WINTHROP
University Hospital
Your Health Means Everything.

New Hire Processing
Instruction Sheet- Residents

The attached forms must be completed and returned to Human Resources prior to your first day of employment.

- **Employee Supplemental Form:** Please complete as much information as possible, including the department you will be working for and the date employment commences.

- **Employment Eligibility Verification (I-9):** It is federally mandated that you provide proof of employment eligibility to work and be paid by Winthrop University Hospital.

  Please complete, sign, and date section 1. DO NOT FILL OUT section 2, only supply the necessary documentation listed on the back of this form. Your documents will be photocopied and returned to you.

  US CITIZENS: Provide any one item from List **A** (OR) One item from List **B** and one item from List **C**.
  NON-US CITIZENS: Provide one document from List **A**.

- **W-4:** The minimum items that must be filled in are # 1, 2, 3, & 5. The form **MUST** be signed and dated. In the employer ID# section, please provide your employee ID# which is on the card provided by employee health.

  Please Note: We are unable to advise you regarding the number of allowances you are entitled to claim. The worksheet on the back of the W-4 may be helpful in determining this. Please contact your accountant, and if necessary, file a revised form at later date.

- **Form IT-2104:** Complete the top portion of the first page to be returned; keep pages 3 and 4 for your records. The form **MUST** be signed and dated in order to be processed. If you do not complete this form we will use the number of allowances you claimed on federal Form W-4.

- **EEO Self-Identification Form:** The information on this EEO Self-Identification Form is being requested and will be used solely for equal employment opportunity record-keeping and reporting purposes. Submission of this form by you is voluntary. Please be assured that you will not be subjected to any adverse treatment if you do not provide the information requested.

- **Direct Deposit Form (Optional):** Direct Deposit becomes effective after approximately two (2) paychecks. In addition to your account number, please provide a voided blank check if you wish for your paycheck to be deposited into your checking account or the ABA routing number if you wish for your paycheck to be deposited into your savings account.

- **Winthrop University Hospital Health and Welfare Plan HIPPA Privacy Notice:** Should be read, completed, and returned to Human Resources. The packet of information is yours to keep.

- **Disclosure & Authorization Form:** By completing this form you agree that Winthrop-University Hospital may rely on this authorization to order background reports, including investigative consumer reports, from companies other than ADP Screening and Selection Services without asking me for my authorization again as allowed by law.

WINTHROP
University Hospital
Your Health Means Everything.

Employee Supplemental Form

Please print clearly and complete in full:

Employee Name: _____
First Name Middle Initial Last Name

Home Telephone Number: (_____) _____

Cell Telephone Number: (_____) _____

Date of Birth: _____

Marital Status: ☐ Married ☐ Single

Ages Of Dependent Children:_____

Languages Spoken:

Primary: _____

Other Language (s): _____

Sex: ☐ Male ☐ Female

In Case Of Accident Notify: _____

Relationship: _____

Address: _____
Street City State Zip Code

Primary Telephone Number: **(_____)** _____

Other Telephone Number: **(_____)** _____

Date of Hire: _____

Department Name: _____

Employee Signature: _____ **Date:** _____

OMB No. 1615-0047; Expires 08/31/12

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

Form I-9, Employment Eligibility Verification

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

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

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

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

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

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

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

Employee's Signature | Date *(month/day/year)*

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

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

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

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

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

Signature of Employer or Authorized Representative	Print Name	Title
Business or Organization Name and Address *(Street Name and Number, City, State, Zip Code)*		Date *(month/day/year)*
Winthrop University Hospital 259 1st St. Mineola, NY. 11501		

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

A. New Name *(if applicable)*	B. Date of Rehire *(month/day/year) (if applicable)*

C. If employee's previous grant of work authorization has expired, provide the information below for the document that establishes current employment authorization.

Document Title: _____ Document #: _____ Expiration Date *(if any)*: _____

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

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

LISTS OF ACCEPTABLE DOCUMENTS

All documents must be unexpired

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

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

Form W-4 (2012)

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

Exemption from withholding. If you are exempt, complete **only** lines 1, 2, 3, 4, and 7 and sign the form to validate it. Your exemption for 2012 expires February 18, 2013. See Pub. 505, Tax Withholding and Estimated Tax.

Note. If another person can claim you as a dependent on his or her tax return, you cannot claim exemption from withholding if your income exceeds $950 and includes more than $300 of unearned income (for example, interest and dividends).

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

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

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

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

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

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

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

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

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

Personal Allowances Worksheet (Keep for your records.)

A	Enter "1" for **yourself** if no one else can claim you as a dependent	A ____
B	Enter "1" if: • 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 $61,000 ($90,000 if married), enter "2" for each eligible child; then **less** "1" if you have three to seven eligible children or **less** "2" if you have eight or more eligible children. • If your total income will be between $61,000 and $84,000 ($90,000 and $119,000 if married), enter "1" for each eligible child	G ____
H	Add lines A through G and enter total here. (**Note.** This may be different from the number of exemptions you claim on your tax return.) ▶	H ____

For accuracy, complete all worksheets that apply.

- 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

2012

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 2012, 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 2012 itemized deductions. These include qualifying home mortgage interest, charitable contributions, state and local taxes, medical expenses in excess of 7.5% of your income, and miscellaneous deductions	1	$
2	Enter: { $11,900 if married filing jointly or qualifying widow(er); $8,700 if head of household; $5,950 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 2012 adjustments to income and any additional standard deduction (see Pub. 505)	4	$
5	**Add** lines 3 and 4 and enter the total. (Include any amount for credits from the *Converting Credits to Withholding Allowances for 2012 Form W-4* worksheet in Pub. 505.)	5	$
6	Enter an estimate of your 2012 nonwage income (such as dividends or interest)	6	$
7	**Subtract** line 6 from line 5. If zero or less, enter "-0-"	7	$
8	**Divide** the amount on line 7 by $3,800 and enter the result here. Drop any fraction	8	
9	Enter the number from the **Personal Allowances Worksheet,** line H, page 1	9	
10	**Add** lines 8 and 9 and enter the total here. If you plan to use the **Two-Earners/Multiple Jobs Worksheet,** also enter this total on line 1 below. Otherwise, **stop here** and enter this total on Form W-4, line 5, page 1	10	

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

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

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

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

4	Enter the number from line 2 of this worksheet	4	
5	Enter the number from line 1 of this worksheet	5	
6	**Subtract** line 5 from line 4	6	
7	Find the amount in **Table 2** below that applies to the **HIGHEST** paying job and enter it here	7	$
8	**Multiply** line 7 by line 6 and enter the result here. This is the additional annual withholding needed	8	$
9	Divide line 8 by the number of pay periods remaining in 2012. For example, divide by 26 if you are paid every two weeks and you complete this form in December 2011. Enter the result here and on Form W-4, line 6, page 1. This is the additional amount to be withheld from each paycheck	9	$

Table 1

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 - 12,000	1	8,001 - 15,000	1
12,001 - 22,000	2	15,001 - 25,000	2
22,001 - 25,000	3	25,001 - 30,000	3
25,001 - 30,000	4	30,001 - 40,000	4
30,001 - 40,000	5	40,001 - 50,000	5
40,001 - 48,000	6	50,001 - 65,000	6
48,001 - 55,000	7	65,001 - 80,000	7
55,001 - 65,000	8	80,001 - 95,000	8
65,001 - 72,000	9	95,001 - 120,000	9
72,001 - 85,000	10	120,001 and over	10
85,001 - 97,000	11		
97,001 - 110,000	12		
110,001 - 120,000	13		
120,001 - 135,000	14		
135,001 and over	15		

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 - $70,000	$570	$0 - $35,000	$570
70,001 - 125,000	950	35,001 - 90,000	950
125,001 - 190,000	1,060	90,001 - 170,000	1,060
190,001 - 340,000	1,250	170,001 - 375,000	1,250
340,001 and over	1,330	375,001 and over	1,330

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.

New York State Department of Taxation and Finance

Employee's Withholding Allowance Certificate

New York State • New York City • Yonkers

IT-2104

2012

Print or type

First name and middle initial | Last name | Your social security number

Permanent home address *(number and street or rural route)* | Apartment number

City, village, or post office | State | ZIP code

Single or Head of household ☐ Married ☐

Married, but withhold at higher single rate ☐

Note: If married but legally separated, mark an ***X*** in the *Single or Head of household* box.

Are you a resident of New York City? ..... Yes ☐ No ☐

Are you a resident of Yonkers? ..... Yes ☐ No ☐

Complete the worksheet on page 3 before making any entries.

1 Total number of allowances you are claiming for New York State and Yonkers, if applicable *(from line 20)* ..... **1.**

2 Total number of allowances for New York City *(from line 31)* ..... **2.**

Use lines 3, 4, and 5 below to have additional withholding per pay period under special agreement with your employer.

3 New York State amount ..... **3.**

4 New York City amount ..... **4.**

5 Yonkers amount ..... **5.**

I certify that I am entitled to the number of withholding allowances claimed on this certificate.

Employee's signature | Date

Penalty — A penalty of $500 may be imposed for any false statement you make that decreases the amount of money you have withheld from your wages. You may also be subject to criminal penalties.

Employee: detach this page and give it to your employer; keep pages 3 and 4 for your records.

Employers only: Mark an ***X*** in box A and/or box B to indicate why you are sending a copy of this form to New York State *(see instr.)*:

A. Employee claimed more than 14 exemption allowances for NYS ..... A. ☐

B. Employee is a new hire or a rehire.... B. ☐ First date employee performed services for pay *(mm-dd-yyyy) (see instr.)*:

Are dependent health insurance benefits available for this employee? ..... Yes ☐ No ☐

If *Yes*, enter the date the employee qualifies *(mm-dd-yyyy)*:

Employer's name and address *(Employer: complete this section only if you are sending a copy of this form to the NYS Tax Department.)* | Employer identification number

Winthrop University Hospital 259 1st Street Mineola, NY. 11501

Instructions

Changes effective for 2012

The chart in Part 4 and the additional dollar amounts in the instructions on page 2, used to compute your withholding allowances or to enter an additional dollar amount on line(s) 3, 4, or 5, have been revised for tax year 2012. If you filed a 2011 Form IT-2104 and used the charts in Part 4 or the additional dollar amounts, you should complete a new 2012 Form IT-2104 and give it to your employer.

Who should file this form

This certificate, Form IT-2104, is completed by an employee and given to the employer to instruct the employer how much New York State (and New York City and Yonkers) tax to withhold from the employee's pay. The more allowances claimed, the lower the amount of tax withheld.

If you do not file Form IT-2104, your employer may use the same number of allowances you claimed on federal Form W-4. Due to differences in tax law, this may result in the wrong amount of tax withheld for New York State, New York City, and Yonkers. Complete Form IT-2104 each year and file it with your employer if the number of allowances you may claim is different from federal Form W-4 or has changed. Common reasons for completing a new Form IT-2104 each year include the following:

- You started a new job.
- You are no longer a dependent.
- Your individual circumstances may have changed (for example, you were married or have an additional child).
- You itemize your deductions on your personal income tax return.
- You claim allowances for New York State credits.
- You owed tax or received a large refund when you filed your personal income tax return for the past year.
- Your wages have increased and you expect to earn $100,000 or more during the tax year.
- The total income of you and your spouse has increased to $100,000 or more for the tax year.
- You have significantly more or less income from other sources or from another job.
- You no longer qualify for exemption from withholding.
- You have been advised by the Internal Revenue Service that you are entitled to fewer allowances than claimed on your original federal Form W-4, and the disallowed allowances were claimed on your original Form IT-2104.

Exemption from withholding

You cannot use Form IT-2104 to claim exemption from withholding. To claim exemption from income tax withholding, you **must** file

Form IT-2104-E, *Certificate of Exemption from Withholding*, with your employer. You must file a new certificate each year that you qualify for exemption. This exemption from withholding is allowable only if you had no New York income tax liability in the prior year, you expect none in the current year, **and** you are over 65 years of age, under 18, or a full-time student under 25. You may also claim exemption from withholding if you are a military spouse and meet the conditions set forth under the Servicemembers Civil Relief Act as amended by the Military Spouses Residency Relief Act. If you are a dependent who is under 18 or a full-time student, you may owe tax if your income is more than $3,000.

Withholding allowances

You may **not** claim a withholding allowance for yourself or, if married, your spouse. Claim the number of withholding allowances you compute in Part 1 and Part 3 on page 3 of this form. If you want more tax withheld, you may claim fewer allowances. **If you claim more than 14 allowances,** your employer **must send** a copy of your **Form IT-2104** to the New York State Tax Department. You may then be asked to verify your allowances. If you arrive at negative allowances (less than zero) on lines 1, 2, 20, or 31, and your employer cannot accommodate negative allowances, **enter *0*** and see *Additional dollar amount(s)* below.

Income from sources other than wages — If you have more than $1,000 of income from sources other than wages (such as interest, dividends, or alimony received), reduce the number of allowances claimed on line 1 and line 2 (if applicable) of the IT-2104 certificate by one for each $1,000 of nonwage income. If you arrive at negative allowances (less than zero), see *Withholding allowances* above. You may also consider filing estimated tax, especially if you have significant amounts of nonwage income. Estimated tax requires that payments be made by the employee directly to the Tax Department on a quarterly basis. For more information, see the instructions for Form IT-2105, *Estimated Income Tax Payment Voucher for Individuals*, or see *Need help?* on page 4.

Other credits (Worksheet line 13) — If you will be eligible to claim any credits other than the credits listed in the worksheet, such as an investment tax credit, you may claim additional allowances as follows:

- If you expect your New York adjusted gross income to be less than $50,000, divide the amount of the expected credit by 60 and enter the result (rounded to the nearest whole number) on line 13.
- If you expect your New York adjusted gross income to be $50,000 or more, divide the amount of the expected credit by 70 and enter the result (rounded to the nearest whole number) on line 13.

Example: *You expect your New York adjusted gross income to exceed $50,000. In addition, you expect to receive a flow-through of an investment tax credit from the S corporation of which you are a shareholder. The investment tax credit will be $160. Divide the expected credit by 70. 160/70 = 2.2857. The additional withholding allowance(s) would be 2. Enter **2** on line 13.*

Married couples with both spouses working — If you and your spouse both work, you should each file a separate IT-2104 certificate with your respective employers. You should each mark an ***X*** in the box *Married, but withhold at higher single rate* on the certificate front, and divide the total number of allowances that you compute on line 20 and line 31 (if applicable) between you and your working spouse. Your withholding will better match your total tax if the higher wage-earning spouse claims all of the couple's allowances and the lower wage-earning spouse claims zero allowances. **Do not** claim more total allowances than you are entitled to. If you and your spouse's combined wages are between $100,000 and $150,000, use the chart in Part 4 to compute the number of allowances to transfer to line 19.

Taxpayers with more than one job — If you have more than one job, file a separate IT-2104 certificate with each of your employers. Be sure to claim only the total number of allowances that you are entitled to. Your withholding will better match your total tax if you claim all of your allowances at your higher-paying job and zero allowances at the lower-paying job. In addition, to make sure that you have enough tax withheld, if you are a single taxpayer or head of household with two or more jobs, reduce the number of allowances by six on line 1 and line 2 (if applicable) on the certificate you file with your higher-paying job employer. If you arrive at negative allowances (less than zero), see *Withholding allowances* above.

If your combined wages are between $100,000 and $150,000, use the chart in Part 4 to compute the number of allowances to transfer to line 19. Substitute the words *Highest paying job* for *Higher earner's wages* within the chart.

Dependents — If you are a dependent of another taxpayer and expect your income to exceed $3,000, you should reduce your withholding allowances by one for each $1,000 of income over $2,500. This will ensure that your employer withholds enough tax.

Following the above instructions will help to ensure that you will not owe additional tax when you file your return.

Heads of households with only one job — If you will use the head-of-household filing status on your state income tax return, mark the *Single or Head of household* box on the front of the certificate. If you have only one job, you may also wish to claim two additional withholding allowances on line 14.

Married couples with only one spouse working — If your spouse does not work and has no income subject to state income tax, mark the *Married* box on the front of the certificate. You may also wish to claim two additional allowances on line 15.

Additional dollar amount(s)

You may ask your employer to withhold an additional dollar amount each pay period by completing lines 3, 4, and 5 on Form IT-2104. In most instances, if you compute a negative number of allowances using the worksheet on page 3 and your employer cannot accommodate a negative number, for each negative allowance claimed you should have an additional $1.50 of tax withheld per week for New York State withholding on line 3, and an additional $0.80 of tax withheld per week for New York City withholding on line 4. Yonkers residents should use 15% (.15) of the New York State amount for additional withholding for Yonkers on line 5.

Note: If you are requesting that your employer withhold an additional dollar amount on lines 3, 4, or 5 of this allowance certificate, the additional dollar amount, as determined by these instructions or by using the chart in Part 4, is accurate for a weekly payroll. Therefore, if you are paid other than weekly, you will need to adjust the dollar amount(s) that you compute. For example, if you are paid biweekly, you must double the dollar amount(s) computed using the worksheet on page 3.

Avoid underwithholding

Form IT-2104, together with your employer's withholding tables, is designed to ensure that the correct amount of tax is withheld from your pay. If you fail to have enough tax withheld during the entire year, you may owe a large tax liability when you file your return. The Tax Department must assess interest and may impose penalties in certain situations in addition to the tax liability. Even if you do not file a return, we may determine that you owe personal income tax, and we may assess interest and penalties on the amount of tax that you should have paid during the year.

Employers

Box A — If you are required to submit a copy of an employee's Form IT-2104 to the Tax Department because the employee claimed more than 14 allowances, mark an ***X*** in box A and send a copy of Form IT-2104 to: **NYS Tax Department, Income Tax Audit Administrator, Withholding Certificate Coordinator, W A Harriman Campus, Albany NY 12227.**

Due dates for sending certificates received from employees claiming more than 14 allowances are:

Quarter	Due date	Quarter	Due date
January – March	April 30	July – September	October 31
April – June	July 31	October – December	January 31

Box B — If you are submitting a copy of this form to comply with New York State's New Hire Reporting Program, mark an ***X*** in box B. Enter the first day any services are performed for which the employee will be paid wages, commissions, tips and any other type of compensation. For services based solely on commissions, this is the first day an employee working for commissions is eligible to earn commissions. Also, mark an ***X*** in the *Yes* or *No* box indicating if dependent health insurance benefits are available to this employee. If *Yes*, enter the date the employee qualifies for coverage. Mail the completed form, within 20 days of hiring, to: **NYS Tax Department, New Hire Notification, PO Box 15119, Albany NY 12212-5119.** To report newly-hired or rehired employees online instead of submitting this form, go to *www.nynewhire.com.*

Worksheet

Part 1 — Complete this part to compute your withholding allowances for New York State and Yonkers (line 1).

6 Enter the number of dependents that you will claim on your state return *(do not include yourself or, if married, your spouse)* ... **6.** _____

For lines 7, 8, and 9, enter *1* for each credit you expect to claim on your state return.

7 College tuition credit ... **7.** _____

8 New York State household credit ... **8.** _____

9 Real property tax credit ... **9.** _____

For lines 10, 11, and 12, enter *3* for each credit you expect to claim on your state return.

10 Child and dependent care credit ... **10.** _____

11 Earned income credit ... **11.** _____

12 Empire State child credit ... **12.** _____

13 Other credits *(see instructions)* ... **13.** _____

For lines 14 and 15, enter *2* if either situation applies.

14 Head of household status **and** only one job ... **14.** _____

15 Married couples with only **one** spouse working **and** only one job ... **15.** _____

16 Enter an estimate of your federal adjustments to income, such as alimony you will pay for the tax year and deductible IRA contributions you will make for the tax year. Total estimate $_____.
Divide this estimate by $1,000. Drop any fraction and enter the number ... **16.** _____

17 If you expect to itemize deductions on your state tax return, complete Part 2 below and enter the number from line 28.
All others enter ***0*** ... **17.** _____

18 Add lines 6 through 17 ... **18.** _____

19 If you have more than one job, or are married with both spouses working, and your combined wages are between $100,000 and $150,000, enter the appropriate number from the chart in Part 4. All others enter ***0*** ... **19.** _____

20 Subtract line 19 from line 18. Enter the result, including negative amounts, here and on line 1. If your employer cannot accommodate negative allowances, enter ***0*** here and on line 1 and see *Additional dollar amounts* in the instructions.
(If you have more than one job, or if you and your spouse both work, see instructions.) ... **20.** _____

Part 2 — Complete this part only if you expect to itemize deductions on your state return.

21 Enter your estimated federal itemized deductions for the tax year ... **21.** _____

22 Enter your estimated state, local, and foreign income taxes or state and local general sales taxes included on line 21
(if your estimated New York AGI is over $1 million, you must enter on line 22 all estimated federal itemized deductions included on line 21 except charitable contributions) ... **22.** _____

23 Subtract line 22 from line 21 ... **23.** _____

24 Enter your estimated college tuition itemized deduction ... **24.** _____

25 Add lines 23 and 24 ... **25.** _____

26 Based on your federal filing status, enter the applicable amount from the table below ... **26.** _____

Standard deduction table

Single (cannot be claimed as a dependent) ...	$ 7,500	Qualifying widow(er) ...	$15,000
Single (can be claimed as a dependent) ...	$ 3,000	Married filing jointly ...	$15,000
Head of household ...	$10,500	Married filing separate returns ...	$ 7,500

27 Subtract line 26 from line 25 *(if line 26 is larger than line 25, enter **0** here and on line 17 above)* ... **27.** _____

28 Divide line 27 by $1,000. Drop any fraction and enter the result here and on line 17 above ... **28.** _____

Part 3 — Complete this part to compute your withholding allowances for New York City (line 2).

29 Enter the amount from line 6 above ... **29.** _____

30 Add lines 14 through 17 above and enter total here ... **30.** _____

31 Add lines 29 and 30. Enter the result here and on line 2 ... **31.** _____

Part 4 — This chart is for taxpayers with more than one job, or married couples with both spouses working, and combined wages between $100,000 and $150,000. All others do not have to use this chart.

Enter the number of allowances (top number) on line 19, or the additional withholding (bottom dollar amount) on line 3.

	Combined wages between $100,000 and $150,000									
Higher earner's wages ↓	**$100,000 to 105,000**	**$105,000 to 110,000**	**$110,000 to 115,000**	**$115,000 to 120,000**	**$120,000 to 125,000**	**$125,000 to 130,000**	**$130,000 to 135,000**	**$135,000 to 140,000**	**$140,000 to 145,000**	**$145,000 to 150,000**
under $90,000	1 $1.00	2 $2.50	3 $4.00	4 $5.50	5 $7.00	6 $8.50	7 $10.00	8 $12.00	9 $13.00	10 $15.00
$90,000 – $100,000		2 $2.50	3 $4.00	4 $5.50	5 $7.00	6 $8.50	7 $10.00	8 $11.50	9 $13.00	10 $14.50
$100,000 – $110,000		1 $1.50	2 $3.00	3 $4.50	4 $6.00	5 $7.50	6 $9.00	7 $10.50	8 $12.00	9 $13.50
$110,000 – $120,000			1 $1.50	2 $3.00	3 $4.50	4 $6.00	5 $7.50	6 $9.00	7 $10.50	8 $12.00
$120,000 – $130,000					2 $3.00	3 $4.50	4 $6.00	5 $7.50	6 $9.00	7 $10.50
$130,000 – $140,000							3 $4.50	4 $6.00	5 $7.50	6 $9.00
$140,000 – $150,000									4 $6.00	5 $7.50

Privacy notification

The Commissioner of Taxation and Finance may collect and maintain personal information pursuant to the New York State Tax Law, including but not limited to, sections 5-a, 171, 171-a, 287, 308, 429, 475, 505, 697, 1096, 1142, and 1415 of that Law; and may require disclosure of social security numbers pursuant to 42 USC 405(c)(2)(C)(i).

This information will be used to determine and administer tax liabilities and, when authorized by law, for certain tax offset and exchange of tax information programs as well as for any other lawful purpose.

Information concerning quarterly wages paid to employees is provided to certain state agencies for purposes of fraud prevention, support enforcement, evaluation of the effectiveness of certain employment and training programs and other purposes authorized by law.

Failure to provide the required information may subject you to civil or criminal penalties, or both, under the Tax Law.

This information is maintained by the Manager of Document Management, NYS Tax Department, W A Harriman Campus, Albany NY 12227; telephone (518) 457-5181.

Need help?

Visit our Web site at ***www.tax.ny.gov***

- get information and manage your taxes online
- check for new online services and features

Telephone assistance

Automated income tax refund status: (518) 457-5149

Personal Income Tax Information Center: (518) 457-5181

To order forms and publications: (518) 457-5431

Text Telephone (TTY) Hotline (for persons with hearing and speech disabilities using a TTY): (518) 485-5082

WINTHROP
University Hospital
Your Health Means Everything.

EEO Self-Identification Form

Winthrop University Hospital is an equal employment opportunity employer. Certain laws and regulations regarding equal employment opportunity require us to compile annual statistical reports on applicants for employment. In order to comply with these laws and regulations, we are requesting your cooperation in completing this EEO Self Identification Form.

The information on this EEO Self-Identification Form is being requested and will be used solely for equal employment opportunity record-keeping and reporting purposes. Submission of this form by you is voluntary. Please be assured that you will not be subjected to any adverse treatment if you do not provide the information requested.

1. Are you Hispanic or Latino?

☐ Yes

☐ No

2. If you answered "No", please select all that apply of the following categories that best describes your race/ethnicity:

☐ White (Not Hispanic or Latino).

☐ Black or African American (Not Hispanic or Latino).

☐ Native Hawaiian or Other Pacific Islander (Not Hispanic or Latino).

☐ Asian (Not Hispanic or Latino).

☐ American Indian or Alaska Native (Not Hispanic or Latino).

☐ Two or More Races (Not Hispanic or Latino).

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

White--A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.

Black or African American--A person having origins in any of the Black racial groups of Africa.

Native Hawaiian or Other Pacific Islander--A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.

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.

American Indian or Alaska Native--A person having origins in any of the original peoples of North and South America (including Central America), and who maintains tribal affiliation or community attachment.

WINTHROP
University Hospital

PAY CHECK DIRECT DEPOSIT

I understand that although I can have my check directly deposited to any bank, the money may not appear in my account until Monday or Tuesday after the actual pay day. I also understand that I must verify that the deposit was made, before I write any checks since Winthrop-University Hospital will not be responsible for any checks returned to my account, due to insufficient funds.

PLEASE NOTE: There is a 10 day prenote period-when you change accounts, you will have a check to cash. It will go direct deposit to the new account the following payroll if there aren't any errors.

I ACCEPT THESE TERMS: _____ _____
PLEASE PRINT YOUR NAME Employee #

Work Ext. or Home telephone number: _____ Ext. # : _____

Home Address: _____

Checking Account #:

1. _____ Amount (if applicable):$_____

2. _____ Amount (if applicable):$_____

Saving Account #:

1. _____ ABA/Routing #:_____Amount (if applicable): $_____

2. _____ ABA/Routing #: _____Amount (if applicable): $_____

☐ Please indicate if you would like your **paycheck** or **stub** mailed to the above address.

☐ Please stop direct deposit. Account # _____

☐ Please check this box if your check/stub had been mailed previously and you want it to go to your department instead.

DIRECT DEPOSIT INTO A CHECKING ACCOUNT REQUIRES A VOIDED CHECK WITH THE CORRECT ACCOUNT # ON IT

_____ _____
SIGNATURE DATE

WINTHROP
University Hospital
Your Health Means Everything.

Health and Welfare Plan Privacy Notice Acknowledgement

I, _____, acknowledge that I have
(Print Name)

been provided with a copy of Winthrop University Hospital

Health and Welfare Plan's Privacy notice.

Date: _____

Signature: _____

Employee ID#: _____

WINTHROP-UNIVERSITY HOSPITAL HEALTH & WELFARE PLAN

NOTICE OF HEALTH INFORMATION PRIVACY PRACTICES

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

The Health Plans or options sponsored by Winthrop-University Hospital (referred to in this Notice as the "**Health Plans**") may use or disclose health information about participants (employees and their covered dependents) as required for purposes of administering the Health Plans, such as for reviewing and paying claims and utilization review. Some of these functions are handled directly by Winthrop-University Hospital employees who are responsible for overseeing the operation of the Health Plans, while other functions may be performed by other companies under contract with the Health Plans (those companies are generally referred to as "service providers"). Regardless of who handles health information for the Health Plans, the Health Plans have established policies that are designed to prevent the misuse or unnecessary disclosure of protected health information.

Please note that the rest of this Notice uses the capitalized word, "**Plan**" to refer to each Health Plan sponsored by Winthrop-University Hospital, including any Winthrop-University Hospital employees who are responsible for handling health information maintained by the Health Plans as well as any service providers who handle health information under contract with the Health Plans. This Notice applies to each Health Plan maintained by Winthrop-University Hospital, including plans or programs that provide medical, vision, prescription drug, dental, and health care flexible spending account benefits. However, if any of the Plan's health benefits are provided through insurance contracts, you will receive a separate notice, similar to this one, from the insurer and only that notice will apply to the insurer's use of your health information.

The Plan is required by law to maintain the privacy of certain health information about you and to provide you this Notice of the Plan's legal duties and privacy practices with respect to that protected health information. This Notice also provides details regarding certain rights you may have under Federal law regarding medical information about you that is maintained by the Plan.

You should review this Notice carefully and keep it with other records relating to your health coverage. The Plan is required by law to abide by the terms of this Notice while it is in effect. **This Notice is effective beginning January 15, 2011** and will remain in effect until it is revised.

If the Plan's health information privacy policies and procedures are changed so that any part of this Notice is no longer accurate, the Plan will revise this Privacy Notice. A copy of any revised Privacy Notice will be available upon request to the Privacy Contact Person indicated later in this Notice. Also, if required under applicable law, the Plan will automatically provide a copy of any revised notice to employees who participate in the Plan.

The Plan reserves the right to apply any changes in its health information policies retroactively to all health information maintained by the Plan, including information that the Plan received or created before those policies were revised.

Protected Health Information

This Notice applies to health information possessed by the Plan that includes identifying information about an individual. Such information, regardless of the form in which it is kept, is referred to in this Notice as **Protected Health Information** or "**PHI**". For example, any health record that includes details such as your name, street address, date of birth or Social Security number would be covered. However, information taken from a document that does not include such obvious identifying details is also Protected Health Information if that information, under the circumstances, could reasonably be expected to allow a person who receives or accesses that information to identify you as the subject of the information. Information that the Plan possesses that is not Protected Health Information is not covered by this Notice and may be used for any purpose that is consistent with applicable law and with the Plan's policies and requirements.

How the Plan Uses or Discloses Health Information

Protected Health Information may be used or disclosed by the Plan as necessary for the operation of the Plan. For example, PHI may be used or disclosed for the following Plan purposes:

- ***Treatment.*** If a provider who is treating you requests any part or all of your health care records that the Plan possesses, the Plan generally will provide the requested information. (There is an exception for psychotherapy notes. If the Plan possesses any psychotherapy notes, those documents, with rare exceptions, will be used or disclosed only according to your specific authorization.)

  For example, if your current physician asks the Plan for PHI in connection with a treatment plan the physician has for you, the Plan generally will provide that PHI to the physician.

- ***Payment.*** The Plan's agents or representatives may use or disclose PHI about you to determine eligibility for plan benefits, facilitate payment for services you receive from health care providers, to review claims and to coordinate benefits. This includes, if appropriate, disclosing information to the Plan Sponsor, as needed to facilitate the Plan's payment function.

  For example, if the Plan needs to process a payment to your current physician, but requires additional PHI to process that payment, it may request that PHI from the physician.

- ***Other health care operations.*** The Plan may also use or disclose PHI as needed for various purposes that are related to the operation of the Plan. These purposes include utilization review programs, quality assurance reviews, contacting providers regarding treatment alternatives, contacting participants to provide appointment reminders or to provide information about treatment alternatives or other heath-related benefits and services that may be of interest to them, insurance or reinsurance contract renewals and other functions that are appropriate for purposes of administering the Plan. This includes, if appropriate, disclosing information to the Plan Sponsor, as needed to facilitate the Plan's health care operations function.

  For example, if the Plan wishes to undertake a review of utilization patterns under the Plan, it may request necessary PHI from your physician.

In addition to the typical Plan purposes described above, Protected Health Information also may be used or disclosed as permitted or required under applicable law for the following purposes:

- ***Use or disclosure required by law.*** To the extent that the Plan is legally required to provide Protected Health Information to a government agency or anyone else, it will do so. However, the Plan will not use or disclose more information than it determines is required by applicable law.

- ***Disclosure for public health activities.*** The Plan may disclose PHI to a public health authority that is authorized to collect such information (or to a foreign government agency, at the direction of a public health authority) for purposes of preventing or controlling injury, disease or disability.

  The Plan may also disclose PHI to a public health authority or other government agency that is responsible for receiving reports of child abuse or neglect.

In addition, certain information may be provided to pharmaceutical companies or other businesses that are regulated by the Food and Drug Administration (FDA), as appropriate for purposes relating to the quality, safety and effectiveness of FDA-regulated products. For example, disclosure might be appropriate for purposes of reporting adverse reactions, assisting with recalls and contacting patients who have received products that have been recalled.

Also, to the extent permitted by applicable law, the Plan may disclose PHI, as part of a public health investigation or intervention, to an individual who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading a disease or condition.

- ***Disclosures about victims of abuse, neglect or domestic violence.*** (The following does not apply to disclosures regarding child abuse or neglect, which may be made only as provided under ***Disclosure for public health activities***.)

  If required by law, the Plan may disclose PHI relating to a victim of abuse, neglect or domestic violence, to an appropriate government agency. Disclosure will be limited to the relevant required information. The Plan will inform the individual if any PHI is disclosed as provided in this paragraph or the next one.

  If disclosure is not required by law, the Plan may disclose relevant PHI relating to a victim of abuse, neglect or domestic violence to an authorized government agency, to the extent permitted by applicable law, if the Plan determines that the disclosure is necessary to prevent serious harm to the individual or to other potential

victims. Also, to the extent permitted by law, the Plan may release PHI relating to an individual to a law enforcement official, if the individual is incapacitated and unable to agree to the disclosure of PHI and the law enforcement official indicates that the information is necessary for an immediate enforcement activity and is not intended to be used against the individual.

- ***Health oversight activities.*** The Plan may disclose protected health information to a health oversight agency (this includes Federal, State or local agencies that are responsible for overseeing the health care system or a particular government program for which health information is needed) for oversight activities authorized by law. This type of disclosure applies to oversight relating to the health care system and various government programs as well as civil rights laws. This disclosure would not apply to any action by the government in investigating a participant in the Plan, unless the investigation relates to the receipt of health benefits by that individual.

- ***Disclosures for judicial and administrative proceedings.*** The Plan may disclose protected health information in the course of any judicial or administrative proceeding in response to an order from a court or an administrative tribunal. Also, if certain restrictive conditions are met, the Plan may disclose PHI in response to a subpoena, discovery request or other lawful process. In either case, the Plan will not disclose PHI that has not been expressly requested or authorized by the order or other process.

- ***Disclosures for law enforcement purposes.*** The Plan may disclose protected health information for a law enforcement purpose to a law enforcement official if certain detailed restrictive conditions are met.

- ***Disclosures to medical examiners, coroners and funeral directors following death.*** The Plan may disclose protected health information to a coroner or medical examiner for the purpose of identifying a deceased person, determining a cause of death, or other duties as authorized by law. The Plan also may disclose PHI to a funeral director as needed to carry out the funeral director's duties. PHI may also be disclosed to a funeral director, if appropriate, in reasonable anticipation of an individual's death.

- ***Disclosures for organ, eye or tissue donation purposes.*** The Plan may disclose protected health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of cadaveric organs, eyes, or tissue for the purpose of facilitating organ, eye or tissue donation and transplantation.

- ***Disclosures for research purposes.*** If certain detailed restrictions are met, the Plan may disclose protected health information for research purposes.

- ***Disclosures to avert a serious threat to health or safety.*** The Plan may, consistent with applicable law and standards of ethical conduct, use or disclose protected health information, (1) if it believes the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public; and the disclosure is made to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat; or (2) if it believes the disclosure is necessary for law enforcement authorities to identify or apprehend an individual because of a statement by an individual admitting participation in a violent crime that the Plan reasonably believes may have caused serious physical harm to the victim or where it appears that the individual has escaped from a correctional institution or from lawful custody.

- ***Disclosures for specialized government functions.*** If certain conditions are met, the Plan may use and disclose the protected health information of individuals who are Armed Forces personnel for activities deemed necessary by appropriate military command authorities to assure the proper execution of the military mission. Also, the Plan may use and disclose the PHI of individuals who are foreign military personnel to their appropriate foreign military authority under similar conditions.

  The Plan may also use or disclose PHI to authorized federal officials for the conduct of lawful intelligence, counter-intelligence, and other national security activities or for the provision of protective services to the President or other persons as authorized by Federal law relating to those protective services.

- ***Disclosures for workers' compensation purposes.*** The Plan may disclose protected health information as authorized by and to the extent necessary to comply with laws relating to workers' compensation or other similar programs.

Uses and Disclosures That Are Not Permitted Without Your Authorization

The Plan will not use or disclose Protected Health Information for any purpose that is not mentioned above, except as specifically authorized by you. If the Plan needs to use or disclose PHI for a reason not listed above, it will request your permission for that specific use and will not use PHI for that purpose except according to the specific terms of your **authorization**. In addition, you may complete an Authorization Form if you want the Plan to use or disclose health information to you, or to someone else at your request, for any reason.

Any authorization you provide will be limited to specified information, and the intended use or disclosure as well as any person or organization that is permitted to use, disclose or receive the information must be specified in the Authorization Form. Also, an authorization is limited to a specific limited time period and it expires at the end of that period. Finally, you always have the right to revoke a previous authorization by making a written request to the Plan. The Plan will honor your request to revoke an authorization but the revocation will not apply to any action that the Plan took in accord with the authorization before you informed the Plan that you were revoking the authorization.

No Use or Disclosure of PHI for Underwriting

Under applicable law, the Plan generally may not use or disclose genetic information, including information about genetic testing and family medical history, for underwriting purposes. The Plan may use or disclose PHI for underwriting purposes, assuming the use or disclosure is permitted based on the above rules, including the rules for uses and disclosures of PHI for Treatment or Health Care Operations purposes as described above. However, any PHI that is used or disclosed for underwriting purposes will not include genetic information.

"Underwriting purposes" is defined under federal law and generally includes any Plan rules relating to (1) eligibility (including enrollment and continued eligibility) for benefits under the Plan (including changes in deductibles or other cost-sharing mechanisms in return for activities such as completing a health risk assessment or participating in a wellness program); (2) the computation of premium or contribution amounts under the Plan (including discounts or payments or differences in premiums based on activities such as completing a health risk assessment or participating in a wellness program); (3) the application of any preexisting condition exclusion under the Plan; and (4) other activities related to the creation, renewal, or replacement of a contract for health insurance or health benefits. However, "underwriting purposes" generally does not include rules relating to the determination of whether a particular expense or claim is medically appropriate.

Your Health Information Rights

Under Federal law, you have the following rights:

- *You may request restrictions with regard to certain types of uses and disclosures.* This includes the uses and disclosures described above for treatment, payment and other health care operations purposes. If the Plan agrees to the restrictions you request, it will abide by the terms of those restrictions. However, under the law, the Plan is not required to accept any restriction. If the Plan determines that a requested restriction will interfere with the efficient administration of the Plan or is otherwise inappropriate, it may decline the restriction. If you want to request a restriction, you should submit a written request describing the restriction to the Privacy Contact Person listed in this Notice.

  In one situation (which is more likely to apply to a health care provider than to this Plan), the Plan is required to agree to a request for a restriction on disclosure of PHI if the disclosure is to another health plan for purposes of payment or health care operations. If the PHI is limited to a health care item or service for which the health care provider involved has been paid in full by you (or by someone else, other than the Plan or other health coverage, on your behalf), the Plan will agree to your request that such information not be provided to another health plan.

- *You may request that certain information be provided to you in a confidential manner.* This right applies only if you inform the Plan in writing (submitted to the Privacy Contact Person listed in this Notice) that the ordinary disclosure of part or all of the information might endanger you. For example, an individual may not want information about certain types of treatment to be sent to his or her home address because someone else who lives there might have access to it. In such a case, the individual could request that the information be sent to an alternate address. The Plan will honor such a request if it is reasonable, but reserves the right to reject a request that would impose too much of an administrative burden or financial risk on the Plan.

- *You may request access to certain medical records possessed by the Plan and you may inspect or copy those records.* This right applies to all enrollment, claims processing, medical management and payment records maintained by the Plan and also to any other information possessed by the Plan that is used to make decisions about you or your health coverage. However, there are certain limited exceptions. Specifically, the Plan may deny access to psychotherapy notes and to information prepared in anticipation of litigation.

If you want to request access to any medical records, you should contact the Privacy Contact Person listed in this Notice. If you request copies of any records, the Plan may charge reasonable fees to cover the costs of providing those copies to you, including, for example, copying charges and the cost of postage if you request that copies be mailed to you. You will be informed of any fees that apply before you are charged.

- *You may request that protected health information maintained by the Plan be amended.* If you feel that certain information maintained by the Plan is inaccurate or incomplete, you may request that the information be amended. The Plan may reject your request if it finds that the information is accurate and complete. Also, if the information you are challenging was created by some other person or organization, the Plan ordinarily would not be responsible for amending that information unless you provide information to the Plan to establish that the originator of the information is not in a position to amend it. If you want to request that any medical record maintained by the Plan be amended, you should provide your request in writing to the Privacy Contact Person listed in this Notice. Your request should describe the records that you want to be changed, each change you are requesting and your reasons for believing that each requested change should be made.

The Plan normally will respond to a request for an amendment within 60 days after it receives your request. In certain cases, the Plan may take up to 30 additional days to respond to your request.

If the Plan denies your request, you will have the opportunity to prepare a statement to be included with your health records to explain why you believe that certain information is incomplete or inaccurate. If you do prepare such a statement, the Plan will provide that statement to any person who uses or receives the information that you challenged. The Plan may also prepare a response to your statement and that response will be placed with your records and provided to anyone who receives your statement. A copy will also be provided to you.

- *You have the right to receive details about certain non-routine disclosures of health information made by the Plan.* You may request an accounting of all disclosures or health information, with certain exceptions. This accounting would not include disclosures that are made for Treatment, Payment and other health plan operations, disclosures made pursuant to an individual authorization from you, disclosures made to you and certain other types of disclosures. Also, your request will not apply to any disclosures made more than 6 years before the date your request is properly submitted to the Plan. You may receive an accounting of disclosures once every 12 months at no charge. The Plan may charge a reasonable fee for any additional requests during a 12 month period.

- *You have the right to request and receive a paper copy of this Privacy Notice*. If the Plan provides this Notice to you in an electronic form, you may request a paper copy and the Plan will provide one. You should contact the Privacy Contact Person identified at the end of this Notice if you want a paper copy.

Health Information Complaint Procedures Privacy Contact Person

If you believe your health information privacy rights have been violated, you may file a complaint with the Plan. To file a complaint, you should write to the Winthrop-University Hospital, Human Resources Department, 259 First Street, Mineola, NY 11501.

In addition to your right to file a complaint with the Plan, you may file a complaint with the U.S. Department of Health & Human Services. (Details are available on the Internet at http://www.hhs.gov/ocr/privacy) You will never be retaliated against in any way as a result of any complaint that you file.

Additional Information

After reading this Notice, if you have questions about the Plan's health information privacy policies and procedures or if you need additional information, send an email to BenefitsOffice@winthrop.org or call (516) 663-2912.

WINTHROP
University Hospital
Your Health Means Everything.

BACKGROUND CHECK DISCLOSURE AND AUTHORIZATION FORM

In the interests of maintaining the safety and security of our customers, employees and property, Winthrop-University Hospital will order a "consumer report" (a background report) on you in connection with your employment application, and if you are hired, or if you already work for Winthrop-University Hospital, may order additional background reports on you for employment purposes.

The background check company, ADP Screening and Selection Services, will prepare the background report for Winthrop-University Hospital. ADP Screening and Selection Services is located at 301 Remington Street, Fort Collins, CO, 80524, and can be reached at 800-367-5933.

The background report may contain information concerning your character, general reputation, personal characteristics, mode of living, and credit standing. The types of information that may be ordered include but are not limited to: Social Security number verification; criminal, public, educational and, as appropriate, driving records checks; verification of prior employment; reference, licensing and certification checks; credit reports; and drug testing results. The information may be obtained from private and public record sources, including personal interviews with your associates, friends, and neighbors. (An "investigative consumer report" is a background report that includes information from such personal interviews, except in California where that term means any background report.) The nature and scope of the most common form of investigative consumer report is an investigation into your education and/or employment history conducted by ADP Screening and Selection Services or another outside organization.

You may request more information about the nature and scope of an investigative consumer report, if any, by telephoning Winthrop-University Hospital at 516-663-2925. A summary of your rights under the Fair Credit Reporting Act is also being provided to you with this form.

STATE SPECIFIC NOTICES

If you live or work for Winthrop-University Hospital in the states listed below, please note the following:

CALIFORNIA: You may review the file that ADP Screening and Selection Services has for you, and order a copy of the file, upon submitting proper identification and paying copying costs, by coming to their offices during normal business hours and on reasonable notice, or by mail. You may also ask for a file disclosure summary by telephone. ADP Screening and Selection Services can answer questions about information in your file, including any coded information. If you come in person, another person can come with you, as long as that person can show proper identification.

MAINE: If you ask, you have the right to know whether Winthrop-University Hospital ordered an investigative consumer report on you. You may request the name, address, and telephone number of the nearest office for ADP Screening and Selection Services. You will get this information within 5 business days of our receipt of your request. You have the right to ask ADP Screening and Selection Services for a free copy of the report.

MARYLAND: If Winthrop-University Hospital obtains credit history information on you, it will be used to evaluate whether you would present an unacceptable risk of theft or other dishonest behavior in the job for which you are being considered.

MASSACHUSETTS/NEW JERSEY: If you submit a request to us in writing, you have the right to know whether Winthrop-University Hospital ordered an investigative consumer report from ADP Screening and Selection Services. You may inspect and order a free copy of the report by contacting ADP Screening and Selection Services.

MINNESOTA: If you submit a request to us in writing, you have the right to get from Winthrop-University Hospital a complete and accurate disclosure of the nature and scope of the consumer report or investigative consumer report ordered, if any.

NEW YORK: If you submit a request to us in writing, you have the right to know whether Winthrop-University Hospital ordered a consumer report or an investigative consumer report from ADP Screening and Selection Services, and you will be provided with the name and address of ADP Screening and Selection Services. You may inspect and order a free copy of the report as by contacting ADP Screening and Selection Services. A copy of Article 23A of the New York Correction Law is being provided with this form.

OREGON: If Winthrop-University Hospital obtains credit history information on you, it will be used to evaluate whether you would present an unacceptable risk of theft or other dishonest behavior in the job for which you are being considered.

WASHINGTON STATE: If you submit a request to us in writing, you have the right to get from Winthrop-University Hospital a complete and accurate disclosure of the nature and scope of the investigative consumer report we ordered, if any. You also have the right to ask ADP Screening and Selection Services for a written summary of your rights under the Washington Fair Credit Reporting Act. If Winthrop-University Hospital obtains information bearing on your creditworthiness, credit standing or credit capacity it will be used to evaluate whether you would present an unacceptable risk of theft or other dishonest behavior in the job for which you are being considered.

AUTHORIZATION FOR BACKGROUND CHECKS

After carefully reading this Background Check Disclosure and Authorization form, I authorize Winthrop-University Hospital to order my background report, including investigative consumer reports. I understand that Winthrop-University Hospital may rely on this authorization to order additional background reports, including investigative consumer reports, during my employment without asking me for my authorization again as allowed by law.

I also authorize the following agencies and entities to disclose to ADP Screening and Selection Services and its agents all information about or concerning me, including but not limited to: my past or present employers, learning institutions, including colleges and universities, law enforcement and all other federal, state and local courts, the military, credit bureaus, testing facilities, motor vehicle records agencies, all other private and public sector repositories of information; and any other person, organization, or agency with any information about or concerning me. The information that can be disclosed to ADP Screening and Selection Services and its agents includes, but is not limited to, information concerning my employment history, earnings history, education, credit history, motor vehicle history, criminal history, military service, professional credentials and licenses, and substance abuse testing.

I agree Winthrop-University Hospital may rely on this authorization to order background reports, including investigative consumer reports, from companies other than ADP Screening and Selection Services without asking me for my authorization again as allowed by law. I also agree that a copy of this form is valid like the signed original. I certify that all of my personal information on this form is *true and correct* and understand that dishonesty will disqualify me from consideration for employment with Winthrop-University Hospital, or if I am hired or already work for Winthrop-University Hospital, that my employment may be terminated.

Last Name _____ First _____ Middle _____

Maiden/Other Names _____ Years Used _____

Social Security Number _____

Driver's License Number _____ State _____

FOR IDENTIFICATION PURPOSES ONLY: Date of Birth ____/____/____ (Month/Day/Year)

Addresses Within The Past Seven Years (*use a separate sheet as needed*)

Present Street Address _____

City/State/ZIP _____

Prior Street Address _____

From _____/_____/_____ (Month/Day/Year) To _____/_____/_____ (Month/Day/Year)

City/State/ZIP _____

Prior Street Address _____

From _____/_____/_____ (Month/Day/Year) To _____/_____/_____ (Month/Day/Year)

City/State/ZIP _____

Prior Street Address _____

From _____/_____/_____ (Month/Day/Year) To _____/_____/_____ (Month/Day/Year)

City/State/ZIP _____

_____ _____/_____/_____

Signature Date: (Month/Day/Year)

If you live or work for the Company in California, Minnesota or Oklahoma: Check this box if you would like a free copy of your background check report

Para informacion en espanol, visite www.ftc.gov/credit o escribe a la FTC Consumer Response Center, Room 130-A 600 Pennsylvania Ave. N.W., Washington, DC 20580.

A Summary of Your Rights Under the Fair Credit Reporting Act

The federal Fair Credit Reporting Act (FCRA) promotes the accuracy, fairness and privacy of information in the files of consumer reporting agencies. There are many types of consumer reporting agencies, including credit bureaus and specialty agencies (such as agencies that sell information about check writing histories, medical records, and rental history records). Here is a summary of your major rights under the FCRA. **For more information, including information about additional rights, go to www.ftc.gov/credit or write to: Consumer Response Center, Room 130-A, Federal Trade Commission, 600 Pennsylvania Ave. N.W., Washington, DC 20580.**

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

• **You have the right to know what is in your file.** You may request and obtain all the information about you in the files of a consumer reporting agency (your "file disclosure"). You will be required to provide proper identification, which may include your Social Security number. In many cases, the disclosure will be free. You are entitled to a free file disclosure if:

- A person has taken adverse action against you because of information in your credit report;
- You are the victim of identify theft and place a fraud alert in your file;
- Your file contains inaccurate information as a result of fraud;
- You are on public assistance;
- You are unemployed but expect to apply for employment within 60 days.

In addition, by September 2005 all consumers will be entitled to one free disclosure every 12 months upon request from each nationwide credit bureau and from nationwide specialty consumer reporting agencies. See www.ftc.gov/credit for additional information.

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

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

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

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

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

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

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

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

• **Identity theft victims and active duty military personnel have additional rights.** For more information, visit www.ftc.gov/credit.

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

TYPE OF BUSINESS:	CONTACT:
Consumer reporting agencies, creditors and others not listed below	**Federal Trade Commission: Consumer Response Center - FCRA** Washington, DC 20580 1-877-382-4357
National banks, federal branches/agencies of foreign banks (word "National" or initials "N.A." appear in or after bank's name)	**Office of the Comptroller of the Currency** Compliance Management Mail Stop 6-8 Washington, DC 20219 1-800-613-6743
Federal Reserve System member banks (except national banks and federal branches/agencies of foreign banks)	**Federal Reserve Board** **Division of Consumer & Community Affairs** Washington, DC 20551 202-452-3693
Savings associations and federally chartered savings banks (word "Federal" or initials "F.S.B." appear in federal institution's name)	**Office of Thrift Supervision** Consumer Complaints Washington, DC 20552 800-842-6929
Federal credit unions (words "Federal Credit Union" appear in institution's name)	**National Credit Union Administration** 1775 Duke Street Alexandria, VA 22314 703-519-4600
State-chartered banks that are not members of the Federal Reserve System	**Federal Deposit Insurance Corporation** Consumer Response Center 2345 Grand Avenue, Suite 100 Kansas City, Missouri 64108-2638 1-877-275-3342
Air, surface, or rail common carriers regulated by former Civil Aeronautics Board or Interstate Commerce Commission	**Department of Transportation** Office of Financial Management Washington, DC 20590 202-366-1306
Activities subject to the Packers and Stockyards Act of 1921	**Department of Agriculture** Office of Deputy Administrator - GIPSA Washington, DC 20250 202-720-7051

NEW YORK CORRECTION LAW
ARTICLE 23-A
LICENSURE AND EMPLOYMENT OF PERSONS PREVIOUSLY CONVICTED OF ONE OR MORE CRIMINAL OFFENSES

§750. Definitions. For the purposes of this article, the following terms shall have the following meanings:

(1) "Public agency" means the state or any local subdivision thereof, or any state or local department, agency, board or commission.

(2) "Private employer" means any person, company, corporation, labor organization or association which employs ten or more persons.

(3) "Direct relationship" means that the nature of criminal conduct for which the person was convicted has a direct bearing on his fitness or ability to perform one or more of the duties or responsibilities necessarily related to the license, opportunity or job in question.

(4) "License" means any certificate, license, permit or grant of permission required by the laws of this state, its political subdivisions or instrumentalities as a condition for the lawful practice of any occupation, employment, trade, vocation, business or profession. Provided, however, that "license" shall not, for the purposes of this article, include any license or permit to own, possess, carry, or fire any explosive, pistol, handgun, rifle, shotgun, or other firearm.

(5) "Employment" means any occupation, vocation or employment, or any form of vocational or educational training. Provided, however, that "employment" shall not, for the purposes of this article, include membership in any law enforcement agency.

§751. Applicability. The provisions of this article shall apply to any application by any person for a license or employment at any public or private employer, who has previously been convicted of one or more criminal offenses in this state or in any other jurisdiction, and to any license or employment held by any person whose conviction of one or more criminal offenses in this state or in any other jurisdiction preceded such employment or granting of a license, except where a mandatory forfeiture, disability or bar to employment is imposed by law and has not been removed by an executive pardon, certificate of relief from disabilities or certificate of good conduct. Nothing in this article shall be construed to affect any right an employer may have in respect to an intentional misrepresentation in connection with an application for employment made by a prospective employee or previously made by a current employee.

§752. Unfair discrimination against persons previously convicted of one or more criminal offenses prohibited. No application for any license or employment, and no employment or license held by an individual, to which the provisions of this article are applicable, shall be denied or acted upon adversely by reason of the individual's having been previously convicted of one or more criminal offenses, or by reason of a finding of lack of "good moral character" when such finding is based upon the fact that the individual has previously been convicted of one or more criminal offenses, unless:

(1) There is a direct relationship between one or more of the previous criminal offenses and the specific license or employment sought or held by the individual; or

(2) The issuance or continuation of the license or the granting or continuation of the employment would involve an unreasonable risk to property or to the safety or welfare of specific individuals or the general public.

§753. Factors to be considered concerning a previous criminal conviction; presumption.

1. In making a determination pursuant to section seven hundred fifty-two of this chapter, the public agency or private employer shall consider the following factors:

(a) The public policy of this state, as expressed in this act, to encourage the licensure and employment of persons previously convicted of one or more criminal offenses. (b) The specific duties and responsibilities necessarily related to the license or employment sought or held by the person. (c) The bearing, if any, the criminal offense or offenses for which the person was previously convicted will have on his fitness or ability to perform one or more such duties or responsibilities.

(d) The time which has elapsed since the occurrence of the criminal offense or offenses.

(e) The age of the person at the time of occurrence of the criminal offense or offenses.

(f) The seriousness of the offense or offenses.

(g) Any information produced by the person, or produced on his behalf, in regard to his rehabilitation and good conduct.

(h) The legitimate interest of the public agency or private employer in protecting property, and the safety and welfare of specific individuals or the general public.

2. In making a determination pursuant to section seven hundred fifty-two of this chapter, the public agency or private employer shall also give consideration to a certificate of relief from disabilities or a certificate of good conduct issued to the applicant, which certificate shall create a presumption of rehabilitation in regard to the offense or offenses specified therein.

§754. Written statement upon denial of license or employment. At the request of any person previously convicted of one or more criminal offenses who has been denied a license or employment, a public agency or private employer shall provide, within thirty days of a request, a written statement setting forth the reasons for such denial.

§755. Enforcement.

1. In relation to actions by public agencies, the provisions of this article shall be enforceable by a proceeding brought pursuant to article seventy-eight of the civil practice law and rules.

2. In relation to actions by private employers, the provisions of this article shall be enforceable by the division of human rights pursuant to the powers and procedures set forth in article fifteen of the executive law, and, concurrently, by the New York city commission on human rights.