



Employee Personal Profile

New Employee. Please complete this form and return to the office of Human Resources

Current or Previous Employee. (Please indicate your current or previous position) _____

Employee Information

Full Name: _____ Date of Birth: _____
Last First Middle Month Day Year

Social Security _____

Number: Address: _____
Street Address Apartment/Unit #

City State ZIP Code

Phone: _____ Email: _____ Gender: _____

Marital Status: Single Married Divorced Separated Other: _____

Ethnicity/Race (check all that apply): Are You Hispanic/Latino? Yes No

American Indian/Alaska Native Asian Black/African-American Native Hawaiian/Pacific Islander White

Are you a citizen of the United States? YES NO If no, are you authorized to work in the U.S.? YES NO

Are you a member of the Teacher's Retirement System of Alabama? YES NO Employment Date: _____

If yes, were you an active member on or before January 1, 2013? YES NO Division Assigned: _____

Active Member Retired Member Campus Assigned: _____

If you are a student, are you currently enrolled full-time? Yes No

Education

Highest Education Level: _____ Highest Degree and Major: _____

Date Acquired: _____ Institution Name: _____

Emergency Contact

Name: _____ Relationship: _____

Phone: _____

Annual W2 statements are setup to send electronically. If you would like to receive a paper copy **in addition** to the electronic copy please initial here: _____

Signature: _____ Date: _____



Employee's Withholding Tax Exemption Certificate

Every employee, on or before the date of commencement of employment, shall furnish his or her employer with a signed Alabama withholding exemption certificate relating to the number of withholding exemptions which he or she claims, which in no event shall exceed the number to which the employee is entitled. In the event the employee inflates the number of exemptions allowed by this Chapter on Form A4, the employee shall pay a penalty of five hundred dollars (\$500) for such action pursuant to Section 40-29-75.

Part I – To be completed by the employee

EMPLOYEE NAME _____ EMPLOYEE SOCIAL SECURITY NUMBER _____

STREET ADDRESS _____ CITY _____ STATE _____ ZIP CODE _____

HOW TO CLAIM YOUR WITHHOLDING EXEMPTIONS

1. If you claim no personal exemption for yourself and wish to withhold at the highest rate, write the figure "0", sign and date Form A4 and file it with your employer. _____
2. If you are SINGLE or MARRIED FILING SEPARATELY, a \$1,500 personal exemption is allowed.
Write the letter "S" if claiming the SINGLE exemption or "MS" if claiming the MARRIED FILING SEPARATELY exemption _____
3. If you are MARRIED or SINGLE CLAIMING HEAD OF FAMILY, a \$3,000 personal exemption is allowed.
Write the letter "M" if you are claiming an exemption for both yourself and your spouse or "H" if you are single with qualifying dependents and are claiming the HEAD OF FAMILY exemption _____
4. Number of dependents (other than spouse) that you will provide more than one-half of the support for during the year. *See dependent qualification below.* _____
5. Additional amount, if any, you want deducted each pay period. \$ _____
6. **This line to be completed by your employer:** Total exemptions (example: employee claims "M" on line 3 and "2" on line 4. Employer should use column M-2 (married with 2 dependents) in the withholding tables) _____

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

Employee's Signature _____ Date _____

Part II – To be completed by the employer

EMPLOYER NAME _____ EMPLOYER IDENTIFICATION NUMBER (EIN) _____

ADDRESS _____ CITY _____ STATE _____ ZIP CODE _____

Employers are required to keep this certificate on file. If the employee is believed to have claimed more exemption than legally entitled or claims 8 or more dependent exemptions, the employer should contact the Department at the following address or phone number for verification: Alabama Department of Revenue, Withholding Tax Section, P.O. Box 327480, Montgomery, AL 36132-7480, by phone at (334) 242-1300, or by fax at (334) 242-0112. If the employee does not qualify for the exemptions claimed upon verification, the employer is required to withhold at the highest rate until the employee submits a corrected Form A4 reflecting the proper exemption they are entitled to claim.

DEPENDENTS: To qualify as your dependent (Line 4 above), a person must receive more than one-half of his or her support from you for the year and must be related to you as follows:

- Your son or daughter (including legally adopted children), grandchild, stepson, stepdaughter, son-in-law, or daughter-in-law;
- Your father, mother, grandparent, stepfather, stepmother, father-in-law, or mother-in-law;
- Your brother, sister, stepbrother, stepsister, half-brother, half-sister, brother-in-law, or sister-in-law;
- Your uncle, aunt, nephew, or niece (but only if related by blood).

Employee's Withholding Certificate

Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay.
Give Form W-4 to your employer.
Your withholding is subject to review by the IRS.

2024

| | | | |
|---|---|-----------|--|
| Step 1: Enter Personal Information | (a) First name and middle initial | Last name | (b) Social security number |
| | Address | | Does your name match the name on your social security card? If not, to ensure you get credit for your earnings, contact SSA at 800-772-1213 or go to www.ssa.gov . |
| | City or town, state, and ZIP code | | |
| | (c) <input type="checkbox"/> Single or Married filing separately <input type="checkbox"/> Married filing jointly or Qualifying surviving spouse <input type="checkbox"/> Head of household (Check only if you're unmarried and pay more than half the costs of keeping up a home for yourself and a qualifying individual.) | | |

Complete Steps 2–4 ONLY if they apply to you; otherwise, skip to Step 5. See page 2 for more information on each step, who can claim exemption from withholding, and when to use the estimator at www.irs.gov/W4App.

Step 2: Multiple Jobs or Spouse Works

Complete this step if you (1) hold more than one job at a time, or (2) are married filing jointly and your spouse also works. The correct amount of withholding depends on income earned from all of these jobs.

Do **only one** of the following.

(a) Use the estimator at www.irs.gov/W4App for most accurate withholding for this step (and Steps 3–4). If you or your spouse have self-employment income, use this option; **or**

(b) Use the Multiple Jobs Worksheet on page 3 and enter the result in Step 4(c) below; **or**

(c) If there are only two jobs total, you may check this box. Do the same on Form W-4 for the other job. This option is generally more accurate than (b) if pay at the lower paying job is more than half of the pay at the higher paying job. Otherwise, (b) is more accurate

Complete Steps 3–4(b) on Form W-4 for only ONE of these jobs. Leave those steps blank for the other jobs. (Your withholding will be most accurate if you complete Steps 3–4(b) on the Form W-4 for the highest paying job.)

| | | | |
|--|--|-------------|----|
| Step 3: Claim Dependent and Other Credits | If your total income will be \$200,000 or less (\$400,000 or less if married filing jointly): Multiply the number of qualifying children under age 17 by \$2,000 \$ _____ Multiply the number of other dependents by \$500 \$ _____ Add the amounts above for qualifying children and other dependents. You may add to this the amount of any other credits. Enter the total here | 3 | \$ |
| Step 4 (optional): Other Adjustments | (a) Other income (not from jobs). If you want tax withheld for other income you expect this year that won't have withholding, enter the amount of other income here. This may include interest, dividends, and retirement income | 4(a) | \$ |
| | (b) Deductions. If you expect to claim deductions other than the standard deduction and want to reduce your withholding, use the Deductions Worksheet on page 3 and enter the result here | 4(b) | \$ |
| | (c) Extra withholding. Enter any additional tax you want withheld each pay period | 4(c) | \$ |

| | | | |
|------------------------------------|--|--|----------------------|
| Step 5: Sign Here | Under penalties of perjury, I declare that this certificate, to the best of my knowledge and belief, is true, correct, and complete. | | |
| | _____ Employee's signature (This form is not valid unless you sign it.) | | _____ Date |

| | | | |
|-----------------------|-----------------------------|--------------------------|--------------------------------------|
| Employers Only | Employer's name and address | First date of employment | Employer identification number (EIN) |
|-----------------------|-----------------------------|--------------------------|--------------------------------------|



Employment Eligibility Verification

Department of Homeland Security

U.S. Citizenship and Immigration Services

USCIS
Form I-9
OMB No.1615-0047
Expires 07/31/2026

START HERE: Employers must ensure the form instructions are available to employees when completing this form. Employers are liable for failing to comply with the requirements for completing this form. See below and the [Instructions](#).

ANTI-DISCRIMINATION NOTICE: All employees can choose which acceptable documentation to present for Form I-9. Employers cannot ask employees for documentation to verify information in **Section 1**, or specify which acceptable documentation employees must present for **Section 2** or Supplement B, Reverification and Rehire. Treating employees differently based on their citizenship, immigration status, or national origin may be illegal.

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

| | | | | | | |
|--|-----------------------------|---|----------------------------|---------------------------|--------------------------------|---|
| Last Name (Family Name) | | First Name (Given Name) | | Middle Initial (if any) | Other Last Names Used (if any) | |
| Address (Street Number and Name) | | | Apt. Number (if any) | City or Town | | State ZIP Code |
| Date of Birth (mm/dd/yyyy) | U.S. Social Security Number | | Employee's Email Address | | Employee's Telephone Number | |
| <p>I am aware that federal law provides for imprisonment and/or fines for false statements, or the use of false documents, in connection with the completion of this form. I attest, under penalty of perjury, that this information, including my selection of the box attesting to my citizenship or immigration status, is true and correct.</p> | | Check one of the following boxes to attest to your citizenship or immigration status (See page 2 and 3 of the instructions.): | | | | |
| | | <input type="checkbox"/> 1. A citizen of the United States | | | | |
| | | <input type="checkbox"/> 2. A noncitizen national of the United States (See Instructions.) | | | | |
| | | <input type="checkbox"/> 3. A lawful permanent resident (Enter USCIS or A-Number.) | | | | |
| <input type="checkbox"/> 4. A noncitizen (other than Item Numbers 2. and 3. above) authorized to work until (exp. date, if any) | | | | | | |
| If you check Item Number 4. , enter one of these: | | | | | | |
| USCIS A-Number | | OR | Form I-94 Admission Number | | OR | Foreign Passport Number and Country of Issuance |
| Signature of Employee | | | | Today's Date (mm/dd/yyyy) | | |

If a preparer and/or translator assisted you in completing Section 1, that person MUST complete the [Preparer and/or Translator Certification](#) on Page 3.

Section 2. Employer Review and Verification: Employers or their authorized representative must complete and sign **Section 2** within three business days after the employee's first day of employment, and must physically examine, or examine consistent with an alternative procedure authorized by the Secretary of DHS, documentation from List A OR a combination of documentation from List B and List C. Enter any additional documentation in the Additional Information box; see Instructions.

| | List A | OR | List B | AND | List C |
|---------------------------|--|----|--------|-----|--------|
| Document Title 1 | | | | | |
| Issuing Authority | | | | | |
| Document Number (if any) | | | | | |
| Expiration Date (if any) | | | | | |
| Document Title 2 (if any) | <p>Additional Information</p> <p>Check here if you used an alternative procedure authorized by DHS to examine documents.</p> | | | | |
| Issuing Authority | | | | | |
| Document Number (if any) | | | | | |
| Expiration Date (if any) | | | | | |
| Document Title 3 (if any) | | | | | |
| Issuing Authority | | | | | |
| Document Number (if any) | | | | | |
| Expiration Date (if any) | | | | | |

| | | |
|--|--|--|
| <p>Certification: I attest, under penalty of perjury, that (1) I have examined the documentation presented by the above-named employee, (2) the above-listed documentation appears 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.</p> | | First Day of Employment (mm/dd/yyyy): |
| Last Name, First Name and Title of Employer or Authorized Representative | | Signature of Employer or Authorized Representative |
| | | Today's Date (mm/dd/yyyy) |
| Employer's Business or Organization Name | | Employer's Business or Organization Address, City or Town, State, ZIP Code |

For reverification or rehire, complete [Supplement B, Reverification and Rehire](#) on Page 4.

LISTS OF ACCEPTABLE DOCUMENTS

All documents containing an expiration date must be unexpired.

* Documents extended by the issuing authority are considered unexpired.

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

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

| 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 |
|---|----|---|-----|---|
| <ol style="list-style-type: none"> 1. U.S. Passport or U.S. Passport Card 2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551) 3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa 4. Employment Authorization Document that contains a photograph (Form I-766) 5. For an individual temporarily authorized to work for a specific employer because of his or her status or parole: <ol style="list-style-type: none"> a. Foreign passport; and b. Form I-94 or Form I-94A that has the following: <ol style="list-style-type: none"> (1) The same name as the passport; and (2) An endorsement of the individual's status or parole 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. 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 | OR | <ol style="list-style-type: none"> 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 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. School ID card with a photograph 4. Voter's registration card 5. U.S. Military card or draft record 6. Military dependent's ID card 7. U.S. Coast Guard Merchant Mariner Card 8. Native American tribal document 9. Driver's license issued by a Canadian government authority <li style="text-align: center;">For persons under age 18 who are unable to present a document listed above: 10. School record or report card 11. Clinic, doctor, or hospital record 12. Day-care or nursery school record | AND | <ol style="list-style-type: none"> 1. A Social Security Account Number card, unless the card includes one of the following restrictions: <ol style="list-style-type: none"> (1) NOT VALID FOR EMPLOYMENT (2) VALID FOR WORK ONLY WITH INS AUTHORIZATION (3) VALID FOR WORK ONLY WITH DHS AUTHORIZATION 2. Certification of report of birth issued by the Department of State (Forms DS-1350, FS-545, FS-240) 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 4. Native American tribal document 5. U.S. Citizen ID Card (Form I-197) 6. Identification Card for Use of Resident Citizen in the United States (Form I-179) 7. Employment authorization document issued by the Department of Homeland Security <p style="margin-left: 20px;">For examples, see Section 7 and Section 13 of the M-274 on uscis.gov/i-9-central.</p> <p style="margin-left: 20px;">The Form I-766, Employment Authorization Document, is a List A, Item Number 4, document, not a List C document.</p> |
| <p>Acceptable Receipts</p> <p>May be presented in lieu of a document listed above for a temporary period.</p> <p>For receipt validity dates, see the M-274.</p> | | | | |
| <ul style="list-style-type: none"> • Receipt for a replacement of a lost, stolen, or damaged List A document. • Form I-94 issued to a lawful permanent resident that contains an I-551 stamp and a photograph of the individual. • Form I-94 with "RE" notation or refugee stamp issued to a refugee. | OR | <p>Receipt for a replacement of a lost, stolen, or damaged List B document.</p> | AND | <p>Receipt for a replacement of a lost, stolen, or damaged List C document.</p> |

*Refer to the Employment Authorization Extensions page on [I-9 Central](#) for more information.



Supplement A, Preparer and/or Translator Certification for Section 1

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

USCIS
Form I-9
Supplement A
OMB No. 1615-0047
Expires 07/31/2026

| | | |
|--|--|---|
| Last Name (<i>Family Name</i>) from Section 1 . | First Name (<i>Given Name</i>) from Section 1 . | Middle initial (if any) from Section 1 . |
|--|--|---|

Instructions: This supplement must be completed by any preparer and/or translator who assists an employee in completing Section 1 of Form I-9. The preparer and/or translator must enter the employee's name in the spaces provided above. Each preparer or translator must complete, sign, and date a separate certification area. Employers must retain completed supplement sheets with the employee's completed Form I-9.

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 | | Date (<i>mm/dd/yyyy</i>) | |
| Last Name (<i>Family Name</i>) | First Name (<i>Given Name</i>) | Middle Initial (<i>if any</i>) | |
| Address (<i>Street Number and Name</i>) | City or Town | State | ZIP Code |

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 | | Date (<i>mm/dd/yyyy</i>) | |
| Last Name (<i>Family Name</i>) | First Name (<i>Given Name</i>) | Middle Initial (<i>if any</i>) | |
| Address (<i>Street Number and Name</i>) | City or Town | State | ZIP Code |

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 | | Date (<i>mm/dd/yyyy</i>) | |
| Last Name (<i>Family Name</i>) | First Name (<i>Given Name</i>) | Middle Initial (<i>if any</i>) | |
| Address (<i>Street Number and Name</i>) | City or Town | State | ZIP Code |

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 | | Date (<i>mm/dd/yyyy</i>) | |
| Last Name (<i>Family Name</i>) | First Name (<i>Given Name</i>) | Middle Initial (<i>if any</i>) | |
| Address (<i>Street Number and Name</i>) | City or Town | State | ZIP Code |



Supplement B, Reverification and Rehire (formerly Section 3)

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

**USCIS
Form I-9
Supplement B**
OMB No. 1615-0047
Expires 07/31/2026

| | | |
|--|--|---|
| Last Name (<i>Family Name</i>) from Section 1. | First Name (<i>Given Name</i>) from Section 1. | Middle initial (if any) from Section 1. |
|--|--|---|

Instructions: This supplement replaces Section 3 on the previous version of Form I-9. Only use this page if your employee requires reverification, is rehired within three years of the date the original Form I-9 was completed, or provides proof of a legal name change. Enter the employee's name in the fields above. Use a new section for each reverification or rehire. Review the Form I-9 instructions before completing this page. Keep this page as part of the employee's Form I-9 record. Additional guidance can be found in the [Handbook for Employers: Guidance for Completing Form I-9 \(M-274\)](#)

| Date of Rehire (<i>if applicable</i>) | New Name (<i>if applicable</i>) | | |
|---|-----------------------------------|-------------------------|----------------|
| Date (<i>mm/dd/yyyy</i>) | Last Name (Family Name) | First Name (Given Name) | Middle Initial |

Reverification: If the employee requires reverification, your employee can choose to present any acceptable List A or List C documentation to show continued employment authorization. Enter the document information in the spaces below.

| | | |
|----------------|--------------------------|--|
| Document Title | Document Number (if any) | Expiration Date (if any) (<i>mm/dd/yyyy</i>) |
|----------------|--------------------------|--|

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 documentation, the documentation I examined appears to be genuine and to relate to the individual who presented it.

| | | |
|---|--|------------------------------------|
| Name of Employer or Authorized Representative | Signature of Employer or Authorized Representative | Today's Date (<i>mm/dd/yyyy</i>) |
|---|--|------------------------------------|

| | |
|--|---|
| Additional Information (Initial and date each notation.) | Check here if you used an alternative procedure authorized by DHS to examine documents. |
|--|---|

| Date of Rehire (<i>if applicable</i>) | New Name (<i>if applicable</i>) | | |
|---|-----------------------------------|-------------------------|----------------|
| Date (<i>mm/dd/yyyy</i>) | Last Name (Family Name) | First Name (Given Name) | Middle Initial |

Reverification: If the employee requires reverification, your employee can choose to present any acceptable List A or List C documentation to show continued employment authorization. Enter the document information in the spaces below.

| | | |
|----------------|--------------------------|--|
| Document Title | Document Number (if any) | Expiration Date (if any) (<i>mm/dd/yyyy</i>) |
|----------------|--------------------------|--|

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 documentation, the documentation I examined appears to be genuine and to relate to the individual who presented it.

| | | |
|---|--|------------------------------------|
| Name of Employer or Authorized Representative | Signature of Employer or Authorized Representative | Today's Date (<i>mm/dd/yyyy</i>) |
|---|--|------------------------------------|

| | |
|--|---|
| Additional Information (Initial and date each notation.) | Check here if you used an alternative procedure authorized by DHS to examine documents. |
|--|---|

| Date of Rehire (<i>if applicable</i>) | New Name (<i>if applicable</i>) | | |
|---|-----------------------------------|-------------------------|----------------|
| Date (<i>mm/dd/yyyy</i>) | Last Name (Family Name) | First Name (Given Name) | Middle Initial |

Reverification: If the employee requires reverification, your employee can choose to present any acceptable List A or List C documentation to show continued employment authorization. Enter the document information in the spaces below.

| | | |
|----------------|--------------------------|--|
| Document Title | Document Number (if any) | Expiration Date (if any) (<i>mm/dd/yyyy</i>) |
|----------------|--------------------------|--|

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 documentation, the documentation I examined appears to be genuine and to relate to the individual who presented it.

| | | |
|---|--|------------------------------------|
| Name of Employer or Authorized Representative | Signature of Employer or Authorized Representative | Today's Date (<i>mm/dd/yyyy</i>) |
|---|--|------------------------------------|

| | |
|--|---|
| Additional Information (Initial and date each notation.) | Check here if you used an alternative procedure authorized by DHS to examine documents. |
|--|---|

Direct Deposit Authorization Agreement

GADSDEN STATE COMMUNITY COLLEGE

I hereby authorize Gadsden State Community College, to initiate credit entries and to initiate, if necessary, debit entries and adjustments for any credit entries in error to my account indicated below and the bank named below, to credit and debit the same entries to such account. ****Note: To ensure that your check is deposited into the correct account – notify Payroll if you currently have direct deposit.**

BANK NAME: _____

CITY: _____ **STATE:** _____

Account Type: _____ **Checking** _____ **Savings**

ACCOUNT NUMBER: _____

BANK TRANSIT NO: _____

This authority is to remain in full force and effect until Gadsden State Community College has received written notification from me on its termination in such time and in such manner as to afford Gadsden State Community College a reasonable time to act on it.

NAME: (print) _____

SSN/G#: _____

SIGNATURE: _____

DATE: _____

EMAIL ADDRESS: _____

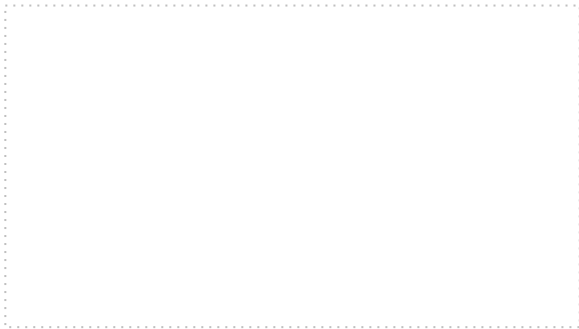
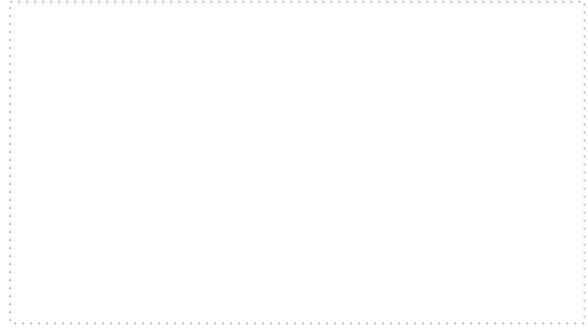
****All direct deposit stubs will be sent via email****

ATTACH VOIDED BLANK CHECK

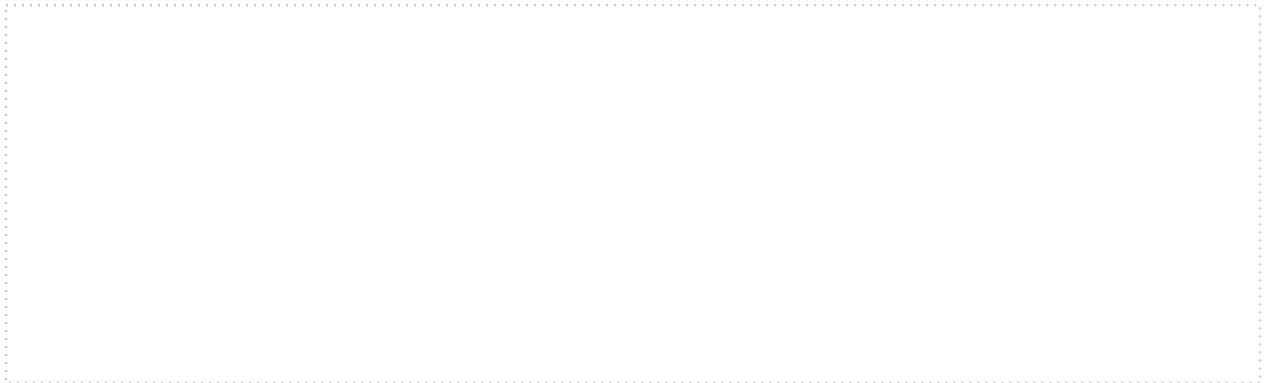
OR

Letter from bank verifying the correct routing and account number

Insert your forms of identification from the I-9 form here:

A large, empty rectangular box with a dotted border, intended for the first form of identification from the I-9 form.A large, empty rectangular box with a dotted border, intended for the second form of identification from the I-9 form.

Insert voided check or a statement on letterhead from your bank verifying your routing information:

A large, empty rectangular box with a dotted border, intended for a voided check or a bank statement on letterhead verifying routing information.



CARDINAL ALERT



Cardinal Alert is an emergency notification service that will allow us to contact all enrolled students and employees via cell phone, text message, home phone, and e-mail. Please provide the below information to be set up as a user.

First Name

Last Name

Campus

A #

Contact Info
Home Phone

Cell Phone

Email

GADSDEN STATE COMMUNITY COLLEGE FAMILY RELATIONSHIP DISCLOSURE FORM

Employee's Name: _____

Job Title/Position: _____

Employment Date: _____ Full-Time Part-Time

Salary Schedule: _____ Rank: _____ Step: _____ Annual Salary: _____

For purposes of this disclosure, relative includes any person related within the fourth degree of affinity or consanguinity to any job, position, or office of profit with the state or with any of its agencies.

Are you a relative of any employee of the Alabama Community College System or any member of the Alabama Community College System Board of Trustees?

Yes No

If yes, list the name(s), relationship, and employer or the position of the relative(s)

My signature below affirms that all information contained herein is correct to the best of my knowledge.

Employee's Name Printed

Employee's Signature

Date

Gadsden State Community College
Student Records Access Form

Employee Name: _____
Last Name First Name Middle Initial

Social Security Number: _____

Job Title: _____ Department: _____

Please read, sign, and date the bottom of this form and return to the Human Resources Office. This form must be returned before a contract and/or paycheck is processed.

FERPA (Confidentiality Statement)

Along with the right to access the transcripts and records of students at Gadsden State Community College comes the responsibility to maintain the rights of students, particularly as outlined in the Family Educational Rights and Privacy Act (FERPA). The College Catalog, Semester Schedule Bulletins, and Faculty/Staff Handbook state the policy regarding student records at Gadsden State Community College. Student records are open to members of the faculty and staff who have a legitimate need to know their contents; however, you do have a responsibility to maintain confidentiality. Under the terms of FERPA, Gadsden State Community College has established the following items as directory information: *student's name, address, telephone number, date of birth, and major fields of study, as well as information about students' participation in officially recognized activities and sports, the weight and height of members of athletic teams, the dates of attendance by students, degrees and awards received, and the most recent previous educational agency or institution attended by a student.* No other information may be released without written consent of the student. Grades, Social Security Numbers, Race, Ethnicity, and Student Schedules must not be released to anyone other than the student under discussion and never over the telephone or by e-mail.

All paperwork containing personally identifiable information and is not part of the students' official records, must be disposed of in a safe and timely manner. It is recommended that all personally identifiable information not part of the educational record be shredded. Please refer questions to the Office of the Registrar (256) 549-8263.

I have read the above and agree to maintain the confidentiality of student records. I understand that failure to maintain such confidentiality may be a violation of State Board of Education policy and Federal Law.

Employee Signature

Date

Gadsden State Community College

Email Monitoring

GSCC may monitor all information stored, transmitted, received, or contained in the College email systems. Workplace files, internet use, and email may be monitored by the College. Information flowing through or stored on computers within the network is not considered confidential and is subject to monitoring by network administrators.

Computer Hardware/Software

Any personally-owned computing property or peripheral equipment (including wireless devices) brought to the College cannot be connected to the College network without the approval of the employee's Supervisor and Computer Services. Personally-owned software cannot be loaded onto a College-owned computer unless it is directly related to the job position and is approved by the Supervisor. If any approved personally-owned computer software is loaded onto a College-owned computer, the license and documents must remain with the College computer on campus in the event of an audit. Computer software may be audited by Computer Services and others.

I have read, understand, and will fully comply with the above policies on computer usage at Gadsden State Community College.

Employee

Date

Please print name: _____



GADSDEN STATE

COMMUNITY COLLEGE

P. O. Box 227, Gadsden, AL 35902-0227

www.gadsdenstate.edu

Memorandum

TO: All Employees

FROM: Kevin L. Willoughby, M.Ed., SHRM-CP
Director of Human Resources

SUBJECT: Harassment and Discrimination Policy
ACCS Board of Trustee's Policy on Harassment

DATE: May 17, 2022

All employees are required to read and acknowledge receipt of the College's Policy against Harassment and Discrimination and the ACCS Board of Trustee's Policy on Harassment; copies of the policies are attached. The Policy against Harassment and Discrimination can be found on the College's website and in the Employee Handbook. For more information on the ACCS Board of Trustee's Policy on Harassment, please access the Alabama Community College System's website at www.accs.cc.

Please read the policies and return the signed form to Human Resources.

I acknowledge receipt of the College's Policy against Harassment and Discrimination and the ACCS Board of Trustee's Policy on Harassment. I also acknowledge that I have read and understand the contents of both policies.

Name (print)

Position

Signature

Date

I have read, understand, and will fully comply with the Conflict of Interest and Ethics Policy and Procedure.

Employee's Name (Please Print)

Employee's Signature

Date

This policy cannot regulate or eliminate all situations of conflict of interest, but is intended to enable faculty and staff to recognize situations that raise an appearance of impropriety and to ensure that such situations are properly reviewed and resolved. All GSCC employees must disclose actual or perceived conflicts so that they can be managed appropriately. Disclosure will not necessarily restrict or preclude an individual's activities. In most cases, problems arise when the conflict is not disclosed, or when it is not assessed or managed.

Information Security Awareness for New Gadsden State Community College Employees

What is Information Security?

Information Security (InfoSec) is the prevention of unauthorized access, use, disclosure, disruption, modification, inspection, recording or destruction of information.

Please note that InfoSec is concerned with all forms of data, not just electronic data.

_____ *(Please initial here to indicate that you understand the above)*

Why is Gadsden State concerned about Information Security?

Gadsden State is concerned about InfoSec because we recognize the extreme value of the data we are entrusted with. Additionally, we recognize that the modern cyber-landscape is not a friendly place for lax security. We also strive to adopt best practices and be the best stewards of institutional data we can be. Lastly, adequate InfoSec policy and procedures are mandated by the federal government and is essential for Gadsden State to keep Title IV federal financial aid.

_____ *(Please initial here to indicate that you understand the above)*

What type of threats is Gadsden State vulnerable to?

Internally, Gadsden State is vulnerable to threats such as unsecured work areas, unsecured portable devices, and lax enforcement of established policies.

Externally, Gadsden State is vulnerable to threats such as cyber-attacks, malware (spyware, ransomware, etc.), and social engineering.

_____ *(Please initial here to indicate that you understand the above)*

What is Social Engineering?

Social Engineering involves the use of deception to manipulate individuals into divulging confidential or personal information that may be used for fraudulent purposes.

Social Engineering is viewed as a major threat to InfoSec at Gadsden State. To protect yourself, and Gadsden State, from social engineering remember the following:

1. Stay aware and educate yourself. The most important step you can take is to keep yourself educated about different types of social engineering threats. Participate in InfoSec-related professional development and other InfoSec related presentations.
2. Determine if the person requesting information from you is authorized to have access to that information. A common tactic is to put someone on the spot by creating a sense of urgency or importance. Know that the ITS Helpdesk will never contact you to ask for any passwords. Also,

do not respond to any unsolicited emails asking you to update your login information. The Gadsden State Information Technology Services department will never call, or send out an email, asking for login information. In the rare occurrence that the College should ever have to ask you to divulge Gadsden State credentials, it is a requirement that you **must** confirm the legitimacy of the request with your direct supervisor.

3. Understand that you have a responsibility for the data you use. As a steward of GSCC data, you are responsible for the data you handle in your day-to-day duties. You must ensure that any data you are entrusted with remains secure.

_____ (Please initial here to indicate that you understand the above)

What do I do if there is a data breach?

Data breaches must be reported.

Any known or suspected data breach must be reported to the GSCC information security assurance team to initiate an appropriate investigation. The preferred method is to email infosec@gadsdenstate.edu. A response will be sent confirming receipt of the notice. During normal business hours, the incident may alternatively be reported to the IT Help Desk by calling 256-549-8341.

It is in your best interest to report a data breach even if you are at fault. The damage from a data breach can be mitigated much more easily if little time has passed. The longer the data has been exposed the harder it is to determine who has accessed the data.

_____ (Please initial here to indicate that you understand the above)

What is my part in InfoSec?

1. Educate yourself and stay aware of threats to InfoSec.
2. Comply with existing policy (some relevant policies found in the employee handbook are; F-8.3 Computer Use and Internet Access, M-1.11 Sensitive Data Policy, and M-1.12 Data Breach Policy).
3. Be aware that Gadsden State is involved in an ongoing process to define and refine policies and procedures related to Information Security. Changes to our processes may occur at any time. Your cooperation is appreciated, and required.

_____ (Please initial here to indicate that you understand the above)

I acknowledge I have read and understand this Information Security Awareness document

Signature _____ **Date** _____

As Employees of Gadsden State Community College, We are Fully Committed to Making our Students our First Priority. Our values are:

Student Centric

We have a primary focus on our students and will ensure they have a positive collegiate experience and are prepared for career success.

Commitment to Learning

We are lifelong learners acquiring knowledge and skills and seeking opportunities to collaborate as we grow and contribute to the greater good of all.

Integrity

We will adhere to moral and ethical principles because character matters.

Customer Service

We will respect, support and assist our students and colleagues as we all learn and grow together.

Excellence

We are a distinguished college, supported by accomplished personnel, focused on graduating exemplary students who will make an exceptional difference in our world.

Employees are the heart of our organization and the facilitators of student success. The impact an employee has on a student – or not – is reflected in our enrollment, retention, and completion outcome measures.

These value statements reflect our beliefs about organizational/individual behavior and must be demonstrated by each employee as a whole – thereby, making it impossible to commit to some values but not others. Peer accountability is essential to ensure that these values dictate how we interact with others and how we perform our duties. Any variance shall be discussed with the employee to ensure there is a full understanding of the expectations of “how we conduct business.”

Each employee is asked to affirm his/her commitment to our values and to doing everything possible to assist a student in being successful at Gadsden State!

Employee Signature

Date

ETHICS TRAINING

All employees (Full-Time and Part-Time) are required to complete Ethics Training.

- Go directly to the Alabama Ethics Commission website at www.ethics.alabama.gov.

- Click on the Education tab, then scroll down to Training Video. Click on Ethics Training Video.

At the end, complete the form and print a certificate. Please send a copy of the certificate to the Office of Human Resources with your onboarding packet to the dropbox link. Or take a screenshot at the end and email to jobs@gadsdenstate.edu.

Kevin Willoughby
Director of Human Resources
Gadsden State Community College
P. O. Box 227
Gadsden, AL 35902-0227
256-549-8236
kwilloughby@gadsdenstate.edu



ONLINE HARASSMENT PREVENTION TRAINING

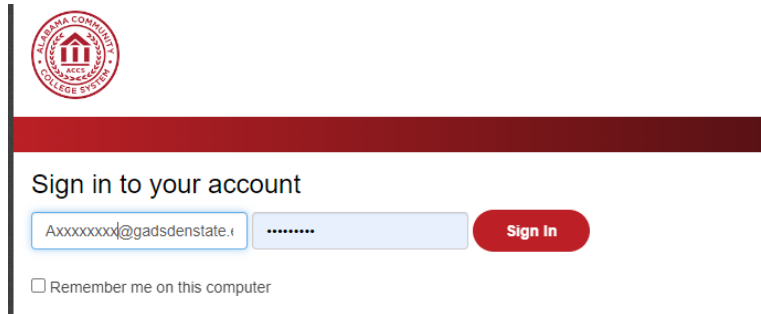
As part of our awareness and prevention programs for faculty and staff, Gadsden State Community College requires you to complete the online Harassment Prevention for Employees training course.

To access this training course:

NEOED Learn log-in information.

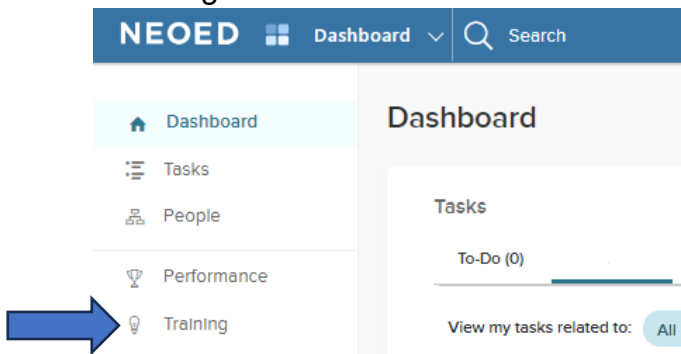
Step 1. Click the following link: <https://login.neoed.com/authentication/saml/login/accs>

You will be routed to a screen that looks like this:



Step 2. Use your Single Sign-on (SSO). This is your Axxxxxxx@gadsdenstate.edu username and password. This should be the same password you use for Banner, Outlook and other Gadsden State sign-on platforms.

Step 3. You will be directed to the NEOED Dashboard, and you should see the following screen:



Step 4: Click on Training and the Task/Training Course will be available to begin.

Note: All employees are required to complete on-line harassment and discrimination training within 30 days of the first day of employment. The online training will be assigned through NeoEd Learn after you attend orientation. (You won't have access to this website until after you start work)



Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 12-31-2026)

PART A: General Information

Even if you are offered health coverage through your employment, you may have other coverage options through the Health Insurance Marketplace ("Marketplace"). To assist you as you evaluate options for you and your family, this notice provides some basic information about the Health Insurance Marketplace and health coverage offered through your employment.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options in your geographic area.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium and other out-of-pocket costs, but only if your employer does not offer coverage, or offers coverage that is not considered affordable for you and doesn't meet certain minimum value standards (discussed below). The savings that you're eligible for depends on your household income. You may also be eligible for a tax credit that lowers your costs.

Does Employment-Based Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that is considered affordable for you and meets certain minimum value standards, you will not be eligible for a tax credit, or advance payment of the tax credit, for your Marketplace coverage and may wish to enroll in your employment-based health plan. However, you may be eligible for a tax credit, and advance payments of the credit that lowers your monthly premium, or a reduction in certain cost-sharing, if your employer does not offer coverage to you at all or does not offer coverage that is considered affordable for you or meet minimum value standards. If your share of the premium cost of all plans offered to you through your employment is more than 9.12%¹ of your annual household income, or if the coverage through your employment does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit, and advance payment of the credit, if you do not enroll in the employment-based health coverage. For family members of the employee, coverage is considered affordable if the employee's cost of premiums for the lowest-cost plan that would cover all family members does not exceed 9.12% of the employee's household income.^{1,2}

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered through your employment, then you may lose access to whatever the employer contributes to the employment-based coverage. Also, this employer contribution -as well as your employee contribution to employment-based coverage- is generally excluded from income for federal and state income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis. In addition, note that if the health coverage offered through your employment does not meet the affordability or minimum value standards, but you accept that coverage anyway, you will not be eligible for a tax credit. You should consider all of these factors in determining whether to purchase a health plan through the Marketplace.

¹ Indexed annually; see <https://www.irs.gov/pub/irs-drop/rp-22-34.pdf> for 2023.

² An employer-sponsored or other employment-based health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs. For purposes of eligibility for the premium tax credit, to meet the "minimum value standard," the health plan must also provide substantial coverage of both inpatient hospital services and physician services.

When Can I Enroll in Health Insurance Coverage through the Marketplace?

You can enroll in a Marketplace health insurance plan during the annual Marketplace Open Enrollment Period. Open Enrollment varies by state but generally starts November 1 and continues through at least December 15.

Outside the annual Open Enrollment Period, you can sign up for health insurance if you qualify for a Special Enrollment Period. In general, you qualify for a Special Enrollment Period if you've had certain qualifying life events, such as getting married, having a baby, adopting a child, or losing eligibility for other health coverage. Depending on your Special Enrollment Period type, you may have 60 days before or 60 days following the qualifying life event to enroll in a Marketplace plan.

There is also a Marketplace Special Enrollment Period for individuals and their families who lose eligibility for Medicaid or Children's Health Insurance Program (CHIP) coverage on or after March 31, 2023, through July 31, 2024. Since the onset of the nationwide COVID-19 public health emergency, state Medicaid and CHIP agencies generally have not terminated the enrollment of any Medicaid or CHIP beneficiary who was enrolled on or after March 18, 2020, through March 31, 2023. As state Medicaid and CHIP agencies resume regular eligibility and enrollment practices, many individuals may no longer be eligible for Medicaid or CHIP coverage starting as early as March 31, 2023. The U.S. Department of Health and Human Services is offering a temporary Marketplace Special Enrollment period to allow these individuals to enroll in Marketplace coverage.

Marketplace-eligible individuals who live in states served by HealthCare.gov and either- submit a new application or update an existing application on HealthCare.gov between March 31, 2023 and July 31, 2024, and attest to a termination date of Medicaid or CHIP coverage within the same time period, are eligible for a 60-day Special Enrollment Period. **That means that if you lose Medicaid or CHIP coverage between March 31, 2023, and July 31, 2024, you may be able to enroll in Marketplace coverage within 60 days of when you lost Medicaid or CHIP coverage.** In addition, if you or your family members are enrolled in Medicaid or CHIP coverage, it is important to make sure that your contact information is up to date to make sure you get any information about changes to your eligibility. To learn more, visit HealthCare.gov or call the Marketplace Call Center at 1-800-318-2596. TTY users can call 1-855-889-4325.

What about Alternatives to Marketplace Health Insurance Coverage?

If you or your family are eligible for coverage in an employment-based health plan (such as an employer-sponsored health plan), you or your family may also be eligible for a Special Enrollment Period to enroll in that health plan in certain circumstances, including if you or your dependents were enrolled in Medicaid or CHIP coverage and lost that coverage. Generally, you have 60 days after the loss of Medicaid or CHIP coverage to enroll in an employment-based health plan, but if you and your family lost eligibility for Medicaid or CHIP coverage between March 31, 2023 and July 10, 2023, you can request this special enrollment in the employment-based health plan through September 8, 2023. Confirm the deadline with your employer or your employment-based health plan.

Alternatively, you can enroll in Medicaid or CHIP coverage at any time by filling out an application through the Marketplace or applying directly through your state Medicaid agency. Visit <https://www.healthcare.gov/medicaid-chip/getting-medicaid-chip/> for more details.

How Can I Get More Information?

For more information about your coverage offered through your employment, please check your health plan's summary plan description or contact

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

PART B: Information About Health Coverage Offered by Your Employer

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

| | | | |
|--|----------------|---|--|
| 3. Employer name Gadsden State Community College | | 4. Employer Identification Number (EIN) 63-0501425 | |
| 5. Employer address PO Box 227 | | 6. Employer phone number 256.549.8236 | |
| 7. City Gadsden | 8. State AL | 9. ZIP code 35902 | |
| 10. Who can we contact about employee health coverage at this job? Public Education Employees' Health Insurance Plan (PEEHIP) | | | |
| 11. Phone number (if different from above) 1-877-517-0020 | | 12. Email address peehipinfo@rsa-al.gov | |

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

- As your employer, we offer a health plan to:
 All employees. Eligible employees are:

- Some employees. Eligible employees are:

Full-time employees and permanent part-time employees employed in any public institution of education within the state of Alabama that provides instruction for any combination of grades K-14 exclusively, under the auspices of the State Board of Education. A permanent part-time employee must agree to payroll deduction for a pro-rata portion of the premium cost for a full-time employee based on the percentage of time the permanent part-time worked is employed.

- With respect to dependents:

- We do offer coverage. Eligible dependents are:

An employee's spouse as defined by Alabama law to whom the employee is currently and legally married (excludes divorced or common-law spouses).

A child under the age of 26 who is the employee's biological child, legally adopted child, stepchild, or foster child placed with the employee by an authorized placement agency or by judgment, decree, or other order of any court of competent jurisdiction. Any other children such as a grandchild, must meet the same requirements as a foster child.

A dependent child of any age incapable of self-sustaining employment because of a physical or mental handicap and is chiefly dependent on the employee for support. The handicap must have existed prior to the time the child attained age 26 and was covered as a dependent on the employee's PEEHIP policy before age 26.

- We do not offer coverage.

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

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

If you decide to shop for coverage in the Marketplace, [HealthCare.gov](https://www.healthcare.gov) will guide you through the process. Here's the employer information you'll enter when you visit [HealthCare.gov](https://www.healthcare.gov) to find out if you can get a tax credit to lower your monthly premiums.

The information below corresponds to the Marketplace Employer Coverage Tool. Completing this section is optional for employers, but will help ensure employees understand their coverage choices.

13. Is the employee currently eligible for coverage offered by this employer, or will the employee be eligible in the next 3 months?

Yes (Continue)

13a. If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage? _____ (mm/dd/yyyy) (Continue)

No (STOP and return this form to employee)

14. Does the employer offer a health plan that meets the minimum value standard*?

Yes (Go to question 15) No (STOP and return form to employee)

15. For the lowest-cost plan that meets the minimum value standard* offered only to the employee (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/ she received the maximum discount for any tobacco cessation programs, and didn't receive any other discounts based on wellness programs.

a. How much would the employee have to pay in premiums for this plan? \$ _____
b. How often? Weekly Every 2 weeks Twice a month Monthly Quarterly Yearly

If the plan year will end soon and you know that the health plans offered will change, go to question 16. If you don't know, STOP and return form to employee.

16. What change will the employer make for the new plan year? _____

Employer won't offer health coverage

Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)

a. How much would the employee have to pay in premiums for this plan? \$ _____
b. How often? Weekly Every 2 weeks Twice a month Monthly Quarterly Yearly

* An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)