent upon anyone who feels he or she has been harassed to avail themselves of this policy and procedure.

Engaging in harassment is unacceptable conduct which will not be tolerated. Any student found to have engaged in harassment will be subject to disciplinary action up to and including suspension. Any employee found to have engaged in harassment will be subject to disciplinary action up to and including termination. Managers and supervisors who know or should have known of harassment and fail to report such behavior, or fail to take immediate, appropriate action, will be subject to disciplinary action up to and including termination.

In determining whether alleged harassing conduct warrants corrective action, all relevant circumstances, including the context in which the conduct occurred, will be considered. Facts will be judged on the basis of what is reasonable to persons of ordinary sensitivity and not on the particular sensitivity or reaction of an individual.

**Assurance / Protection Against Retaliation**

This policy seeks to encourage students, faculty, and other employees to express freely, responsibly, and in an orderly way opinions and feelings about any problem or complaint of harassment. Retaliation against persons who report or provide information about harassment or behavior that might constitute harassment is also strictly prohibited. Any act of reprisal, including internal interference, coercion, and restraint, by a
University employee or by one acting on behalf of the University, violates this policy and will result in appropriate disciplinary action.

DSU also recognizes that false accusations of harassment can have serious effects on innocent persons. If the investigation results in finding that the complainant has acted maliciously or has recklessly made false accusations, the accuser will be subject to appropriate disciplinary actions. Retaliation is a serious violation of this policy and should be reported immediately.

Confidentiality
Delta State University will do everything consistent with enforcement of this policy and with the law to protect the privacy of the individuals involved and to ensure that the complainant and the accused are treated fairly. Information about individual complaints and their disposition is considered confidential and will be shared only on a “need to know” basis. All reasonable steps will be taken to assure that the complainant and the alleged offender are protected by the highest degree of confidentiality possible. Both parties are advised, however, that once an inquiry or an investigation has begun, anonymity may be impossible.

Prompt Reporting of Allegations
Persons who believe they have been victims of harassment should report the incident(s) immediately to appropriate administrative personnel as set forth below. Delay in reporting makes it more difficult to establish the facts of a case and may contribute to the repetition of offensive behavior.

If a complainant is able and feels safe, he or she should clearly explain to the respondent that the behavior is objectionable and request that it cease. The complainant should do so as soon as possible after the incident occurs. Communication with the respondent may be in person, on the telephone, or in writing. If the behavior does not stop, or if the complainant believes some adverse employment or educational consequences may result from the discussion, he or she may utilize a documented grievance process. There are two modes for resolving complaints, the informal grievance report and the formal grievance procedure.

Informal Report
Informal means are encouraged as the beginning point, but the choice of where to begin normally rests with the complainant. The informal complaint seeks resolution through discussion and mediation facilitated by the mediator, either the Vice President for Student Services or the Director of Human Resources.

Students:
The informal complaint seeks resolution through discussion and mediation facilitated by the Vice President of Student Services. Students who believe for any reason that they cannot effectively submit their informal complaint to the Vice President of Student Affairs should direct their complaint to the Provost/Vice President for Academic Affairs.

Faculty and Staff:
The informal complaint seeks resolution through discussion and mediation facilitated by the Director of Human Resources. Faculty and staff who believe for any reason that they cannot effectively submit their informal complaint to the Director of Human Resources should direct their complaint to either the Provost/Vice President for Academic Affairs or the Vice President for Finance & Administration.
The informal complaint does not involve, at any stage, a “finding” of guilt, nor does it mandate disciplinary action. The focus of the investigation in the informal report is to stop inappropriate behavior, investigate, and facilitate resolutions, if possible.

If a grievance is pursued through this informal complaint procedure, the complainant must initiate the request. The complaint should be brought as soon as possible after the most recent incident.
The role of the Vice President of Student Affairs and the Director of Human Resources will be to investigate the complaint, act as a neutral third party (mediator) and facilitate resolution. If the informal report procedure does not resolve the complaint, the complainant may initiate a formal grievance procedure. However, if the mediator(s) believe that the matter is sufficiently grave because it seems to be part of a persistent pattern, because of the nature of the alleged offense, or because the complainant seeks to have a sanction imposed, then the mediator(s) can initiate either a formal procedure or take other appropriate action.

**Process**

A. The mediator(s) will hold a discussion with the complainant to determine the nature of the complaint and provide the complainant with an explanation of all provisions of the policy.

B. The mediator(s) will meet with the respondent, assist him or her in interpreting the complaint, and request information regarding their position. The mediator(s) will facilitate communication between the parties of their respective positions. If desirable and agreeable to both parties, the mediator(s) may bring together the complainant and respondent and/or others who may be able to contribute to the resolution of the complaint.

C. If a resolution satisfactory to both complainant and respondent is reached, DSU may consider the complaint concluded. DSU may, however, deem further investigation necessary in order to address any disciplinary issues.

D. If a complaint is resolved informally, no record of the complaint will be entered into either employment files or student records. However, the mediator(s) will, in the form of a confidential file memorandum, record the fact of the complaint and the resolution achieved. A copy of the memorandum will be retained in confidential files for a period of three years.

**Formal Complaint**

Any individual who believes that he or she has been the object of harassment may bring a formal complaint. The following sections identify appropriate reporting channels that students and employees should contact regarding harassment.

**Student Complaints**

1. If the formal complaint is against a faculty member, graduate assistant, or staff member in an academic or administrative department, it should be directed to the Vice President for Student Affairs. This also applies to students participating in internships, field placements, student teaching, and off-campus academic settings.

2. If the formal complaint is against a student, not acting in an instructional or other employment capacity, it should be directed to the Vice President for Student Affairs.

3. Students who believe for any reason that they cannot effectively submit their formal complaint through the above channels can direct their complaint to either the Provost/Vice President of Academic Affairs.

4. **Faculty and Staff Complaints**

   1. If the formal complaint is against a faculty member, other instructional personnel, or staff employed in a college or school, it should be directed to the Director of Human Resources.

   2. If the formal complaint is against a staff member in a department other than a college or school, it should be directed to the Director of Human Resources.
3. If the formal complaint is against a student, not acting in an instructional or other employment capacity, it should be directed to the Vice President for Student Affairs.

4. Faculty and staff who believe for any reason they cannot effectively submit their formal complaint through the above channels can direct their complaint to either the Provost/Vice President of Academic Affairs or the Vice President for Finance & Administration.

Faculty, staff, and students who are victims of assault or harassment may seek advice and referral from the University's Counseling Services. This office, which keeps all information confidential, neither receives complaints nor conducts investigations.

**Filing the Formal Complaint**
The process is initiated when a written, signed complaint is submitted. When a written complaint is received, it will be treated as a formal complaint unless it specifically states that complainant desires to use the informal process. (However, any apparently legitimate complaint, regardless of its form, will be investigated and resolved to the extent deemed appropriate under the circumstances). The signed complaint should include the names of the individuals involved, a description of what occurred, and the time(s), place(s), and date(s) of the event(s).

**Notice to Parties**
After a formal complaint has been received, the investigator(s) will promptly notify all parties in writing of: the charge, including the names of all parties; DSU’s policy and procedure on harassment, and the name(s) of the individual(s) who will conduct the formal investigation on behalf of DSU.

**Formal Investigation**
The investigator(s) will ask the respondent to submit a detailed statement describing what occurred at the time of the alleged incident and listing the names of any witnesses with a brief description of what each may have seen or been told. The investigator(s) will then furnish each party with a copy of the other party’s statement. Within five (5) working days after receipt of the statement, each party will prepare and submit a detailed written response to the other party’s statement.

The investigator(s) may conduct interviews with witnesses. If possible, statements of witnesses will be in writing and signed; however, the investigator(s) may prepare written summaries of oral statements made by the witnesses. The investigator(s) must inform each witness that his or her statement will be furnished to each of the respective parties. When the investigation is complete, the investigator(s) will prepare a written preliminary report. The report should describe the evidence in detail, have attached summaries, and other relevant documents, and contain recommendations. The complainant and respondent will have two (2) working days in which to share their response to this report with the investigator(s). The investigator(s) will consider responses and prepare a final report to be sent to the complainant, respondent, and the President.

**Appeal Process / Final Decision**
Either party may respond to the final report of the investigator(s) by written letter to the President. This letter should contain arguments as to why the recommendation(s) of the investigator(s) should be modified, accepted, or rejected. The President shall consider both the report of the investigator(s) and the letters of the respective parties. The decision of the President is final. The complainant and the respondent will be notified of the outcome of the investigation.

**False Allegations**
DSU recognizes that the question of whether a particular course of conduct constitutes harassment requires a factual determination. DSU also recognizes that false accusations of harassment can have serious effects on innocent persons. If the investigation results in finding that the complainant has acted maliciously or has recklessly made false accusations, the accuser will be subject to appropriate disciplinary actions.
Record Keeping
All written records generated through the use of the formal complaint procedure shall be kept for a period of three years in respective student’s records or the employee’s records in the Human Resources Department.

Responsibilities of Delta State University Supervisors
All members of the university community have a general responsibility to contribute in a positive way to a university environment that is free of harassment. Supervisory personnel, however, have additional responsibilities. Supervisory personnel are not only responsible for educating and sensitizing employees in their units about harassment issues, but they are also directed to take all appropriate steps to prevent and stop harassment in their areas of responsibility. Supervisory personnel who are contacted by an individual seeking to file a complaint about harassment in their department or area of responsibility shall assist the complainant in contacting the appropriate personnel.

Rights and Responsibilities of the Respondent
1. The right to have an opportunity to fully respond to the complaint.
2. The right to have the complaint investigated and resolved in a timely manner.
3. The responsibility not to take any actions against the complainant that could be considered retaliation. There should be no contact between the supervisor and complainant during the course of action.
4. The right to know the steps taken to resolve the complaint. Investigators will fully inform the individual on the status of the investigation.
5. The responsibility of providing as much information as possible as requested by the investigator(s) in order to provide a fair and just resolution to the complaint.
6. The responsibility of maintaining confidentiality. The nature of the complaint should not be disclosed to persons not involved.

RELATED DOCUMENTS

- Applicable Federal Law
Drug Free Environment

POLICY STATEMENT

Delta State University is committed to maintaining a drug-free environment in conformity with appropriate state and federal laws.

DEFINITIONS

Employee: This generally includes faculty and staff employees who are working on paid appointments by the University. It generally excludes students or temporary employees. For specific information on who is considered an employee, contact the Human Resources Department.

Supervisor: An employee designated by management who exercises major supervisory functions over another employee or employees. These functions include hiring, evaluating, assigning work, and disciplining employees.

PROCEDURES and RESPONSIBILITIES

Delta State University is committed to maintaining a drug-free environment in conformity with state and federal laws as set forth in the Uniform Controlled Substance Law of the State of Mississippi and the Drug-Free Workplace Act of 1988. As a result of these laws and of the policy of this institution that the campus of Delta State University be a drug-free environment, employees are specifically prohibited from the possession, use, manufacture, distribution, sale or in any other way involved with a controlled substance both on and off campus, except as permitted in the relevant legislation. The term "employee" shall specifically include full-time and part-time. Each employee must abide by the requirements of this policy as a condition of employment at this university.

Delta State University will make available to all present and new employees a copy of this policy.

Employees are encouraged to seek assistance voluntarily on a confidential basis by contacting the person’s immediate supervisor or the University Counseling Center. Assistance with substance abuse problems is available through several centers for alcohol and drug education in the Delta area.

Supervisors must confidentially refer for counseling any person under their supervision who appears to be having difficulty with substance abuse.

Delta State University has established a Drug-Free Awareness Program that is administered jointly through the University Counseling Center and Human Resources Office. This program includes supervisory training programs, confidential referrals to rehabilitation programs approved for such purposes by a federal, state, or local health agency.

Any staff member who has been convicted of a criminal drug statute violation occurring in the workplace must notify the supervisor no later than five (5) days after the conviction.

Sanctions

Depending upon the facts related to any drug conviction or use, the employee may be:
suspended pending further investigation; required to participate in a drug abuse assistance program; issued a written warning; or terminated. For terminations, the applicable termination procedure will apply, based upon the status of the employee. Any action will be initiated within thirty (30) days after the facts become known by the University.

If faculty or staff members fail to notify their immediate supervisor of any criminal drug statute conviction for a violation occurring in the workplace within five (5) days after such conviction, they will be suspended pending investigation with termination possible. For purposes of this policy "conviction" means a finding of guilt (including a plea of nolo contendere) or imposition of sentence, or both, by any judicial body charged with the responsibility to determine violations of the federal or state criminal drug statutes.

Upon notification of such conviction, the University is required by law to notify the applicable funding agency (or agencies) within ten (10) days if the employee is working in a position funded by federal monies.

If an employee is suspected of violating any criminal drug statute in the workplace, the DSU Police Department will be called to begin investigation of the case.

RELATED DOCUMENTS