Dorchester County Public Schools
Office of Human Resources
New Hire Forms Handbook
2013 – 2014

Dorchester County Public Schools
700 Glasgow Street
Cambridge, MD 21613
(410) 228-4747
Revised: 11/12/2013

Dorchester County Public Schools
Office of Human Resources

New Hire Forms Overview

Form	Link	Entity
I-9, Employment Eligibility Verification	http://www.uscis.gov/files/form/i-9.pdf (OMB No. 1615- 0047; Expires 03/31/2016)	Federal
Federal Tax Withholding	http://www.irs.gov/pub/irs-pdf/fw4.pdf	Federal
Employee's Maryland Withholding Exemption Certificate	http://forms.marylandtaxes.com/current_forms/mw507.pdf	State
Consent for release of information / background clearance request	http://www.dhr.state.md.us/blog/wp-content/uploads/2012/10/bgclear.pdf (DHR/SSA 1279) (10/2003)	State
Application for criminal history record check	DCPS_Criminal_History_Record_Check_form	DCPS
DCPS background supplemental form	DCPS_Supplemental_Form_to_the_Application_for_Criminal_Record_Check	DCPS
Maryland New Hire Registry Reporting Form	https://newhire-reporting.com/Downloads/MDForm.pdf	State
Pamphlet Welcome to the Employees' and Teachers' Pension System	http://www.sra.state.md.us/Participants/Members/Downloads/Welcome_to_Reformed_ETPS.pdf	State
Application for membership (Form 001) (Rev. 03/2012)	http://www.sra.state.md.us/Participants/Members/Downloads/Forms/Form_1.pdf	State
Designation of beneficiary (Form 004) (Rev. 01/2013)	http://www.sra.state.md.us/Participants/Downloads/Forms/Form_4.pdf	State
Initial Application for Certification	https://educator.marylandpublicschools.org/Login.aspx	MSDE
Verification of satisfactory educational experience	http://www.msde.maryland.gov/NR/rdonlyres/AC0390E0-E16C-412B-B9B8-28ABBA29DBEB/33966/Verification_of_Experience_11072012_.pdf	MSDE
Teacher Employment Verification Form	DCPS_Employment_Verification_form	DCPS
New Hire Form	DCPS_New_Hire_Form	DCPS
Direct Deposit Authorization Agreement Form	http://dcps.k12.md.us/files/Direct%20Deposit%20Authorization%20Form.pdf	DCPS

Dorchester County Public Schools
Office of Human Resources

20/24 Pays (10 month / 12 month)	DCPS_24_Pay_Plan_Form	DCPS
Summer Savings Form	DCPS_Summer_Savings_Form_2013_2014	DCPS
Race and Ethnicity Identification Form	DCPS_Race_and_Ethnicity_Identification_Form	DCPS
CareFirst BlueCross BlueShield application	BCBS_Application	DCPS
Flexible Spending Account application	2014_FSA_Enrollment_Form	DCPS
Life Insurance beneficiary designation	www.prudential.com/mybenefits In the Control Number field, please enter 51586	DCPS
DCPS Calendar	http://dcps.k12.md.us/files/School%20Calendar%20-%20FY2014-Approved%205.16.13.pdf	DCPS
DCPS Handbook / Calendar	http://dcps.k12.md.us/files/1012-13_Calendar-LowRes.pdf	DCPS
Duty days	DCPS_Duty_Days_FY2014	DCPS
Ten-Month Employee Work Calendar	http://dcps.k12.md.us/files/Workdays%20FY14-10mo.8.6.13%20rev.pdf	DCPS
Eleven- and Twelve-Month Employee Work Calendar	http://dcps.k12.md.us/files/Workdays%20FY14-11&12mo.5.20.13.pdf	DCPS
Pay Dates	PAY_DATES_2013_2014	DCPS
Payroll Schedule with Due Dates	2013_2014_Payroll_Schedule_with_Due_Dates	DCPS
SafeSchools memo	http://www.dorchester.md.safeschools.com/login	DCPS
Employee Access Center login	https://eac.spihost.net/DOR/EAC5/Login.aspx	DCPS
DE-T / DE-ESPA Sick Leave Bank	http://dcps.k12.md.us/files/SLB%20membership%20form%202013.pdf	DE
A&S / Support Unit I / Support Unit II / Teachers	http://dcps.k12.md.us/Negotiated%20Agreements.html	DCPS

Instructions for Employment Eligibility Verification

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

USCIS
Form I-9
OMB No. 1615-0047
Expires 03/31/2016

Read all instructions carefully before completing this form.

Anti-Discrimination Notice. It is illegal to discriminate against any work-authorized individual in hiring, discharge, recruitment or referral for a fee, or in the employment eligibility verification (Form I-9 and E-Verify) process based on that individual's citizenship status, immigration status or national origin. 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. For more information, call the Office of Special Counsel for Immigration-Related Unfair Employment Practices (OSC) at 1-800-255-7688 (employees), 1-800-255-8155 (employers), or 1-800-237-2515 (TDD), or visit www.justice.gov/crt/about/osc.

What Is the Purpose of This Form?

Employers must complete Form I-9 to document verification of the identity and employment authorization of each new employee (both citizen and noncitizen) hired after November 6, 1986, to work in the United States. In the Commonwealth of the Northern Mariana Islands (CNMI), employers must complete Form I-9 to document verification of the identity and employment authorization of each new employee (both citizen and noncitizen) hired after November 27, 2011. Employers should have used Form I-9 CNMI between November 28, 2009 and November 27, 2011.

General Instructions

Employers are responsible for completing and retaining Form I-9. For the purpose of completing this form, the term "employer" means all employers, including those recruiters and referrers for a fee who are agricultural associations, agricultural employers, or farm labor contractors.

Form I-9 is made up of three sections. Employers may be fined if the form is not complete. Employers are responsible for retaining completed forms. Do not mail completed forms to U.S. Citizenship and Immigration Services (USCIS) or Immigration and Customs Enforcement (ICE).

Section 1. Employee Information and Attestation

Newly hired employees must complete and sign Section 1 of Form I-9 **no later than the first day of employment.** Section 1 should never be completed before the employee has accepted a job offer.

Provide the following information to complete Section 1:

Name: Provide your full legal last name, first name, and middle initial. Your last name is your family name or surname. If you have two last names or a hyphenated last name, include both names in the last name field. Your first name is your given name. Your middle initial is the first letter of your second given name, or the first letter of your middle name, if any.

Other names used: Provide all other names used, if any (including maiden name). If you have had no other legal names, write "N/A."

Address: Provide the address where you currently live, including Street Number and Name, Apartment Number (if applicable), City, State, and Zip Code. Do not provide a post office box address (P.O. Box). Only border commuters from Canada or Mexico may use an international address in this field.

Date of Birth: Provide your date of birth in the mm/dd/yyyy format. For example, January 23, 1950, should be written as 01/23/1950.

U.S. Social Security Number: Provide your 9-digit Social Security number. Providing your Social Security number is voluntary. However, if your employer participates in E-Verify, you must provide your Social Security number.

E-mail Address and Telephone Number (Optional): You may provide your e-mail address and telephone number. Department of Homeland Security (DHS) may contact you if DHS learns of a potential mismatch between the information provided and the information in DHS or Social Security Administration (SSA) records. You may write "N/A" if you choose not to provide this information.

All employees must attest in Section 1, under penalty of perjury, to their citizenship or immigration status by checking one of the following four boxes provided on the form:

1. **A citizen of the United States**
2. **A noncitizen national of the United States:** Noncitizen nationals of the United States are persons born in American Samoa, certain former citizens of the former Trust Territory of the Pacific Islands, and certain children of noncitizen nationals born abroad.
3. **A lawful permanent resident:** A lawful permanent resident is any person who is not a U.S. citizen and who resides in the United States under legally recognized and lawfully recorded permanent residence as an immigrant. The term "lawful permanent resident" includes conditional residents. If you check this box, write either your Alien Registration Number (A-Number) or USCIS Number in the field next to your selection. At this time, the USCIS Number is the same as the A-Number without the "A" prefix.
4. **An alien authorized to work:** If you are not a citizen or national of the United States or a lawful permanent resident, but are authorized to work in the United States, check this box.

   If you check this box:

   a. Record the date that your employment authorization expires, if any. Aliens whose employment authorization does not expire, such as refugees, asylees, and certain citizens of the Federated States of Micronesia, the Republic of the Marshall Islands, or Palau, may write "N/A" on this line.

   b. Next, enter your Alien Registration Number (A-Number)/USCIS Number. At this time, the USCIS Number is the same as your A-Number without the "A" prefix. If you have not received an A-Number/USCIS Number, record your Admission Number. You can find your Admission Number on Form I-94, "Arrival-Departure Record," or as directed by USCIS or U.S. Customs and Border Protection (CBP).

      (1) If you obtained your admission number from CBP in connection with your arrival in the United States, then also record information about the foreign passport you used to enter the United States (number and country of issuance).

      (2) If you obtained your admission number from USCIS *within the United States*, or you entered the United States without a foreign passport, you must write "N/A" in the Foreign Passport Number and Country of Issuance fields.

Sign your name in the "Signature of Employee" block and record the date you completed and signed Section 1. By signing and dating this form, you attest that the citizenship or immigration status you selected is correct and that you are aware that you may be imprisoned and/or fined for making false statements or using false documentation when completing this form. To fully complete this form, you must present to your employer documentation that establishes your identity and employment authorization. Choose which documents to present from the Lists of Acceptable Documents, found on the last page of this form. You must present this documentation no later than the third day after beginning employment, although you may present the required documentation before this date.

Preparer and/or Translator Certification

The Preparer and/or Translator Certification must be completed if the employee requires assistance to complete Section 1 (e.g., the employee needs the instructions or responses translated, someone other than the employee fills out the information blocks, or someone with disabilities needs additional assistance). The employee must still sign Section 1.

Minors and Certain Employees with Disabilities (Special Placement)

Parents or legal guardians assisting minors (individuals under 18) and certain employees with disabilities should review the guidelines in the *Handbook for Employers: Instructions for Completing Form I-9 (M-274)* on **www.uscis.gov/I-9Central** before completing Section 1. These individuals have special procedures for establishing identity if they cannot present an identity document for Form I-9. The special procedures include **(1)** the parent or legal guardian filling out Section 1 and writing "minor under age 18" or "special placement," whichever applies, in the employee signature block; and **(2)** the employer writing "minor under age 18" or "special placement" under List B in Section 2.

Section 2. Employer or Authorized Representative Review and Verification

Before completing Section 2, employers must ensure that Section 1 is completed properly and on time. Employers may not ask an individual to complete Section 1 before he or she has accepted a job offer.

Employers or their authorized representative must complete Section 2 by examining evidence of identity and employment authorization within 3 business days of the employee's first day of employment. For example, if an employee begins employment on Monday, the employer must complete Section 2 by Thursday of that week. However, if an employer hires an individual for less than 3 business days, Section 2 must be completed no later than the first day of employment. An employer may complete Form I-9 before the first day of employment if the employer has offered the individual a job and the individual has accepted.

Employers cannot specify which document(s) employees may present from the Lists of Acceptable Documents, found on the last page of Form I-9, to establish identity and employment authorization. Employees must present one selection from List A **OR** a combination of one selection from List B and one selection from List C. List A contains documents that show both identity and employment authorization. Some List A documents are combination documents. The employee must present combination documents together to be considered a List A document. For example, a foreign passport and a Form I-94 containing an endorsement of the alien's nonimmigrant status must be presented together to be considered a List A document. List B contains documents that show identity only, and List C contains documents that show employment authorization only. If an employee presents a List A document, he or she should **not** present a List B and List C document, and vice versa. If an employer participates in E-Verify, the List B document must include a photograph.

In the field below the Section 2 introduction, employers must enter the last name, first name and middle initial, if any, that the employee entered in Section 1. This will help to identify the pages of the form should they get separated.

Employers or their authorized representative must:

1. Physically examine each original document the employee presents to determine if it reasonably appears to be genuine and to relate to the person presenting it. The person who examines the documents must be the same person who signs Section 2. The examiner of the documents and the employee must both be physically present during the examination of the employee's documents.
2. Record the document title shown on the Lists of Acceptable Documents, issuing authority, document number and expiration date (if any) from the original document(s) the employee presents. You may write "N/A" in any unused fields.

   If the employee is a student or exchange visitor who presented a foreign passport with a Form I-94, the employer should also enter in Section 2:

   a. The student's Form I-20 or DS-2019 number (Student and Exchange Visitor Information System-SEVIS Number); **and** the program end date from Form I-20 or DS-2019.
3. Under Certification, enter the employee's first day of employment. Temporary staffing agencies may enter the first day the employee was placed in a job pool. Recruiters and recruiters for a fee do not enter the employee's first day of employment.
4. Provide the name and title of the person completing Section 2 in the Signature of Employer or Authorized Representative field.
5. Sign and date the attestation on the date Section 2 is completed.
6. Record the employer's business name and address.
7. Return the employee's documentation.

Employers may, but are not required to, photocopy the document(s) presented. If photocopies are made, they should be made for **ALL** new hires or reverifications. Photocopies must be retained and presented with Form I-9 in case of an inspection by DHS or other federal government agency. Employers must always complete Section 2 even if they photocopy an employee's document(s). Making photocopies of an employee's document(s) cannot take the place of completing Form I-9. Employers are still responsible for completing and retaining Form I-9.

Unexpired Documents

Generally, only unexpired, original documentation is acceptable. The only exception is that an employee may present a certified copy of a birth certificate. Additionally, in some instances, a document that appears to be expired may be acceptable if the expiration date shown on the face of the document has been extended, such as for individuals with temporary protected status. Refer to the *Handbook for Employers: Instructions for Completing Form I-9 (M-274)* or I-9 Central (www.uscis.gov/I-9Central) for examples.

Receipts

If an employee is unable to present a required document (or documents), the employee can present an acceptable receipt in lieu of a document from the Lists of Acceptable Documents on the last page of this form. Receipts showing that a person has applied for an initial grant of employment authorization, or for renewal of employment authorization, are not acceptable. Employers cannot accept receipts if employment will last less than 3 days. Receipts are acceptable when completing Form I-9 for a new hire or when reverification is required.

Employees must present receipts within 3 business days of their first day of employment, or in the case of reverification, by the date that reverification is required, and must present valid replacement documents within the time frames described below.

There are three types of acceptable receipts:

1. A receipt showing that the employee has applied to replace a document that was lost, stolen or damaged. The employee must present the actual document within 90 days from the date of hire.
2. The arrival portion of Form I-94/I-94A with a temporary I-551 stamp and a photograph of the individual. The employee must present the actual Permanent Resident Card (Form I-551) by the expiration date of the temporary I-551 stamp, or, if there is no expiration date, within 1 year from the date of issue.
3. The departure portion of Form I-94/I-94A with a refugee admission stamp. The employee must present an unexpired Employment Authorization Document (Form I-766) or a combination of a List B document and an unrestricted Social Security card within 90 days.

When the employee provides an acceptable receipt, the employer should:

1. Record the document title in Section 2 under the sections titled List A, List B, or List C, as applicable.
2. Write the word "receipt" and its document number in the "Document Number" field. Record the last day that the receipt is valid in the "Expiration Date" field.

By the end of the receipt validity period, the employer should:

1. Cross out the word "receipt" and any accompanying document number and expiration date.
2. Record the number and other required document information from the actual document presented.
3. Initial and date the change.

See the *Handbook for Employers: Instructions for Completing Form I-9 (M-274)* at **www.uscis.gov/I-9Central** for more information on receipts.

Section 3. Reverification and Rehires

Employers or their authorized representatives should complete Section 3 when reverifying that an employee is authorized to work. When rehiring an employee within 3 years of the date Form I-9 was originally completed, employers have the option to complete a new Form I-9 or complete Section 3. When completing Section 3 in either a reverification or rehire situation, if the employee's name has changed, record the name change in Block A.

For employees who provide an employment authorization expiration date in Section 1, employers must reverify employment authorization on or before the date provided.

Some employees may write "N/A" in the space provided for the expiration date in Section 1 if they are aliens whose employment authorization does not expire (e.g., asylees, refugees, certain citizens of the Federated States of Micronesia, the Republic of the Marshall Islands, or Palau). Reverification does not apply for such employees unless they chose to present evidence of employment authorization in Section 2 that contains an expiration date and requires reverification, such as Form I-766, Employment Authorization Document.

Reverification applies if evidence of employment authorization (List A or List C document) presented in Section 2 expires. However, employers should not reverify:

1. U.S. citizens and noncitizen nationals; or
2. Lawful permanent residents who presented a Permanent Resident Card (Form I-551) for Section 2.

Reverification does not apply to List B documents.

If both Section 1 and Section 2 indicate expiration dates triggering the reverification requirement, the employer should reverify by the earlier date.

For reverification, an employee must present unexpired documentation from either List A or List C showing he or she is still authorized to work. Employers CANNOT require the employee to present a particular document from List A or List C. The employee may choose which document to present.

To complete Section 3, employers should follow these instructions:

1. Complete Block A if an employee's name has changed at the time you complete Section 3.
2. Complete Block B with the date of rehire if you rehire an employee within 3 years of the date this form was originally completed, and the employee is still authorized to be employed on the same basis as previously indicated on this form. Also complete the "Signature of Employer or Authorized Representative" block.
3. Complete Block C if:
   a. The employment authorization or employment authorization document of a current employee is about to expire and requires reverification; or
   b. You rehire an employee within 3 years of the date this form was originally completed and his or her employment authorization or employment authorization document has expired. (Complete Block B for this employee as well.)

   To complete Block C:
   a. Examine either a List A or List C document the employee presents that shows that the employee is currently authorized to work in the United States; and
   b. Record the document title, document number, and expiration date (if any).
4. After completing block A, B or C, complete the "Signature of Employer or Authorized Representative" block, including the date.

   For reverification purposes, employers may either complete Section 3 of a new Form I-9 or Section 3 of the previously completed Form I-9. Any new pages of Form I-9 completed during reverification must be attached to the employee's original Form I-9. If you choose to complete Section 3 of a new Form I-9, you may attach just the page containing Section 3, with the employee's name entered at the top of the page, to the employee's original Form I-9. If there is a more current version of Form I-9 at the time of reverification, you must complete Section 3 of that version of the form.

What Is the Filing Fee?

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

USCIS Forms and Information

For more detailed information about completing Form I-9, employers and employees should refer to the *Handbook for Employers: Instructions for Completing Form I-9 (M-274).*

You can also obtain information about Form I-9 from the USCIS Web site at www.uscis.gov/I-9Central, by e-mailing USCIS at **I-9Central@dhs.gov**, or by calling **1-888-464-4218**. For TDD (hearing impaired), call **1-877-875-6028.**

To obtain USCIS forms or the *Handbook for Employers*, you can download them from the USCIS Web site at www.uscis.gov/forms. You may order USCIS forms by calling our toll-free number at **1-800-870-3676**. You may also obtain forms and information by contacting the USCIS National Customer Service Center at **1-800-375-5283**. For TDD (hearing impaired), call **1-800-767-1833**.

Information about E-Verify, a free and voluntary program that allows participating employers to electronically verify the employment eligibility of their newly hired employees, can be obtained from the USCIS Web site at www.dhs.gov/E-Verify, by e-mailing USCIS at **E-Verify@dhs.gov** or by calling **1-888-464-4218**. For TDD (hearing impaired), call **1-877-875-6028.**

Employees with questions about Form I-9 and/or E-Verify can reach the USCIS employee hotline by calling **1-888-897-7781**. For TDD (hearing impaired), call **1-877-875-6028.**

Photocopying and Retaining Form I-9

A blank Form I-9 may be reproduced, provided all sides are copied. The instructions and Lists of Acceptable Documents must be available to all employees completing this form. Employers must retain each employee's completed Form I-9 for as long as the individual works for the employer. Employers are required to retain the pages of the form on which the employee and employer enter data. If copies of documentation presented by the employee are made, those copies must also be kept with the form. Once the individual's employment ends, the employer must retain this form for either 3 years after the date of hire or 1 year after the date employment ended, whichever is later.

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

USCIS Privacy Act Statement

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

PURPOSE: This information is collected by employers to comply with the requirements of the Immigration Reform and Control Act of 1986. This law requires that employers verify the identity and employment authorization of individuals they hire for employment to preclude the unlawful hiring, or recruiting or referring for a fee, of aliens who are not authorized to work in the United States.

DISCLOSURE: Submission of the information required in this form is voluntary. However, failure of the employer to ensure proper completion of this form for each employee may result in the imposition of civil or criminal penalties. In addition, employing individuals knowing that they are unauthorized to work in the United States may subject the employer to civil and/or criminal penalties.

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

Paperwork Reduction Act

An agency may not conduct or sponsor an information collection and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. The public reporting burden for this collection of information is estimated at 35 minutes per response, including the time for reviewing instructions and completing and retaining the form. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to: U.S. Citizenship and Immigration Services, Regulatory Coordination Division, Office of Policy and Strategy, 20 Massachusetts Avenue NW, Washington, DC 20529-2140; OMB No. 1615-0047. **Do not mail your completed Form I-9 to this address.**

Employment Eligibility Verification

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

USCIS
Form I-9
OMB No. 1615-0047
Expires 03/31/2016

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

Last Name *(Family Name)*	First Name *(Given Name)*	Middle Initial	Other Names Used *(if any)*

Address *(Street Number and Name)*	Apt. Number	City or Town	State	Zip Code

Date of Birth *(mm/dd/yyyy)*	U.S. Social Security Number	E-mail Address	Telephone Number
	___-___-___		

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:

Foreign Passport Number: _____

Country of Issuance: _____

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

3-D Barcode
Do Not Write in This Space

Signature of Employee	Date *(mm/dd/yyyy)*

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.

Signature of Preparer or Translator	Date *(mm/dd/yyyy)*

Last Name *(Family Name)*	First Name *(Given Name)*

Address *(Street Number and Name)*	City or Town	State	Zip Code

STOP ***Employer Completes Next Page*** 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:		Document Title:
Issuing Authority:		Issuing Authority:		Issuing Authority:
Document Number:		Document Number:		Document Number:
Expiration Date *(if any)(mm/dd/yyyy)*:		Expiration Date *(if any)(mm/dd/yyyy)*:		Expiration Date *(if any)(mm/dd/yyyy)*:
Document Title:				
Issuing Authority:				
Document Number:				
Expiration Date *(if any)(mm/dd/yyyy)*:				
Document Title:				
Issuing Authority:				
Document Number:				
Expiration Date *(if any)(mm/dd/yyyy)*:				

3-D Barcode
Do Not Write in This Space

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.)***

Signature of Employer or Authorized Representative	Date *(mm/dd/yyyy)*	Title of Employer or Authorized Representative
Last Name *(Family Name)* First Name *(Given Name)*		Employer's Business or Organization Name
Employer's Business or Organization Address *(Street Number and Name)*	City or Town	State / Zip Code

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.

LIST A Documents that Establish Both Identity and Employment Authorization	OR	LIST B Documents that Establish Identity	AND	LIST C Documents that Establish Employment Authorization
1. U.S. Passport or U.S. Passport Card		1. Driver's license or ID card issued by a State or outlying possession of the United States provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		1. A Social Security Account Number card, unless the card includes one of the following restrictions: (1) NOT VALID FOR EMPLOYMENT (2) VALID FOR WORK ONLY WITH INS AUTHORIZATION (3) VALID FOR WORK ONLY WITH DHS AUTHORIZATION
2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551)		2. ID card issued by federal, state or local government agencies or entities, provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		2. Certification of Birth Abroad issued by the Department of State (Form FS-545)
3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa		3. School ID card with a photograph		3. Certification of Report of Birth issued by the Department of State (Form DS-1350)
4. Employment Authorization Document that contains a photograph (Form I-766)		4. Voter's registration card		4. Original or certified copy of birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal
5. For a 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. U.S. Military card or draft record		5. Native American tribal document
		6. Military dependent's ID card		6. U.S. Citizen ID Card (Form I-197)
		7. U.S. Coast Guard Merchant Mariner Card		7. Identification Card for Use of Resident Citizen in the United States (Form I-179)
		8. Native American tribal document		
		9. Driver's license issued by a Canadian government authority		
		For persons under age 18 who are unable to present a document listed above:		
		10. School record or report card		8. Employment authorization document issued by the Department of Homeland Security
		11. Clinic, doctor, or hospital record		
		12. Day-care or nursery school record		
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				

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.

Form W-4 (2013)

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 2013 expires February 17, 2014. See Pub. 505, Tax Withholding and Estimated Tax.

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

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 2013. See Pub. 505, especially if your earnings exceed $130,000 (Single) or $180,000 (Married).

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

Personal Allowances Worksheet (Keep for your records.)

A	Enter "1" for **yourself** if no one else can claim you as a dependent	A
B	Enter "1" if: • You are single and have only one job; or • You are married, have only one job, and your spouse does not work; or • Your wages from a second job or your spouse's wages (or the total of both) are $1,500 or less.	B
C	Enter "1" for your **spouse.** But, you may choose to enter "-0-" if you are married and have either a working spouse or more than one job. (Entering "-0-" may help you avoid having too little tax withheld.)	C
D	Enter number of **dependents** (other than your spouse or yourself) you will claim on your tax return	D
E	Enter "1" if you will file as **head of household** on your tax return (see conditions under **Head of household** above)	E
F	Enter "1" if you have at least $1,900 of **child or dependent care expenses** for which you plan to claim a credit (**Note.** Do **not** include child support payments. See Pub. 503, Child and Dependent Care Expenses, for details.)	F
G	**Child Tax Credit** (including additional child tax credit). See Pub. 972, Child Tax Credit, for more information. • If your total income will be less than $65,000 ($95,000 if married), enter "2" for each eligible child; then **less** "1" if you have three to six eligible children or **less** "2" if you have seven or more eligible children. • If your total income will be between $65,000 and $84,000 ($95,000 and $119,000 if married), enter "1" for each eligible child	G
H	Add lines A through G and enter total here. (**Note.** This may be different from the number of exemptions you claim on your tax return.) ►	H

For accuracy, complete all worksheets that apply.

- If you plan to **itemize** or **claim adjustments to income** and want to reduce your withholding, see the **Deductions and Adjustments Worksheet** on page 2.
- If you are **single and have more than one job** or are **married and you and your spouse both work** and the combined earnings from all jobs exceed $40,000 ($10,000 if married), see the **Two-Earners/Multiple Jobs Worksheet** on page 2 to avoid having too little tax withheld.
- If **neither** of the above situations applies, **stop here** and enter the number from line H on line 5 of Form W-4 below.

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

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

Employee's Withholding Allowance Certificate

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

OMB No. 1545-0074

2013

1 Your first name and middle initial	Last name	2 **Your social security number**
Home address (number and street or rural route)	3 ☐ Single ☐ Married ☐ Married, but withhold at higher Single rate. **Note.** If married, but legally separated, or spouse is a nonresident alien, check the "Single" box.	
City or town, state, and ZIP code	4 **If your last name differs from that shown on your social security card, check here. You must call 1-800-772-1213 for a replacement card.** ► ☐	

5	Total number of allowances you are claiming (from line H above **or** from the applicable worksheet on page 2)	5
6	Additional amount, if any, you want withheld from each paycheck	6 $
7	I claim exemption from withholding for 2013, and I certify that I meet **both** of the following conditions for exemption. • Last year I had a right to a refund of **all** federal income tax withheld because I had **no** tax liability, **and** • This year I expect a refund of **all** federal income tax withheld because I expect to have **no** tax liability. If you meet both conditions, write "Exempt" here ►	7

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

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

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

Deductions and Adjustments Worksheet

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

1	Enter an estimate of your 2013 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, 1949) of your income, and miscellaneous deductions. For 2013, you may have to reduce your itemized deductions if your income is over $300,000 and you are married filing jointly or are a qualifying widow(er); $275,000 if you are head of household; $250,000 if you are single and not head of household or a qualifying widow(er); or $150,000 if you are married filing separately. See Pub. 505 for details	1	$
2	Enter: { $12,200 if married filing jointly or qualifying widow(er); $8,950 if head of household; $6,100 if single or married filing separately }	2	$
3	**Subtract** line 2 from line 1. If zero or less, enter "-0-"	3	$
4	Enter an estimate of your 2013 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 2013 Form W-4* worksheet in Pub. 505.)	5	$
6	Enter an estimate of your 2013 nonwage income (such as dividends or interest)	6	$
7	**Subtract** line 6 from line 5. If zero or less, enter "-0-"	7	$
8	**Divide** the amount on line 7 by $3,900 and enter the result here. Drop any fraction	8	
9	Enter the number from the **Personal Allowances Worksheet,** line H, page 1	9	
10	**Add** lines 8 and 9 and enter the total here. If you plan to use the **Two-Earners/Multiple Jobs Worksheet,** also enter this total on line 1 below. Otherwise, **stop here** and enter this total on Form W-4, line 5, page 1	10	

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

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

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

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

4	Enter the number from line 2 of this worksheet	4	
5	Enter the number from line 1 of this worksheet	5	
6	**Subtract** line 5 from line 4	6	
7	Find the amount in **Table 2** below that applies to the **HIGHEST** paying job and enter it here	7	$
8	**Multiply** line 7 by line 6 and enter the result here. This is the additional annual withholding needed	8	$
9	Divide line 8 by the number of pay periods remaining in 2013. 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 2013. Enter the result here and on Form W-4, line 6, page 1. This is the additional amount to be withheld from each paycheck	9	$

Table 1

Married Filing Jointly		All Others	
If wages from **LOWEST** paying job are—	Enter on line 2 above	If wages from **LOWEST** paying job are—	Enter on line 2 above
$0 - $5,000	0	$0 - $8,000	0
5,001 - 13,000	1	8,001 - 16,000	1
13,001 - 24,000	2	16,001 - 25,000	2
24,001 - 26,000	3	25,001 - 30,000	3
26,001 - 30,000	4	30,001 - 40,000	4
30,001 - 42,000	5	40,001 - 50,000	5
42,001 - 48,000	6	50,001 - 70,000	6
48,001 - 55,000	7	70,001 - 80,000	7
55,001 - 65,000	8	80,001 - 95,000	8
65,001 - 75,000	9	95,001 - 120,000	9
75,001 - 85,000	10	120,001 and over	10
85,001 - 97,000	11		
97,001 - 110,000	12		
110,001 - 120,000	13		
120,001 - 135,000	14		
135,001 and over	15		

Table 2

Married Filing Jointly		All Others	
If wages from **HIGHEST** paying job are—	Enter on line 7 above	If wages from **HIGHEST** paying job are—	Enter on line 7 above
$0 - $72,000	$590	$0 - $37,000	$590
72,001 - 130,000	980	37,001 - 80,000	980
130,001 - 200,000	1,090	80,001 - 175,000	1,090
200,001 - 345,000	1,290	175,001 - 385,000	1,290
345,001 - 385,000	1,370	385,001 and over	1,540
385,001 and over	1,540		

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

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

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

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

FORM
MW507

Purpose. Complete Form MW507 so that your employer can withhold the correct Maryland income tax from your pay. Consider completing a new Form MW507 each year and when your personal or financial situation changes.

Basic Instructions. Enter on line 1 below, the number of personal exemptions that you will be claiming on your tax return; however, if you wish to claim more exemptions, or if your adjusted gross income will be more than $100,000 if you are filing single or married filing separately ($150,000, if you are filing jointly or as head of household), you must complete the Personal Exemption Worksheet on page 2. Complete the Personal Exemption Worksheet on page 2 to further adjust your Maryland withholding based upon itemized deductions, and certain other expenses that exceed your standard deduction and are not being claimed at another job or by your spouse. However, you may claim fewer (or zero) exemptions.

Additional withholding per pay period under agreement with employer. If you are not having enough tax withheld, you may ask your employer to withhold more by entering an additional amount on line 2.

Exemption from withholding. You may be entitled to claim an exemption from the withholding of Maryland income tax if:

a. last year you did not owe any Maryland Income tax and had a right to a full refund of any tax withheld; AND

b. this year you do not expect to owe any Maryland income tax and expect to have a right to a full refund of all income tax withheld.

If you are eligible to claim this exemption, complete Line 3 and your employer will not withhold Maryland income tax from your wages.

Students and Seasonal Employees whose annual income will be below the minimum filing requirements should claim exemption from withholding. This provides more income throughout the year and avoids the necessity of filing a Maryland income tax return.

Certification of nonresidence in the State of Maryland. Complete Line 4. This line is to be completed by residents of the District of Columbia, Pennsylvania, Virginia or West Virginia who are employed in Maryland and who do not maintain a place of abode in Maryland for 183 days or more.

Line 4 is **NOT** to be used by residents of other states who are working in Maryland, because such persons are liable for Maryland income tax and withholding from their wages is required.

If you are domiciled in the District of Columbia, Pennsylvania or Virginia and maintain a place of abode in Maryland for 183 days or more, you become a statutory resident of Maryland and you are required to file a resident return with Maryland reporting your total income. You must apply to your domicile state for any tax credit to which you may be entitled under the reciprocal provisions of the law. If you are domiciled in West Virginia, you are not required to pay Maryland income tax on wage or salary income, regardless of the length of time you may have spent in Maryland.

Under the Service members Civil Relief Act, as amended by the Military Spouses Residency Relief Act, you may be exempt from Maryland income tax on your wages if (i) your spouse is a member of the armed forces present in Maryland in compliance with military orders; (ii) you are present in Maryland solely to be with your spouse; and (iii) you maintain your domicile in another state. If you claim exemption under the SCRA enter your state of domicile (legal residence) on Line 5; enter "EXEMPT" in the box to the right on Line 5; and attach a copy of your spousal military identification card to Form MW507. **In addition, you must also complete and attach Form MW507M.**

Duties and responsibilities of employer. Retain this certificate with your records. You are required to submit a copy of this certificate and accompanying attachments to the Compliance Division, Compliance Programs Section, 301 West Preston Street, Baltimore, MD 21201, when received if:

1. you have any reason to believe this certificate is incorrect;
2. the employee claims more than 10 exemptions;
3. the employee claims an exemption from withholding because he/she had no tax liability for the preceding tax year, expects to incur no tax liability this year and the wages are expected to exceed $200 a week;
4. the employee claims an exemption from withholding on the basis of nonresidence; or
5. the employee claims an exemption from withholding under the Military Spouses Residency Relief Act.

Upon receipt of any exemption certificate (Form MW 507), the Compliance Division will make a determination and notify you if a change is required.

Once a certificate is revoked by the Comptroller, the employer must send any new certificate from the employee to the Comptroller for approval before implementing the new certificate.

If an employee claims exemption under 3 above, a new exemption certificate must be filed by February 15th of the following year.

Duties and responsibilities of employee. If, on any day during the calendar year, the number of withholding exemptions that the employee is entitled to claim is less than the number of exemptions claimed on the withholding exemption certificate in effect, the employee shall file a new withholding exemption certificate with the employer within 10 days after the change occurs.

FORM
MW507

Employee's Maryland Withholding Exemption Certificate

Print full name	Social Security number
Street Address, City, State, Zip	County of residence (or Baltimore City)

☐ Single ☐ Married (surviving spouse or unmarried Head of Household) Rate ☐ Married, but withhold at Single rate

1. Total number of exemptions you are claiming not to exceed line f in Personal Exemption Worksheet on page 2 ..... 1.

2. Additional withholding per pay period under agreement with employer..... 2. $

3. I claim exemption from withholding because I do not expect to owe Maryland tax. See instructions above and check boxes that apply.
☐ a. Last year I did not owe any Maryland Income tax and had a right to a full refund of all Income tax withheld and
☐ b. This year I do not expect to owe any Maryland income tax and expect to have the right to a full refund of all income tax withheld. (This includes seasonal and student employees whose annual income will be below the minimum filing requirements).
If both a and b apply, enter year applicable _____ (year effective) Enter "EXEMPT" here ..... 3.

4. I claim exemption from withholding because I am domiciled in one of the following states. Check state that applies.
☐ District of Columbia ☐ Pennsylvania ☐ Virginia ☐ West Virginia
I further certify that I do not maintain a place of abode in Maryland as described in the instructions above. Enter "EXEMPT" here . 4.

5. I certify that I am a legal resident of the state of _____ and am not subject to Maryland withholding because I meet the requirements set forth under the Servicemembers Civil Relief Act, as amended by the Military Spouses Residency Relief Act.
Enter "EXEMPT" here ..... 5.

Under the **penalty of perjury**, I further certify that I am entitled to the number of withholding allowances claimed on line 1 above, or if claiming exemption from withholding, that I am entitled to claim the exempt status on line 3, 4 or 5, whichever applies.

Employee's signature	Date
Employer's Name and address including zip code (For employer use only)	Federal employer identification number

Personal Exemptions Worksheet

Line 1

a. Multiply the number of your personal exemptions by the value of each exemption from the table below. (Generally the value of your exemption will be $3,200; however, if your federal adjusted gross income is expected to be over $100,000, the value of your exemption may be reduced. **Do not claim any personal exemptions that you are currently claiming at another job, or any exemptions being claimed by your spouse.** To qualify as your dependent, you must be entitled to an exemption for the dependent on your federal income tax return for the corresponding tax year. **NOTE:** Dependent taxpayers may not claim themselves as an exemption.. . . . . a. _____

b. Multiply the number of additional exemptions you are claiming for dependents who are 65 years of age or older by the value of each exemption from the table below. . . . . b. _____

c. Enter the estimated amount of your itemized deductions (excluding state and local income taxes) that exceed the amount of your standard deduction, alimony payments, allowable childcare expenses, qualified retirement contributions, business losses and employee business expenses for the year. Do not claim any additional amounts you are currently claiming at another job; or any amounts being claimed by your spouse. **NOTE:** Standard deduction allowance is 15% of Maryland adjusted gross income with a minimum of $1,500 and a maximum of $2,000. . . . . .c. _____

d. Enter $1,000 for additional exemptions for taxpayer and/or spouse at least 65 years of age and/or blind. . . d. _____

e. Add total of lines **a** through **d**. . . . . e. _____

f. Divide the amount on line e by $3,200. **Drop any fraction. Do not round up.** This is the **maximum** number of exemptions you may claim for withholding tax purposes. .....f. _____

If Your federal AGI is		**If you will file your tax return**	
		Single or Married Filing Separately **Your Exemption is**	Joint, Head of Household or Qualifying Widow(er) **Your Exemption is**
$100,000 or less		**$3,200**	**$3,200**
Over	**But not over**		
$100,000	**$125,000**	**$1,600**	**$3,200**
$125,000	**$150,000**	**$800**	**$3,200**
$150,000	**$175,000**	**$0**	**$1,600**
$175,000	**$200,000**	**$0**	**$800**
In excess of $200,000		**$0**	**$0**

FEDERAL PRIVACY ACT INFORMATION

Social Security numbers must be included. The mandatory disclosure of your Social Security number is authorized by the provisions set forth in the Tax-General Article of the Annotated Code of Maryland. Such numbers are used primarily to administer and enforce the individual income tax laws and to exchange income tax information with the Internal Revenue Service, other states and other tax officials of this state. Information furnished to other agencies or persons shall be used solely for the purpose of administering tax laws or the specific laws administered by the person having statutory right to obtain it.

State of Maryland-Child Protective Services Program

CONSENT FOR RELEASE OF INFORMATION/BACKGROUND CLEARANCE REQUEST

INSTRUCTIONS

1. Type or print legibly in ink. INCOMPLETE FORMS WILL BE RETURNED.
2. Submit a separate form for each individual whose name is to be searched.
3. Provide proof of identify and sign Part III in the presence of a Notary Public.
4. This form must be notarized.
5. Return the completed form to either:

   Local Department of Social Services in the area where you reside
   or
   Department of Human Resources
   In-Home Services
   Social Services Administration
   311 W. Saratoga Street, Room 553
   Baltimore, MD 21201

Part I: PURPOSE OF SEARCH: *(Complete below and the person that this search pertains to must sign the form on the reverse in part III.)*

☐ A. RELEASE TO SELF:

☐ 1. To determine if I have been found responsible for indicated or unsubstantiated disposition for a child abuse or neglect investigation.

☐ 2. To determine if I have any remaining appeal rights

☐ B. RELEASE TO AN AGENCY/INDIVIDUAL RELATED TO:

☐ Foster Parent ☐ School Personnel ☐ Day Care Center
☐ Kinship Care Provider ☐ Institutional Employee ☐ Family Day Care Provider
☐ Adoptive Parent ☐ CASA ☐ Other Employment (Explain _____
☐ Custody Evaluation ☐ Volunteer ☐ Other (Explain) _____

1. Requesting Agency Or Individual Name		2. Name Of Agency Representative		
3. Address	City	State	Zip	Telephone

☐ C. RELEASE OF SUMMARY OF AGENCY FINDING:

I am aware that I have an **indicated** disposition following a child abuse or neglect investigation and I authorize the agency to release a summary to the individual/agency identified in part I as to why I was found responsible.

Part II: TO BE COMPLETED IN FULL, BY INDIVIDUAL WHOSE NAME IS BEING SEARCHED

1. IDENTIFYING INFORMATION:

Last Name	First	Full Middle	Maiden/Birth Name

Social Security #	Race	Sex	Birthdate	Other Names Used

2. CURRENT ADDRESS — City — State — Zip

3. PRIOR ADDRESS(S) AND DATE(S) *(Within The Past 7 Years)* — City — State — Zip — Date

City — State — Zip — Date

4. CURRENT SPOUSE — Last, First, Full Middle — Race — Sex — Birth Date

5. PREVIOUS SPOUSE — Last, First, Full Middle — Race — Sex — Birth Date

6. FULL NAMES OF ALL CHILDREN LIVING WITH YOU *(Also include adult children not living with you. Attach additional paper if needed)*

Last, First, Full Middle	Race	Sex	Birth Date	Last, First, Full Middle	Race	Sex	Birth Date

Part III: AUTHORIZATION ***(Check either 1 or 2 below.)***

Pursuant to Maryland Code of Regulation Section 07.02.07.19, pertaining to the confidentiality of Child Protective Services records and reports, I hereby authorize the Maryland Department of Human Resources (DHR):

☐ 1. To **notify** _____ *(self, agency, or individual listed in part I*) as to whether a local department of social services has identified me as responsible for "indicated" child abuse or neglect in any record maintained by the Maryland DHR, any Local Department of Social Services, and Child Protective Services.

☐ 2. To **release a summary** of the indicated finding to _____*(self, agency, or individual listed in part I*).

SIGNATURE: *This form must sign in the presence of a Notary Public by the person named in part II.* DATE:

Part IV. CERTIFICATE OF ACKNOWLEDGEMENT OF INDIVIDUAL BEFORE A NOTARY PUBLIC

City/County of: _____ State of: _____

Acknowledged before me this _____ Day of _____ 20____

_____
Notary Public

My Commission expires: _____

Part V. BACKGROUND CLEARANCE FINDINGS *(for Local Department or DHR use only)*

☐ 1. We are unable to determine at this time if the individual for whom a search has been requested has a CPS finding. Form returned to requesting agency. Date _____

☐ 2. Sent to DHR or Local Department of Social Services: Name _____
Date _____

Date returned from Local Department _____

☐ 3. Based on information provided by Local Departments of Social Services, we have determined that _____ is listed in the Central Registry as being responsible for an ☐ Indicated/ ☐ Unsubstantiated disposition of ☐ Abuse / ☐Neglect in reference to an investigation conducted in _____. Child Protective Service Case/File/Referral #: _____.

☐ 4. Holding for Appeal Appeal Date _____ Appeal Disposition _____

☐ 5. Notification sent to Requesting Agency/Individual: Date_____

☐ 6. Notification sent to Person: Date_____

☐ 7. Summary Provided: Date _____

☐ 8. As of this date, the individual whose name was being searched is NOT identified in the Central Registry as being responsible for abuse or neglect.

Criminal History Record Check

Last Name: _____

First Name: _____

Sex: _____ **Race**: _____

Height: _____ **Weight**: _____

Eye Color: _____ **Hair Color**: _____

Date of Birth: _____

State you were born in: _____

Country of Citizenship: _____

Street Address/Apt #: _____

City/State/Zip Code: _____

Have you been convicted of a crime/probation? _____

Do you have pending charges? _____

Signature: _____

Date: _____

Every Child a Success

THE BOARD OF EDUCATION OF DORCHESTER COUNTY

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Supplemental Form to the Application for Criminal Record Check & Disclosure Statement and Verification of Fingerprint Completion

(§5-560 et. seq of the Family Law Article.)

PLEASE READ CAREFULLY AND ANSWER EACH QUESTION. YOU ARE REQUIRED TO SIGN AND RETURN THIS FORM ALONG WITH YOUR APPLICATION FOR EMPLOYMENT. APPLICATIONS WILL NOT BE CONSIDERED UNLESS THIS FORM IS RETURNED WITH YOUR APPLICATION.

* "CONVICTION" MEANS A PLEA OR VERDICT OF GUITY OR A PLEA OF NOLO CONTENDERE. IF CONVICTIONS, PROBATION BEFORE JUDGMENT DISPOSITIONS, OR OTHER DISPOSITIONS HAVE BEEN EXPUNGED FROM THE APPLICANT'S CRIMINAL RECORD, THE AFOREMENTIONED DO NOT HAVE TO BE REPORTED.

1. Have you ever been convicted of a crime? *_____Yes *_____ No

2. Have you ever received a probation before judgment disposition in a criminal proceeding?
*_____ Yes *_____ No

3. Have you ever received a not criminally responsible disposition in a criminal proceeding?
*_____Yes *_____ No

4. Are you now a Defendant facing pending criminal charges in any Court?
*_____Yes *_____ No

***If you check yes to any of the above, please describe on an attached sheet.**

I UNDERSTAND THAT ALL STATEMENTS MADE ON THIS FORM ARE TRUE TO THE BEST OF MY KNOWLEDGE AND IF LATER DISCOVERED TO BE UNTRUE, WILL BE JUSTIFICATION FOR IMMEDIATE DISMISSAL.

Printed Name_____ **Signature**_____

Last four digits of SSN_____ **Date**_____

The Maryland State Department of Education (MSDE), Division of Certification and Accreditation, requires verification that a local school system conduct a Criminal Background Investigation on each new certificated employee, as required of an employer by the Family Law Article of the Annotated Code of Maryland *(§5-560 et. seq of the Family Law Article.)*

This serves as verification that the following employee has been fingerprinted as required by the Family Law Article as part of the Criminal Background Investigation.

Fingerprints completed by:

_____	_____	_____
Printed Name	**Signature**	**Date**

Maryland New Hire Registry Reporting Form

Send completed forms to:
Maryland State Directory of New Hires
PO Box 1316
Baltimore, MD 21203-1316
Fax: (410) 281-6004 or toll-free fax 1 (888) 657-3534

To ensure the highest level of accuracy, please print neatly in capital letters and avoid contact with the edges of the boxes. The following will serve as an example:

A	B	C

1	2	3

EMPLOYER INFORMATION

Federal Employer Id Number (FEIN):

Please use the same FEIN that appears on quarterly wage reports.

State Unemployment Insurance Number (MD Only SUIN):

If SUIN not issued yet, please write "APPLIEDFOR" in the above box. If Exempt, write "EXEMPT".

Employer Name:

Employer Address *(Please indicate the address where the Income Withholding Orders should be sent):*

Employer City:

Employer State:

Zip Code (5 digit):

Employer Phone (optional):

Employer Fax (optional):

Contact Name (optional):

Email (optional):

EMPLOYEE INFORMATION

Employee Social Security Number (SSN):

Date of Hire (mm/dd/yyyy):

Employee First Name:

Middle Initial (optional):

Employee Last Name:

Employee Address:

Employee City:

Employee State:

Zip Code (5 digit):

Date of Birth mm/dd/yyyy (optional):

Employee Salary (Dollars and Cents):

Hourly

Monthly

Yearly

Are health care benefits available to employee? (Y/N):

Employee Gender (M)ale/(F)emale:

Reports must be submitted within 20 days of the date of hire or rehire

Rev (09/02)

Questions? Call us at (410) 281-6000 or toll-free 1 (888) MDHIRES (634-4737). Report online at www.mdnewhire.com

Service Retirement

There are two types of service retirement: normal and early. Normal service retirement provides full benefits, while early service retirement provides a reduced benefit. Your eligibility for either type of service retirement depends on two factors: your service credit and age.

Normal: At least 90 years of combined age and years of eligibility service. For example:

- Age 57 with 33 years of service,
- Age 60 with 30 years of service or
- Age 63 with 27 years of service

Active members with at least 10 years of eligibility service become eligible for normal service retirement at age 65.

Early: Age 60 with at least 15 years of eligibility service.

When you retire, you will be able to choose from a number of payment options. These options range from the Basic Allowance, which provides the highest monthly allowance for you alone, to options that reduce your monthly payment but provide varying degrees of protection to your beneficiary(ies) upon your death.

During Retirement

As a retiree, once you have been retired one full year as of July 1, your retirement allowance may be adjusted each July to help your benefit payments keep pace with inflation.

If You Leave Employment Before Retirement

If you should leave employment once you have accrued at least 10 years of eligibility service, you are vested and have earned the right to receive a future benefit based on your service at termination. If you withdraw any of your contributions at termination, you will forfeit the right to a future benefit.

If you are not vested at the time of termination and you don't anticipate returning to membership, you should contact the agency to receive a refund of any contributions with interest you may have made.

Resources

Visit the State Retirement Agency online at sra.maryland.gov for newsletters, member handbooks, retirement benefit estimators, printable forms and updates on the System's financial performance.

To visit the office or write a letter:

State Retirement Agency
120 East Baltimore Street
Baltimore, MD 21202-6700

To speak with a retirement benefits specialist:

410-625-5555 or 1-800-492-5909

Or e-mail sra@sra.state.md.us

SRPS
MARYLAND
STATE RETIREMENT
and PENSION SYSTEM

Butterfly photo courtesy of Sue Muller
Howard County Department of Recreation & Parks

Welcome to the

Employees' & Teachers' Pension System

For members enrolled on or after July 1, 2011

Baltimore Checkerspot Butterfly
Maryland State Insect

Maryland State Retirement
and Pension System
120 East Baltimore Street
Baltimore, MD 21202-6700

410-625-5555
1-800-492-5909

sra.maryland.gov

10/11

Welcome!

The Maryland State Retirement and Pension System has a long history of providing retirement benefits to employees and teachers of Maryland state and municipal employers.

This overview deals with the highlights of the Employees' and Teachers' Pension System for members enrolled on or after July 1, 2011. Please refer to the pension system handbook on our website at sra.maryland.gov for more details about any of these topics.

A retirement coordinator, usually someone in your human resources department, can help you file enrollment forms and answer basic questions about your benefits. The Maryland State Retirement Agency also maintains a staff of retirement benefits specialists to answer questions from members and retirees.

Enrollment

Membership in the Employees' and Teachers' Pension System is mandatory. You must enroll by submitting an *Application for Membership* (Form 1), a *Designation of Beneficiary* (Form 4) and a valid proof of birth date. The forms are available from your retirement coordinator.

If you have membership credit in another Maryland state or Maryland local retirement/pension system, you may be able to transfer that service credit to your new plan. To qualify for the transfer, your employment must be continuous and you must apply within one year of becoming a member in your new system. Contact a retirement benefits specialist if this situation applies to you.

Employee Contributions

You contribute seven percent of your annual compensation to the Pension System.

Service Credit

You earn service credit toward your retirement benefits each day you work and pay your required contribution. Your service credit and age determine when you are eligible for retirement and how much your retirement benefit will be.

Eligibility service is used to determine when you are eligible for a benefit. You earn one year of eligibility service during any fiscal year when you work a minimum of 500 regular hours, excluding overtime.

The amount of your retirement benefit is based on creditable service which is determined on the hours you work in a fiscal year. A full-time employee will earn one month of creditable service for each month of employment.

Your Benefits

The Pension System provides survivor, disability and service retirement benefits. More information on your benefits is available online at sra.maryland.gov.

Survivor Benefits

The Pension System provides valuable beneficiary protection for members who die during active membership.

If a member dies after accruing at least one year of eligibility service, or dies in the course of duty, the beneficiary(ies) receives a one-time payment of the member's annual salary plus the member's accumulated contributions and interest.

If a member is eligible to retire or has at least 25 years of eligibility service at the time of death, his or her

sra.maryland.gov

surviving spouse may be eligible to receive a monthly benefit in lieu of the one-time payment if the spouse is the sole primary beneficiary.

In lieu of the survivor benefits mentioned here, if a member of the Employees' and Teachers' Pension System is killed in the line of duty, a monthly allowance of two-thirds of the member's average final compensation will be paid to the surviving spouse (if no spouse, to the member's children under age 18. If no spouse or minor children, the benefit is paid to the member's dependent parent for life.) Plus, a return of the member's accumulated contributions with interest is paid to the designated beneficiary.

Disability Benefits

If you are permanently and totally disabled from performing your job duties, as determined by the System's medical board, you may be eligible for a lifetime monthly disability retirement benefit.

Types of Disability Retirement

There are two types of disability benefits:

Ordinary: Any permanently disabling physical or mental condition.

Accidental: Any permanently disabling condition caused by injuries sustained from an accident on the job.

To file for ordinary disability, you must have accrued five years of eligibility service. As an active member, you are eligible to file for accidental disability from your first day on the job provided you file within five years of the date of the accident.

Your retirement coordinator can provide you with the necessary forms to file for a disability retirement benefit.

sra.maryland.gov

MARYLAND STATE RETIREMENT AGENCY
120 EAST BALTIMORE STREET
BALTIMORE, MD 21202-6700

APPLICATION FOR MEMBERSHIP

FOR RETIREMENT USE ONLY **FORM 1 (REV. 3/12)**

IMPORTANT: PLEASE READ THE INSTRUCTIONS ON THE SECOND PAGE OF THIS FORM.

SECTION ONE — TO BE COMPLETED BY APPLICANT

APPLICANT'S SOCIAL SECURITY NUMBER | GENDER (M or F) | DATE OF BIRTH (Month Day Year)

APPLICANT'S NAME (First Initial Last)

HOME ADDRESS (Number and Street)

City | State | Zip Code

Home Phone Number

1. Have you ever been a member of the Maryland State Retirement and Pension System? ..... Yes ☐ No ☐
2. Have you ever been a member of the Optional Retirement Plan (ORP)? ..... Yes ☐ No ☐
3. Are you presently receiving a retirement allowance from the Maryland State Retirement and Pension System? .... Yes ☐ No ☐
4. Are you presently a member of another State or local retirement or pension system operated under the laws of Maryland or any political subdivision of Maryland? ..... Yes ☐ No ☐
   IMPORTANT: If yes, read carefully the transfer provisions on the back of this form and then initial here: _____.
5. Have you attached acceptable proof of birth date as described on the back of this form? ..... Yes ☐ No ☐

I certify that all statements made on this application are correct. I authorize any required deductions from my salary at the prescribed rate. And if I am presently a member of another State or local retirement or pension system, I have read and understand the transfer provisions.

Applicant's Complete Signature _____ Date _____

SECTION TWO — TO BE COMPLETED BY RETIREMENT COORDINATOR

A. IS THE APPLICANT A PERMANENT EMPLOYEE? ..... Yes ☐ No ☐
   If part-time, what percentage of time is the applicant employed? ..... _____ percent
B. When did applicant begin present continuous service? ..... Month_____ Day_____ Year_____
C. What is the applicant's complete job classification or title?_____
D. Is applicant's current position Optional Retirement Plan (ORP) eligible? ..... Yes ☐ No ☐
   If yes and the applicant checked "Yes" to question 2 above (individual previously participated), STOP and complete Form 60 *Election Not to Participate in the Teachers'/Employees' System by Faculty or Administrative Officers of Institutions of Higher Learning*.
E. What is the applicant's annual salary? $_____ What is the applicant's annual standard hours?_____
F. If applying for membership in the Law Enforcement Officers' Pension System, does the applicant meet the eligibility requirements? ..... Yes ☐ No ☐
G. If the applicant is eligible to request a transfer of service credit between retirement or pension systems as a result of this new employment, have you reviewed the transfer provisions on page two with the applicant? ..... Yes ☐ No ☐

INDICATE SYSTEM: ☐ Teachers' Pension ☐ Employees' Pension ☐ Correctional Officers' Retirement ☐ State Police Retirement ☐ Law Enforcement Officers' Pension

EMPLOYING AGENCY CODE | # OF RETIREMENT CONTRIBUTIONS DEDUCTED PER FISCAL YEAR | SYSTEM

FOR RETIREMENT USE ONLY
MO DAY YEAR
ENTRANCE DATE

Retirement Coordinator's Complete Signature/Date _____ Telephone # _____

INSTRUCTIONS

Purpose of this Form: The Application for Membership form provides the Maryland State Retirement Agency ("Agency") with the information necessary to properly enroll new members in the Maryland State Retirement and Pension System ("System").

Instructions for Applicant (Section One):

1. Use a pen, print clearly, and provide the information requested in ***Section One***, including: your Social Security number, gender, date of birth, first name, middle initial, last name, home address including city, state, and zip code, and home telephone number.
2. Review and answer all of the questions in ***Section One***. Note that if you answer "Yes" to question #4, you must read the important information at the bottom of this page on Transfer Provisions, and then initial in the space provided.
3. Sign and date the form.
4. Make a copy of the form for your records and submit the form to your retirement coordinator along with a visible and readable copy of your proof of birth date document. Acceptable documents validating your date of birth include: your valid driver's license, Maryland identification card, birth certificate, and United States passport.
5. It is strongly recommended by the Agency that at the same time you submit your completed *Application for Membership* form to your retirement coordinator that you also submit a completed *Designation of Beneficiary* form. The *Designation of Beneficiary* form allows you to name the person (beneficiary) or persons (beneficiaries) that you want to receive any death benefits payable if you die while a member of the System.

Instructions for Retirement Coordinator (Section Two):

1. Review the applicant's answers to questions 1-5 in ***Section One.***

   If the applicant answered "Yes" in question 3, please call the Agency to determine if he or she should be enrolled in the System.
2. Use a pen, print clearly, and answer questions A – G in ***Section Two***. Pay particular attention to questions D and G.

   If in question D, you have indicated that the applicant's current position is eligible to participate in the Optional Retirement Plan (ORP) and the applicant has indicated in question 2 from ***Section One*** that he or she has ever previously participated in the ORP then the applicant is NOT eligible for enrollment in the System.

   If in question G, you have indicated that the applicant is eligible to transfer service credit then you must review the Transfer Provisions on page two of the form with the applicant.
3. Indicate the retirement or pension system of participation for the applicant by checking the appropriate box.
4. Enter the required information in the employee agency code, number of retirement contributions to be deducted per year, and the system box.
5. Sign and date the form.
6. Make a copy of the completed form and the proof of birth date document for your files, and mail the original form and a copy of the proof of birth date document to the Agency.

Transfer Provisions for Service Credit Earned in Another Maryland State or Maryland Local Retirement or Pension System

If an applicant was previously a member of the Maryland State Retirement and Pension System or a member of another retirement or pension system administered by a political subdivision within Maryland (e.g. county government, city government, etc.), and their current employment requires a membership change in a retirement or pension system, the applicant may be eligible to transfer their service from their previous retirement or pension system to their new retirement or pension system with the Maryland State Retirement and Pension System.

To be eligible to transfer service credit, the following requirements must be met:

1. The applicant's employment must be continuous, meaning a change in jobs without a break in employment.
2. The transfer of service must be completed within one (1) year of the applicant becoming a member of the new retirement of pension system.

To transfer service credit from one retirement or pension system within the Maryland State Retirement and Pension System to another retirement or pension system within the Maryland State Retirement and Pension System, a completed *Election to Transfer Service* (Form 37) must be submitted to the Agency.

To transfer service credit from a retirement or pension system outside of the Maryland State Retirement and Pension System (e.g. a county, city, or local government system) to a retirement or pension system within the Maryland State Retirement and Pension System to another retirement, a completed *Request to Purchase Previous Service* (Form 26) must be submitted to the Agency.

If you need help to complete this form or require clarification, please call 410-625-5555 or 1-800-492-5909.

MARYLAND STATE RETIREMENT AGENCY
120 EAST BALTIMORE STREET
BALTIMORE, MARYLAND 21202-6700

DESIGNATION OF BENEFICIARY

IMPORTANT: Please return completed form to the address listed above. Print clearly and read the instructions first. Fill in all sections. Retain a copy for your records.

FOR RETIREMENT USE ONLY **FORM 4 (REV. 10/13)**

APPLICANT'S SOCIAL SECURITY NUMBER

CHECK ONE: ☐ Working ☐ Vested ☐ Retired (If retiring, retirement date _____)

IMPORTANT: If you are retired under Option 2, 3, 5 or 6, **STOP**. You cannot use this form. You must complete a Form 66 to initiate any beneficiary changes.

APPLICANT'S NAME

First Initial Last

HOME ADDRESS

Number and Street

City State Zip Code

PRIMARY BENEFICIARY(IES) All money shall be paid in equal shares to the primary beneficiary(ies) who are living at the time of my death.

☐ Check if you used an additional Form 4 to name additional primary beneficiaries.

BENEFICIARY'S NAME RELATIONSHIP* _____ Gender: _____ (M or F) Birthdate: _____ Month Day Year

First Initial Last

*If spouse, please indicate state/jurisdiction where marriage license was issued: _____ Date of marriage: _____

BENEFICIARY'S ADDRESS _____

BENEFICIARY'S NAME RELATIONSHIP _____ Gender: _____ (M or F) Birthdate: _____ Month Day Year

First Initial Last

BENEFICIARY'S ADDRESS _____

CONTINGENT BENEFICIARY(IES) If all primary beneficiaries die before me all money shall be paid in equal shares to the following person(s) who are living at the time of my death.

☐ Check if you used an additional Form 4 to name additional contingent beneficiaries.

BENEFICIARY'S NAME RELATIONSHIP _____ Gender: _____ (M or F) Birthdate: _____ Month Day Year

First Initial Last

BENEFICIARY'S ADDRESS _____

BENEFICIARY'S NAME RELATIONSHIP _____ Gender: _____ (M or F) Birthdate: _____ Month Day Year

First Initial Last

BENEFICIARY'S ADDRESS _____

TO THE MARYLAND STATE RETIREMENT AGENCY: I authorize the Maryland State Retirement Agency to pay the death benefit to my designated beneficiary or beneficiaries. I agree on behalf of my estate, heirs and assigns that the payment made by the agency will release the agency from any further obligation regarding this benefit. I direct the agency to pay the death benefit to my estate if I have not designated any beneficiary or if all of the primary and contingent beneficiaries I have named die before me. I understand that I may change beneficiaries at any time by filing a new Designation of Beneficiary form with the Maryland State Retirement Agency. Any new Designation of Beneficiary form I file will replace this form. I understand certain payment due to a minor shall be made only to the legal guardian of that minor. SIGN IN THE PRESENCE OF A NOTARY PUBLIC. (Form not valid unless notarized.)

Signature _____ **Date Signed** _____

This form must be signed and notarized in order to be valid.

Please check (✓) for your plan:

- ( ) **1** Teachers' Retirement Plan
- ( ) **2** Employees' Retirement Plan
- ( ) **2C** Correctional Officers' Retirement Plan
- ( ) **3** State Police
- ( ) **6** Teachers' Pension Plan (Incl. Bifurcated)
- ( ) **7** Employees' Pension Plan (Incl. Bifurcated)
- ( ) **8** Law Enforcement Officers' Retirement Plan
- ( ) **9** Law Enforcement Officers' Pension Plan

State of _____ County of _____ (or City of Baltimore)
On this _____ day of _____, 20 _____, before me, the undersigned officer,

Official Seal must be affixed

personally appeared _____, known to me
NAME OF PERSON WHOSE SIGNATURE IS BEING ACKNOWLEDGED *

(or satisfactorily proven) to be the person whose name is subscribed to the within instrument and acknowledged that (he/she) executed the same for the purposes therein contained. In witness whereof I hereunto set my hand and official seal.

Signature of Notary Public _____

Printed Name of Notary Public _____ My Commission Expires _____

*** IMPORTANT: If the name of the individual whose signature is being acknowledged is not filled in, this form will be INVALID and have no legal effect.**

PLEASE READ CAREFULLY BEFORE FILLING OUT FORM

1. **Purpose of this form:**
   Active Members: Use this form to name the person or persons (beneficiaries) you want to receive any accumulated retirement contributions and death benefits if you die while you are employed.

   Vested Members: The person or persons you designate on this form receive your accumulated retirement contributions, if any. No death benefits are payable upon the death of a vested member.

   Retirees: Use this form only if you chose Basic Allowance, Option #1 or #4. The person or persons named receive one payment if your death occurs on the 16th of the month or later (Basic Allowance), any remaining portion of the present value of your benefit (Option #1) or the remaining portion of your accumulated contributions (Option #4).

   If you are a member of more than one system, you must properly complete a *Designation of Beneficiary* (Form 4) for each system. Judges use Form 4.1. Legislators use Form 55.

   If you are retired under Option 2, 3, 5 or 6, **STOP**. You cannot use this form. You must complete a *Request for Calculation of Joint Survivorship by a Retiree Considering Changing a Beneficiary* (Form 66.) Please see the Maryland State Retirement Agency (MSRA) Web site at www.sra.state.md.us or call a Retirement Benefits Specialist.

2. **Changing beneficiaries:**
   You may change your beneficiaries at any time by completing a new form and filing it with the Maryland State Retirement Agency located at 120 East Baltimore Street, Baltimore, Maryland 21202. You must fill out a new form and file it with the MSRA each time you add, subtract or change beneficiaries.

   The most recent form on file at the Maryland State Retirement Agency replaces any form(s) previously filed with the MSRA.

3. **Number of beneficiaries**
   Fill out only the spaces needed. If you need space for more beneficiaries, complete another form and check the box or boxes to show that you have used a second form.

4. **Full names of beneficiaries:**
   Give the full names of your beneficiaries. For example, "Mary Jones", not "Mrs. John Jones."

5. **Who can be a beneficiary:**
   Beneficiaries do not need to be related to you.

   Minor children:
   You may name minor children as beneficiaries, but in some cases payments can only be made to the legal guardian of a minor. You cannot use this form to name a legal guardian for minor children.

   Your estate:
   You may name "my estate". Do not name a personal representative of your estate as your beneficiary. Instead, use the space for the beneficiary's address to show the address of the person or business that will administer your estate.

   Trustee:
   If you have established an Agreement of Trust or Testamentary Trust, you may name "Trustee as appointed by Agreement of Trust or Will" in the space provided for the beneficiary's address. Give the address of the Trustee or of the person or business that will administer the trust.

   Church or charitable organization:
   List the complete corporate or legal name.

   Monthly allowance for husband or wife:
   If you die before retirement and your age and/or years of service at death meet certain requirements, your husband or wife is eligible to elect to receive either a one-time payment or a monthly allowance. If you want your husband or wife to be eligible to make this election, you must name him or her as your only primary beneficiary. You may still name contingent beneficiaries, but they are not eligible for a monthly allowance.

6. The total benefits due at your death are paid in equal shares to the living beneficiaries named on your Designation of Beneficiary form. If you name multiple primary beneficiaries, and one of the primary beneficiaries dies before you, the total benefits due at your death are divided in equal shares among the remaining primary beneficiaries. If all primary beneficiaries die before you, and one of multiple contingent beneficiaries also dies before you, then the total benefits payable at your death are divided equally among the remaining contingent beneficiaries.

   A deceased beneficiary's share of your total benefits cannot be paid to that deceased beneficiary's heirs. Payment is made only to the living beneficiaries listed on your Designation of Beneficiary form

7. **Notarization**
   Sign in the presence of a Notary Public. This form is not valid unless notarized.

Properly completed forms should be mailed to:

Maryland State Retirement Agency
120 E. Baltimore St.
Baltimore, MD 21202-6700

NEED HELP?

IF YOU NEED HELP TO COMPLETE THIS FORM, CALL A RETIREMENT BENEFITS SPECIALIST
AT 410-625-5555 (LOCAL) or 1-800-492-5909 (TOLL FREE)
sra.maryland.gov

Educator Information System Portal

The portal is for the use of educators who hold or wish to hold a Maryland State Department of Education (MSDE) educator certificate. For other general inquiries about certification, please refer to the MSDE Certification Branch home page.

NEW USER

Select the NEW USER option ABOVE if you are new to this site.
If you had an account prior to May 7, 2007, you need to create a new user account.

Existing users, please log in:

* = Required Field

*Username:

*Password:

Your password must contain 8-14 characters including at least one upper case letter, one lower case letter, and at least one numeral.

Forgot your Username or Password? Login

Prefer paper? Click here to download application forms.

Certification Branch, Maryland State Department of Education
200 West Baltimore Street, Baltimore, MD 21201
Phone: 410-767-0412 TTY/TDD: 410-333-6442/Toll Free: 866-772-8922

Certification Branch
200 West Baltimore Street
Baltimore, MD 21201

www.mdcert.org

Verification of satisfactory educational experience is required for applicants with one or more years of full-time teaching or other professional experience in a public or an accredited nonpublic school.

Applicant: **Complete this section only and then forward for verification. Please print or type this information.**

Social Security Number: _____ Date of Birth _____

Name: _____ _____ _____
Last First Former

Address: _____
Street

_____ _____ _____
City /State/Zip Code Telephone E-mail

Applicant Signature _____ Date _____

Employer: The above-named person was employed in your district or school(s). Please complete each section below to indicate the dates of service and performance rating for each specific assignment. Performance ratings will be confidential and will be used only for determining eligibility for certification. **Print or type this information and send the completed form to the Maryland State Department of Education at the above address.**

School/School District	State	Dates of Service From To	Performance Rating	Grade and Subject Taught (50% or more; one subject per box)
			○ Satisfactory ○ Unsatisfactory	
			○ Satisfactory ○ Unsatisfactory	
			○ Satisfactory ○ Unsatisfactory	
			○ Satisfactory ○ Unsatisfactory	
			○ Satisfactory ○ Unsatisfactory	

_____ _____
Printed Name of Authorized Official **Signature of Authorized Official**

_____ _____
Title **Date**

_____ _____
Address **City/State/Zip Code**

_____ _____
Phone **E-mail**

Dorchester County Public Schools Office of Human Resources

Every Child A Success!

Dorchester County Public Schools Employment Verification

Dorchester County Public Schools
Office of Human Resources
700 Glasgow Street
Cambridge, MD 21613

Phone: 410-228-4747
FAX: 410-221-5269
www.dcps.k12.md.us

_____ _____
Print Name Date

_____ _XXX-XX-_____
Signature Social Security Number (four)

To Whom It May Concern:
I have been employed by the Dorchester County Public School System. Since my salary will be determined by my years of verified teaching experience, I would appreciate your completing the form below and forwarding this information to the Dorchester County Public Schools Office of Human Resources. I give my permission for the release of the following information.

TO BE COMPLETED BY PREVIOUS EMPLOYER

Dates of Contracted Service		Type of Employment				
From Mo/Day/Yr	**To Mo/Day/Yr**	**Full or Part Time**	**School District**	**Position**	**Subject**	**Reason for Termination Month/Year**

If period of employment included any extended period of leave, please explain:

_____

Did this teacher earn tenure in another Maryland School System? ☐ Yes or ☐ No
Was performance satisfactory*? ☐ Yes or ☐ No

***Maryland State Board of Education Bylaw 13A.12.01 defines satisfactory as experience for which the annual overall evaluation rating is satisfactory or better.**

If you are a Maryland school system, please state the number of sick days remaining**_____

**** Maryland State Board of Education Bylaw 13A.07.03.02.B.(3)**

_____ _____
SIGNATURE EMPLOYER

_____ _____
POSITION ADDRESS

_____ _____
DATE CITY, STATE, ZIP CODE

New Hire Form

Employee Information:

Social Security Number:	Last Name:		First Name:	Middle Names (as shown on birth certificate	Previous last name:
Preferred Name, if different than First Name	Suffix, (i.e. Jr., III):	Date of Birth:	Race:	Gender	Marital Status
Home Address:		City:		State:	Zip:
Home Telephone Number:	Cell Phone:	Other Phone Number:		E-mail address	

EMERGENCY CONTACTS: (Please list two contacts)

Name:	Relation:	Name:	Relation:
Address:		Address:	
Daytime Phone Number:	Cell Phone Number:	Daytime Phone Number:	Cell Phone Number:

Employee Signature: _____ Date: _____

Dorchester County Public Schools | Office of Human Resources

Every Child A Success!

AUTHORIZATION AGREEMENT FOR DIRECT DEPOSIT

Employee Name	Social Security Number
Checking Account Number	Savings Account Number
Bank Name	Routing Number
School	**You must attach a check marked "VOID" that has your name and account number preprinted so we can verify account information with the bank.**

I hereby authorize the Dorchester County Board of Education to deposit 100% of my net salary to my account in the bank itemized above, hereinafter called the "Bank," to credit same to such account.

This Authorization Agreement is to remain in full force and effect until my employer and the Bank each have received written notification of its termination from me, in such a manner as to afford my employer and/or the Bank, as the case may be, reasonable opportunity to act on it. This Authorization Agreement may also be terminated by my employer.

In the event the Payroll Department notifies the Bank that funds to which I am not entitled have been deposited to my account inadvertently, I hereby authorize and direct the bank to return said funds to the Payroll Department of my employer as soon as possible.

Once completed, this form should be sent to the Board of Education's Office of Human Resources for processing.

PLEASE NOTE: Direct Deposit will go into effect immediately after the form is received in the Finance Office.

Employee Signature	Date

Revised 09/17/2013 JSG

DORCHESTER COUNTY BOARD OF EDUCATION

24-PAY PLAN FORM

Each school year, the standard pay cycle for all ten-month employees is 20 pays per year, beginning August 30 and continuing until June 15. Direct deposit occurs twice per month and is deposited to the account(s), designated by the employee, on the 15th and last day of the month. ***An option*** you may ***elect*** is to defer a **fixed amount** from each pay check to spread the net pay from your 20 pay checks in order to approximate getting the same amount per pay period spread over 24 payments. If you wish to receive your net standard salary in 24 payments (semi-monthly over 12 months), rather than in 20 payments (over 10 months), you may elect to do so. If you would like to participate, please complete the form below and return it to the Central Office Payroll Department by **no later than June 30 of each year. The 24-pay method will be effective beginning with your paycheck at the end of August and continue through August 15 of the following year. Reminder: By signing up for this program, the net pay you receive in August of the first year will be lower than the net pay you received on June 15 of the preceding school year. Should you have questions please contact the Central Office Payroll Department via e-mail at woolfordm@dcpsmd.org or call 410-221-1111 extension 1047.**

A NEW DEDUCTION FORM MUST BE COMPLETED FOR EACH SCHOOL YEAR

To calculate your deduction, please complete the information below.
Enter your salary information below and perform the calculations.

1. $_____ ÷ 20 = $_____ A
   (Annual Salary)

2. $_____ ÷ 24 = $_____ B
   (Annual Salary)

3. A – B = $_____ C

4. C x 65% = $_____ D*

* The amount on Line D is the deduction amount needed from each of your standard 20 paychecks to set aside money to fund your additional four (4) paychecks per year. This should result in 24 nearly equal (net) payments to your bank account between August 31 and August 15 (of the following summer). This amount may not be exact due to changes in your earnings, tax withholding, and other deductions during the year. There are no taxes or other deductions withheld from the four (4) summer paychecks. All tax and related deductions for your standard salary are taken over the 20 standard pays that occur from August 31 to June 15 each year. The four (4) extra checks (if there are no other earnings during the summer) are a distribution of the money that you have elected to save for these summer payments.

By signing below, the employee elects to set aside the indicated amount as a savings amount to be paid to the employee from June 30 to August 15 the following year.

Name:_____ **Employee#**_____ **School:** _____
(PLEASE PRINT) (3 to 5 numbers)

Please deduct $_____ **from each of my regular pays for 20 pays. I understand that this money cannot be returned to me until direct deposits are issued over the summer.

PLEASE NOTE: Your 24-Pay Plan will be Direct Deposited.

Signature: _____ Date:_____

DORCHESTER COUNTY BOARD OF EDUCATION

SUMMER SAVINGS FORM

The standard pay cycle for all ten-month employees is 20 pays per year, starting August 30 and continuing until June 15. Direct deposit occurs twice per month and is deposited to employees' designated bank account(s) by the 15th and last day of the month. As an option, you may elect to defer a **fixed amount** from each pay check to create a "summer savings" plan. Employees may elect any amount of their standard net salary to save and then receive the total amount saved, divided over four (4) semi-monthly pay dates in the summer, following the year that the employee elects to "save" their earnings. If you wish to receive four (4) equal payments during the summer months, it is necessary to enroll in the Summer Savings Plan.

If you would like to participate, please complete the form below and return it to the Central Office Payroll Department by **no later than June 30 each year. If this is the first year you elect to participate in the summer savings program, the amount you select to have deducted from each of your standard 20 paychecks will be effective beginning with your paycheck at the end of August. That deduction amount will continue through June 15 of the following year. Reminder: By signing up for this program, the net pay you receive in August of the first year you enroll will be lower than the paycheck you received on June 15 of the preceding school year. The total net earnings for the year will be the same whether you elect to receive 20 or 24 pays. Should you have questions, please contact our Central Office Payroll Department via e-mail at woolfordm@dcpsmd.org or call 410-221-1111 x 1047.**

A NEW DEDUCTION FORM MUST BE COMPLETED FOR EACH SCHOOL YEAR

The total savings will be paid to the employee in four (4) equal payments via direct deposit on the regularly-scheduled pay cycle during the summer.

By signing below, the employee elects to set aside the specified amount per pay to establish a total amount saved to be distributed to the employee by direct deposit to his/her designated bank account, beginning June 30 and ending on August 15 of the following year.

Name:_____ **Employee #**_____ **School:** _____
(PLEASE PRINT) (3 to 5 numbers)

Please deduct $_____ from each of my regular pays for 20 pays. I understand that this money cannot be returned to me until direct deposits are issued the following summer. (**Even Dollar Deductions Not Less Than $20)**

PLEASE NOTE: Your Summer Savings will be Direct Deposited.

Signature:_____

Date:_____

Dorchester County Public Schools | Office of Human Resources

Every Child A Success!

Race and Ethnicity Identification Form

To Staff: Under federal and State law the racial and ethnic classifications used to describe staff and students in public schools in Maryland have been modified. Please update the information currently on file in your employment record by completing and returning this form to **Brenda Davis in the HR Office asap**. If this form is not returned by the above date, the current information will be converted to the new classifications as described in the Ethnic and Racial classifications below.

EMPLOYEE'S LEGAL NAME _____	**DATE**_____

DIRECTIONS: Part 1

Read the definition below and place an "X" in the box that indicates the respondent's heritage. If this form is NOT returned the ethnicity will be coded as NO, Not "Hispanic or Latino".

Hispanic or Latino

A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race. The term, "Spanish origin," can be used in addition to "Hispanic or Latino".

Part 1: **Are you Hispanic or Latino?** CHECK ONE

☐ YES

☐ NO

DIRECTIONS: Part 2

Using the descriptions below, place an "X" in the box or boxes that indicate the respondent's race. You must select at least one race, regardless of Hispanic ethnicity. More than one response can be selected. If this form is **NOT** returned, the respondent's race will be identified by someone from the school district.

Part 2:			**Check one or more races:**
	1	**American Indian or Alaska Native**	A person having origins in any of the original peoples of North and South America (including Central America), and who maintains a tribal affiliation or community attachment.
	2	**Asian**	A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.
	3	**Black or African American**	A person having origins in any of the black racial groups of Africa.
	4	**Native Hawaiian or Other Pacific Islander**	A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Island.
	5	**White**	A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.

I verify the information on this form is accurate.

_____

Employee Signature Date

I refuse to re-identify my race and ethnicity.

_____

Employee Signature Date

I am the observer who identified the individual listed on this form.

_____

Signature and Title Date

MEMBERSHIP APPLICATION

PLEASE PRINT — PRESS FIRMLY

CareFirst BlueCross BlueShield

10455 Mill Run Circle, Owings Mills, MD 21117

1. TYPE OF REQUEST ☐ NEW MEMBER ☐ CHANGE OF COVERAGE ☐ CHANGE OF SUBSCRIBER OR DEPENDENT INFORMATION ☐ RE-ENROLLMENT ☐ TERMINATION OF DEPENDENT

2. SUBSCRIBER INFORMATION (YOUR EMPLOYER WILL COMPLETE THE 4 SHADED BOXES IN THIS SECTION.)

Last Name	First Name	MI	Social Security/Membership No.	Group Number
			__ __ __/__ __/__ __ __ __	__ __ __ __

Street Address	Apt. No.	Employment Date	Department Number
		__/__/__	

City	State	Zip	Employment Status	Effective Date
			☐ Active ☐ Retired	__/__/__

Sex	Date of Birth	Home Phone Number	Business Phone Number	Ext.	Employee/Payroll Number
☐ M ☐ F	__/__/__	(__ __) __ __ __-__ __ __ __	(__ __) __ __ __-__ __ __ __	__ __ __ __	

Subscriber's Marital Status	Date of Marriage	Name of Employer
☐ Single ☐ Married	__/__/__	

3. MEDICARE AND TEFRA INFORMATION

If Eligible for Medicare: *Hospital Insurance* *Claim No.* _____ *Hospital Insurance Effective Date* __/__/__ *Medical Insurance Effective Date* __/__/__

If actively employed and TEFRA applicable, complete primary carrier selection. *Subscriber:* Blue Cross ☐ or Medicare ☐ *Spouse:* Blue Cross ☐ or Medicare ☐

4. OTHER HEALTH INSURANCE INFORMATION — (WE REQUIRE THE INFORMATION REQUESTED IN THIS SECTION.)

Do you or your dependents have any other health insurance policy or Blue Cross/Blue Shield other than through your employer? ☐ Yes ☐ No	Name of Spouse's Employer:
If yes, Name of Person Covered Date of Birth:	Name of Insurance Company: City: State:
Name of Employer:	Policy or Certificate No.:
If covered by Maryland or other Blue Cross/Blue Shield Plan *Membership No.:*	*City:* *State:*

5. COVERAGE LEVEL SELECTION

Check coverage level desired ☐ Individual ☐ Husband & Wife ☐ Parent & Child ☐ Family

6. GENERAL DEPENDENT INFORMATION

Add or Change A or C	If the **LAST NAME** of a child is **DIFFERENT**, check the "Sole Support" column to indicate that you provide the sole support for the minor dependent. Dependents	Last Name	First	M.I.	Sole Support	SEX	REL	Date of Birth	Social Security Number
	Spouse						SP	/ /	
	Child						CH	/ /	
	Child						CH	/ /	
	Child						CH	/ /	
	Child						CH	/ /	
	Child						CH	/ /	

7. DETAILED DEPENDENT INFORMATION — ARE ANY OF YOUR DEPENDENTS:

Covered by Medicare? ☐ No ☐ Yes *Name:* _____ Medicare No.: _____

Handicapped?	*Effective Date*		*Effective Date*
No ☐ Yes ☐ *Name:*	__/__/__	*Name:*	__/__/__

Full time college student? No ☐ Yes ☐

Name: _____ *School Name:* _____

Name: _____ *School Name:* _____

8. TERMINATION OF DEPENDENTS

Do NOT use this section to change coverage level. *See Instructions: Dependent Termination Only.*	*Write Correct Reason Code*	*Reason Codes*
Name _____ Date of Reason __/__/__	Reason _____	1. Divorce 2. Death 3. Entered military
Name _____ Date of Reason __/__/__	Reason _____	4. Child reached eligibility age limit 5. Other

READ CAREFULLY. THIS APPLICATION, WHEN ACCEPTED, IS PART OF THE CONTRACT.

I hereby apply, on behalf of myself and each dependent listed above, for the health coverage indicated. If this application is accepted, coverage will be provided according to the terms and conditions of the health care contract between CareFirst BlueCross BlueShield and my employer. I agree to be bound by that health care contract and to pay current and future charges for the health coverage provided. My employer is authorized to deduct the appropriate amount for such charges from my pay for that purpose.

I hereby authorize any physician, hospital, or other provider of service to furnish any information, reports, records, or copies of records, relating to care or services rendered to me or any of the dependents listed above to, CareFirst BlueCross BlueShield. Such information is to be held confidential.

I have carefully read this application and agree to its terms. The information provided is true and complete and is submitted in order to cause the issuance of the health coverage selected.

THIS INFORMATION IS SUBJECT TO VERIFICATION. FAILURE TO COMPLETE ANY SECTION MAY DELAY CLAIMS PAYMENT.

EMPLOYEE'S SIGNATURE (Subscriber) DATE SPOUSE'S SIGNATURE (Required for TEFRA) DATE

REMOVE PAGE 1 & 2, ATTACH TO A TRANSMITTAL (UNT0003-1S OR UNT0005-1S), THEN FORWARD ALL TO CAREFIRST BLUECROSS BLUESHIELD OR YOUR ADMINISTRATOR.

CareFirst BlueCross BlueShield is the business name of CareFirst of Maryland, Inc. and is an independent licensee of the Blue Cross and Blue Shield Association.
® Registered trademark of the Blue Cross and Blue Shield Association. ®' Registered trademark of CareFirst of Maryland, Inc.

Participation and Salary Reduction Agreement
Dorchester County Public Schools
Plan year: Janaury 1, 2014 through December 31, 2014

I. Participant Identification (please print or type)

Participant Name:_____Social Security Number:_____/_____/_____

Address: _____DOB: _____/_____/_____

City:_____ State: _____ Zip:_____ Email:_____

II. Agreement to Participate and Salary Reduction Agreement
Please check below your benefit choices. Sign and date the form and return to the Benefits Coordinator.

Check the boxes for the benefits you are selecting and indicate the amount of salary reduction for each pay period for the Medical Flexible Spending Account and Dependent Care Flexible Spending Account.

I hereby authorize my employer to reduce my cash compensation as indicated below for each pay period during the Plan Year following the date of this agreement.

Flexible Spending Arrangements	**Salary Reduction Per Pay**		**Number of Pay periods**		**Annual Election**
[ ] Dependent Care FSA (not to exceed $5000.00 annually)	_____.____	**X**	20	**=**	_____.___
[ ] Medical Expense FSA (not to exceed $2500.00 annually)	_____.____	**X**	20	**=**	_____.___

Waiver

[ ] I decline participation in the Flexible Benefits Plan

I understand that this election form cannot be revoked or changed during the plan year, unless there is a change in my family status (e.g. marriage, divorce, death of spouse or child, birth or adoption of child, and termination of employment of spouse) which justifies the revocation or change. I understand that salary reductions must be reimbursed for qualified expenses incurred during the plan year and may not be carried over into future plan years. If at the end of the plan year, the total reduction in compensation exceeds the substantiated expenses, the difference in amounts will be the property of the employer. I understand that I will be required to submit a separate written notice to my Employer to enroll in a Limited Plan if I have a family member who is making contributions to a Health Savings Account (HSA) under section 223 of the Internal Revenue Code.

I certify that the card will only be used for eligible medical expenses (and if applicable eligible dependent care expenses) at eligible providers. I further certify that the amount of eligible expenses is not reimbursable from any other source, nor will I attempt to be reimbursed from any other source. I will maintain substantiation for all expenses and where required provide applicable substantiation upon request. If I cannot produce adequate substantiation, I must repay the Plan for such an expense. Failure to repay the Plan will result in the moneys being withheld from my pay. If I terminate employment or participation in the plan, I will return the debit card to my employer.

I have examined this agreement and to the best of my knowledge, it is true, correct and complete.

_____ _____
Participant's Signature Date

_____ _____
Agreed and accepted by Date
The Employer's Representative

IMPORTANT INFORMATION ABOUT BENEFICIARY DESIGNATIONS

Use this form to designate or make changes to the beneficiary(ies) of your Group Insurance death proceeds. The information on this form will replace any prior beneficiary designation. You may name anyone or any entity as your beneficiary and you may change your beneficiary at any time by completing a new Group Insurance Beneficiary Designation/Change form. Common designations include individuals, estates, corporation/organizations and trusts. **Payment will be made to the named beneficiary. If there is no named beneficiary, or the named beneficiary predeceased the insured, settlement will be made in accordance with the terms of your Group Contract.**

DEFINITIONS

You may find the following definitions helpful in completing this form:

Primary Beneficiary(ies) - the person(s) or entity you choose to receive your life insurance proceeds. Payment will be made in equal shares unless otherwise specified. In the event that a designated primary beneficiary predeceases the insured, the proceeds will be paid to the remaining primary beneficiaries in equal shares or all to the sole remaining primary beneficiary.

Contingent Beneficiary(ies) - the person(s) or entity you choose to receive your life insurance proceeds if the primary beneficiary(ies) die (or the entity dissolves) before you die. Payment will be made in equal shares unless otherwise specified. In the event that a designated contingent beneficiary predeceases the insured, the proceeds will be paid to the remaining contingent beneficiaries in equal shares or all to the sole remaining contingent beneficiary.

INSTRUCTIONS FOR DESIGNATING A PRIMARY OR CONTINGENT BENEFICIARY

1. EMPLOYEE INFORMATION

- All information in this section is required.
- Unless otherwise indicated in Section 1, the information supplied on the form will apply to ALL coverages offered under the employer's group plan.

2. BENEFICIARY DESIGNATION

- You may name more than one primary and more than one contingent beneficiary. This form allows you to name up to four primary and four contingent beneficiaries. If you need additional space, please attach a separate sheet of paper.
- Please indicate the percentage share designated to each primary beneficiary. **The total for all primary beneficiaries must equal 100%.** If no percentages are specified, the proceeds will be split evenly among those named. Payment will be made to the named beneficiary. If there is no named beneficiary, or the named beneficiary predeceased the insured, settlement will be made in accordance with the terms of your Group Contract. **If designating percentages for contingent beneficiaries, the percentage for all contingent beneficiaries must also equal 100%.**
- You can name an individual, corporation/organization, trust, or an estate as a beneficiary. The following examples may be helpful in designating beneficiaries:

  Individual: "Mary A. Doe"
  - Each name should be listed as first name, middle initial, last name ("Mary A. Doe," not "Mrs. M. Doe")
  - Include the address, relationship and Date of Birth for each individual listed.
  - Indicate the percentage to be assigned to each individual.

  Estate: "Estate of the Insured"
  - Select "Other" as the Beneficiary Description and write "Estate" in the blank space provided.
  - Indicate the percentage to be assigned to the Estate of the Insured.

  Corporation/Organization: "ABC Charitable Organization"
  - Select "Corporation/Organization" as the Beneficiary Description.
  - Write the legal name of the corporation or organization in the space for the Beneficiary's First Name.
  - You must provide the address, city and state of operation for each organization or corporation listed.
  - Indicate the percentage to be assigned to the corporation or organization.

  Trust: "The John Doe Trust. A Trust with a trust agreement dated 1/1/99 whose Trustee is Jane Smith."
  - Select "Trust" as the Beneficiary Description.
  - Indicate the percentage to be assigned to the trust.
  - Complete Section 3, Trust Designation.

3. TRUST DESIGNATION

- Complete this section if you have named a trust as a primary or contingent beneficiary in Section 2. Fill in the name and address for each trustee.
- Fill in the title and date of the Trust Agreement in the space provided.

4. AUTHORIZATION/SIGNATURE

- The employee must read, sign and date the authorization.
- Submit the completed form to your Benefits Administrator or Human Resources (as directed by your employer) and keep a copy for your records.

Prudential

Group Insurance Beneficiary Designation/Change

1. EMPLOYEE INFORMATION (please print)

Last Name	First Name	MI	Employee ID # (if applicable)	Marital Status (check one) ☐ Married ☐ Widowed ☐ Single ☐ Divorced	Gender (check one) ☐ Male ☐ Female	Has this insurance been assigned? ☐ Yes ☐ No
Address			City	State	ZIP Code	Daytime Phone / Home Phone / Date of Birth / Date of Hire / Date of Retirement (if applicable)
Name of Employer/Group Policyholder			Group Policy No	**Unless otherwise indicated below, this Beneficiary Designation/Change form applies to ALL coverages offered under my employer's group plan.** This form applies only to my		coverage(s).

2. BENEFICIARY DESIGNATION: I hereby revoke any previous designations of primary beneficiary(ies) and contingent beneficiary(ies), if any, and in the event of my death, designate the following:

A. Primary Beneficiaries

Beneficiary Description (check one)	First Name	MI	Last Name	Address (include city, state, ZIP)	Relationship	Date of Birth	% Share
☐ Individual ☐ Other_____ ☐ Trust ☐ Corporation/Organization							
☐ Individual ☐ Other_____ ☐ Trust ☐ Corporation/Organization							
☐ Individual ☐ Other_____ ☐ Trust ☐ Corporation/Organization							
☐ Individual ☐ Other_____ ☐ Trust ☐ Corporation/Organization							
						TOTAL: (must equal 100)	

B. Contingent Beneficiaries

Beneficiary Description (check one)	First Name	MI	Last Name	Address (include city, state, ZIP)	Relationship	Date of Birth	% Share
☐ Individual ☐ Other_____ ☐ Trust ☐ Corporation/Organization							
☐ Individual ☐ Other_____ ☐ Trust ☐ Corporation/Organization							
☐ Individual ☐ Other_____ ☐ Trust ☐ Corporation/Organization							
☐ Individual ☐ Other_____ ☐ Trust ☐ Corporation/Organization							
						TOTAL: (must equal 100)	

3. TRUST DESIGNATION - COMPLETE IF A TRUST HAS BEEN NAMED AS A BENEFICIARY IN SECTION 2

Trustee's Name (First, MI, Last)	Address (include city, state, ZIP)

And successor(s) in trust, as Trustee(s) under _____ *Title of Agreement* **dated** _____ *Date of Agreement* **as amended and executed by me and said Trustee.**

4. AUTHORIZATION/SIGNATURE I authorize my plan administrator to record and consider the individuals/institutions that I have named on this form as beneficiaries for benefits under the applicable employee benefit plans. If designating a trust as a beneficiary, I understand Prudential assumes no obligation as to the validity or sufficiency of any executed Trust Agreement and does not pass on its legality. In making payment to any Trustee(s), Prudential has the right to assume that the Trustee(s) is acting in a fiduciary capacity until notice to the contrary is received by Prudential at its Group Life Claim office. I agree that if Prudential makes any payment(s) to the Trustee(s) before notice is received, Prudential will not make payment(s) again.

Employee's Signature **X** _____ Date _____

The employee must sign and date this form. The signature date must be the date the employee actually signed the form.

Group Life coverage is issued by The Prudential Insurance Company of America, 751 Broad Street, Newark, NJ 07102. Please refer to the Booklet-Certificate, which is made a part of the Group Contract, for all plan details, including any exclusions, limitations and restrictions which may apply. Prudential and the Rock logo are registered service marks of The Prudential Insurance Company of America and its affiliates.

GL.2001.169 Ed. 12/2011

ORIGINAL APPROVAL: October 18, 2012

Dorchester County Public Schools
2013-2014 School Calendar

REVISED/APPROVED: May 16, 2013

July-13

S	M	T	W	T	F	S
	1	2	3	4	5	6
7	8	9	10	11	12	13
14	15	16	17	18	19	20
21	22	23	24	25	26	27
28	29	30	31			

August-13

S	M	T	W	T	F	S
				1	2	3
4	5	6	7	8	9	10
11	12	13	14	15	16	17
18	19	20	21	22	23	24
25	26	27	28	29	30	31

September-13

S	M	T	W	T	F	S
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30					

October-13

S	M	T	W	T	F	S
		1	2	3	4	5
6	7	8	9	10	11	12
13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	28	29	30	31		

November-13

S	M	T	W	T	F	S
					1	2
3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27	28	29	30

December-13

S	M	T	W	T	F	S
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30	31				

		Teacher Days	Student Days
JULY			
4	Schools/Offices Closed - Independence Day		
AUGUST		8	5
14-20	New Teachers Report		
21	All Teachers Begin		
26	Grades 1-5, 6, and 9 Report		
27	Grades 1-12 Report		
28	Grades PreK and K Report		
SEPTEMBER		20	19
2	Schools/Offices Closed - Labor Day		
25	Interims		
30	Professional Development Day (Closed to Students)		
OCTOBER		22	21
1	Parent Conference Day (Closed to Students)		
18	Schools/Offices Closed - MSEA Convention		
31	End of Term I (45 days)		
NOVEMBER		18	18
13	Early Student Dismissal-PD for Teachers		
27-29	Schools/Offices Closed - Thanksgiving Holiday		
DECEMBER		15	14
5	Interims		
9	Parent Conf Day/Prof Dev Day (Closed to Students)		
23-31	Schools Closed		
JANUARY		21	21
1	Schools/Offices Closed - New Year's Day		
8	Early Student Dismissal-PD for Teachers		
20	Martin Luther King, Jr.'s Birthday		
21	End of Term II (45 days)		
FEBRUARY		19	18
12	Early Student Dismissal-PD for Teachers		
17	Presidents' Day		
20	Interims		
24	Parent Conf Day/Prof Dev Day (Closed to Students)		
MARCH		21	21
27	End of Term III (45 days)		
APRIL		20	20
9	Early Student Dismissal-PD for Teachers		
18-21	Schools Closed - Spring Break		
30	Interims		
MAY		21	21
26	Schools/Offices Closed - Memorial Day		
JUNE			
10	End of Term IV (45 days)	7	7
10	Last Day For Students/Teachers		
	TOTAL DAYS (See Notes Below)	**192**	**185**

January-14

S	M	T	W	T	F	S
			1	2	3	4
5	6	7	8	9	10	11
12	13	14	15	16	17	18
19	20	21	22	23	24	25
26	27	28	29	30	31	

February-14

S	M	T	W	T	F	S
						1
2	3	4	5	6	7	8
9	10	11	12	13	14	15
16	17	18	19	20	21	22
23	24	25	26	27	28	

March-14

S	M	T	W	T	F	S
						1
2	3	4	5	6	7	8
9	10	11	12	13	14	15
16	17	18	19	20	21	22
23	24	25	26	27	28	29
30	31					

April-14

S	M	T	W	T	F	S
		1	2	3	4	5
6	7	8	9	10	11	12
13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	28	29	30			

May-14

S	M	T	W	T	F	S
				1	2	3
4	5	6	7	8	9	10
11	12	13	14	15	16	17
18	19	20	21	22	23	24
25	26	27	28	29	30	31

June-14

S	M	T	W	T	F	S
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30					

New Teachers Begin | Teachers Begin | First and Last Days of School for Students | Holidays for Students and Teachers | No School for Students | Early Student Dismissal | Interims and End of Terms

NOTE 1: Five (5) days have been added to the calendar for inclement weather. In the event all five (5) days are not used, they will be deducted at the end of the school year.
NOTE 2: Guidance Counselors shall be available to work a minimum of 2 days, at the principal's discretion, immediately following the teachers' last day of school to provide adequate coverage as determined by the principal. To enable end-of-year work days, 2 to 4 days during the school year will be designated by the principal as non-workdays for the counselors.

2013-2014 DUTY DAYS				
Attendance Reporting Period	**Duty Days 11/12 Month**	**Duty Days 10 Month**	**Date Leave Recorded**	**Due Date**
JULY 2013	**4/18**	**0**	**August 15, 2013**	**8/1**
AUGUST 2013	**20**	**8**	**September 13, 2013**	**9/3**
SEPTEMBER 2013	**20**	**20**	**October 15, 2013**	**10/1**
OCTOBER 2013	**22**	**22**	**November 15, 2013**	**11/1**
NOVEMBER 2013	**18**	**18**	**December 15, 2013**	**12/3**
DECEMBER 2013	**15/17**	**15**	**January 13, 2014**	**1/2**
JANUARY 2014	**21**	**21**	**February 15, 2014**	**2/1**
FEBRUARY 2014	**19**	**19**	**March 15, 2014**	**3/1**
MARCH 2014	**21**	**21**	**April 13, 2014**	**4/2**
APRIL 2014	**20**	**20**	**May 15, 2014**	**5/1**
MAY 2014	**21**	**21**	**June 15, 2014**	**6/3**
JUNE 2014	**10/20**	**7**	**July 13, 2014**	**6/29**

Eleven- and Twelve-Month Employee Work Calendar

School Year 2013 - 2014

O = First and Last Day of Work
X = Holidays and Non-workdays

Month	Day(s)	11-Month Asst Principals	12-Month Staff
Jul	4		X
	24*	O	
Aug			
Sep	2	X	X
Oct	18	X	X
Nov	27,28,29	X	X
Dec	23	X	
	24,25,26	X	X
	27,30	X	
	31	X	X
Jan	1	X	X
	20	X	X
Feb	17	X	X
Mar			
Apr	18,21	X	X
May	26	X	X
Jun	13*	O	
Total Work Days		**215****	**244**

*First day of work, last day of work, or other duty days may be adjusted by the building principal; however, total work days for the school year will equal 215.
**Any days missed due to inclement weather will be added to the end of the work calendar. Assistant principals should coordinate with their principals to determine work schedule when schools are closed due to inclement weather.

Dorchester County Board of Education

Memo

To: All Staff

From:

Date: 11/14/2013

Re: Pay Dates for the 2013-2014 School Year

Please note the following pay dates for the 2013-2014 school year.

July 15, 2013	***January 15, 2014**
July 31, 2013	***January 31, 2014**
August 15, 2013	***February 14, 2014**
***August 30, 2013**	***February 28, 2014**
***September 13, 2013**	***March 14, 2014**
***September 30, 2013**	***March 31, 2014**
***October 15, 2013**	***April 15, 2014**
***October 31, 2013**	***April 30, 2014**
***November 15, 2013**	***May 15, 2014**
***November 26, 2013**	***May 30, 2014**
***December 13, 2013**	***June 13, 2014**
***December 30, 2013**	June 30, 2014

*Applies to 10-month employees – The last salary check of the school year for 10-month employees is June 13, 2014

2013-2014 PAYROLL SCHEDULE WITH DUE DATES

Pay Date	Payroll Run Date	Green Attendance Sheets Buff Colored Timesheets		Administrators & Supv. Monthly Pink Timesheets		AESOP Substitute History by Date & Sign-in Sheets		Blue-Yellow -Green Timesheets	
		Dated	Due Date	Dated	Due Date	Dated	Due Date	Dated	Due Date
07/15/13 Monday	07/09/13 Tuesday	05/26-6/08 6/9-6/22	06/14/13 06/27/13	Jun 1 - Jun 30	07/01/13			Jun 16 - Jun 30	07/01/13
07/31/13 Wednesday	07/25/13 Thursday	6/23-7/06	07/12/13					Jul 1 - Jul 15	07/16/13
08/15/13 Thursday	08/08/13 Thursday	7/7-7/20	07/23/13	Jul 1 - Jul 31	08/01/13			Jul 16 - Jul 31	08/01/13
08/30/13 Friday	08/26/13 Monday	7/21-8/03	08/06/13					Aug 1- Aug 15	08/16/13
09/13/13 Friday	09/09/13 Monday	8/04-8/17	08/21/13	Aug 1 - Aug 31	09/03/13	Aug 21 - Aug 30	09/03/13	Aug 16 - Aug 30	09/03/13
09/30/13 Friday	09/24/13 Tuesday	8/18-8/31	09/05/13			Sep 1 - Sep 13	09/16/13	Sep 1 - Sep 15	09/16/13
10/15/13 Tuesday	10/09/13 Wednesday	9/01-9/14	09/17/13	Sep 1 - Sep 30	10/01/13	Sep 16 - Sep 30	10/01/13	Sep 16 - Sep 30	10/01/13
10/31/13 Thursday	10/25/13 Friday	9/15-9/28	10/01/13			Oct 1 - Oct 15	10/16/13	Oct 1 - Oct 15	10/16/13
11/15/13 Friday	11/11/13 Monday	9/29-10/12	10/15/13	Oct 1 - Oct 31	11/01/13	Oct 16 - Oct 31	11/01/13	Oct 16 - Oct 31	11/01/13
11/26/13 Friday	11/21/13 Thursday	10/13-10/26	10/29/13			Nov 1 - Nov 15	11/15/13	Nov 1 - Nov 15	11/15/13
12/13/13 Friday	12/09/13 Monday	10/27-11/09	11/12/13	Nov 1 - Nov 30	12/02/13	Nov 16 - Nov 26	12/02/13	Nov 18 - Nov 30	12/02/13
12/30/13 Monday	12/23/13 Monday	11/10-11/23	11/25/13			Dec 2 - Dec 13	12/16/13	Dec 1 - Dec 15	12/16/13

2013-2014 PAYROLL SCHEDULE WITH DUE DATES

Pay Date	Payroll Run Date	Green Attendance Sheets & Buff Colored Timesheets		Administrators & Supv. Monthly Pink Timesheets		AESOP Substitute History by Date & Sign-in Sheets		Blue-Green-Yellow Timesheets	
		Dated	**Due Date**	Dated	**Due Date**	Dated	**Due Date**	Dated	**Due Date**
01/15/14 Wednesday	**1/9/14 Thursday**	11/24-12/7 12/8-12/21	**12/10/13** **12/20/13**	Dec 1 - Dec 31	**01/02/14**	Dec 16 - Dec 20	**12/20/13**	Dec 16 - Dec 30	**01/02/14**
01/31/14 Friday	**1/27/13 Monday**	12/22-1/4	**01/07/14**			Jan 1 - Jan 15	**01/17/14**	Jan 1 - Jan 15	**01/17/14**
02/14/14 Friday	**2/10/14 Monday**	1/5-1/18	**01/21/14**	Jan 1 - Jan 31	**02/03/14**	Jan 16 - Jan 31	**02/03/14**	Jan 16 - Jan 31	**02/03/14**
02/28/14 Friday	**2/24/13 Monday**	1/19-2/1	**02/04/14**			Feb 1 - Feb 14	**02/17/14**	Feb 1 - Feb 15	**02/17/14**
03/14/14 Friday	**3/10/14 Monday**	2/2-2/15	**02/18/14**	Feb 1 - Feb 28	**03/03/14**	Feb 17 - Feb 28	**03/03/14**	Feb 18 - Feb 28	**03/03/14**
03/31/14 Monday	**3/25/14 Tuesday**	2/16-3/1	**03/04/14**			Mar 1 - Mar 15	**03/17/14**	Mar 1 - Mar 15	**03/17/14**
04/15/14 Tuesday	**4/9/14 Wednesday**	3/2-3/15	**03/18/14**	Mar 1 - Mar 31	**04/01/14**	Mar 16 - Mar 30	**04/01/14**	Mar 16 - Mar 31	**04/01/14**
04/30/14 Wednesday	**4/24/14 Thursday**	3/16-3/29	**04/01/14**			Apr 1 - Apr 15	**04/16/14**	Apr 1 - Apr 15	**04/16/14**
05/15/14 Thursday	**5/9/14 Friday**	3/30-4/12	**04/15/14**	Apr 1 - Apr 30	**05/01/14**	Apr 16 - Apr 30	**05/01/14**	Apr 16 - Apr 30	**05/01/14**
05/30/14 Friday	**5/23/14 Friday**	4/13-4/26	**04/28/14**			May 1 - May 15	**05/16/14**	May 1 - May 15	**05/16/14**
06/13/14 Friday	**6/9/14 Monday**	4/27-5/10	**05/13/14**	May 1 - May 31	**06/02/14**	May 16 - May 30	**06/02/14**	May 16 - May 30	**06/03/12**
06/27/14 Friday	**6/23/14 Monday**	5/11-5/24 5/25-6/7	**05/27/14** **06/10/14**			Jun 1 - Jun 13	**06/16/14**	Jun 1 - Jun 15	**06/16/14**

Dorchester County Public Schools
Office of Human Resources

Contacts

Central Office Address: 700 Glasgow Street, Cambridge, MD 21613
Phone Number: 410-228-4747 **Office Hours:** Mon.-Fri. 7:00 a.m. – 5 p.m.

Contact:	Regarding:
OFFICE OF HUMAN RESOURCES	
Administrator: Jeffrey S. Grafton Phone: 410-228-4747 ext. 1063 Fax: 410-221-5269 Email: graftonj@dcpsmd.org **Assistant Administrator:** Anna Howie Phone: 410-228-4747 ext. 1058 Fax: 410-221-5269 Email: howiea@dcpsmd.org	• Employee Relations • Negotiations • Policies/Procedures • Professional Development • Hiring • 403(b) • Recruiting • Interviewing • MSDE Certification • Direct Deposit Changes • Changes to tax withholding amounts • Address Changes • W-4 Changes • Employment Verification • Fingerprinting
BENEFITS COORDINATOR	
Benefits Coordinator: Brenda Davis Phone: 410-228-4747 ext. 1059 Fax: 410-221-5269 Email: davisb@dcpsmd.org	• Health Insurance Eligibility • Status Changes affecting benefits • COBRA • Life Insurance • Change of Beneficiaries • Family Medical Leave Act • Flexible Spending Account • Employment Verification • Medicare Eligibility • Fingerprinting
HUMAN RESOURCES SPECIALIST	
Human Resources Specialist: Kimberly Presley Phone: 410-228-4747 ext. 1013 Fax: 410-221-5269 Email: presleyk@dcpsmd.org	• Substitute Coordinator • Professional Development • New Employee Processing • Course Reimbursement • Employment Verification • Fingerprinting • Aesop (Substitutes) • Unemployment