

Welcome To Pulaski County Special School District

Please print this New Hire Packet. Complete and bring with you to one of the scheduled New Hire Meetings.

The New Hire Paperwork and Insurance meetings have been scheduled for the following dates at 1:00 PM in the Board Room at Central Office (you do NOT have call and schedule an appointment): Monday July 13, Tuesday July 14, Thursday July 23, Monday July 27, Tuesday July 28, Tuesday August 4 and Monday August 10.

I will review your file with you at the New Hire Meeting one-on-one to make sure we have everything that you need to get paid.

Required Documentation for your Personnel File

It is Mandatory to provide originals of the following documents:

Arkansas Teaching Certificate (1 original) not a color copy

All College transcripts(official) not a color copy

Copies, faxes or email are sufficient for the following documents:

Social Security Card
 Drivers License
 Birth Certificate or Passport
 PRAXIS or NTE scores

Pulaski County Special School District



Kristy Manees, Personnel Specialist kmanees@pcssd.org

Phone: 501-234-2035 Fax: 501-490-9897

MEMO

TO: New Certified Employees

FROM: Kristy Manees, Certified Personnel Specialist

RE: 2015-2016 New Employee New Hire requirements

The information listed below is provided to create your personnel file with PCSSD and to help guide you through your first year with us.

When you come to Human Resources you we will complete several documents for your file. The following forms will be provided to you:

- Arkansas Teacher Retirement packet
- Background check release
- Arkansas Child Maltreatment form
- I-9
- W-4
- Substitute information
- Verification of Experience (for previous employment experience)
- Direct deposit authorization
- Insurance applications (Juliet Bogy at 501-234-2127)

It is mandatory to provide <u>originals</u> of the following documents:

- AR Teaching Certificate (1 original) not a color copy
- All college transcripts (originals) not a color copy

Copies, faxes or email kmanees@pcssd.org are sufficient for the following documents:

- Social Security card
- Driver's license
- Birth certificate or a passport
- PRAXIS or NTE scores

If you do not turn in one or more of the required documents it may result in forfeiture of benefits, nonpayment, substitute or incorrect salary, or a delay in receiving your contract that may take 2-4 weeks to correct.

It is your responsibility to submit the documentation within 30 days of hire to receive the salary and benefits you're eligible to receive. If you realize you have submitted the correct documentation and you are being paid incorrectly please contact us as soon as possible. I can be contacted by phone at 501-234-2035, email kmanees@pcssd.org or fax at 501-490-9897.

Thank you for joining us at PCSSD. I hope 2015-2016 is a productive and rewarding year.

The New Hire Paperwork and Insurance meeting have been schedule for the following dates at 1 p.m. in the Board Room at Central Office (you do NOT have call and schedule an appointment):

Monday, July 13 • Tuesday, July 14 • Thursday, July 23 • Monday, July 27 • Tuesday, July 28 • Tuesday, August 4 and Monday, August 10.

| Name: | Employee Number: |
|--|--------------------------------|
| Home Number: N | lobile Number: |
| Emergency Contact: | |
| Name: | |
| Phone Number: | 21 |
| Special Skill Sets: Piease check any that pert | ain to you |
| CPR Certified | Food Service Supervisor |
| Amateur Radio Operator | Races Certified – Radio Amateu |
| | Civil Emergency Services |
| First Aid Certified | Emergency Medical Technician |
| Certified Counselor | Paramedic |
| Fluent in Spanish | Lives 0 to 2 miles from work |
| Fire Fighter | Lives 2 to 5 miles from work |
| Crisis Counselor | Lives 5 to 10 miles from work |
| | |

work

HVAC Mechanic

Licensed Plumber

Active or Reserve Military

APSCN Student System Trained

(AED) Trained

Registered Nurse

Search and Rescue Certified

Law Enforcement Officer

Licensed Practical Nurse

Master Electrician

Other Skills or Comments:

Employee Information for Disaster Plan Form

Fill out all information

Special Skill Sets (Please check any boxes that pertain to you.)

At least ONE Box will pertain to everyone!

Employee Information for Disaster Plan

| Name: Emplo | yee Number: |
|--|---------------------------------|
| Home Number: Mobile | Number: |
| | |
| Emergency Contact: | |
| Name: | |
| Phone Number: | |
| Special Skill Sets: Please check any that pertain to | you |
| CPR Certified | Food Service Supervisor |
| Amateur Radio Operator | Races Certified – Radio Amateur |
| | Civil Emergency Services |
| First Aid Certified | Emergency Medical Technician |
| Certified Counselor | Paramedic |
| Fluent in Spanish | Lives 0 to 2 miles from work |
| Fire Fighter | Lives 2 to 5 miles from work |
| Crisis Counselor | Lives 5 to 10 miles from work |
| Automatic External Defibrillator | Lives more than 10 miles from |
| (AED) Trained | work |
| Registered Nurse | Active or Reserve Military |
| Search and Rescue Certified | HVAC Mechanic |
| Law Enforcement Officer | Licensed Plumber |
| Licensed Practical Nurse | APSCN Student System Trained |
| Master Electrician | |

Other Skills or Comments: ______

NOTIFICATIONLETTER

Dear Employee:

ACA § 624-101 requires full open disclosure and approval before a school distict employee may sell, lease, provide services, or enter into other transactions with the school distict where best he is employed.

A C.A. §6:24-101 does not apply to reindousements and for proper week related expenses. However, in the case of hims family members of actiministrators and/or board members, the distint must meet all equivanents set firth in AC.A. §6:24-101 and Act 1381 of 2005.

A C.A. § 6-24-101 applies when the school employee is financially interested in the transaction. Financially interested means ownership or more than 5% interest; holding a position of director; patien; or top level management; and/or the employee's compensation is based on the transaction with the district

Therefore, employees of this district have an affirmative obligation under A.C.A.§6-24-101 to disclose relationships with verifors before the district enders into the contract or before services are performed. Disclosure is to be made to the superimentent of the district Forms for this purpose will be provided by the district.

Technology employees who establish specifications or approve technology purchases and their family members must disclose relationships and financial interest before the distict may enter into technology taxes advocs with the technology employee or a family member.

A C.A. § 6:24-101 requires proper disclosure and approval of the transaction at an open board meeting. In certain instances, approval by the Commissioner of the Department of Fishcation's required.

Therefore, every district employee will be required to disclose any potential worder relationship by completing a disclosure from provided by the district. Palme to fully disclose could result in criminal felory charges being brought against the employee. A copy of ACA § 6-24-101 is available in the certical office if you wish to review the law. The Act may also be viewed at www.arkicg.state.arus.

Sincerely. These

Notification Letter

Please Read and Sign.

nciano iza procesi je te dete. Namo i de decine contracti na cara da la esperio a Bristiko artikete. A capa di ACA, (6.34. (A) serabite to ite cana chico i pu nati te capa la esp De Admy de de devel di navecalegene con



Pulaski County Special School District

Dr. Jerry Guess, Superintendent 925 East Dixon Road Little Rock, AR 72206 Phone: 501.490.2000 Fax: 501.490.0483

Notification Letter

Dear Employee:

ACA. § 6-24-101 requires full open disclosure and approval before a school district employee may sell, lease, provide services, or enter into other transactions with the school district where he/she is employed.

ACA §6-24-101 does not apply to reimbursements paid for proper work-related expenses. However, in the case of hiring family members of administrators and/or board members, the district must meet all requirements set forth in ACA. §6-24-101 and Act 1381 of 2005.

ACA \$6-24-101 applies when the school employee is financially interested in the transaction. Financially interested means ownership or more than 5% interest, holding a position of director, partner, or top level management, and/or the employee's compensation is based on the transaction with the district.

Therefore, employees of this district have an affirmative obligation under A.C.A § 6-24-101 to disclose relationships with vendors before the district enters into the contract or before services are performed. Disclosure is to be made to the superintendent of the district. Forms for this purpose will be provided by the district.

Technology employees who establish specifications or approve technology purchases and their family members must disclose relationships and financial interest before the district may enter into technology transactions with the technology employee or a family member.

AC.A. § 6-24-101 requires proper disclosure and approval of the transaction at an open board meeting. In certain instances, approval by the Commissioner of the Department of Education is required.

Therefore, every district employee will be required to disclose any potential vendor relationship by completing a disclosure form provided by the district. Failure to fully disclose could result in criminal felony charges being brought against the employee. A copy of ACA § 6-24-101 is available in the central office if you wish to review the law. The Act may also be viewed at www.arkleg.state.ar.us.

Sincerely,

Superintendent

Please sign below to acknowledge receipt of this notification.

School Employee (Print Name and Location)

Signature

| School Districts | 5 | | | | | Form # Revised 8/200 1400 West Third, Little Rock, AR 722 Phone (601) 682-1517 or (800) 666-287 Fax (801) 682-2 Wabsite – http://www.artm.go |
|---|--------|---------|---------|----------------|-------------|---|
| | | Me | embe | rship | Data Fo | rm |
| | | To | be Co | mplete | d by Meml | ber |
| * | | | | | | |
| Member's Social Secur | ity Nu | mber | | | | |
| | | | | | | |
| Name (Last, First, Middle | | | | | | |
| Maldon Name (If applicat | 10) _ | | _ | | | |
| Address | - | | | | | |
| The second second | | | Memi | ber's Da | te of Birth | |
| County of Residence | | | - | | | |
| City | here | 141-1 | | | State | Zip |
| Nemo of Course (Including | Der | Work | (| | | Home () |
| Name of Spouse (Last, Fil | | | - | | i., | |
| Spouse's Date of Birth | | | | | | |
| Member's Signature | | | | | | Date |
| | | | | | | |
| Previous Service: | | | Men | nber Hi | story | |
| Arkansas Public Schools | п | Yes | | No | Deter | |
| Arkansas State Agency | | Yes | | No | | |
| Arkansas Highway Dept | | Yes | D | No | | |
| Arkansas State Police | | Yes | | No | | / |
| Private Schools | - | Yes | | No | | |
| Out-of-State Service | | Yes | | No | | |
| Active Military Service | | Yes | | No | Dates | |
| lave you ever participated lave you ever been a mem lave you ever received a re | ber of | ATRS? | Cl Ye | s 🗆 M s 🗆 M | lo lo | ∿-Crof, Vallc) □ Yes □ No |
| | | | | | by Emplo | |
| | | | School | Distric | :t · _] | Employer Code |
| ember's Primary Position | | | | | | i |
| | | | | | | mber of days? |
| | | | | | | arified by ATRS |
| ember's first pald day of se | rvice | Month/1 | Day/Yea | ar) | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |

ARTRS Membership Data Form

Page 1

Please **print legibly** and fill out the first two sections completely.



| | | Completed | | |
|------------------------------|----------------|-----------------|----------------|--------------------------|
| Member's Social Security | Number | | | |
| Name (Last, First, Middle) | | | | |
| | | | | |
| | | | | |
| Male Female | | | | |
| County of Residence | | | | |
| | | | | Zip |
| | | | | Home () |
| | | | | |
| | | | | |
| | | | | |
| Member's Signature | | | | Date |
| | | Member His | story | |
| Previous Service: | | | , cory | |
| Arkansas Public Schools | Yes | 🛛 No | Dates | |
| Arkansas State Agency | Yes | 🛛 No | | |
| Arkansas Highway Dept | Yes | No | Dates | |
| Arkansas State Police | Yes | No | Dates | |
| Private Schools | Yes | No No | | |
| Out-of-State Service | Yes | | | |
| Active Military Service | Yes | 🛛 No | Dates | |
| Have you ever participated i | n an Alternate | e Retirement Pl | an? (ie. TIAA- | -Cref. Valic) 🔲 Yes 🔲 No |
| Have you ever been a mem | | | | |
| Have you ever received a re | fund? | 🗆 Yes 🗖 N | No | |
| | To | be Complete | d by Employ | /er |
| School District Pulaski Co | ounty Specia | I School Distri | ict E | Employer Code 00211 |
| | | | | |
| | | | | mber of days? |
| | | | | erified by ATRS |
| | • | | • | |
| member o mot paid day of ot | | | | |
| | | | | |

ARTRS Membership Data Form

(Please fill out both forms provided. They are NOT the same.)

Lump Sum Death Benefit



Form # 9 Effective 7/1/2007 1400 West Third, Little Rock, AR 72201 Phone (501) 682-1517 or (600) 686-2877 Fax (501) 682-2359 Website - http://www.artre.gov

LUMP SUM DEATH BENEFIT - BENEFICIARY DESIGNATION FORM

Arkansas Code Annotated § 24-7-720 provides that upon the death of an active or rotined momber of the Arkansas Teacher Referement System (ATRS), with 10 or more years of actual service, a Lump Sum Death Benefit payment in a mount set by the Doard of Insulees shall be paid to such person(s) as the member has designated in writing and like with IRTS. Elective for an ember dying after June 30, 2000, if there is no designated person surviving, the lump sum shall be paid to the member state.

| Member's Name | |
|----------------|------------------------|
| withing single | Social Security Number |
| Addrass | Occal Security Number |
| | |

| City | | |
|------|-------|-----|
| City | State | 7 |
| | | Zip |

PART 1 - Designation of Primary Beneficiary(ies)

I horeby designate the following as the primary tenedialary(se) of the Lump Sum Death Benefit due fram ATRG. In the event of my death, Lathorize ATRS to make perpend of the benefit to each beneficiary(se) who are living at the time of my death. Lundershaft the could shares will be distributed among mittigle surviving primary beneficiaries. At least one primary beneficiary must be loted.

| Name of Primary Beneficiary(ies) | SSN | Date of Birth | Relationship | Address |
|----------------------------------|-----|---------------|--------------|---------|
| | | | | |
| | | | | |
| | | | | |

PART 2 - Designation of Contingent Beneficiary(ies) - OPTIONAL

A contingent beneficiary will receive all benefits upon fion member's death only if all primary beneficiaries predecease the momber. I havely designate the following as contingent baneficiary(les) of the Lump Sam Death Bonefit. I understand that equal shares will be distributed anxing multiple surviving contingent beneficiaries.

| Name of Contingent Dawatering P. A. | | | | |
|-------------------------------------|-----|---------------|--------------|---------|
| Name of Contingent Beneficiary(ies) | SSN | Date of Birth | Relationship | Address |
| 10 | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| his DougEst | | | | |

This Beneficiary Designation shall become effective on the date received by ATRS and shall supersedo and cancel all Lump Sum Death Beneficiary Designations filed previously with ATRS.

Member Signature

State of

County of

To Be Completed By Notary Public

(Notary Seal)

Date

| Subscribed and Sworn before me on this | day of | ; 20 |
|--|--------|------|
| | uay of | , 20 |

Notary Signature _____ My commission expires:



Form #4 Effective 7/1/2006 1400 West Third, Little Rock, AR 72201 Phone (501) 682-1517 or (600) 686-2877 Fax (501) 682-2359 Websito - http://www.artis.gov

DISPOSITION OF RESIDUE - BENEFICIARY DESIGNATION FORM

Disposition of

Residue

Arkanses Code Annetated (24-7-700 provides that if a member of the Arkanses Teacher Referement System (ATRS) dies prior to novelving anaulty banefits capati to the amount of accumulated contributions (if any) standing to the member's cost at his/her death, the readult bleakers will be paid to such person(s) as the member has designated in writing and flow with PARS. Effective to another drying after June 30, 2000, (if there is no designated person euroving, the readulte shall be paid to the member's costate. Paket the mediate blaces is not designated person euroving, the readulte shall be amounty does not become payable at the member's death.]

| Member's Name Address | Social S | ecurity Number |
|--|----------|--|
| City | State | Zip |
| PART 1 - Designation of Primary Beneficiary(ies) | | <i>up</i> |
| I hereby designate the following as the primary beneficiar my death. Lauthorize ATRS to make | | I balance due from ATRS. In the count of |

| Name of Primary Beneficiary(ies) | SSN | Date of Birth | Relationship | Address |
|--|--|---|--|--|
| | | | | |
| | | | | |
| ART 2 - Decimption of Cantle | | | | |
| Contingent beneficiary will receive of | bradite | | | |
| A contingent beneficiary will receive all member. I hereby designate the followi | benefits upo | on the member's | death only if all prim | ary beneficiarles predecease th elance. I understand that equal |
| A contingent beneficiary will receive all member. I hereby designate the followi shares will be distributed among multip | benefits upo | on the member's | death only if all prim | ary beneficiarles predecease th selance. I undersland that equal Address |
| PART 2 - Designation of Continge A confingent beneficiary will receive all member. I hereity designate the followi shares will be distributed among multip Name of Contingent Benoficiary(les) | benefits upo ng as contin le surviving | on the member's gent beneficiary(contingent benefi | death only if all prim los) of any rosidual b claries. | elance. I understand that equal |

This Beneficiary Designation shall become effective on the date received by ATRS and shall supersede and cancel all Residue Death Beneficiary Designations filed previously with ATRS.

Member Signature

State of County of

To Be Completed By Notary Public

| | tan | | |
|--|-----|--|--|
| | | | |

Date

Subscribed and Swom before me on this _____ day of ______ , 20

Notary Signature _____ My commission expires:



LUMP SUM DEATH BENEFIT - BENEFICIARY DESIGNATION FORM

Arkansas Code Annotated § 24-7-720 provides that upon the death of an active or retired member of the Arkansas Teacher Retirement System (ATRS), with 10 or more years of actual service, a Lump Sum Death Benefit payment in an amount set by the Board of Trustees shall be paid to such person(s) as the member has designated in writing and filed with ATRS. Effective for a member dying after June 30, 2006, if there is no designated person surviving, the lump sum shall be paid to the member's estate.

| Member's Name | Social Security Number | |
|---------------|------------------------|-----|
| Address | | |
| City | State | Zip |

PART 1 - Designation of Primary Beneficiary(ies)

I hereby designate the following as the primary beneficiary(ies) of the Lump Sum Death Benefit due from ATRS. In the event of my death, I authorize ATRS to make payment of the benefit to such beneficiary(ies) who are living at the time of my death. I understand that equal shares will be distributed among multiple surviving primary beneficiaries. At least one primary beneficiary must be listed.

| Name of Primary Beneficiary(ies) | SSN | Date of Birth | Relationship | Address |
|----------------------------------|-----|---------------|--------------|---------|
| | | | | |
| | | | | |
| | | | | |

PART 2 - Designation of Contingent Beneficiary(ies) - OPTIONAL

A contingent beneficiary will receive all benefits upon the member's death only if all primary beneficiaries predecease the
member. I hereby designate the following as contingent beneficiary(ies) of the Lump Sum Death Benefit. I understand that
equal shares will be distributed among multiple surviving contingent beneficiaries.Name of Contingent Beneficiary(ies)SSNDate of BirthRelationshipAddress

| | | |
|--|------|--|
| | | |

This Beneficiary Designation shall become effective on the date received by ATRS and shall supersede and cancel all Lump Sum Death Beneficiary Designations filed previously with ATRS.

| Member Signature | Date | <u></u> |
|--|--------------------------|---------------|
| To Be Cor | npleted By Notary Public | |
| State of) County of) | | (Notary Seal) |
| Subscribed and Sworn before me on this | _day of, 20 | |
| Notary Signature | My commission expires: | |



Form # 4 Revised 3/2013 1400 West Third, Little Rock, AR 72201 Phone (501) 682-1517 or (800) 666-2877 Fax (501) 682-2359 Website - http://www.artrs.gov

DISPOSITION OF RESIDUE - BENEFICIARY DESIGNATION FORM

If a member of the Arkansas Teacher Retirement System (ATRS) dies with residual account balance(s) standing to the member's credit at his/her death, the residual balance(s) will be paid to such person(s) as the member has designated in writing and filed with ATRS. Effective for a member dying after June 30, 2006, if there is no designated person surviving, the residue shall be paid to the member's estate. [Note that the residual contribution and T-DROP balances are only paid to beneficiaries if a survivor or retirement option annuity does not become payable at the member's death.]

| Member's Name | Social Security Nur | nber |
|---------------|---------------------|------|
| Address | | |
| City | State | Zip |

PART 1 - Designation of Primary Beneficiary(ies)

I hereby designate the following as the primary beneficiary(ies) of any residual balance due from ATRS. In the event of my death, I authorize ATRS to make payment of the benefit to such beneficiary(ies) who are living at the time of my death. I understand that equal shares will be distributed among multiple surviving primary beneficiaries. At least one primary beneficiary must be listed.

| Name of Primary Beneficiary(ies) | SSN | Date of Birth | Relationship | Address |
|----------------------------------|-----|---------------|--------------|---------|
| | | | | |
| | | | | |
| | | | | |

PART 2 - Designation of Contingent Beneficiary(ies) - OPTIONAL

| A contingent beneficiary will receive all be member. I hereby designate the following shares will be distributed among multiple | as contingent | t beneficiary(ies | s) of any residua | · · |
|---|---------------|-------------------|-------------------|---------|
| Name of Contingent Beneficiary(ies) | SSN | Date of Birth | Relationship | Address |
| | | | | |
| | | | | |
| | | | | |

This Beneficiary Designation shall become effective on the date received by ATRS and shall supersede and cancel all Residue Designations filed previously with ATRS.

| Member Signature | Date | |
|--|----------------------------|---------------|
| То Ве | Completed By Notary Public | (Notary Seal) |
| State of) County of) | | (|
| Subscribed and Sworn before me on this | _ day of, 20 | |
| Notary Signature | My commission expires: | |

| 8 | Employment Eligibility Verification Department of Homeland Security U.S. Citizenship and Immigration Services | | | | | USCIS Form 1-9 OMB No. 1615-0047 Expires 03/31/2016 |
|---|--|---|---------------------------|--------------------------------|---------------------|--|
| START HERE, Read Instru ANTI-DISCRIMINATION NOT document(s) they will accept fe expiration date may also const | ICE: It is illegal to discr ore an employee. The r | iminato against efusal to hire ar | work-authorized individua | s. Employers | CANN | IOT specify which |
| Section 1. Employee In than the first day of employ | | | | and sign Sec | tion 1 | of Form I-9 no later |
| Last Name (Family Name) | First Nan | ne ('Givon Name) | Middle Initial | Other Names | Used (| '# any) |
| Address (Sirect Number and Na | ms) | Apt. Number | City of Town | Sti | 6e | Zip Code |
| Date of Birth (mm/dd/yyyy) U.S | Social Security Number | E-mail Address | | | Tolep | base Number |
| am aware that federal laws concertion with the complex attest, under penalty of par- al a citizen of the Unded Sta A catizen of the Unded Sta A namatitien antional of the A nama citizen antional of the Size instructions For aliven autorized to an A nama categorized and States, include the Mello Forging Passport Nuo Control of Issuesce. | tion of this form. jignr, that I am (check tes o United States (See is net (Alien Registration 1 net) (sepiration date. I op net) (sepiration date. I op n | one of the fol structions) iumber/USCIS pleatile, mmiddl Registration N | lowing): Number): | Somo allens I R Form I-94 A | nilly wr climiae | te "NVA" in this field. |
| | | assport Numbe | r and Country of Issuance | fields. (See | nstrui | diona) |
| Signature of Employee. | | | | Date (mm/tR | mm). | |
| Propater and/or Translate stropbyre) attest, under penalty of per- formation is true and corre- signature of Preparel or Translate ast Name (Pemily Name) uddress (Street Number and Nam | jury, that I have assis et. | ted in the com | | that to the b | est of | |
| | | | | | | |
| | E E | mployer Com | pletes Next Page | | | Page 7 of 9 |
| am 14 03.08/13 N | | | inter New Parts | 5 | | photos |
| | 0 10 | | leter New Parts | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |

Form I-9 Employment Eligibility Verification

Please fill out section 1 Be sure to sign and date



Employment Eligibility Verification

Department of Homeland Security

U.S. Citizenship and Immigration Services

START HERE. Read instructions carefully before completing this form. The instructions must be available during completion of this form. ANTI-DISCRIMINATION NOTICE: It is illegal to discriminate against work-authorized individuals. Employers CANNOT specify which document(s) they will accept from an employee. The refusal to hire an individual because the documentation presented has a future expiration date may also constitute illegal discrimination.

| Section 1. Employee I than the first day of employ | | | | and sign Se | ection 1 o | f Form I-9 no later |
|---|-------------------------------|-----------------|-------------------------------|---------------|--------------------|---------------------------------------|
| Last Name (Family Name) | First Nam | ne (Given Name |) Middle Initial | Other Name | es Used <i>(if</i> | any) |
| Address (Street Number and Na | ame) | Apt. Number | City or Town | 5 | State | Zip Code |
| Date of Birth (mm/dd/yyyy) U. | S. Social Security Number | E-mail Addres | S | | Teleph | one Number |
| I am aware that federal law connection with the comple | | ment and/or f | ines for false statements | or use of | false doo | cuments in |
| I attest, under penalty of pe | erjury, that I am (check | one of the fo | llowing): | | | |
| A citizen of the United Sta | ates | | | | | |
| A noncitizen national of t | he United States (See ir | nstructions) | | | | |
| A lawful permanent resid | ent (Alien Registration N | Number/USCIS | S Number): | | | |
| An alien authorized to work (See instructions) | until (expiration date, if ap | plicable, mm/dd | /уууу) | Some alien | s may writ | e "N/A" in this field. |
| For aliens authorized to v | work, provide your Alien | Registration N | lumber/USCIS Number Ol | R Form I-94 | Admissi | on Number: |
| 1. Alien Registration Num | nber/USCIS Number: | | | | | |
| 0 | R | | | | Do No | 3-D Barcode of Write in This Space |
| 2. Form I-94 Admission N | Number: | | | | | |
| If you obtained your ac States, include the follo | | BP in connect | ion with your arrival in the | United | | |
| Foreign Passport N | umber: | | | | | |
| Country of Issuance | 2 | | | | | |
| • | | | er and Country of Issuance | e fields. (Se | e instruc | tions) |
| , | | | | | | , |
| Signature of Employee: | | | | Date (mm | /dd/yyyy): | |
| Preparer and/or Translatemployee.) | tor Certification (To l | be completed a | and signed if Section 1 is p | repared by | a persor | other than the |
| l attest, under penalty of pe information is true and corr | | sted in the co | mpletion of this form and | that to the | e best of | my knowledge the |
| Signature of Preparer or Transla | ator: | | | | Date (r | nm/dd/yyyy): |
| Last Name (Family Name) | | | First Name (Give | en Name) | | |
| Address (Street Number and Na | ame) | | City or Town | | State | Zip Code |
| | | | | | 1 | 1 |

STOP

STOP

Section 2. Employer or Authorized Representative Review and Verification

(Employers or their authorized representative must complete and sign Section 2 within 3 business days of the employee's first day of employment. You must physically examine one document from List A OR 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.)

Employee Last Name, First Name and Middle Initial from Section 1:

| List A Identity and Employment Authorization | OR List B Identity | AND | List C Employment Authorization |
|---|---|------|---|
| Document Title: | Document Title: | Docu | ument Title: |
| | Driver's License | Soc | cial Security Card |
| Issuing Authority: | Issuing Authority: | | ng Authority: |
| | State of Arkansas | SS | Admin/US Government |
| Document Number: | Document Number: | Docu | ument Number: |
| Expiration Date (<i>if any</i>)(mm/dd/yyyy): | Expiration Date (<i>if any</i>)(<i>mm/dd/yyyy</i>): | Expi | ration Date (if any)(mm/dd/yyyy): |
| Document Title: | | | |
| Issuing Authority: | | | |
| Document Number: | | | |
| Expiration Date (if any)(mm/dd/yyyy): | | | |
| Document Title: | | | 3-D Barcode Do Not Write in This Space |
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| Document Number: | | | |
| Expiration Date (if any)(mm/dd/yyyy): | | | |

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 (n | nm/dd/yyyy): | | | (S | see instructions to | r exempti | ons.) |
|---|--------------------------|------------------|-------------------------|--------|--------------------------------|---------------------|---------------------------|
| Signature of Employer or Authorized Representativ | re E | Date <i>(I</i> | mm/dd/yyyy) | | Title of Employer or A | Authorized F | Representative |
| Last Name (Family Name) | First Name <i>(Given</i> | Name | e) | Emplo | l oyer's Business or Org | anization N | ame |
| | | | | Pul | aski Co. Spec | cial Sch | nool District |
| Employer's Business or Organization Address (Stre | eet Number and Na | ame) | City or Tow | n | | State | Zip Code |
| 925 E. Dixon Road | | | Little | Roci | k | AR | 72206 |
| Section 3. Reverification and Rehin A. New Name (<i>if applicable</i>) Last Name (<i>Family Na</i> C. If employee's previous grant of employment author presented that establishes current employment at | ame) First Name (| Given d, prov | Name) vide the infor | Mi | ddle Initial B. Date of | Rehire <i>(if a</i> | pplicable) (mm/dd/yyyy): |
| Document Title: | Docum | · · | | | | Expiration D | ate (if any)(mm/dd/yyyy): |
| I attest, under penalty of perjury, that to the k the employee presented document(s), the do | cument(s) I have | e exa | mined app | ear to | be genuine and to | relate to th | ne individual. |
| Signature of Employer or Authorized Representativ | ve: Date (n | nm/da | ууууу): | Prin | t Name of Employer o | or Authorized | a 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.

| | LIST A Documents that Establish Both Identity and Employment Authorization | DR | LIST B Documents that Establish Identity AN | ID | LIST C Documents that Establish Employment Authorization |
|----|--|----------|---|----|--|
| 2. | U.S. Passport or U.S. Passport Card Permanent Resident Card or Alien Registration Receipt Card (Form I-551) Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine- | | Driver's license or ID card issued by a State or outlying possession of the United States provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address | 1. | A Social Security Account Number card, unless the card includes one of the following restrictions: (1) NOT VALID FOR EMPLOYMENT (2) VALID FOR WORK ONLY WITH INS AUTHORIZATION (3) VALID FOR WORK ONLY WITH |
| 4. | readable immigrant visa Employment Authorization Document that contains a photograph (Form I-766) | | government agencies or entities, provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address | 2. | DHS AUTHORIZATION |
| 5. | For a nonimmigrant alien authorized to work for a specific employer because of his or her status: | | School ID card with a photograph Voter's registration card U.S. Military card or draft record | 3. | Certification of Report of Birth issued by the Department of State (Form DS-1350) Original or certified copy of birth |
| | a. Foreign passport; and b. Form I-94 or Form I-94A that has the following: (1) The same name as the passport; | 6. 7. | Military dependent's ID card U.S. Coast Guard Merchant Mariner Card | 4. | certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal |
| | and (2) An endorsement of the alien's | 8. | Native American tribal document | 5. | - |
| | nonimmigrant status as long as that period of endorsement has | 9. | Driver's license issued by a Canadian government authority | 6. | U.S. Citizen ID Card (Form I-197) |
| | not yet expired and the proposed employment is not in conflict with any restrictions or limitations identified on the form. | F | For persons under age 18 who are unable to present a document listed above: | 7. | Identification Card for Use of Resident Citizen in the United States (Form I-179) |
| 6. | Passport from the Federated States of Micronesia (FSM) or the Republic of the Marshall Islands (RMI) with Form I-94 or Form I-94A indicating nonimmigrant admission under the Compact of Free Association Between the United States and the FSM or RMI | 11 | . School record or report card | 8. | Employment authorization document issued by the Department of Homeland Security |

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.

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W-4 Form

Fill out the bottom part of this form.

Please be sure to put the number of exemptions you want to claim in box 5.

(Example if you want zero dependents write 0 in box 5. Don't leave it blank.)

Form W-4 (2015)

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 2015 expires February 16, 2016. 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 \$350 of unearned income (for example, interest and dividends).

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

Is age 65 or older,

Is blind, or

• Will claim adjustments to income; tax credits; or itemized deductions, on his or her tax return.

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

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

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

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

Tax credits. You can take projected tax credits into account in figuring your allowable number of withholding allowances. Credits for child or dependent care expenses and the child tax credit may be claimed using the **Personal Allowances Worksheet** below. See Pub. 505 for information on converting your other credits into withholding allowances. Nonwage income. If you have a large amount of nonwage income, such as interest or dividends, consider making estimated tax payments using Form 1040-ES, Estimated Tax for Individuals. Otherwise, you may owe additional tax. If you have pension or annuity income, see Pub. 505 to find out if you should adjust your withholding on Form W-4 or W-4P.

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

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

Check your withholding. After your Form W-4 takes effect, use Pub. 505 to see how the amount you are having withheld compares to your projected total tax for 2015. See Pub. 505, especially if your earnings exceed \$130,000 (Single) or \$180,000 (Married).

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

| | Persona | al Allowances Works | heet (Keep for your records.) | | | |
|--------------|--|-------------------------------------|---|-----------------------|----------------|----------|
| Α | Enter "1" for yourself if no one else can | claim you as a dependent | | | A | |
| | You are single and have | ve only one job; or | |) | | |
| в | Enter "1" if: { • You are married, have | only one job, and your sp | oouse does not work; or | }. | B | |
| | Your wages from a sec | ond job or your spouse's v | vages (or the total of both) are \$1,50 | 00 or less. J | | |
| С | Enter "1" for your spouse. But, you may | choose to enter "-0-" if ye | ou are married and have either a w | vorking spouse (| or more | |
| | than one job. (Entering "-0-" may help yo | u avoid having too little ta | ax withheld.) | | · · C | |
| D | Enter number of dependents (other than | your spouse or yourself) | you will claim on your tax return . | | D | |
| Е | Enter "1" if you will file as head of house | hold on your tax return (s | ee conditions under Head of hou | sehold above) | E | |
| F | Enter "1" if you have at least \$2,000 of cl | hild or dependent care e | xpenses for which you plan to cla | im a credit . | F | |
| | (Note. Do not include child support payn | nents. See Pub. 503, Child | d and Dependent Care Expenses, | for details.) | | |
| G | Child Tax Credit (including additional ch | ild tax credit). See Pub. 9 | 72, Child Tax Credit, for more info | rmation. | | |
| | • If your total income will be less than \$6 | 5,000 (\$100,000 if married | d), enter "2" for each eligible child; | then less "1" if | you | |
| | have two to four eligible children or $\ensuremath{\text{less}}$ | • | - | | | |
| | • If your total income will be between \$65,000 |) and \$84,000 (\$100,000 and | I \$119,000 if married), enter "1" for ea | ch eligible child . | G | |
| н | Add lines A through G and enter total here. (I | Note. This may be different f | rom the number of exemptions you c | laim on your tax re | eturn.) 🕨 H | |
| | | | ncome and want to reduce your wit | hholding, see the | Deductions | |
| | For accuracy, and Adjustments We of the single and end of the sing | | or are married and you and your | anawaa hath w | will and the e | ambinad |
| | worksheets earnings from all jobs | exceed \$50,000 (\$20,000 if | f married), see the Two-Earners/M | ultiple Jobs Wo | rksheet on p | age 2 to |
| | that apply. avoid having too little ta | ax withheld. | | | · | 0 |
| | • If neither of the abov | e situations applies, stop h | ere and enter the number from line I | H on line 5 of For | m W-4 below | |
| | Separate here and | give Form W-4 to your en | ployer. Keep the top part for your | records | | |
| | | olo Withholding | Allowanaa Cartifiaa | | | |
| Form | W-4 Employe | | s Allowance Certifica | te | OMB No. 154 | 15-0074 |
| Depart | | | er of allowances or exemption from wit | | 201 | 5 |
| Interna 1 | I Revenue Service Subject to review by t Your first name and middle initial | Last name | e required to send a copy of this form | 2 Your social | security numb | or |
| • | | Last hame | | | Security numb | CI |
| | Home address (number and street or rural route | (a) | | | | |
| | | 5) | 3 Single Married Married Mar Note. If married, but legally separated, or spo | ried, but withhold a | • • | |
| | City or town, state, and ZIP code | | | | | • |
| | | | 4 If your last name differs from that check here. You must call 1-800- | - | - | · |
| 5 | Total number of allowances you are cla | iming (from line H above | | | 5 | |
| 6 | Additional amount, if any, you want wit | | | on page 2) | 5 6 \$ | |
| 7 | I claim exemption from withholding for | | | · · · · · | | |
| ' | Last year I had a right to a refund of a | · · · · | - | | | |
| | This year I expect a refund of all fede | | | , | | |
| | If you meet both conditions, write "Exe | | - | 7 | | |
| Unde | er penalties of perjury, I declare that I have ex | · · | | elief, it is true, co | rrect, and cor | nplete. |
| Eme | lovoo's signaturo | | | | | |
| ⊂mp /Thio | loyee's signature | | | Date N | | |

| (This f | orm is not valid unless you sign it.) | | Da | le 🕨 |
|---------|---|--------------------------|----|--------------------------------------|
| 8 | Employer's name and address (Employer: Complete lines 8 and 10 only if sending to the IRS.) | 9 Office code (optional) | 10 | Employer identification number (EIN) |
| Pulas | ki County Special School District 925 E Dixon Road Little Rock AR 72206 | | | 716020058 |
| For Pr | ivacy Act and Paperwork Reduction Act Notice, see page 2. | Cat. No. 10220Q | | Form W-4 (2015) |

Form W-4 (2015)

6,001 -

13,001 -

24,001 - 26,000

26,001 - 34,000

34,001 - 44,000

44,001

50,001 - 65,000

65,001

75,001

80,001 - 100,000

100,001 - 115,000

115,001

-

-

-

130,001 - 140,000

140,001 - 150,000

150,001 and over

13,000

24,000

50,000

75,000

80,000

- 130,000

1

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12

13

14 15 8,001 -

17,001 -

26,001 -

34,001 -

44.001 -

75,001 -

110,001 - 125,000

125,001 - 140,000

140,001 and over

85 001

17,000

26,000

34,000

44,000

75.000

85,000

- 110.000

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8

9

10

75,001 - 135,000

135,001 - 205,000

205,001 - 360,000

360,001 - 405,000

405,001 and over

1,000

1,120

1,320

1,400

1,580

| | | | Deduct | ions and A | djustments Works | heet | | | |
|----------|--|---|--|---|--|---|-------------------------------|-------------|--------------------------|
| Note | . Use this worl | ksheet <i>only</i> if | you plan to itemize d | eductions or | claim certain credits or | adjustments | to income. | | |
| 1 | and local taxes, income, and mis and you are mar | medical expense cellaneous dedu ried filing jointly o | es in excess of 10% (7.5% ctions. For 2015, you may r are a qualifying widow(er) | % if either you o have to reduce ; \$284,050 if you | g home mortgage interest, or your spouse was born bef your itemized deductions if y are head of household; \$258 ng separately. See Pub. 505 | ore January 2, 1 our income is ov 3,250 if you are si | 951) of your ver \$309,900 | 1 \$ | |
| | | | ied filing jointly or qu | | • · · | | | • • | |
| 2 | | 9,250 if head | | | | | | 2 \$ | |
| | · · · | , | or married filing sepa | arately | J | | | <u> </u> | |
| 3 | | - | . If zero or less, enter | • | | | | 3\$ | |
| 4 | Enter an estin | nate of your 20 | 015 adjustments to inc | come and any | additional standard dec | | | 4 \$ | |
| 5 | | • | | • | nt for credits from the | • | , | | |
| | | | | | o. 505.) | | | 5\$ | |
| 6 | Enter an estir | mate of your 2 | 2015 nonwage incom | e (such as div | vidends or interest) . | | | 6 \$ | |
| 7 | | - | . If zero or less, enter | | | | | 7 \$ | |
| 8 | Divide the ar | nount on line | 7 by \$4,000 and ente | | ere. Drop any fraction | | | 8 | |
| 9 | Enter the nur | nber from the | Personal Allowance | es Workshee | t, line H, page 1 | | | 9 | |
| 10 | Add lines 8 a | nd 9 and ente | er the total here. If yo | u plan to use | the Two-Earners/Mul | tiple Jobs W | orksheet, | | |
| | also enter thi | s total on line | 1 below. Otherwise, | stop here an | d enter this total on Fo | rm W-4, line { | 5, page 1 | 10 | |
| | | Two-Earne | rs/Multiple Jobs | Worksheet | (See Two earners of | or multiple j | obs on pa | ge 1.) | |
| Note | . Use this worl | ksheet <i>only</i> if | the instructions unde | r line H on pa | ge 1 direct you here. | | | | |
| 1 | Enter the numb | per from line H, | page 1 (or from line 10 a | above if you use | ed the Deductions and A | djustments Wo | orksheet) | 1 | |
| 2 | | | | | ST paying job and en | | | | |
| | | ed filing jointl | y and wages from the | e highest pay | ng job are \$65,000 or | less, do not e | enter more | | |
| | | | | | | | | 2 | |
| 3 | | | - | | om line 1. Enter the re | • | | | |
| | | | | | of this worksheet | | | 3 | |
| Note | | | enter "-0-" on Form | | age 1. Complete lines 4 a year-end tax bill. | 4 through 9 b | elow to | | |
| 4 | Enter the nur | nber from line | 2 of this worksheet | | | 4 | | | |
| 5 | Enter the nur | nber from line | 1 of this worksheet | | | 5 | | | |
| 6 | Subtract line | 5 from line 4 | | | | | | 6 | |
| 7 | Find the amo | unt in Table 2 | 2 below that applies t | o the HIGHE | ST paying job and ente | er it here . | | 7 \$ | |
| 8 | Multiply line | 7 by line 6 an | d enter the result her | e. This is the | additional annual withh | olding neede | d | 8 \$ | |
| 9 | | | | | r example, divide by 25 | | | | |
| | | | | | ere are 25 pay periods | | | | |
| | the result here | | | nis is the addit | onal amount to be with | | | 9 \$ | |
| <u> </u> | | | le 1 | | | | ble 2 | | |
| | Married Filing | Jointly | All Other | S | Married Filing | Jointly | | All Othe | rs |
| | es from LOWEST job are— | Enter on line 2 above | If wages from LOWEST paying job are— | Enter on line 2 above | If wages from HIGHEST paying job are— | Enter on line 7 above | If wages from paying job a | | Enter on line 7 above |
| | \$0 - \$6,000 | 0 | \$0 - \$8.000 | 0 | \$0 - \$75,000 | \$600 | \$0 | - \$38.000 | \$600 |

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

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

38,001 - 83,000

83,001 - 180,000 180,001 - 395,000

395,001 and over

1,000

1,120

1,320

1,580

Page 2

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.

| VERIFICATION OF CERTIFIED EXPERIENCE | | | | | | | | | |
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| | | N DEC | PCSS | | RTMEN | - , | | | |
| 925 East Dixon Road/PO Box 8601 Littl | | | | DEPA | RIMEN | | 1-490-2000 | Fax 501 | -490-9897 |
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| ro: | | | | _ DA | TE: | | | | |
| AX: Please furnish verification of service in your syster | n by com | nleting an | d returning | this form | within 10 | lavs to: P | ulaski County | Snecial | School District |
| Attn: Human Resources Dept, PO Box 86 | i01, Little | Rock, AF | R 72216 <u>or</u> | fax to K | risty Mane | es, Perso | nnel Speciali | st at 501- | 490-9897. |
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Verification of <u>Certified</u> <u>Experience</u>

You will need Verification from each district for experience credit up to 17 years.

It is your responsibility to fax or send verification forms to the appropriate person and to be sure that they have been returned for credit. The form request for your previous district to return within a 10 day period.

VERIFICATION OF CERTIFIED EXPERIENCE



HUMAN RESOURCES DEPARTMENT

| 925 East Dixon Road/PO Box 8601 Little Rock, AR 72216 | | | | | | Phone 50 | 1-490-2000 Fax 501 | -490-9897 |
|--|------------------------------------|-----------------------------|---|-----------|------------------------------------|----------------------------------|---|-------------------------------|
| 0: | | | | DA | TE: | | | |
| AX: | | | | | | | | |
| Please furnish verification of service in your Attn: Human Resources Dept, PO E | system, by com Box 8601, Little | pleting an Rock, AF | d returning R 72216 <u>or</u> | this form | n <u>within 10 (</u> risty Mane | <u>days</u> to: Pu es, Persor | Ilaski County Special nnel Specialist at 501 | School District -490-9897. |
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Days of sick leave accumulated at time of resignation: ______ School District Accredited by: _____

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| mber or Social | Security | Bank Routing Number |
| | First | |

Back of card

REQUIRED: Attach a Blank Voided Check

Date

EMPLOYEE'S AUTHORIZATION

I authorize Pulaski County Special School District to automatically deposit my pay in my account described on the reverse side of this agreement.

I authorize Pulaski County Special School District to initiate a reversing debit entry to authorize my bank to refund to PCSSD a deposit made in error to my account.

This authority is to remain in full force and effect until my employer has received written notification from me of its termination in such time and in such manner as to afford my employer a reasonable opportunity to act on it.

Please complete reverse side

Signature

Direct Deposit Is Mandatory for All Employees

Direct deposit cards will be available the day of the new hire meeting. Be sure to bring a VOIDED check with you to the meeting.

Degree Information Sheet

Complete the top of this form only.

| Bachelors Degree | Awarded | | Emplo | yee ID# | |
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| Additional Degree | e(s) Awarded | | Name of College | | |
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| Masters Degree A | Awarded | | Name of College | | | | |
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Pulaski County Special School District

RELEASE OF INFORMATION AND CRIMINAL BACKGROUND CHECK

Lauthorizz Pulaski Courty Special School District, or its agent, to investigate my background, prior employment, and criminal history. Lunderstand that I may have the right to request disclorarce of centain information obtained by the District in the course of its investigation of my background and experience. To request this information, contact CS Background 30 Riverview, Batesville AR, 72501 870-613-6309.

I authorize my prior employers, references, and any other individuals contacted by the District to release any and all information requested and absolves those parties who provide information requested from any and all liability related to their doing so.

| Date: | | |
|-------------------|----------------------------|----|
| Signature: | | |
| Print Name: | Maiden Name (If applicable |): |
| Social Security#: | | |
| Date of Birth: | | |

I understand that failure to sign this release will prohibit me from working with the Pulaski County Special School District.

PULASKI COUNTY SPECIAL SCHOOL DISTRICT

The following information requested is strictly voluntary. It will not be part of your application for employment. This information is used for statistical purposes only. Please check appropriate box.

| ******** | | |
|-----------------|--|------|
| Black | | |
| Asian | | |
| American Indian | | |
| Hispanic | | |
| Culture | | |
| Other | | |
| | | |
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| Female | | |
| Male | | |
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Release of Information and Criminal Background Check

This give us authorization to run <u>a background</u> check



Pulaski County Special School District 925 East Dixon Road/PO Box 8601 Little Rock, AR 72216-8601

RELEASE OF INFORMATION/CRIMINAL BACKGROUND CHECK

I authorize Pulaski County Special School District, or its agent, to investigate my background, prior employment, and criminal history. I understand that I may have the right to request disclosures of certain information obtained by the District in the course of its investigation of my background and experience.

I authorize my prior employers, references and any other individuals contacted by the District to release any and all information requested and absolve those parties who provide information requested from any and all liability related to their doing so.

| Date: | |
|--------------------|---|
| Signature: | |
| Print Name: | |
| Social Security #: | - |
| Date of Birth: | - |

I understand that failure to sign this release will prohibit me from working with the Pulaski County Special School District.

| | PULASKI COUNTY SPECIAL SCHOOL DISTRICT | |
|------|--|--|
| Name | Date | |
| | | |

Social Security Number _____ Male ____ Female ____

Date of Birth _____

The following information requested is strictly voluntary. It will not be part of your application for employment. This information is used for statistical purposes only.

Please check appropriate box.



ONLY FOR ARKANSAS DEPARTMENT OF EDUCATION USE AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION By the Arkansas Child Maltreatment Central Registry

ApplicateInstructing: Complete this form, have it scientised, and submit a preprinted check or a U.S. money order for \$10.00 mode pupple to the Arkanuas Department of Human Services. DO NOT SUND CASH OK A TEMPORARY CHECK-YOUR REQUEST WELL NOT BE PROCESSED. Make and keep a copy of this form for your records.

INCOMPLETE OR UNNOTARIZED FORMS WILL NOT BE PROCESSED BY THE CENTRAL REGISTRY OR THE ADEL

| 1 | P.O. Box 1437, Slo | t S 566 | tral Registry | []14 | cented To | racher | |
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| /Year): | | Age: | Recolutionity: | | | Gender: | - |
| | | | Physical Addres | 80 | | | |
| or P.O. Br | ax. | | | Street | | | |
| State | Zip Code | | | City | State | Zip Code | |
| | (home) | | (cell) | | | | (other) |
| Day/Mon | th/Year) for all of t | he applicant's | children, attach ad | ditional | paper if | secessary: | |
| | | | | | | | |
| | | | | | | | |
| | | Child's | | | | | |
| | a: vYear): or P.O. B State | P.O. Box 1437, Slo Little Rock, Arkans Pirst r: or P.O. Box State Zip Code (houst) | P.O. Bue 147, Shets 566 Little Rock, Arkansa 722(3) ?): Final Middle w: | P.O. Der 147, Slad 5 66 Little Rock, Arbanes 72283 First Middle r: r: re r: re r: re r: re r: re r: re re re re re re re re re re | P.O. Deci 147, Slot 5 56 Little Rod, Adrassa 7263 First Middle Last r: r: or P.O. Bux Physical Address: Store Zip Code City (bass) (eff) (bass) (ceff) (bass) (ceff) (bass City Date of Brite: | P.O. Daci 1417, Shot 556 Little Rock, Arkansan 72203 Dison-locan First Middle Last r: r: or P.O. Bux Phytical Address: dot P.O. Bux Phytical Address: for P.O. Bux Dison Cliffy State (basy) for all of the applicant's children, which Additional paper (f (Child') Date of Elithe | P.O. Box 147, Shet S 566 Little Rock, Arkanan 72213 First Middle Last r: r: r: r: r: r: r: r |

undersigned applicant as an offender of a true report of child malirestment to the ARKANSAS DEFARTMENT OF EDUCA By signing below, I averar or affirm that the foregoing statements are true to the best of my knowledge and belief under penalty of perjury.

Applicant's Signature: _____ Date _____
State of Arkaniss County of

On this the _____day of _____20 ____before ms, _____(uame of notecy), the undersigned notary, personally append _____(applicast" name) known to ms (or satisfactory prevent) to be the person whome name(u) where subscribed to the within instrument and acknowledged that hubbering excession die name for the purposes therein constituted.

In witness whereof I hereunto set my hand and official teal.
Notacy Public: My Commission Ilspirm: ______

| Paul Brower | 501-234-2032 | 501-490-9897 |
|--------------------------------|--|--------------|
| School/District Contact Person | District Phone Number | District Fax |
| 925 East Dixon Rd | Pulaski County Special School District | 6003 |
| School Mailing Address | School District | LEA Number |

ADE Form Effective Date (01/15/13)

Arkansas Child Maltreatment Central Registry & Fingerprinting

DO NOT MAIL THIS FORM. BRING IT TO THE NEW HIRE MEETING TO SUBMIT TO PCSSD. The District pays all fees for these background checks.

ONLY FOR ARKANSAS DEPARTMENT OF EDUCATION USE AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION By the Arkansas Child Maltreatment Central Registry

Applicant Instructions: Complete this form.

INCOMPLETE OR UNNOTARIZED FORMS WILL NOT BE PROCESSED BY THE CENTRAL REGISTRY OR THE ADE!

| | | | | | nsed Tea | ck Only One: acher d/Classified | |
|---|--|---|---|--|----------|--|-----------------|
| Applicant's full name (print or type): | First | Middle | | Last | | | |
| List ALL other names used: | | | | | | | |
| Applicant's Social Security Number: | | | | | | | |
| Applicant's Birth Date (Month/Day/Yea | r): | Age: | Race/ethnicity: | | | _ Gender: _ | |
| Applicant's mailing address: | | | Physical Address | : | | | |
| Applicant's mailing address: | .O. Box | | ,,,,,,,,,,,,,,,,,,,,,,,,,,,, | Street | | | |
| City | State Zip Co | ode | | City | State | Zip Code | |
| Applicant's phone number : | (hom | e) | (cell) | | | (| other) |
| Child's Full Name: Child's Full Name: Child's Full Name: Child's Full Name: I hereby request that the Arkansas Child undersigned applicant as an offender of By signing below, I swear or affirm the penalty of perjury. Applicant's Signature: | a true report of child at the foregoing sta 0, before me, _(applicant's name) t and acknowledged | Child's I Child's I al Registry release a maltreatment to the itements are true to) known to me (or sa that he/she/they exe | ARKANSAS DI the best of my k Date Date | EPARTN (nowledg), the undo n) to be th | ersigned | DF EDUCAT elief under – notary, pers n whose nam | onally ne(s) |
| In witness whereof I hereunto set my ha | nd and official seal. | | | | | | |
| Notary Public: | | | My Commission | Expires: | | | |
| | (APPLICANTS DO |) NOT WRITE BELOW | THIS LINE) | | | | |
| Paul Brewer | | 501-23 | 34-2000 | | 5 | 01-490-98 | 397 |
| School/District Contac | et Person | District] | Phone Number | | | District Fa | x |
| 925 East Dixon | | | | ecial So | chool | | |
| School Mailing Addre | SS | School I | District | | | LEA Numl | ber |



Certified Fingerprinting Information Form

Please Print

| First Name |
|------------------------|
| Last Name |
| Social Security Number |
| Race |
| Gender 🔲 Female 🔲 Male |
| Height |
| Weight |
| Eye Color |
| Hair Color |
| Date of Birth |
| Place of Birth |

INFORMATION FOR SUBSTITUTE CALLING SYSTEM

| Social Security N | umber. | | | | |
|-------------------|----------|--------|------------|----------|----------|
| Address: | | | | | |
| | | STREET | | CITY, AR | ZIP CODE |
| Phone: | | | | | |
| | | | | | |
| Gender: | | | Ethnicity: | | |
| | | | | | |
| Teaching Assign | ment(s): | | | | |
| | | | | | |
| School Location | | | | | - |

Information for Substitute Calling <u>System</u>

| INFORM | ATION F | OR SUBSTI | TUTE CALL | ING SYSTEM |
|-------------------|----------|------------|-----------|------------|
| | | | | |
| | | | | |
| Name: | | | | |
| Social Security N | Number: | | | |
| Address: | | | | |
| Phone: | STREE | Т | CITY, AR | ZIP CODE |
| | | | | |
| Gender: | | Ethnicity: | | |
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| Teaching Assign | ment(s): | | | |
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| School Location | | | | |
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