# Personal Information

**Oklahoma State University**  
Complete form and send to OSU Human Resources  
106 Whitehurst, Stillwater.

**Employee ID:**

**Citizenship Status:**
- [ ] Citizen  
- [ ] International  
- [ ] Biweekly  
- [ ] Monthly  
- [ ] Permanent Resident

### Section 1: All Employees Complete

<table>
<thead>
<tr>
<th>Prefix</th>
<th>Last Name (incl suffix, e.g. Jr, Sr, III)</th>
<th>First Name</th>
<th>Middle Name</th>
<th>Check if <strong>Name Change</strong> &amp; attach a copy of new social security card &amp; photo ID.</th>
<th></th>
</tr>
</thead>
</table>

### Section 2: All NEW Employees Complete - **Current** Employees, Enter only fields that need updated

<table>
<thead>
<tr>
<th>Marital Status</th>
<th>Gender</th>
<th>Hispanic?</th>
<th>Birth Date (MMDDYYYY)</th>
<th>White</th>
<th>Asian</th>
<th>Black</th>
<th>Amer Indian / Alaskan Natv</th>
<th>Native Hawaiian or Pacific Islander</th>
</tr>
</thead>
</table>

**Permanent Home Address (within USA to mail W-2)**

<table>
<thead>
<tr>
<th>Address Line 1</th>
<th>Telephone Number (w/ AC)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address Line 2</td>
<td></td>
</tr>
<tr>
<td>City</td>
<td>State</td>
</tr>
</tbody>
</table>

**Personal Email Account:**

**Emergency Contact**

<table>
<thead>
<tr>
<th>Contact Name</th>
<th>Contact Relationship</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contact Address (Street Address, City, State, Zip Code)</td>
<td>Contact Work Phone (w/ AC)</td>
</tr>
<tr>
<td>Contact Home Phone (w/ AC)</td>
<td></td>
</tr>
</tbody>
</table>

### Section 3: All Faculty and Regular Staff Employees Must Complete

**Educational Background **** List your HIGHEST degree or diploma first ******

<table>
<thead>
<tr>
<th>Degree</th>
<th>Year Rec’d</th>
<th>Institution Name and Location</th>
<th>Field of Study</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

This form only changes the basic employee demographic information in Banner and most benefits. This form does not change your beneficiary information or retirement provider information.

**Employee Signature**  
**Telephone Number**  
**Date**
LOYALTY OATH
(51 O.S., 36.2A)

I do solemnly swear (or affirm) that I will support the Constitution and the laws of the United States of America and the Constitution and the laws of the State of Oklahoma, and that I will faithfully discharge, according to the best of my ability, the duties of my office or employment during such time as I am

(Here put name of office, or, if an employee, insert "An Employee of_____" followed by the complete designation of the employing officer, agency, authority, commission, department or institution.)

__________________________________________
Signature of Affiant

State of __________________________

County of __________________________

Signed and sworn to (or affirmed) before me on this _________ day of ____________________________ , ______ by ____________________________ .

Print name of person taking the oath

Signature of Notary Public, or other officer authorized to administer oaths or affirmations.

(Seal, if any)

Title and Rank (if other than a Notary Public)

My Commission Expires: __________________________

Commission Number: __________________________

(OKSOS-08/2017)
Oklahoma Teachers’ Retirement System
Notification Form

Oklahoma Teacher’s Retirement System (OTRS) regulations state that employees participating in OTRS through their full-time employer must also participate through their part-time employer. (Example: an adjunct employee hired to teach 3 hours at OSU and who is a full-time employee, participating in OTRS at OU would mark “YES” in the first section below. An OSU faculty member teaching an overload at OSU does NOT need to complete this form, but they would need to notify OU if they teach adjunct at OSU).

Regulations also require OSU to remit employer-paid contributions for any employee who is retired and currently receiving OTRS retirement income. If you are one of these retirees, answer “YES” you are retired through OTRS.

If you do NOT participate in OTRS, mark “NO.”

If you are unsure if you are a current participating member of OTRS, please contact OTRS at (877) 738-6365.

For the above reasons, if you have a job or status change that could affect contributions to OTRS, please contact Human Resources to fill out another form.

☐ YES, I participate in OTRS through my current or previous (Please circle one) full-time employer.
   The name of the institution is: _______________________________

☐ NO, I am NOT a participating member of OTRS through a full-time employer.

☐ YES, I am an OTRS retiree, and currently receive a monthly retirement check from OTRS.

_____________________________   ________________  ______________________
Print Name  Date of Birth   Employee ID

_____________________________     ______________________
Signature        Date

RETURN ORIGINAL FORM TO OSU BENEFITS, 106 WHITEHURST, STILLWATER, OK 74078

FOR OFFICE USE ONLY. EFFECTIVE DATE: _________________________

☐ TRN, if current OTRS participant with another institution
☐ TRX, if retired from OTRS
☐ No action, if not a participant or retired with OTRS

☐
State of Oklahoma Outstanding Wages Beneficiary Designation

In accordance with Title 40, O.S., Section 165.3a, Oklahoma State University (OSU) offers its employees the option of designating a beneficiary to receive the employee’s final check in the event of an employee’s death while an employee of OSU.

If you elect to name a beneficiary, you must complete the section below, Outstanding Wages Beneficiary Designation Form, and submit to OSU Benefits, 106 Whitehurst. Should you desire to change your beneficiary at some point in the future, it will be your responsibility to complete and submit to OSU Benefits, another Outstanding Wages Beneficiary Designation Form. For example, if you name your spouse and are later divorced, you may want to complete a new form.

Primary Beneficiary: Receives priority distribution upon the employee’s death. Contingent Beneficiary: Receives distribution only if the primary beneficiary(ies) are deceased at the time of the employee’s death.

If an employee does not elect to name a beneficiary, OSU’s payroll office will issue the employee’s final paycheck, including any pay for unused annual/vacation leave, in accordance with Title 40, O.S., Section 165.3a, Payment of wages to surviving spouse and children. Please be advised that if your final check is processed without the naming of a beneficiary, your surviving spouse, or if there is no surviving spouse, your dependent children, or their guardians or the conservators of their estates, will receive in equal shares a total up to the maximum $3,000 allowed by law. Any remaining payment would go into the estate and go through probate. Please be advised that access to the funds processed to an estate may be delayed due to the probate process.

Primary Beneficiary

<table>
<thead>
<tr>
<th>Relationship:</th>
<th>DOB: (mm/dd/yyyy):</th>
<th>Social Security Number:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Full Name:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Address:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Street</td>
<td>City</td>
<td>State</td>
</tr>
</tbody>
</table>

Beneficiary: Primary:_____ OR Contingent: _____ Relationship:________

<table>
<thead>
<tr>
<th>DOB: (mm/dd/yyyy):</th>
<th>Social Security Number:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Full Name:</td>
<td></td>
</tr>
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<td></td>
</tr>
<tr>
<td>Street</td>
<td>City</td>
</tr>
</tbody>
</table>

Beneficiary: Primary:_____ OR Contingent: _____ Relationship:________

<table>
<thead>
<tr>
<th>DOB: (mm/dd/yyyy):</th>
<th>Social Security Number:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Full Name:</td>
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<td></td>
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<tr>
<td>Street</td>
<td>City</td>
</tr>
</tbody>
</table>

Beneficiary: Primary:_____ OR Contingent: _____ Relationship:________

<table>
<thead>
<tr>
<th>DOB: (mm/dd/yyyy):</th>
<th>Social Security Number:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Full Name:</td>
<td></td>
</tr>
<tr>
<td>Address:</td>
<td></td>
</tr>
<tr>
<td>Street</td>
<td>City</td>
</tr>
</tbody>
</table>

PRINT EMPLOYEE FULL NAME SIGNATURE OF EMPLOYEE DATE

Return original, signed form to OSU Benefits, 106 Whitehurst, and retain a copy for your records. Please keep all beneficiary information current.
**Employment Eligibility Verification**
**Department of Homeland Security**
**U.S. Citizenship and Immigration Services**

**OMB No. 1615-0047**
**Expires 10/31/2022**

**START HERE:** Read instructions carefully before completing this form. The instructions must be available, either in paper or electronically, during completion of this form. Employers are liable for errors in the completion of this form.

**ANTI-DISCRIMINATION NOTICE:** It is illegal to discriminate against work-authorized individuals. Employers CANNOT specify which document(s) an employee may present to establish employment authorization and identity. The refusal to hire or continue to employ an individual because the documentation presented has a future expiration date may also constitute illegal discrimination.

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

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

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

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

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

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

- [ ] 1. A citizen of the United States
- [ ] 2. A noncitizen national of the United States *(See instructions)*
- [ ] 3. A lawful permanent resident *(Alien Registration Number/USCIS Number)*
- [ ] 4. An alien authorized to work until (expiration date, if applicable, mm/dd/yyyy):

   Some aliens may write "N/A" in the expiration date field. *(See instructions)*

Aliens authorized to work must provide only one of the following document numbers to complete Form I-9: An Alien Registration Number/USCIS Number OR Form I-94 Admission Number OR Foreign Passport Number.

1. Alien Registration Number/USCIS Number: ____________________________
   OR

2. Form I-94 Admission Number: ____________________________
   OR

3. Foreign Passport Number: ____________________________
   Country of Issuance: ____________________________

Signature of Employee

Today's Date (mm/dd/yyyy)

**Preparer and/or Translator Certification (check one):**

- [ ] I did not use a preparer or translator.
- [ ] A preparer(s) and/or translator(s) assisted the employee in completing Section 1. *(Fields below must be completed and signed when preparers and/or translators assist an employee in completing Section 1.)*

I attest, under penalty of perjury, that I have assisted in the completion of Section 1 of this form and that to the best of my knowledge the information is true and correct.

Signature of Preparer or Translator

Today's Date (mm/dd/yyyy)

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

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

(Employers or their authorized representative must complete and sign Section 2 within 3 business days of the employee's first day of employment. You must physically examine one document from List A OR a combination of one document from List B and one document from List C as listed on the "Lists of Acceptable Documents.")

<table>
<thead>
<tr>
<th>Employee Info from Section 1</th>
<th>Last Name (Family Name)</th>
<th>First Name (Given Name)</th>
<th>M.I.</th>
<th>Citizenship/Immigration Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Identity and Employment Authorization</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Document Title</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Issuing Authority</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Document Number</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Expiration Date (if any) (mm/dd/yyyy)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>List A</th>
<th>OR</th>
<th>List B</th>
<th>AND</th>
<th>List C</th>
</tr>
</thead>
<tbody>
<tr>
<td>Document Title</td>
<td></td>
<td>Document Title</td>
<td></td>
<td>Document Title</td>
</tr>
<tr>
<td>Issuing Authority</td>
<td></td>
<td>Issuing Authority</td>
<td></td>
<td>Issuing Authority</td>
</tr>
<tr>
<td>Document Number</td>
<td></td>
<td>Document Number</td>
<td></td>
<td>Document Number</td>
</tr>
<tr>
<td>Expiration Date (if any) (mm/dd/yyyy)</td>
<td></td>
<td>Expiration Date (if any) (mm/dd/yyyy)</td>
<td></td>
<td>Expiration Date (if any) (mm/dd/yyyy)</td>
</tr>
</tbody>
</table>

Additional Information

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

The employee's first day of employment (mm/dd/yyyy): (See instructions for exemptions)

<table>
<thead>
<tr>
<th>Signature of Employer or Authorized Representative</th>
<th>Today's Date (mm/dd/yyyy)</th>
<th>Title of Employer or Authorized Representative</th>
</tr>
</thead>
<tbody>
<tr>
<td>LastName of Employer or Authorized Representative</td>
<td>First Name of Employer or Authorized Representative</td>
<td>Employer's Business or Organization Name</td>
</tr>
</tbody>
</table>

Employer's Business or Organization Address (Street Number and Name) City or Town State ZIP Code

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

A. New Name (if applicable) B. Date of Rehire (if applicable)

<table>
<thead>
<tr>
<th>Last Name (Family Name)</th>
<th>First Name (Given Name)</th>
<th>Middle Initial</th>
<th>Date (mm/dd/yyyy)</th>
</tr>
</thead>
</table>

C. If the employee's previous grant of employment authorization has expired, provide the information for the document or receipt that establishes continuing employment authorization in the space provided below.

<table>
<thead>
<tr>
<th>Document Title</th>
<th>Document Number</th>
<th>Expiration Date (if any) (mm/dd/yyyy)</th>
</tr>
</thead>
</table>

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.

<table>
<thead>
<tr>
<th>Signature of Employer or Authorized Representative</th>
<th>Today's Date (mm/dd/yyyy)</th>
<th>Name of Employer or Authorized Representative</th>
</tr>
</thead>
</table>
**LISTS OF ACCEPTABLE DOCUMENTS**

All documents must be UNEXPIRED

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

<table>
<thead>
<tr>
<th>LIST A</th>
<th>LIST B</th>
<th>LIST C</th>
</tr>
</thead>
<tbody>
<tr>
<td>Documents that Establish Both Identity and Employment Authorization</td>
<td>Documents that Establish Identity</td>
<td>Documents that Establish Employment Authorization</td>
</tr>
<tr>
<td>1. U.S. Passport or U.S. Passport Card</td>
<td>1. Driver's license or ID card issued by a State or outlying possession of the United States provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address</td>
<td>1. A Social Security Account Number card, unless the card includes one of the following restrictions: (1) NOT VALID FOR EMPLOYMENT</td>
</tr>
<tr>
<td>2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551)</td>
<td>2. ID card issued by federal, state or local government agencies or entities, provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address</td>
<td>(2) VALID FOR WORK ONLY WITH INS AUTHORIZATION</td>
</tr>
<tr>
<td>3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa</td>
<td>3. School ID card with a photograph</td>
<td>(3) VALID FOR WORK ONLY WITH DHS AUTHORIZATION</td>
</tr>
</tbody>
</table>
| 5. For a nonimmigrant alien authorized to work for a specific employer because of his or her status:  
   a. Foreign passport; and  
   b. Form I-94 or Form I-94A that has the following:  
      (1) The same name as the passport; and  
      (2) An endorsement of the alien's nonimmigrant status as long as that period of endorsement has not yet expired and the proposed employment is not in conflict with any restrictions or limitations identified on the form. | 5. U.S. Military card or draft record | 3. Original or certified copy of birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal |
| 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 | 6. Military dependent's ID card | 4. Native American tribal document |
| | 7. U.S. Coast Guard Merchant Mariner Card | 5. U.S. Citizen ID Card (Form I-197) |
| | For persons under age 18 who are unable to present a document listed above: | 10. School record or report card |
| | 11. Clinic, doctor, or hospital record | 11. Clinic, doctor, or hospital record |
| | 12. Day-care or nursery school record | 12. Day-care or nursery school record |

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

Refer to the instructions for more information about acceptable receipts.
Federal Tax Withholding Form – U.S. Citizens and Resident Aliens

U.S. Citizens and Resident Aliens Federal withholding will default to Single marital status and no deductions. A different marital status can be set up online via self-service as follows:

1. Log in to Employee Self Service
2. Select Tax Forms
3. Select W-4 Employee’s Withholding Allowance Certificate
4. It is strongly suggested that employees use the IRS Tax Withholding Estimator, which can be accessed by clicking on the “Vendor Web Site” link at the bottom right of the screen, to help estimate whether the amount withheld is sufficient.
5. Select Update (at the bottom of the screen)
6. Enter the date you want the change to be effective (subject to limitations based on the payroll processing schedule).
7. Use the dropdown box labeled “filing status” to indicate your filing status.
8. The “Under Age 17 Amount” is a dollar amount based on $2000 per dependent claimed. Do not enter the number of dependents (1, 2, 3, etc).
9. The “Above Age 17 Amount” is a dollar amount based on $500 per dependent claimed. Do not enter the number of dependents (1, 2, 3, etc).
10. Dependent Amount – it is critical that the total of the “Under Age 17 Amount” and the “Above Age 17 Amount” be correctly entered here. If the total isn’t entered by the user, there won’t be an adjustment.
11. Users are responsible for entering accurate information. Oklahoma State University is not responsible for any taxes owed or fines that might be incurred due to inaccurate information.

State Tax Withholding Forms U.S. Citizens and Resident Aliens – Job Location in Oklahoma

U.S. Citizens and Resident Aliens will default to Oklahoma state tax withholding, Single marital status and 0 allowances.

Marital status and/or number of allowances can be changed by completing the Oklahoma Employee’s Withholding Allowance Certificate form. This form is on the Payroll Services website under Payroll Tax Withholding Forms. https://payroll.okstate.edu/payroll-tax-withholding-forms.

Print, sign and e-mail (encrypted) the completed form to OSU Payroll Services (payroll.services@okstate.edu) or deliver/mail the form to OSU Payroll Services, 409 Whitehurst, Stillwater, OK 74078.

State Tax Withholding Forms – Job Location outside of Oklahoma

If you work and live outside of Oklahoma (wages are earned outside Oklahoma), complete the OSU Out of State Job Location State Tax Withholding Form. This form is on the Payroll Services website under Payroll Tax Withholding Forms. https://payroll.okstate.edu/payroll-tax-withholding-forms.
Print, sign and e-mail (Social Security Number is not on this form so it does not need to be sent encrypted) the completed form to OSU Payroll Services (payroll.services@okstate.edu) or deliver/mail the form to the Payroll Services office at 409 Whitehurst, Stillwater, OK 74078.

If a specific form is required by your state Payroll Services will provide it via e-mail to be completed. Until the required form is received, state taxes will be withheld at the highest withholding rate for your state. You can also go to your State’s website, download, complete and submit the form.

No taxes are withheld if your state does not assess taxes on wages.
Nonresident Alien Federal & State Withholding Forms

All Nonresident Aliens must make an appointment with the ISS Office on the Stillwater campus to complete your withholding and Work Permit forms.

Oklahoma State University
Office of International Students and Scholars
309 Wes Watkins Center
405.744.8117
iss.okstate.edu
AUTOMATIC DEPOSIT TRANSMITTAL

This form is to be used by State and Higher Education Employees in communicating their direct deposit information.

Social Security Number: ___________________________ Date of Birth: ______/_____/______

First Name ___________________________ Last Name ___________________________

(limit to 15 characters) (limit to 15 characters)

I hereby authorize the State of Oklahoma, as per the Oklahoma State Employee’s Direct Deposit Act, 74:292.10 to:

ADD PAYROLL – (Deposit my payroll warrant in my account as indicated below)

REMOVE PAYROLL – (I understand that by terminating Direct Deposit for Payroll this will automatically terminate travel and spending from my direct deposit)

If monies to which I am not entitled are deposited to my account, I authorize the State of Oklahoma to direct the financial institution to return said funds. I understand the payroll date and frequency of payment currently being utilized by my employing agency will not be affected by my decision to use Electronic Fund Transfer.

ONLY ONE ACCOUNT MAY BE USED FOR DIRECT DEPOSIT

☐ CHECKING ☐ SAVINGS ☐ PayCard

Financial Institution Name (Your Bank): ___________________________

City: ___________________________ State: ___________________________

This authority is to remain in full force and effect until: (A) I give my employer written notice using this form (OPM-73) to terminate this direct deposit agreement. (B) I fail to utilize payroll direct deposit for 365 days, at which time this agreement will expire. (C) The event of my death, at which time this agreement expires immediately, upon notification. This information is provided by me to facilitate my personal banking needs and shall be considered personal and held in confidence.

Home Mailing Address: ________________

City: ___________________________ State: ___________________________ ZIP: ___________

Home Telephone Number: ___________________________ Work Telephone Number: ___________________________

Email: ___________________________

Employing Agency: ___________________________

Signature: ___________________________ Date: ______/_____/______

I understand that while a change of enrollment is in process I may, in fact, receive a warrant instead of an electronic transfer.

If this is an initial enrollment or bank routing and/or account number change please attach a voided check or an official document from your financial institution showing the financial institution’s routing number and your account number.

I acknowledge that I have received and understand The fees associated with the PAYCARD.

A signed form must be on file with the employer.
Please mail the completed form to the address below

ATTENTION: Oklahoma State University
Payroll Services
409 Whitehurst
Stillwater, OK 74078
405-744-6372
Do not fill out or submit this form for change of Address or Name change.

1. Social Security Number
   Enter employee social security number.

2. Name
   Type or print employee name exactly as it appears on your account.

3. Type of Account
   Indicate whether your account is a checking or savings account or paycard. If paycard is selected see number 9.

4. Financial Institution Name
   Enter the name of the bank, savings and loan or credit union where your account is held, i.e.: Bank-One.

5. Financial Institution, City, State
   Enter the city and state of your financial institution.

6. Employing Agency
   Enter the name of the state agency you work for.

7. Signature and Date
   Sign and date the request form.  **NOTE**-A request form cannot be processed without your signature as authorization.

8. Voided Check
   For deposit to a checking account, attach to this request a **VOIDED** check from the financial institution of your choice so that we can use the information to make a proper deposit. For a deposit to a savings account, provide a document from your financial institution showing the financial institution’s routing number and your account number. **NOTE**-A request form cannot be processed without this information. Thank you.

9. Paycard
   If paycard is selected, place the following information in the Financial Institution box: Way 2 Go Card, Comerica Bank, ABA 072000096

**WHAT HAPPENS NEXT**

When your payroll, spending, and/or travel reimbursement is included in the Direct Deposit system, or the Paycard you will receive a Notice of Deposit instead of a warrant. The pay stub will not change, you will continue to receive a record of your earnings.

If you should have any problems, follow the procedures listed below:

1. Call your bank and ask for Commercial Direct Deposit Assistance. Advise them that you are on direct deposit through “ACH” (Automated Clearing House). If you still have problems, ask to speak to an Officer of the Bank, a Teller Supervisor or a Customer Service Representative. Write down the names of the people you talk to and the phone number you called.

2. **For Payroll Deposits**
   If you are not satisfied with the results for pay warrants, contact the payroll office of your employer, Direct Deposit Unit. You must have completed Step 1 before calling the Direct Deposit Unit. We will need the Phone Numbers and Names of the people you talked with at your bank.

3. **For Travel Deposits**
   If you are not satisfied with the results for travel warrants, contact your agency representative(s) who processes your travel claims.

4. **For Spending Account Deposits**
   If you are not satisfied with the results for spending account warrants, contact Spending Accounts Administration at the Employees Benefit Council (405) 232-1190.

5. **For Paycard Deposits**
   Contact [https://www.goprogram.com](https://www.goprogram.com) or 844-893-3121.

OPM-73 (1/18/06)
Voluntary Self-Identification of Disability

Why are you being asked to complete this form?

Because we do business with the government, we must reach out to, hire, and provide equal opportunity to qualified people with disabilities. To help us measure how well we are doing, we are asking you to tell us if you have a disability or if you ever had a disability. Completing this form is voluntary, but we hope that you will choose to fill it out. If you are applying for a job, any answer you give will be kept private and will not be used against you in any way.

If you already work for us, your answer will not be used against you in any way. Because a person may become disabled at any time, we are required to ask all of our employees to update their information every five years. You may voluntarily self-identify as having a disability on this form without fear of any punishment because you did not identify as having a disability earlier.

How do I know if I have a disability?

You are considered to have a disability if you have a physical or mental impairment or medical condition that substantially limits a major life activity, or if you have a history or record of such an impairment or medical condition.

Disabilities include, but are not limited to:

- Blindness
- Deafness
- Cancer
- Diabetes
- Epilepsy
- Autism
- Cerebral palsy
- HIV/AIDS
- Schizophrenia
- Muscular dystrophy
- Bipolar disorder
- Major depression
- Multiple sclerosis (MS)
- Missing limbs or partially missing limbs
- Post-traumatic stress disorder (PTSD)
- Obsessive compulsive disorder
- Impairments requiring the use of a wheelchair
- Intellectual disability (previously called mental retardation)

Please check one of the boxes below:

- YES, I HAVE A DISABILITY (or previously had a disability)
- NO, I DON’T HAVE A DISABILITY
- I DON’T WISH TO ANSWER
Federal law requires employers to provide reasonable accommodation to qualified individuals with disabilities. Please tell us if you require a reasonable accommodation to apply for a job or to perform your job. Examples of reasonable accommodation include making a change to the application process or work procedures, providing documents in an alternate format, using a sign language interpreter, or using specialized equipment.

Section 503 of the Rehabilitation Act of 1973, as amended. For more information about this form or the equal employment obligations of Federal contractors, visit the U.S. Department of Labor’s Office of Federal Contract Compliance Programs (OFCCP) website at www.dol.gov/ofccp.

PUBLIC BURDEN STATEMENT: According to the Paperwork Reduction Act of 1995 no persons are required to respond to a collection of information unless such collection displays a valid OMB control number. This survey should take about 5 minutes to complete.
As a Government contractor subject to the VEVRAA we are required to submit a report to the United States Department of Labor each year identifying the number of our employees belonging to each specified “protected veteran”. The following are definitions of “protected veterans”

1. A “disabled veteran” is one of the following:
   - a veteran of the U.S. military, ground, naval or air service who is entitled to compensation (or who but for the receipt of military retired pay would be entitled to compensation) under laws administered by the Secretary of Veterans Affairs; or
   - a person who was discharged or released from active duty because of a service-connected disability.

2. A “recently separated veteran” means any veteran during the three-year period beginning on the date of such veteran’s discharge or release from active duty in the U.S. military, ground, naval, or air service.

3. An “active duty wartime or campaign badge veteran” means a veteran who served on active duty in the U.S. military, ground, naval or air service during a war, or in a campaign or expedition for which a campaign badge has been authorized under the laws administered by the Department of Defense.

4. An “Armed forces service medal veteran” means a veteran who, while serving on active duty in the U.S. military, ground, naval or air service, participated in a United States military operation for which an Armed Forces service medal was awarded pursuant to Executive Order 12985.

I BELONG TO THE FOLLOWING CLASSIFICATIONS OF PROTECTED VETERANS (CHOOSE ALL THAT APPLY):

- [ ] DISABLED VETERAN
- [ ] RECENTLY SEPARATED VETERAN
- [ ] ACTIVE WARTIME OR CAMPAIGN BADGE VETERAN
- [ ] ARMED FORCES SERVICE MEDAL VETERAN
- [ ] I am a protected veteran, but I choose not to self-identify the classifications to which I belong.
- [ ] I am NOT a protected veteran.

Signature
Department
Date
Campus Telephone Number
If you are a disabled veteran it would assist us if you tell us whether there are accommodations we could make that would enable you to perform the essential functions of the job, including special equipment, changes in the physical layout of the job, changes in the way the job is customarily performed, provision of personal assistance services or other accommodations. This information will assist us in making reasonable accommodations for you disability.

Submission of this information is voluntary and refusal to provide it will not subject you to any adverse treatment. The information provided will be used only in ways that are not inconsistent with the Vietnam Era Veterans’ Readjustment Act of 1974, as amended.

The information you submit will be kept confidential, except that (i) supervisors and managers may be informed regarding restrictions on the work or duties of disabled veterans, and regarding necessary accommodations; (ii) first aid and safety personnel may be informed, when and to the extent appropriate, if you have a condition that might require emergency treatment; and (iii) Government officials engaged in enforcing laws administered by the Office of Federal Contract Compliance Programs, or enforcing the Americans with Disabilities Act, may be informed.
The Families First Coronavirus Response Act (FFCRA or Act) requires certain employers to provide their employees with paid sick leave and expanded family and medical leave for specified reasons related to COVID-19. These provisions will apply from April 1, 2020 through December 31, 2020.

▶ PAID LEAVE ENTITLEMENTS
Generally, employers covered under the Act must provide employees:
Up to two weeks (80 hours, or a part-time employee’s two-week equivalent) of paid sick leave based on the higher of their regular rate of pay, or the applicable state or Federal minimum wage, paid at:

- 100% for qualifying reasons #1-3 below, up to $511 daily and $5,110 total;
- 2/3 for qualifying reasons #4 and 6 below, up to $200 daily and $2,000 total; and
- Up to 12 weeks of paid sick leave and expanded family and medical leave paid at 2/3 for qualifying reason #5 below for up to $200 daily and $12,000 total.

A part-time employee is eligible for leave for the number of hours that the employee is normally scheduled to work over that period.

▶ ELIGIBLE EMPLOYEES
In general, employees of private sector employers with fewer than 500 employees, and certain public sector employers, are eligible for up to two weeks of fully or partially paid sick leave for COVID-19 related reasons (see below). Employees who have been employed for at least 30 days prior to their leave request may be eligible for up to an additional 10 weeks of partially paid expanded family and medical leave for reason #5 below.

▶ QUALIFYING REASONS FOR LEAVE RELATED TO COVID-19
An employee is entitled to take leave related to COVID-19 if the employee is unable to work, including unable to telework, because the employee:

| 1. is subject to a Federal, State, or local quarantine or isolation order related to COVID-19; | 5. is caring for his or her child whose school or place of care is closed (or child care provider is unavailable) due to COVID-19 related reasons; or |
| 2. has been advised by a health care provider to self-quarantine related to COVID-19; | 6. is experiencing any other substantially-similar condition specified by the U.S. Department of Health and Human Services; |
| 3. is experiencing COVID-19 symptoms and is seeking a medical diagnosis; | |
| 4. is caring for an individual subject to an order described in (1) or self-quarantine as described in (2); | |

▶ ENFORCEMENT
The U.S. Department of Labor’s Wage and Hour Division (WHD) has the authority to investigate and enforce compliance with the FFCRA. Employers may not discharge, discipline, or otherwise discriminate against any employee who lawfully takes paid sick leave or expanded family and medical leave under the FFCRA, files a complaint, or institutes a proceeding under or related to this Act. Employers in violation of the provisions of the FFCRA will be subject to penalties and enforcement by WHD.