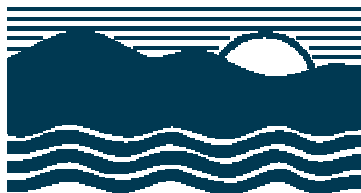


UMCES@work

Orientation Manual

Regular, Faculty

(Faculty, tenured; faculty, non tenured, on track; faculty, non tenured, term contract; faculty, non tenured continuing contract)



University of Maryland
CENTER FOR ENVIRONMENTAL SCIENCE

Introduction

On behalf of the Office of Human Resources, welcome aboard and we hope you enjoy your employment here at the University of Maryland Center for Environmental Science (UMCES). As a regular, faculty member at UMCES, you are entitled to a variety of benefits offered by the State of Maryland, provided that the employee completes the UMCES "New Hire" process. This packet will guide you through this process. Please also visit the UMCES Intranet at <http://www.umces.edu> under "MY UMCES," for access to the UMCES policies and procedures, employee benefits, leave accrual, probation, etc.

If you are viewing this booklet online, you may type in the fields requiring data.

Please read this packet carefully and take note of any time-restricted enrollment of benefits. If you have any questions, please contact either your local Benefits Coordinator (see below) or the Office of Human Resources at 410-221-2017.

UMCES site HR Contacts:

Appalachian Laboratory: Paulette Orndorff
301-689-7102
orndorff@al.umces.edu

Horn Point Laboratory: Patricia Dekker
410-221-8404
dekker@hpl.umces.edu

Chesapeake Biological Laboratory: Janis King
410-326-7263
jking@cbl.umces.edu

Sea Grant College: Theresa Lee
301-405-6385
lee@mdsg.umd.edu

Section 1:

Overview of Employment

Overview of Employment

This booklet has been provided to you by the Office of Human Resources as a brief orientation to your employment at UMCES.

All of the forms included in and with this packet need to be completed and returned to your Benefits Coordinator within 3-5 business days to ensure proper processing of your paycheck and enrollment in benefits. Any questions regarding this booklet should be directed either to your local Benefits Coordinator or the Office of Human Resources at 410-221-2017.

UMCES Policy numbers for rank and promotion of faculty and support faculty is on the next page. Access to the policies is only available via the UMCES Intranet. If you would like [a copy of the policy](#) prior to the start of your appointment, please contact your local Benefits Coordinator.

Section 2:

Leave Policies

Leave Policies

The maintenance of good attendance helps an employee build and maintain a reputation of dependability and responsibility. In addition, it merits consideration when reviewing applicants for promotional opportunities. Good leave management is one sign of a responsible employee. You are expected to maintain good attendance and to be punctual upon arriving and leaving work. Leave requests must be approved in advance, and whenever it is necessary for you to be late or absent due to illness or emergency, it is your responsibility to notify your supervisor prior to the start of your scheduled work shift to explain the reason and to state when you expect to report to work. You should ask your supervisor for specific procedures to be followed in your work unit. All regular faculty appointed on at least a 50 per cent of full-time basis are eligible to earn leave with pay, including annual leave, sick leave, personal leave, and holidays, pro-rated to your %FTE.

Annual Leave

Full time, regular, faculty appointees earn 22 days of annual leave each year at a rate of six hours and 46 minutes per pay period. Once a regular, faculty member reaches 20 years of service, their annual leave increases to 25 days. Annual leave for part-time faculty working 50% or more of full-time is earned proportionate to the percentage of their employment. Annual leave may be accumulated, but only a maximum of 50 workdays may be carried into a new calendar year. A regular, faculty member leaving employment in the University System of Maryland is entitled to compensation for any unused annual leave that has been credited and available for use as of the date of separation.

Personal Leave

Regular, faculty members are entitled to receive up to three days of personal leave each calendar year. The use of personal leave is also subject to supervisory approval, but it cannot be denied if it is requested for the observance of a religious holiday. Personal leave cannot be accrued, is lost at the end of each calendar year, and will not be paid at separation. At the end of each calendar year, unused personal leave will be contributed to the System Leave Reserve Fund.

Sick Leave

Sick leave is accrued at the rate of 15 days per year, and may be accumulated without limitation. It is an extremely valuable privilege intended to provide continuation of income when you are physically unable to work, including incapacity due to pregnancy. It is not intended to be used as a substitute for Annual or Personal Leave, but rather as an insurance policy that increases in value as it is earned. Upon retirement, an additional month of service credit is provided for each 22 days of unused sick leave for members of the State Retirement and Pension System plans. Sick leave of five or more consecutive days requires the submission of written medical documentation to your supervisor, and the University reserves the right to require an independent medical evaluation to determine your physical or mental ability for continued employment. The University monitors the use of sick leave by employees, and employees whose use of the benefit appears excessive may be required to provide medical documentation for each future occasion, regardless of duration. In addition to cases of physical disability, sick leave is also available for required physician appointments and hospital visits, to care for an immediate family member during a severe illness, and for use in the event of a death in the employee's immediate family. Specific regulations regarding the use of sick leave will be explained during your orientation.

Holidays

University employees receive 14 paid holidays per year, and 15 during years of a general or congressional election. Holiday schedules are generally available at the beginning of each new calendar year. The University schedules the observance of certain holidays on days other than the date of occurrence; you must work the calendar date of the holiday to earn the later observance date. In addition, you must work your last scheduled day before and your first scheduled day after the observance date to receive the holiday pay. If you are required to work on a holiday's observance date, you will be granted the holiday on a different day.

Family and Medical Leave

You may be eligible for up to 12 weeks of paid or unpaid, job-protected leave for certain family and medical reasons. If the leave is unpaid,

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provisions may be made to insure continuation of health care coverage. For further information on this, or any other specific questions regarding such leave should be directed to the Director of Human Resources.

Other Available Leave

You may be eligible for other types of paid and/or unpaid leave; including advanced and extended sick leave; leave reserve fund; military leave, jury leave, and subpoena leave; and leave without pay. Specific questions regarding such leave may be directed to the Director of Office of Human Resources.

Section 3:

Overview of Benefits

Overview of Benefits

Retirement

Two types of employer-subsidized pension plans are available to faculty members on regular appointments: the Maryland State Teacher's Pension Program and the Optional Retirement Plan (ORP). Employees make a 2% contribution to the State Pension plan and the State make a 5.25% contribution, for a total of 7.25% contribution of your annual salary. For the ORP, the State contributes the full 7.25% to the employee's ORP account. The State Pension Plan offers many benefits that the ORP does not, such as disability retirement and death benefits. A brochure published by the State Retirement and Pension System entitled "Choosing a Retirement Program" is available at your local HR office with additional descriptions of each plan, along with a comparison of both. The ORP vendors include TIAA CREF, AIG-Valic, and Fidelity. Enrollment forms for all retirement plans must be obtained at your local Benefits Coordinator.

Supplemental Retirement Annuities

Supplemental retirement annuities (SRA) let you put aside extra savings above and beyond the contributions being made to your regular pension plan. Contributions and earnings remain tax-deferred until the money is withdrawn. Contributions are made with pre-tax dollars, lowering your taxable income and therefore your current tax bill. Participation is voluntary, and no contribution is made by the University. Information and Enrollment materials may be obtained from your local Benefits Coordinator.

Health Insurance

Most benefit premiums/costs are paid through payroll deduction and under current law are not included in your taxable income. Most of the benefits described in this section, including all insurance programs, are limited to regular employees who are appointed on at least a 50 per cent of full-time basis. If your appointment is less than full-time, some benefits and earnings will be pro-rated in accordance with the percentage of your appointment. In addition, some plans have enrollment restrictions and/or qualifications requirements. Specific questions may be addressed to the Office of Human Resources. You must **enroll within 60 days** from your original date of employment to be eligible for these programs. Any eligible spouse and/or dependents you wish to enroll require additional documentation for the enrollment process (See Section VI). If you fail to provide the required

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documentation at the time of enrollment, the State of Maryland will not enroll the spouse and/or dependent child at that time. You will have to wait until the next Open Enrollment. Any changes in your coverage status, such as marriage, divorce, birth or adoption of a child, etc., must be submitted **within 60 days** of the change/event to obtain coverage on a current policy. An open enrollment period, usually held annually, provides the opportunity to initiate, change, or add coverage not obtained within the 60-day time limits or during previous years. The plans offered include:

State of Maryland Plans

Health Insurance Plan
Prescription Drug Plan
Dental Plan
Accidental Death & Dismemberment Insurance
Term Life Insurance Plan
Long-Term Care Insurance (UNUM)
Health Care/Dependent Care Spending Accounts

Additional University of Maryland Plans

Long-Term Disability Insurance (UNUM)
Optional Group Life Insurance (UNUM)

The health insurance/vision plan, prescription drug plan and dental plan are subsidized by the State of Maryland. All other plans require the employee to pay the full premium. A rate sheet for benefits and an enrollment form is available in section VI.

Health Insurance/Vision Plan

You are eligible to enroll in one of several flexible health insurance plans offered by USM. There are three types of medical plans available: Preferred Provider Organization (PPO) plans, Point-of-Service (POS) plans, and Health Maintenance Organization (HMO) plans. Each type of plan has a standard set of benefits, by type of plan. In general, all cover regular check-ups, diagnostic tests, and other preventive services. However, certain plans require that you select a primary care physician (PCP) and referral for any visits to specialists. Check with your Benefits Coordinator or with the Office of Human Resources for further information. A vision plan is also provided under your health insurance plan. For information on vision coverage and claims, please contact your health insurance plan at the phone number provided on the card.

Prescription Drug Plan

Prescription drug benefits are independent from your health care plan. Membership in the prescription drug plan provides prescription drugs, insulin, and oral contraceptives with minimum co-payment amounts, and may be selected, as a separate option.

Dental Insurance

The State of Maryland offers one DPOS dental plan and two DHMO plans. It is a good idea to first find a dentist in your area that accepts the dental plan and make sure they are still accepting new patients. You should refer to the specific provisions of your plan to determine what coverage is included and if it is sufficient for your needs. Coverage for services rendered is available in the State of Maryland Employees Benefits Booklet.

Accidental Death and Dismemberment Plan

The Personal Accident and Dismemberment (PAD) plan provides benefits if you die or suffer dismemberment within 365 days of the occurrence of a covered accident. Our PAD plan is with Met Life.

Life Insurance

Two life insurance programs are available and both permit you to include your spouse and dependent children. Premiums are at group rates and are based upon age and the amount of insurance purchased. Employees who do not enroll in the State sponsored term life insurance policy through the Standard Life Insurance Company will not be permitted to enroll until the next Open Enrollment period. Employees who do not enroll in the UNUM Life Insurance Policy within 60 days from their date of employment may be required to submit medical evidence of insurability to qualify at a later date.

Forms to enroll in plans offered through UNUM are not included in this packet. Please see your Benefits Coordinator for an enrollment form.

Flexible Spending Accounts

This benefit is offered through the State of Maryland. The health care plans do not cover all possible medical and dental expenses; and certain other major expenses such as childcare are not covered by insurance at all. The tax laws allow you to contribute money pre-tax into flexible spending accounts. Then, as you have out-of-pocket health care or dependent care expenses, you can pay for these expenses with the pre-tax dollars you have set aside. You can set up either a health care account or a dependent care account, or one of each.

Mental Health/Substance Abuse Program

Mental health, alcoholism, and substance abuse benefits have been combined into one program, which is administered through APS Healthcare, Inc.(APS). All State of MD employees enrolled in either a medical PPO or POS plan will be automatically enrolled in the APD plan and must obtain preauthorization from APS before services are rendered. Medical HMO members must contact their insurance provider for mental health/substance abuse services before services are rendered.

Additional UNUM Plans

- **Long-Term Disability Insurance**

Long-term disability insurance provides for the continuation of a portion of your income while you are disabled, following a mandatory waiting period. Premiums are at group rates and are based upon your age and salary. Employees who do not enroll within 60 days from their date of employment may be required to submit medical evidence of insurability to qualify at a later date. This benefit is not portable.

- **Long Term Care**

Coverage is available to all employees, active and retirees and their family members, including spouses, adult children, siblings, parents (in-laws included) and grandparents (in-laws included). Active employees and their spouses will have premiums payroll deducted. All other family members, retirees and their family members will be directly billed for the coverage by UNUM. Employees may continue this plan under an individual policy through UNUM upon separation.

Tuition Remission

All regular, exempt employees are entitled to tuition remission at any USM Institution on your date of hire if you are hired before the start of the current semester. Your spouse and dependent children are eligible as well once the employee has completed 2 full years of employment. Tuition remission is pro-rated to the employees FTE and is governed by the attending institution's tuition remission policies and procedures. For additional information about tuition remission, please visit the HR Intranet site under "My UMCES" and select Tuition Remission from the Benefits Menu.

Continuation of Coverage

Office of Human Resources
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If you are on a leave of absence without pay, leave State service, or one of your dependents becomes ineligible to continue coverage, you may be able to continue the above health benefits for up to 18 months (36 months in some cases). You will be billed for 100% of the cost (including the portion normally subsidized by the State). See your local Benefits Coordinator for details.

Section 4:
Employee Information Forms

Employee Information Forms

The employee information forms provided in this section are necessary to activate your appointment in the PHR system. The following forms are included in this section:

- **UMCES Employee Data Collection Form**
 - If you have are transferring from another USM institution or State Agency, please see your local Benefits Coordinator for additional forms to transfer service and/or leave balances.

If you have prior USM or State service, please notify your local Benefits Coordinator.

Employee Data Collection Form



| 1. Employee Information | | |
|--|--|--|
| SS#: | | |
| Last Name: | First Name: | Middle Name: |
| Suffix Name (check one): II III IV V Jr. Sr. None | Birth Date: _____ | Racial Identity: <input type="checkbox"/> Not Reported <input type="checkbox"/> Amer Indian/Alaska Nat <input type="checkbox"/> Black/African American <input type="checkbox"/> Asian/Pacific Islander <input type="checkbox"/> Hispanic <input type="checkbox"/> White |
| Gender: <input type="checkbox"/> Female <input type="checkbox"/> Male | Citizenship/Visa Status: _____ | Citizenship Country _____ |
| Visa or Perm. Res. #: _____ | Check Distribution Code: _____ | Retired form State: _____ |
| Military Status (check one): <input type="checkbox"/> Non-Veteran <input type="checkbox"/> Veteran <input type="checkbox"/> Vietnam Veteran <input type="checkbox"/> Active Reserve <input type="checkbox"/> Inactive Reserve <input type="checkbox"/> Retired <input type="checkbox"/> Special Disability | Highest Education Level (check one): <input type="checkbox"/> Less than 7 th grade <input type="checkbox"/> 7 th , 8 th , 9 th grade completed <input type="checkbox"/> 10 th , 11 th grade completed <input type="checkbox"/> High School Grad or GED <input type="checkbox"/> Some Bus. Sch. College (HS Grad) <input type="checkbox"/> Associate Degree Earned <input type="checkbox"/> Bachelor's Degree <input type="checkbox"/> Some Graduate Study <input type="checkbox"/> Advanced Grad Specialist (AGS) <input type="checkbox"/> Master's Degree earned <input type="checkbox"/> Doctoral Degree earned <input type="checkbox"/> First Professional Degree earned | |
| 2. Employee Address Information | | |
| Business/Office Address: | | |
| Business Phone Number: | | |
| Permanent Address: | | |
| City: | County: | State: Zip: |
| 3. Employee Email Address | | |
| Primary Email Address: | | Home Phone: |
| 4. Employee Education Information | | |
| State Degree Earned: | Institution: | |
| Degree: | Degree Date: | |
| 5. Emergency Contact Information | | |
| Contact Name: | Relationship: | |
| Address: | | |
| Home Phone Number: | Cell Phone/Pager: | |
| Work Phone Number: | Email Address: | |

Section 5:
Payroll Forms

Payroll Forms

There are several payroll forms that must be completed and returned to your local Benefits Coordinator in order to initiate your employment. They are as follows:

- Form W-4 Employee Withholding Allowance Certificate
 - NOTE: If you live in the District of Columbia, do not complete this form. Please complete Form D-4 .
- Form I-9-Employment Eligibility Verification***
- State of Maryland Payroll Direct Deposit Authorization, *if desired*.

***Form I-9 requires that 1 or 2 form(s) of identification be provided when you turn this form into your Benefits Coordinator. Please see [Form I-9-List of Acceptable Documents](#) for a list of approved documentation.

***If you are a Non-Resident Alien, you will also need to complete [NRA Payroll Paperwork](#). Please see your local Benefits Coordinator.

***To inquire about Tax Treaty benefits, please see your local Benefits Coordinator or Payroll Processor.

2009 EMPLOYEE WITHHOLDING ALLOWANCE CERTIFICATE FOR MARYLAND STATE GOVERNMENT EMPLOYEES ONLY

Form W-4
Department of the Treasury
Internal Revenue Service

Form MW 507
Comptroller of Maryland

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

Section 1 - Employee Information

| | | | |
|---|-----------------------------|--|---|
| Payroll System (<i>check one</i>) | | Name of Employing Agency | |
| RG <input type="checkbox"/> | CT <input type="checkbox"/> | UM <input type="checkbox"/> | |
| Agency Number | Social Security Number | Employee Name | |
| Home Address (number and street or rural route) | | Address Continued (apartment number, if any) | |
| City | State | Zip Code | County of Residence (<i>required</i>) |

Section 2 - Federal Withholding Form W-4

The federal worksheet is available online at <http://www.irs.gov/pub/irs-pdf/fw4.pdf>

| | | | |
|--|--|--|--|
| 3 Single <input type="checkbox"/> Married <input type="checkbox"/> Married, but withhold at higher Single Rate <input type="checkbox"/> Note. If married, but legally separated, or spouse is a nonresident alien, check the "Single" box. | | 4 If your last name differs from that shown on your social security card, check here. You must call 1-800-772-1213 for a new card. > <input type="checkbox"/> | |
| 5 | Total number of allowances you are claiming (from page 1 or page 2 of the federal worksheet) | | |
| 6 | Additional amount, if any, you want withheld from each paycheck | \$ | |
| 7 | I claim exemption from withholding for 2009, and I certify that I meet both of the following conditions for exemption. <ul style="list-style-type: none"> ● Last year I had a right to a refund of all federal income tax withheld because I had no tax liability and ● This year I expect a refund of all federal income tax withheld because I expect to have no tax liability. If you meet both conditions, write "Exempt" here.....> | | |

Section 3 - Maryland Withholding Form MW 507

The Maryland worksheet is available online at http://forms.marylandtaxes.com/current_forms/MW507.pdf

| | |
|---|----------|
| Withhold at Single Rate <input type="checkbox"/> Married (surviving spouse or unmarried Head of Household) Rate <input type="checkbox"/> Married, but withhold at Single Rate <input type="checkbox"/> | |
| 1. Total number of exemptions you are claiming from Maryland worksheet | 1. _____ |
| 2. Additional withholding per pay period under agreement with employer | 2. _____ |
| 3. I claim exemption from withholding because I do not expect to owe Maryland tax. See instructions below and check boxes that apply. <ul style="list-style-type: none"> <input type="checkbox"/> a. Last year I did not owe any Maryland income tax and had a right to a full refund of all income tax withheld. AND <input type="checkbox"/> b. This year I do not expect to owe any Maryland income tax and expect to have the right to a full refund of all income tax withheld. (This includes seasonal and student employees whose annual income will be below the minimum filing requirement). If both a and b apply, enter year applicable _____ (year effective) Enter "EXEMPT" here 3. _____ | |
| 4. I claim exemption from withholding because I am domiciled in one of the following states. Check state that applies. <ul style="list-style-type: none"> <input type="checkbox"/> Pennsylvania (indicate township/borough under Address Continued in section 1 above.) <input type="checkbox"/> Virginia I further certify that I do not maintain a place of abode in Maryland as described in the instructions on page 2 of the worksheet. | |
| Enter "EXEMPT" here 4. _____ | |

Section 4 - Employee Signature

| | |
|---|------------|
| Under penalties of perjury, I declare that I have examined this certificate and to the best of my knowledge and belief, it is true, correct, and complete. I further certify that I am entitled to the number of withholding allowances claimed on line 1 above, or if claiming exemption from withholding, that I am entitled to claim the exempt status on line 3 or line 4, whichever applies. | |
| Employee's signature (Form is not valid unless you sign it.) _____ | Date _____ |

| | |
|--|--|
| Employer's name and address (including zip code) (For employer use only) Central Payroll Bureau P.O. Box 2396 Annapolis, MD 21404 | Federal Employer identification number 52-6002033 (For State of Maryland - CPB use only) |
|--|--|

Important: The information you supply must be complete. This form will replace in total any certificate you previously submitted.

Web Site - <http://compnet.comp.state.md.us/cpb>

INSTRUCTIONS & WORKSHEET FOR COMPLETING WITHHOLDING FORMS FOR MARYLAND STATE EMPLOYEES

The law requires that you complete an Employee's Withholding Allowance Certificate so that your employer, the state of Maryland, can withhold federal and state income tax from your pay. Your current certificate remains in effect until you change it.

If you have previously filed as "EXEMPT" from federal or state withholding, you must file a new certificate annually by February 15 of each year.

Complete the Employee's Withholding Allowance Certificate as follows:

Section 1 - Employee Information

- Please check type of Payroll - Regular (RG), Contract (CT), or University of Maryland (UM)
- Name of Employing Agency - Enter name of agency
- Agency Number - Provided by Agency Payroll Office
- Employee Social Security Number
- Employee Name - Complete first name, middle initial, last name
- Home Address - Street name and number or R.D. number
- Address Continued - Apartment number or P. O. Box number. Pennsylvania residents enter township or borough in which they reside
- City, State, Zip code - Abbreviate state; enter complete five-digit zip code
- County of Residence - Enter Baltimore City or Maryland County in which you presently reside

Section 2 - Federal Withholding Form W-4

To complete section 2 see federal worksheet online at:

<http://www.irs.gov/pub/irs-pdf/fw4.pdf>

Section 3 - State Withholding Form (Choose Appropriate Form)

- Maryland (Form MW 507) - To complete section 3 see Maryland worksheet page 2 online at:

http://forms.marylandtaxes.com/current_forms/mw507.pdf

- District of Columbia (Form D-4) - To complete section 3 see District of Columbia worksheet online at :

<http://otr.cfo.dc.gov/otr/frames.asp?doc=/otr/lib/otr/tax/forms/D-4.pdf>

- West Virginia (WV/IT-104) - To complete section 3 see West Virginia worksheet online at:

<http://www.state.wv.us/taxrev/uploads/it104.pdf>

Section 4 - Employee Signature - Your signature is required. Withholding Forms are not valid unless signed.

2009 FORM W-4

INSTRUCTIONS - PAGE 1 EMPLOYEE'S FEDERAL WITHHOLDING ALLOWANCE

Form W-4 (2009)

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

Exemption from withholding. If you are exempt, complete **only** lines 1, 2, 3, 4 and 7 and sign the form to validate it. Your exemption for 2009 expires February 16, 2010. See Pub. 505, Tax Withholding and Estimated Tax.

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

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

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

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

Tax credits. You can take projected tax credits into account in figuring your allowable number of withholding allowances. Credits for child or dependent care expenses and the child tax credit may be claimed using the **Personal Allowances Worksheet** below. See Pub. 919, How Do I Adjust My Tax Withholding, for information on converting your other credits into withholding allowances.

Nonwage income. If you have a large amount of nonwage income, such as interest or dividends, consider making estimated tax payments using **Form 1040-ES**, Estimated Tax for Individuals. Otherwise, you may owe additional tax. If you have pension or annuity income, see Pub. 919 to find out if you should adjust your withholding on form W-4 or W-4P.

Two earners/Multiple jobs. If you have a working spouse or more than one job, figure the total number of allowances you are entitled to claim on all jobs using worksheets from only one Form W-4. Your withholding usually will be most accurate when all allowances are claimed on the Form W-4 for the highest paying job and zero allowances are claimed on the others. See Pub. 919 for details.

Nonresident alien. If you are a nonresident alien, see the **Instructions for Form 8233** before completing this Form W-4.

Check your withholding. After your Form W-4 takes effect, use Pub. 919 to see how the dollar amount you are having withheld compares to your projected total tax for 2009. See Pub. 919, especially if your earnings exceed \$130,000 (Single) or \$180,000 (Married).

Recent name change? If your name on line 1 differs from that shown on your social security card, call 1-800-772-1213 to initiate a name change and obtain a social security card showing your correct name.

Personal Allowances Worksheet (Keep for your records.)

| | | | | | | | |
|---|---|--|-------------|----------------|---|---|--|
| A | Enter "1" for yourself if no one else can claim you as a dependent | A _____ | | | | | |
| B | Enter "1" if: <table border="0"><tr><td>• You are single and have only one job; or</td><td rowspan="3">}</td><td rowspan="3">B _____</td></tr><tr><td>• You are married, have only one job, and your spouse does not work; or</td></tr><tr><td>• Your wages from a second job or your spouse's wages (or the total of both) are \$1,500 or less.</td></tr></table> | • You are single and have only one job; or | } | B _____ | • You are married, have only one job, and your spouse does not work; or | • Your wages from a second job or your spouse's wages (or the total of both) are \$1,500 or less. | |
| • You are single and have only one job; or | } | B _____ | | | | | |
| • You are married, have only one job, and your spouse does not work; or | | | | | | | |
| • Your wages from a second job or your spouse's wages (or the total of both) are \$1,500 or less. | | | | | | | |
| C | Enter "1" for your spouse . But, you may choose to enter "-0-" if you are married and have either a working spouse or more than one job. (Entering "-0-" may help you avoid having too little tax withheld.) | C _____ | | | | | |
| D | Enter number of dependents (other than your spouse or yourself) you will claim on your tax return | D _____ | | | | | |
| E | Enter "1" if you will file as head of household on your tax return (see conditions under Head of household above) | E _____ | | | | | |
| F | Enter "1" if you have at least \$1,800 of child or dependent care expenses for which you plan to claim a credit (Note. Do not include child support payments. See Pub. 503, Child and Dependent Care Expenses, for details.) | F _____ | | | | | |
| G | Child Tax Credit (including additional child tax credit). See Pub. 972, Child Tax Credit, for more information. • If your total income will be less than \$61,000 (\$90,000 if married), enter "2" for each eligible child; then less "1" if you have three or more eligible children. • If your total income will be between \$61,000 and \$84,000 (\$90,000 and \$119,000 if married), enter "1" for each eligible child plus "1" additional if you have six or more eligible children. | G _____ | | | | | |
| H | Add lines A through G and enter total here. (Note. This may be different from the number of exemptions you claim on your tax return.) ▶ | H _____ | | | | | |
| | For accuracy, complete all worksheets that apply. <table border="0"><tr><td>• If you plan to itemize or claim adjustments to income and want to reduce your withholding, see the Deductions and Adjustments Worksheet on page 2.</td><td rowspan="3">}</td><td rowspan="3"></td></tr><tr><td>• If you have more than one job or are married and you and your spouse both work and the combined earnings from all jobs exceed \$40,000 (\$25,000 if married), see the Two-Earners/Multiple Jobs Worksheet on page 2 to avoid having too little tax withheld.</td></tr><tr><td>• If neither of the above situations applies, stop here and enter the number from line H on line 5 of Form W-4 below.</td></tr></table> | • If you plan to itemize or claim adjustments to income and want to reduce your withholding, see the Deductions and Adjustments Worksheet on page 2. | } | | • If you have more than one job or are married and you and your spouse both work and the combined earnings from all jobs exceed \$40,000 (\$25,000 if married), see the Two-Earners/Multiple Jobs Worksheet on page 2 to avoid having too little tax withheld. | • If neither of the above situations applies, stop here and enter the number from line H on line 5 of Form W-4 below. | |
| • If you plan to itemize or claim adjustments to income and want to reduce your withholding, see the Deductions and Adjustments Worksheet on page 2. | } | | | | | | |
| • If you have more than one job or are married and you and your spouse both work and the combined earnings from all jobs exceed \$40,000 (\$25,000 if married), see the Two-Earners/Multiple Jobs Worksheet on page 2 to avoid having too little tax withheld. | | | | | | | |
| • If neither of the above situations applies, stop here and enter the number from line H on line 5 of Form W-4 below. | | | | | | | |

Deductions and Adjustments Worksheet

Note. Use this worksheet *only* if you plan to itemize deductions, claim certain credits, adjustments to income, or an additional standard deduction

- 1 Enter an estimate of your 2009 itemized deductions. These include qualifying home mortgage interest, charitable contributions, state and local taxes, medical expenses in excess of 7.5% of your income, and miscellaneous deductions. (For 2009, you may have to reduce your itemized deductions if your income is over \$166,800 (\$83,400 if married filing separately). See *Worksheet 2* in Pub. 919 for details.) . . . 1 \$ _____
- 2 Enter: $\left\{ \begin{array}{l} \$11,400 \text{ if married filing jointly or qualifying widow(er)} \\ \$ 8,350 \text{ if head of household} \\ \$ 5,700 \text{ if single or married filing separately} \end{array} \right\}$ 2 \$ _____
- 3 **Subtract** line 2 from line 1. If zero or less, enter "-0-" 3 \$ _____
- 4 Enter an estimate of your 2009 adjustments to income and any additional standard deduction. (Pub. 919) 4 \$ _____
- 5 **Add** lines 3 and 4 and enter the total. (Include any amount for credits from *Worksheet 8* in Pub. 919.) 5 \$ _____
- 6 Enter an estimate of your 2009 nonwage income (such as dividends or interest) 6 \$ _____
- 7 **Subtract** line 6 from line 5. If zero or less, enter "-0-" 7 \$ _____
- 8 **Divide** the amount on line 7 by \$3,500 and enter the result here. Drop any fraction 8 _____
- 9 Enter the number from the **Personal Allowances Worksheet**, line H, page 1 9 _____
- 10 **Add** lines 8 and 9 and enter the total here. If you plan to use the **Two-Earners/Multiple Jobs Worksheet**, also enter this total on line 1 below. Otherwise, **stop here** and enter this total on Form W-4, line 5, page 1 10 _____

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

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

- 1 Enter the number from line H, page 1 (or from line 10 above if you used the **Deductions and Adjustments Worksheet**) 1 _____
 - 2 Find the number in **Table 1** below that applies to the **LOWEST** paying job and enter it here. **However**, if you are married filing jointly and wages from the highest paying job are \$50,000 or less, do not enter more than "3." 2 _____
 - 3 If line 1 is **more than or equal to** line 2, subtract line 2 from line 1. Enter the result here (if zero, enter "-0-") and on Form W-4, line 5, page 1. **Do not** use the rest of this worksheet 3 _____
- Note.** If line 1 is *less than* line 2, enter "-0-" on Form W-4, line 5, page 1. Complete lines 4-9 below to calculate the additional withholding amount necessary to avoid a year-end tax bill.
- 4 Enter the number from line 2 of this worksheet 4 _____
 - 5 Enter the number from line 1 of this worksheet 5 _____
 - 6 **Subtract** line 5 from line 4 6 _____
 - 7 Find the amount in **Table 2** below that applies to the **HIGHEST** paying job and enter it here 7 \$ _____
 - 8 **Multiply** line 7 by line 6 and enter the result here. This is the additional annual withholding needed 8 \$ _____
 - 9 Divide line 8 by the number of pay periods remaining in 2009. For example, divide by 26 if you are paid every two weeks and you complete this form in December 2008. Enter the result here and on Form W-4, line 6, page 1. This is the additional amount to be withheld from each paycheck 9 \$ _____

Table 1

Table 2

| Married Filing Jointly | | All Others | | Married Filing Jointly | | All Others | |
|---|-----------------------|---|-----------------------|--|-----------------------|--|-----------------------|
| If wages from LOWEST paying job are— | Enter on line 2 above | If wages from LOWEST paying job are— | Enter on line 2 above | If wages from HIGHEST paying job are— | Enter on line 7 above | If wages from HIGHEST paying job are— | Enter on line 7 above |
| \$0 - \$4,500 | 0 | \$0 - \$6,000 | 0 | \$0 - \$65,000 | \$550 | \$0 - \$35,000 | \$550 |
| 4,501 - 9,000 | 1 | 6,001 - 12,000 | 1 | 65,001 - 120,000 | 910 | 35,001 - 90,000 | 910 |
| 9,001 - 18,000 | 2 | 12,001 - 19,000 | 2 | 120,001 - 185,000 | 1,020 | 90,001 - 165,000 | 1,020 |
| 18,001 - 22,000 | 3 | 19,001 - 26,000 | 3 | 185,001 - 330,000 | 1,200 | 165,001 - 370,000 | 1,200 |
| 22,001 - 26,000 | 4 | 26,001 - 35,000 | 4 | 330,001 and over | 1,280 | 370,001 and over | 1,280 |
| 26,001 - 32,000 | 5 | 35,001 - 50,000 | 5 | | | | |
| 32,001 - 38,000 | 6 | 50,001 - 65,000 | 6 | | | | |
| 38,001 - 46,000 | 7 | 65,001 - 80,000 | 7 | | | | |
| 46,001 - 55,000 | 8 | 80,001 - 90,000 | 8 | | | | |
| 55,001 - 60,000 | 9 | 90,001 - 120,000 | 9 | | | | |
| 60,001 - 65,000 | 10 | 120,001 and over | 10 | | | | |
| 65,001 - 75,000 | 11 | | | | | | |
| 75,001 - 95,000 | 12 | | | | | | |
| 95,001 - 105,000 | 13 | | | | | | |
| 105,001 - 120,000 | 14 | | | | | | |
| 120,001 and over | 15 | | | | | | |

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

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

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

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

2009 INSTRUCTIONS



Revenue Administration Division

EMPLOYEE'S STATE OF MARYLAND WITHHOLDING ALLOWANCE

Line 1

Employee Withholding Allowance Certificate

a. Number of personal exemptions (total exemptions on lines A, C and D of the federal W-4 or W-4A worksheet) a. _____

b. Number of additional exemptions for dependents over 65 years of age b. _____

c. Number of additional exemptions for certain items, including estimated itemized deductions, alimony payments, allowable childcare expenses, qualified retirement contributions, business losses and employee business expenses for the year. c. _____

d. Number of additional exemptions for taxpayer and/or spouse at least 65 years of age and/or blind d. _____

e. Total - add lines a through d and enter here and on line 1 (Form MW507) e. _____

Exemptions for dependents - to qualify as your dependent, you must be entitled to an exemption for the dependent on your federal income tax return for the corresponding tax year.

Additional exemptions for dependents over 65 years of age - An additional exemption is allowed for dependents who are 65 years of age or older.

Additional exemptions - You may claim additional exemptions for certain items, including estimated itemized deductions, alimony payments, allowable child care expenses, qualified retirement contributions, business losses and employee business expenses for the year. One additional withholding exemption is permitted for each \$3,200 of estimated itemized deductions or adjustments to income that exceed the standard deduction allowance.

NOTE :Standard deduction allowance is 15% of Maryland adjusted gross income with a minimum of \$1,500 and a maximum of \$2,000 for each taxpayer.

Additional exemptions for taxpayer and/or spouse - An additional \$1,000 may be claimed if the taxpayer and/or spouse is at least 65 years of age and/or blind on the last day of the tax year.

Line 2

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

Line 3

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

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

b. this year you do not expect to owe any Maryland income tax and expect to have the right to a full refund of all income tax withheld. If you are eligible to claim this exemption your employer will not withhold Maryland income tax from your wages.

Students and seasonal employees

whose annual income will be below the minimum filing requirements (annual income less than **\$8,950 for 2009**) should claim exemption from withholding. This provides more income throughout the year and avoids the necessity of filing a Maryland income tax return.

Line 4

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

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

If you are domiciled in the District of Columbia Pennsylvania or Virginia and maintain a place of abode in Maryland for 183 days or more, you become a statutory resident of Maryland and you are required to file a resident return with Maryland reporting your total income. You must apply to your domicile state for any tax credit to which you may be entitled under the reciprocal provisions of the law.

If your are domiciled in West Virginia, you are not required to pay Maryland income tax on wage or salary income, regardless of the length of time you may have spent in Maryland.

GENERAL INSTRUCTIONS

Federal Privacy Act Information - Social Security numbers must be included, The mandatory disclosure of your social security number is authorized by the provisions set forth in the Tax-General Article of the Annotated Code of Maryland. Such numbers are used primarily to administer and enforce the individual income tax laws and to exchange income tax information with the Internal Revenue Service, other states and other tax officials of this state.

Information furnished to other agencies or persons shall be used solely for the purpose of administering tax laws or the specific laws, administered by the person having statutory right to obtain it.

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

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

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

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

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

Duties and Responsibilities of Employee

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

For additional information please call

410-767-1300

or

toll free 1-800-492-1751

or visit our Web sit at

www.marylandtaxes.com

Instructions**Read all instructions carefully before completing this form.**

Anti-Discrimination Notice. It is illegal to discriminate against any individual (other than an alien not authorized to work in the United States) in hiring, discharging, or recruiting or referring for a fee because of that individual's national origin or citizenship status. It is illegal to discriminate against work-authorized individuals. Employers **CANNOT** specify which document(s) they will accept from an employee. The refusal to hire an individual because the documents presented have a future expiration date may also constitute illegal discrimination. For more information, call the Office of Special Counsel for Immigration Related Unfair Employment Practices at 1-800-255-8155.

The purpose of this form is to document that each new employee (both citizen and noncitizen) hired after November 6, 1986, is authorized to work in the United States.

All employees (citizens and noncitizens) hired after November 6, 1986, and working in the United States must complete Form I-9.

Section 1, Employee

This part of the form must be completed no later than the time of hire, which is the actual beginning of employment. Providing the Social Security Number is voluntary, except for employees hired by employers participating in the USCIS Electronic Employment Eligibility Verification Program (E-Verify). **The employer is responsible for ensuring that Section 1 is timely and properly completed.**

Noncitizen nationals of the United States are persons born in American Samoa, certain former citizens of the former Trust Territory of the Pacific Islands, and certain children of noncitizen nationals born abroad.

Employers should note the work authorization expiration date (if any) shown in **Section 1**. For employees who indicate an employment authorization expiration date in **Section 1**, employers are required to reverify employment authorization for employment on or before the date shown. Note that some employees may leave the expiration date blank if they are aliens whose work authorization does not expire (e.g., asylees, refugees, certain citizens of the Federated States of Micronesia or the Republic of the Marshall Islands). For such employees, reverification does not apply unless they choose to present

in **Section 2** evidence of employment authorization that contains an expiration date (e.g., Employment Authorization Document (Form I-766)).

Preparer/Translator Certification

The Preparer/Translator Certification must be completed if **Section 1** is prepared by a person other than the employee. A preparer/translator may be used only when the employee is unable to complete **Section 1** on his or her own. However, the employee must still sign **Section 1** personally.

Section 2, Employer

For the purpose of completing this form, the term "employer" means all employers including those recruiters and referrers for a fee who are agricultural associations, agricultural employers, or farm labor contractors. Employers must complete **Section 2** by examining evidence of identity and employment authorization within three business days of the date employment begins. However, if an employer hires an individual for less than three business days, **Section 2** must be completed at the time employment begins. Employers cannot specify which document(s) listed on the last page of Form I-9 employees present to establish identity and employment authorization. Employees may present any List A document **OR** a combination of a List B and a List C document.

If an employee is unable to present a required document (or documents), the employee must present an acceptable receipt in lieu of a document listed on the last page of this form. Receipts showing that a person has applied for an initial grant of employment authorization, or for renewal of employment authorization, are not acceptable. Employees must present receipts within three business days of the date employment begins and must present valid replacement documents within 90 days or other specified time.

Employers must record in Section 2:

1. Document title;
2. Issuing authority;
3. Document number;
4. Expiration date, if any; and
5. The date employment begins.

Employers must sign and date the certification in **Section 2**. Employees must present original documents. Employers may, but are not required to, photocopy the document(s) presented. If photocopies are made, they must be made for all new hires. Photocopies may only be used for the verification process and must be retained with Form I-9. **Employers are still responsible for completing and retaining Form I-9.**

For more detailed information, you may refer to the *USCIS Handbook for Employers* (Form M-274). You may obtain the handbook using the contact information found under the header "USCIS Forms and Information."

Section 3, Updating and Reverification

Employers must complete **Section 3** when updating and/or reverifying Form I-9. Employers must reverify employment authorization of their employees on or before the work authorization expiration date recorded in **Section 1** (if any). Employers **CANNOT** specify which document(s) they will accept from an employee.

- A.** If an employee's name has changed at the time this form is being updated/reverified, complete Block A.
- B.** If an employee is rehired within three years of the date this form was originally completed and the employee is still authorized to be employed on the same basis as previously indicated on this form (updating), complete Block B and the signature block.
- C.** If an employee is rehired within three years of the date this form was originally completed and the employee's work authorization has expired **or** if a current employee's work authorization is about to expire (reverification), complete Block B; and:
 - 1.** Examine any document that reflects the employee is authorized to work in the United States (see List A or C);
 - 2.** Record the document title, document number, and expiration date (if any) in Block C; and
 - 3.** Complete the signature block.

Note that for reverification purposes, employers have the option of completing a new Form I-9 instead of completing **Section 3**.

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

To order USCIS forms, you can download them from our website at www.uscis.gov/forms or call our toll-free number at 1-800-870-3676. You can obtain information about Form I-9 from our website at www.uscis.gov or by calling 1-888-464-4218.

Information about E-Verify, a free and voluntary program that allows participating employers to electronically verify the employment eligibility of their newly hired employees, can be obtained from our website at www.uscis.gov/e-verify or by calling 1-888-464-4218.

General information on immigration laws, regulations, and procedures can be obtained by telephoning our National Customer Service Center at 1-800-375-5283 or visiting our Internet website at www.uscis.gov.

A blank Form I-9 may be reproduced, provided both sides are copied. The Instructions must be available to all employees completing this form. Employers must retain completed Form I-9s for three years after the date of hire or one year after the date employment ends, whichever is later.


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

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

This information is for employers to verify the eligibility of individuals for employment to preclude the unlawful hiring, or recruiting or referring for a fee, of aliens who are not authorized to work in the United States.

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

Submission of the information required in this form is voluntary. However, an individual may not begin employment unless this form is completed, since employers are subject to civil or criminal penalties if they do not comply with the Immigration Reform and Control Act of 1986.



An agency may not conduct or sponsor an information collection and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. The public reporting burden for this collection of information is estimated at 12 minutes per response, including the time for reviewing instructions and completing and submitting the form. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to: U.S. Citizenship and Immigration Services, Regulatory Management Division, 111 Massachusetts Avenue, N.W., 3rd Floor, Suite 3008, Washington, DC 20529-2210. OMB No. 1615-0047. **Do not mail your completed Form I-9 to this address.**

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

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

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

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

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

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

A citizen of the United States

A noncitizen national of the United States (see instructions)

A lawful permanent resident (Alien #) _____

An alien authorized to work (Alien # or Admission #) _____ until (expiration date, if applicable - month/day/year)

Employee's Signature _____ Date (month/day/year) _____

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

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

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

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

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

| | | |
|---|------------|-----------------------|
| Signature of Employer or Authorized Representative | Print Name | Title |
| Business or Organization Name and Address (Street Name and Number, City, State, Zip Code) | | Date (month/day/year) |

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

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

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

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

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

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

LISTS OF ACCEPTABLE DOCUMENTS

All documents must be unexpired

LIST A

**Documents that Establish Both
Identity and Employment
Authorization**

LIST B

**Documents that Establish
Identity**

LIST C

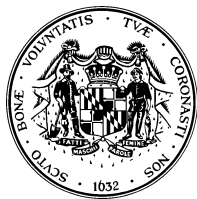
**Documents that Establish
Employment Authorization**

OR

AND

| | | |
|---|---|---|
| 1. U.S. Passport or U.S. Passport Card | 1. Driver's license or ID card issued by a State or outlying possession of the United States provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address | 1. Social Security Account Number card other than one that specifies on the face that the issuance of the card does not authorize employment in the United States |
| 2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551) | | |
| 3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa | 2. ID card issued by federal, state or local government agencies or entities, provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address | 2. Certification of Birth Abroad issued by the Department of State (Form FS-545) |
| 4. Employment Authorization Document that contains a photograph (Form I-766) | 3. School ID card with a photograph | 3. Certification of Report of Birth issued by the Department of State (Form DS-1350) |
| 5. In the case of a nonimmigrant alien authorized to work for a specific employer incident to status, a foreign passport with Form I-94 or Form I-94A bearing the same name as the passport and containing an endorsement of the alien's nonimmigrant status, as long as the period of endorsement has not yet expired and the proposed employment is not in conflict with any restrictions or limitations identified on the form | 4. Voter's registration card | |
| | 5. U.S. Military card or draft record | |
| | 6. Military dependent's ID card | 5. Native American tribal document |
| | 7. U.S. Coast Guard Merchant Mariner Card | |
| | 8. Native American tribal document | 6. U.S. Citizen ID Card (Form I-197) |
| | 9. Driver's license issued by a Canadian government authority | |
| 6. Passport from the Federated States of Micronesia (FSM) or the Republic of the Marshall Islands (RMI) with Form I-94 or Form I-94A indicating nonimmigrant admission under the Compact of Free Association Between the United States and the FSM or RMI | For persons under age 18 who are unable to present a document listed above: | 7. Identification Card for Use of Resident Citizen in the United States (Form I-179) |
| | 10. School record or report card | 8. Employment authorization document issued by the Department of Homeland Security |
| | 11. Clinic, doctor, or hospital record | |
| | 12. Day-care or nursery school record | |

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



State of Maryland

Payroll Direct Deposit Authorization

| | | |
|---|--|--|
| <input type="checkbox"/> Regular | <input type="checkbox"/> Contract | <input type="checkbox"/> University of MD |
| Payroll System (check one) | | |

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

Social Security Number

Employee's Name (please print)

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

Agency Code

Agency Name (please print)

I authorize the State of Maryland Central Payroll Bureau to take the following action with my net salary:

(Check One)

- 1. Deposit directly to my checking account
 (Will take at least two pay periods to allow for pre-note process)

- 2. Change bank and/or checking account to which my net salary is deposited
 (Cancel of old account will occur within 21 days of receipt at CPB; you will receive 2 payroll checks until the new account is established)

- 3. Discontinue direct deposit and issue a payroll check instead
 (Will occur within 21 days) **Do not close account until payroll check is issued**

CPB Use Only

Effective PPE:

Bank Name:
(Omit if action 3 is checked)

**Copy directly from your personal check. Do not include your check number.
Do not use your deposit slip number. Verify carefully.**

| | | |
|-------------|-------------------------|--|
| | | |
| Bank Number | Checking Account Number | |

I authorize the State of Maryland to deposit my net salary to the bank and account named above. This authorization is to remain in force until the State of Maryland receives written notification from me of its termination in time and manner that allows the State and the bank a reasonable opportunity to act upon it. In the event that the State of Maryland notifies the bank that funds to which I am not entitled have been deposited to my account in error, I authorize and direct the bank to return said funds to the State as soon as possible. If the funds erroneously deposited to my account have been drawn from that account so that return of those funds by the bank to the State is not possible, I authorize the State to recover those funds by setting off the amount erroneously paid me from any future payments from the State until the amount of the erroneous deposit has been recovered, in full.

| | | |
|------|--------------------|----------------------|
| Date | Employee signature | Daytime phone number |
|------|--------------------|----------------------|

Instructions:

- Only one checking account is permitted for direct deposit.
- Type or print only (except signature).
- Use black ink only.
- Complete all blocked areas in the top part of form except for the section "CPB use only."
- Read authorization and sign the completed form. **Unsigned or Incomplete forms will be returned.**
- Deposit amount will be *full net amount* of pay.
- If changing your bank and or checking account, you will receive a payroll check until new direct deposit becomes effective.
- Do not send a voided blank check.
- Send completed form to Central Payroll Bureau, P.O. Box 2396, Annapolis, MD 21404. Phone 410-260-7401.

Section 6:

**Health Benefits
and
Retirement Forms**

Health Benefits Forms

Enrollment materials for the State-sponsored programs are included in this section. If you wish to enroll in UNUM Group Life, Long-Term Disability or Long-Term Care, please contact your local Benefits Coordinator for enrollment materials. The forms included in this packet, as well as the UNUM forms not included, must be received by the Office of Human Resources within 60 days of your hire date. **NOTE:** If you are enrolling a spouse and/or dependent child/ren, please see the **Required Supporting Documentation** that must be submitted with your Enrollment Worksheet. If this documentation is not submitted, then the spouse and/or dependent child/ren will not be enrolled.

Deductions for your health benefits should start within 2-3 pay periods of the date on which the paperwork was submitted. If you need your coverage retro-active back to your date of hire, please notify your local Benefits Coordinator at the time you turn in your worksheet.

The following forms have been included in this section. Please complete as follows:

Enrollment Worksheet for State Sponsored Health Benefits (print out and complete)

Please download the following forms, if applicable:

- *If you enroll in the Accidental Death and Dismemberment coverage, complete this form:*
 - Designation of Beneficiary Form**

- *If you enroll in the Met Life Insurance coverage, please complete the following:*
 - Designation of Beneficiary Form**
 - Statement of Health for Met Life Insurance** (*ONLY if you are enrolling in coverage exceeding \$50,000*)

Retirement Forms

Retirement Forms are not included in this packet. Please see your local Benefits Coordinator for this paperwork. Retirement paperwork should be completed and within one week of your hire date to ensure accurate contributions.

STATE OF MARYLAND

ACTIVE & SATELLITE EMPLOYEES HEALTH BENEFITS ENROLLMENT FORM FOR JULY 2008-JUNE 2009

PERSONAL DATA PLEASE PRINT CLEARLY

Name: _____
Address:
 City _____ State _____ Zip Code _____
Home Phone: () _____ - _____
Work Phone: () _____ - _____
Cell Phone: () _____ - _____
Pay Center: _____
Pay Cycle: _____
Social Security Number: _____ / _____ / _____
Date of Birth: ____ / ____ / _____

PLEASE COMPLETE: (MARK ALL APPROPRIATE CIRCLES)

| | | | | | |
|--|---|--------------------------------|----------------------------|--------------------------------|---|
| I work full-time or 50% or more of the normal week: | Pay Center | I am paid: | I am 21-Pay Faculty | Sex: | Marital Status: |
| | <input type="radio"/> Central Payroll | <input type="radio"/> Biweekly | <input type="radio"/> Yes | <input type="radio"/> Male | <input type="radio"/> Single |
| | <input type="radio"/> University of MD | <input type="radio"/> Monthly | <input type="radio"/> No | <input type="radio"/> Female | <input type="radio"/> Limited Divorce/ Legally Separated |
| I work _____ hrs. per week | <input type="radio"/> Satellite (specify agency: _____) | | | <input type="radio"/> Divorced | <input type="radio"/> Widowed |

EMPLOYEE STATUS

ENROLLMENT/CHANGE ACTION REQUESTED

- New Employee. Entry on duty date: _____
- Return from leave of absence/LAW Date: _____
- Transfer from: _____ to _____
(Agency Code) (Agency Code)
- Employee requesting change due to change in family status
- Employee ineligible (e.g., change to part-time less than 50%)

- New Enrollment (New employee/return from LAW):
- Change in family status
 - Add spouse or dependent because of:
 - Marriage Date: _____
 - Birth/Adoption/Appointed Permanent Legal Guardian Date: _____
 - Other: _____
 - Remove spouse or dependent because of:
 - Divorce/Limited Divorce/Legal Separation Date: _____
 - Death Date: _____ (Attach copy of Death Certificate)
 - Dependent no longer eligible-explain: _____
 - Other Change: _____
 - Cancel all coverage-explain: _____

Note on Retroactive Adjustments:
 Employees must contact their Agency Benefits Coordinator to file a Retroactive Adjustment to backdate coverage within 60 days of the date of the Change in Status or Entry on Duty. Newborn Retroactive Adjustments are required to be backdated to date of birth.

DEPENDENT INFORMATION PLEASE PRINT - DEPENDENTS INCLUDE YOUR SPOUSE AND CHILDREN

YOU MAY USE THIS SECTION FOR ADDITIONS (A), CHANGES (C) OR DELETIONS (D) TO YOUR EXISTING HEALTH BENEFITS FILE. COMPLETE ALL INFORMATION FOR EACH ENTRY. PLEASE PRINT CLEARLY.

| A/C/D | LAST NAME | FIRST NAME | MI | SEX | BIRTH DATE | RELATIONSHIP | SOCIAL SECURITY NO. | COVER THIS DEPENDENT FOR: | | |
|-------|-----------|------------|----|-----|------------|--------------|---------------------|---------------------------|------|--------|
| | | | | | | | | HEALTH | DRUG | DENTAL |
| | | | | | | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |
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| | | | | | | | | | | |

NOTE: If you are adding or removing a dependent, please see your Benefits Book for dependent documentation requirements. Tax-qualified dependent children age 25 and over must be disabled prior to reaching age 25.

ENROLLMENT FOR JULY 2008-JUNE 2009

Medical Benefits

OPTIONS

- New Enrollment or Change in Enrollment
- Addition or removal of a dependent
- No, I do not want to start this benefit
- Cancel current coverage

COVERAGE LEVEL

- Individual Only
- Individual & one child; name: _____
- Individual & spouse
- Individual & two or more
- End Stage Renal (ESRD) (Complete Medicare Information below)

MEDICAL PLANS-Choose only one

PPO Plans:

- BC/BS PPO
- MLH Eagle PPO

POS Plans:

- Aetna POS
- BC/BS MD POS
- MD IPA Preferred POS

HMO Plans:

- BlueChoice HMO
- Kaiser HMO
- Optimum Choice HMO

NOTE: Medicare Part D is voluntary. See the Notice of Creditable Coverage letter for the State's prescription drug plan in the Benefits Book.

| NAMES OF INDIVIDUALS WITH MEDICARE | MEDICARE NUMBER | PART A | PART B | PART D | MEDICARE DUE TO (✓): | | |
|------------------------------------|-----------------|-------------------------------------|------------------------------------|---------------------------------------|----------------------|----------|------|
| | | (Hospital Claims) Effective Date | (Medical Claims) Effective Date | (Prescription Drug) Effective Date | Age 65 | Disabled | ESRD |
| Employee | | | | | | | |
| Spouse | | | | | | | |
| Dependent Child | | | | | | | |
| Dependent Child | | | | | | | |

NOTE: Vision and Mental Health/Substance Abuse benefits are available if enrolled in a medical plan. Medical plans do not include Prescription Drug or Dental coverage. See the following sections.

Prescription Coverage

OPTIONS

- New enrollment
- Addition or removal of dependent
- No, I do not want to start this benefit
- Cancel current coverage

COVERAGE LEVEL

- Individual Only
- Individual & one child; name: _____
- Individual & spouse
- Individual & two or more

Dental Coverage

OPTIONS

- New enrollment or change in plan
- Addition or removal of dependent
- No, I do not want to start this benefit
- Cancel current coverage

COVERAGE LEVEL

- Individual Only
- Individual & one child; name: _____
- Individual & spouse
- Individual & two or more

DENTAL PLANS

Check only one dental plan:

- Dental Benefits Providers Dental HMO
- United Concordia Dental HMO
- United Concordia Dental PPO

Personal Accident and Dismemberment

OPTIONS

- New Enrollment or addition/removal of dependent
- Change of benefit amount - select benefit amount
- No, I do not want to start this benefit
- Cancel current coverage

COVERAGE LEVEL

- Employee only coverage
- Family coverage

BENEFIT AMOUNT

- \$100,000
- \$200,000
- \$300,000

Flexible Spending Accounts – SELECTED AMOUNTS ARE PER PAY CHECK

YOU MUST COMPLETE THIS SECTION IF YOU WANT TO PARTICIPATE IN A FLEXIBLE SPENDING ACCOUNT IN JULY 2008-JUNE 2009

HEALTH CARE

OPTIONS

- Enroll in Health Care Spending Account
- Cancel Health Care Spending Account

\$. Write in dollar amount per deduction

DAY CARE

OPTIONS

- Enroll in Day Care Spending Account
- Cancel Day Care Spending Account

\$. Write in dollar amount per deduction

If you will be retiring before July 1, 2009, please be advised that only expenses incurred prior to retirement can be considered for reimbursement. Only expenses for tax-qualified dependents may be reimbursed.

See Benefits Book for Minimum/Maximum deduction amounts. Check with your Benefits Coordinator for your number of deductions, i.e., 24, 21 or 19. **Reminder: This is not a yearly deduction amount. THIS IS THE AMOUNT PER DEDUCTION IN JULY 2008-JUNE 2009.**

State Life Insurance Plan

EMPLOYEE

OPTIONS

- Yes, I want to enroll as a new enrollee in life insurance. Select benefit amount.
- I am currently enrolled in life insurance and making a change. Select benefit amount.
- No, I do not want to start life insurance for myself.
- Cancel employee life insurance.

Choose a Coverage Amount in increments of \$10,000 for yourself:

STOP-If you choose an amount greater than \$50,000, you must fill out a Life Insurance Statement of Health for yourself. Please go to our website www.dbm.maryland.gov to download the Statement of Health form for yourself.

Fill in the amount of Benefit

\$,

SPOUSE

SECTION 2: SPOUSE INSURANCE

NOTE: You cannot enroll your family members unless you, the employee, are enrolled. You cannot select an amount for your dependents greater than 50% of the amount selected for yourself. The amount requested for your spouse can be up to 50% of the amount selected for you, the employee.

OPTIONS

- Having selected life insurance for myself, I wish to have life insurance on my spouse. Select benefit amount.
- I currently have life insurance for my spouse and am making a change. Select benefit amount.
- No, I do not want to start life insurance on my spouse.
- Cancel spouse life insurance on my spouse.

Choose a Coverage Amount in increments of \$5,000 for your spouse-up to 1/2 of the amount chosen for yourself:

STOP-If you choose an amount greater than \$25,000, you must fill out a Life Insurance Statement of Health for your spouse. Please go to our website www.dbm.maryland.gov to download the Statement of Health form for your spouse.

Fill in the amount of Benefit

\$,

CHILDREN

SECTION 3: CHILDREN INSURANCE

NOTE: You cannot enroll your family members unless you, the employee, are enrolled. You cannot select an amount for your dependents greater than 50% of the amount selected for yourself. The amount requested for your children can be up to 50% of the amount selected for you, the employee.

OPTIONS

- Having selected life insurance on my myself, I wish to have life insurance for my child(ren). Select benefit amount.
- I currently have life insurance for my child(ren) and am making a change. Select benefit amount.
- No, I do not want to start life insurance on my child(ren).
- Cancel child life insurance on my child(ren).

Choose a Coverage Amount in increments of \$5,000 for your child(ren)-up to 1/2 of the amount chosen for yourself:

STOP-If you choose an amount greater than \$25,000, you must fill out a Life Insurance Statement of Health for each covered child. Please go to our website www.dbm.maryland.gov to download the Statement of Health form for each covered child.

Fill in the amount of Benefit

\$,

Employee Signature

Please enroll me for the Flexible Benefits indicated on this form. I understand the benefits and limitations provided by the various plans and I authorize the State of Maryland to make the necessary adjustments in my pay based on the choices I have made. To the extent deemed necessary by the Plan Administrator for the proper administration of my coverages, I authorize the release of all medical records and related information pertaining to me or to my dependents. The personal information provided on this enrollment form is warranted to be complete, accurate, and in accordance with Department of Budget and Management (DBM) regulations. **I understand that I cannot cancel or change my enrollment except during an Open Enrollment period or as a result of a change in status permitted by Section 125 of the Internal Revenue Code.**

I understand that if I have enrolled in one or both of the Flexible Spending Accounts, that I must file for reimbursement from those accounts by October 15, 2009 in order to avoid losing my contributions, and that my decision to deposit funds in the Spending Accounts is binding through June 30, 2009 and can only be modified if there is a qualifying change in family status.

I understand that the Flexible Benefits Program offered by the State is subject to modifications and changes and that the benefits I have chosen on this enrollment form are only in effect for July 2008-June 2009. The State of Maryland reserves the right to modify any of the benefits provided and gives no assurances, expressed or implied, that any coverage obtained hereunder will continue beyond June 30, 2009. **I certify that neither I nor my covered dependents are covered under another State of Maryland employee's or retiree's membership for any type of duplicate coverage.**

I CERTIFY THAT I AND ANY DEPENDENTS LISTED FOR COVERAGE ARE ELIGIBLE FOR COVERAGE. I UNDERSTAND THAT ENROLLMENT IN BENEFITS TO WHICH I OR MY DEPENDENTS ARE NOT ENTITLED IS CONSIDERED FRAUD. IN ALL CASES I AM RESPONSIBLE FOR THE ACCURACY OF MY BENEFITS, COVERAGE LEVELS AND DEDUCTIONS. I FURTHER UNDERSTAND THAT IF I WILLFULLY MISREPRESENT THE ELIGIBILITY OF MYSELF OR MY DEPENDENTS ON MY HEALTH BENEFITS APPLICATION, OR FAIL TO TAKE THE NECESSARY ACTION TO REMOVE INELIGIBLE DEPENDENTS, OR IN ANY WAY OBTAIN BENEFITS TO WHICH I AM NOT ENTITLED, MY BENEFITS WILL BE CANCELED. I MAY BE REQUIRED TO REPAY ANY CLAIMS AND INSURANCE PREMIUMS WHICH HAVE BEEN PAID INAPPROPRIATELY, I MAY FACE CHARGES FOR DISMISSAL FROM STATE SERVICE, AND I MAY FACE CRIMINAL INVESTIGATION AND PROSECUTION.

NOTE: If you have any questions concerning the benefits and services that are provided by or excluded under this agreement, please contact a member service representative before signing this application.

Is there any other health insurance coverage in which you, your spouse or any of your dependents are enrolled? Yes No

Specify who is covered, name of Insurance Company and Policy Number: _____

I certify that I have discussed a Retroactive Adjustment with my Agency Benefits Coordinator.

X _____ /_____/_____
Employee Signature Date Work Phone Number (Ext.) Your Home/Cell Phone Number

Agency Signature - Agency Must Sign Here FORMS WILL NOT BE PROCESSED WITHOUT AN AGENCY SIGNATURE

I hereby certify that the person applying for enrollment is employed by the Agency. I certify that I have discussed a Retroactive Adjustment with the employee and have reviewed the form and accompanying documents for accuracy.

X _____ /_____/_____
Agency Benefits Coordinator Date Work Phone Number (Ext.) Department

During the July 1, 2008 - June 30, 2009 Plan Year:

Completed and signed enrollment forms must be given to your Agency Benefits Coordinator. If you are covering dependents, all appropriate dependent documentation must be attached. Please see your Benefits Book for dependent documentation.

Health Benefits information and forms are available on the Department of Budget and Management's website:

www.dbm.maryland.gov

Select *State Employees* and *Health Benefits*.

Section VII:
Additional UMCES Forms

Additional UMCES Forms:

State Vehicle Policy and Acknowledgement: Please complete and submit with a copy of your current Driver's License attached.

Substance Abuse Policy and Acknowledgement: Please sign confirming you have read and understand the Substance Abuse Policy once you have done so.

UMCES Application for Employment: Please complete the application for employment in addition to supplying a copy of your resume.

Once you have completed all of the forms in this packet, **PLEASE BE SURE TO SIGN ALL THE FORMS THAT REQUIRE YOUR SIGNATURE.**

If you have any questions, please contact your local Benefits Coordinator or Suzanne Luers at 410-228-9250 x619.

State Vehicle Policy

1. All drivers who operate University vehicles must comply with all policies, procedures, rules, and instructions governing the use of such vehicles.
2. All drivers must possess a driver's license that is valid in the State of Maryland and have fewer than 6 points for moving violations.
3. University vehicles may be driven only by authorized employees, students, and volunteers. Drivers must be at least 18 years old. Each Institution may designate in writing several qualified students or volunteers to serve as non-employee volunteer drivers when the need for such is justified, subject to the following limitations: (a) travel is directly related to the curricula of the Institution; (b) team travel formally represents the Institution; (c) travel is directly related to the business functions of the Institution, where deemed appropriate and necessary by the Institutional administration; and (d) participation is limited to the specific pre-approved need. Volunteers are subject to a driving record review.
4. University vehicles may be used exclusively for official University business. Personal use is prohibited.
5. Passengers are limited to those persons whose presence is directly related to an official University trip and who are properly authorized to participate in a University function.
6. It is the driver's responsibility to ensure the use of seat belts by all vehicle occupants.
7. All traffic and parking laws are to be obeyed. All violation fines are the responsibility of the individual involved. State and University funds must not be used to pay for any type of fine.
8. All accidents are to be reported to the Police immediately and to MTS at 301.405.5482 within 24 hours even if another vehicle is not involved or there are no apparent injuries or damage. An accident report must be obtained from the Police having jurisdiction where the accident occurred.
9. A monthly travel log must be maintained for each University vehicle. The travel logs shall be retained within departments and made available for audit upon request.
10. University vehicles are to be maintained in accordance with manufacturer recommendations. All warranties are to be fully exercised.
11. Drivers of University vehicles are personally responsible for vehicles operated by them. Should damage result through misuse or gross negligence, the driver may be required to make restitution to the University.
12. The use of a University fuel/service credit card is restricted to the specific vehicle or vehicles to which it is assigned.
13. University vehicles may not be rented or loaned to outside groups, individuals, or organizations. Subject to availability, other campuses within the University System of Maryland may use University vehicles.

UMCES HUMAN RESOURCES DEPARTMENT

State Vehicle Policy

By signing below, I acknowledge that I have received and reviewed and reviewed the policy regarding the rules for drivers of UMCES vehicles.

I am aware that willful disregard of these rules will be considered just cause for disciplinary action.

EMPLOYEE NAME

SOCIAL SECURITY NUMBER

DRIVER LICENSE NUMBER

STATE

EXPIRATION DATE

DATE OF BIRTH

JOB TITLE

STATUS: ***REGULAR EMPLOYMENT (salaried)***

HOURLY

SUMMER EMPLOYEE ONLY

VOLUNTEER

SIGNATURE

EMPLOYEE

DATE

01.01.1991.16

EXECUTIVE ORDER 01.01.1991.16 State of Maryland Substance Abuse Policy

A. Definitions. In this Executive Order the following words have the meanings indicated:

- (1) "Substance" means alcohol or drugs.
- (2) "Alcohol" means ethyl alcohol or ethanol.
- (3) "Drug" means:
 - (a) A controlled dangerous substance;
 - (b) Any other substance which must be dispensed by a licensed health care professional;
or
 - (c) An over-the-counter drug.
- (4) "Abuse" means:
 - (a) The use of an illegal drug;
 - (b) The intentional misuse of an over-the-counter drug, if the misuse impairs the job performance of the State employee or could impair the job performance of an applicant for State employment;
 - (c) The intentional use of any prescription drug in a manner inconsistent with its medically prescribed intended use, or under circumstances where its use is not permitted, if it impairs the job performance of a State employee or could impair the job performance of an applicant for State employment; or
 - (d) The use of alcohol if it impairs job performance of the State employee or could impair the job performance of an applicant for State employment.
- (5) "Workplace" means any place where an employee is performing work for the State of Maryland.
- (6) "Employee" means:
 - (a) A classified, unclassified, contractual, key employee, or other employee or official in the Executive Branch;
 - (b) A volunteer who provides a service to or for a unit in the Executive Branch; or
 - (c) A member of a Board or Commission in the Executive Branch.

(7) "Sensitive Employee" means an employee whose classification or position has been designated sensitive by the employee's appointing authority or personnel system.

(8) "Conviction" means:

(a) A judgment of conviction, whether entered upon a finding of guilt or acceptance of a plea of nolo contendere, and the imposition of sentence; or

(b) The staying of the entry of judgment and the placing of the defendant on probation after a finding of guilty or the acceptance of a plea of nolo contendere.

(9) "Alcohol Driving Offense" means:

(a) Driving or attempting to drive while:

(i) Intoxicated; or

(ii) Under the influence of alcohol; or

(b) Operating or attempting to operate a vessel while:

(i) Intoxicated; or

(ii) Under the influence of alcohol.

(10) "Controlled Dangerous Substance Offense" means:

(a) A controlled dangerous substance violation, under Article 27 of the Annotated Code of Maryland;

(b) An offense of the law of any other jurisdiction if the prohibited conduct would be a controlled dangerous substance violation if committed in this State;

(c) Driving or attempting to drive while:

(i) Under the influence of drugs or drugs and alcohol; or

(ii) Under the influence of a controlled dangerous substance; or

(d) Operating or attempting to operate a vessel while:

(i) Under the influence of drugs or drugs and alcohol; or

(ii) Under the influence of a controlled dangerous substance.

B. General Policy. The State of Maryland establishes and adopts the following substance abuse policy for the Executive Branch of State Government:

(1) The State of Maryland is committed to making good faith efforts to insure a safe, secure, and drug-free workplace for its employees consistent with the Drug-Free Workplace Act as enacted by Congress.

(2) All employees in the workplace must be capable of performing their duties.

(3) Employees experiencing substance abuse problems are encouraged to seek assistance through:

(a) Their employer;

(b) Self-referral to the employer's Employee Assistance Program; or

(c) Self-referral to an alternative certified rehabilitation program.

(4) An appointing authority may not hire anyone whom it knows currently abuses drugs or alcohol.

(5) Employees are prohibited from:

(a) Abusing alcohol or drugs;

(b) Committing a controlled dangerous substance offense; or

(c) Committing an alcohol driving offense.

C. Alcohol Abuse Policy.

(1) Working under the influence of alcohol is a violation of this policy and shall subject the employee to disciplinary action.

(2) An employee charged with an alcohol driving offense must report a finding of guilty, an acceptance of a plea of nolo contendere, or a probation before judgment to the employee's appointing authority within 5 work days.

(3) A sensitive employee shall be suspended for 15 days and required to successfully participate in an alcohol treatment program designated by an employee assistance program the first time the employee is:

(a) Convicted of an at-the-workplace alcohol driving offense; or

(b) Found under the influence of alcohol while at-the-workplace.

(4) A sensitive employee convicted of an off-the-workplace alcohol driving offense, and a non-sensitive employee convicted of any alcohol driving offense shall:

(a) On the first conviction be referred to an employee assistance program, and in addition, be subject to any other appropriate disciplinary actions;

(b) On the second conviction, at a minimum, be suspended for at least 5 days, be referred to an employee assistance program, be required to participate successfully in a treatment program, and in addition, be subject to any other appropriate disciplinary actions, up to and including termination;

(c) On the third conviction, be terminated.

D. Drug Abuse Policy.

(1) Working under the inappropriate influence of prescription drugs or over-the-counter drugs is a violation of this policy and shall subject the employee to disciplinary action.

(2) Working under the influence of a controlled dangerous substance is a violation of this policy and shall subject the employee to disciplinary action.

(3) An employee charged with a controlled dangerous substance offense shall report a finding of guilty, an acceptance of a plea of nolo contendere, or a probation before judgment to the appointing authority within 5 work days.

(4) A sensitive employee convicted of any controlled dangerous substance offense shall be terminated.

(5) A sensitive employee who tests positive for a controlled dangerous substance as a result of a random drug test shall be suspended for 15 work days and be required to successfully participate in a drug treatment program designated by an employee assistance program, as provided for by the appointing authority's drug testing protocol.

(6) A sensitive employee who abuses a legally prescribed drug or an over-the-counter drug shall, on the first offense:

(a) Be suspended for 5 work days; and

(b) Be required to participate successfully in a drug treatment program designated by an employee assistance program.

E. General Sanctions. Any employee otherwise in violation of this Executive Order shall be subject to appropriate progressive disciplinary actions up to and including termination.

F. Law Enforcement.

(1) When an appointing authority learns or, based on observation or reliable information, suspects that an employee has committed a controlled dangerous substance or alcohol offense at the workplace, the appointing authority shall refer the matter to an appropriate law enforcement authority for further investigation and prosecution.

(2) All employees shall cooperate fully with law enforcement authorities in the investigation and prosecution of suspected criminal violations.

G. Employee Education. All appointing authorities shall educate and inform their employees about:

(1) The dangers of drug and alcohol abuse in the workplace and the community at large;

(2) The State of Maryland's policy of maintaining a drug-free workplace;

(3) Any drug and alcohol abuse counseling, rehabilitation, and employee assistance program that is available; and

(4) The penalties that may be imposed upon employees for violations of this Executive Order.

H. Implementation.

(1) The Secretary of Personnel and the head of every other personnel system in the Executive Branch shall adopt such policies and regulations as are necessary or desirable for the implementation of this Executive Order.

(2) All appointing authorities are responsible for implementing and enforcing and monitoring compliance with the requirements of this Executive Order.

(3) All employees are required to acknowledge receipt of a copy of this Executive Order by returning an acknowledgement of receipt to their supervisor for insertion in their personnel file.

Effective date: April 1, 1991 (18:8 Md. R. 848)

Substance Abuse Policy

Maryland State Executive Order 01.01.1991.16 implementation requires that:

All State employees acknowledge receipt of a copy of the State of Maryland Substance Abuse Policy.

Your signature acknowledges receipt of the Policy.

By signing below, I acknowledge that I have received and reviewed a copy of Maryland State Executive Order 01.01.1991.16 regarding the State of Maryland Substance Abuse Policy.

SIGNATURE

EMPLOYEE

DATE

Application for Employment



THE CENTER FOR ENVIRONMENTAL SCIENCE ACTIVELY SUBSCRIBES TO A POLICY OF EQUAL EMPLOYMENT OPPORTUNITY AND WILL NOT DISCRIMINATE AGAINST ANY EMPLOYEE OR APPLICANT BECAUSE OF RACE, SEX, AGE, COLOR, PHYSICAL OR MENTAL DISABILITY, MARITAL STATUS, RELIGION, NATIONAL ORIGIN, OR POLITICAL AFFILIATION.

| | | | |
|--|--------------------|---|--|
| PLEASE PRINT OR TYPE (USE BLACK IN K ONLY) | | | DO NOT WRITE IN THIS SPACE POSITIONS QUALIFIED FOR: 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ TYPING SPEED _____ SHORT HAND SPEED _____ DATE _____ CREDENTIALS VERIFIED _____ |
| LAST NAME | FIRST | MIDDLE | |
| ADDRESS | | APT | |
| CITY | STATE | ZIIP CODE | |
| HOME PHONE | BUSINESS PHONE | SOCIAL SECURITY NUMBER | |
| IIF NOT A U.S. CITIZEN, INDICATE VISA CLASS AND NUMBER | | IIF YOU ARE CURRENTLY EMPLOYED, MAY WE CONTACT YOUR EMPLOYER? YES _____ NO _____ YOUR PREVIOUS EMPLOYERS? YES _____ NO _____ | HOW REFERRED TO THE UNIVERSITY |
| EMPLOYMENT RECORD | | | BEGIN WITH CURRENT OR PORE RECENT POSITION AND WORK BACKWARD. PLEASE COMPLETE IN DETAIL AND EXPLAIN ANY LAPSE FOR WHICH TIME IS NOT ACCOUNTED. INCLUDE PART-TIME AND VOLUNTEER EXPERIENCE. |
| EMPLOYER | EMPLOYED | | YOUR DUTIES AND RESPONSIBILITIES |
| ADDRESS | FROM | TO | |
| TELEPHONE | ____/____/____ | ____/____/____ | |
| YOUR TITLE | BASE SALARY | | |
| NAME AND TITLE OF SUPERVISOR | \$ _____ | \$ _____ | |
| REASON FOR LEAVING | FIRST | LAST | DID YOU SUPERVISE ANYONE? YES NO |
| EMPLOYER | EMPLOYED | | YOUR DUTIES AND RESPONSIBILITIES |
| ADDRESS | FROM | TO | |
| TELEPHONE | ____/____/____ | ____/____/____ | |
| YOUR TITLE | BASE SALARY | | |
| NAME AND TITLE OF SUPERVISOR | \$ _____ | \$ _____ | |
| REASON FOR LEAVING | FIRST | LAST | DID YOU SUPERVISE ANYONE? YES NO |
| EMPLOYER | EMPLOYED | | YOUR DUTIES AND RESPONSIBILITIES |
| ADDRESS | FROM | TO | |
| TELEPHONE | ____/____/____ | ____/____/____ | |
| YOUR TITLE | BASE SALARY | | |
| NAME AND TITLE OF SUPERVISOR | \$ _____ | \$ _____ | |
| REASON FOR LEAVING | FIRST | LAST | DID YOU SUPERVISE ANYONE? YES NO |
| EMPLOYER | EMPLOYED | | YOUR DUTIES AND RESPONSIBILITIES |
| ADDRESS | FROM | TO | |
| TELEPHONE | ____/____/____ | ____/____/____ | |
| YOUR TITLE | BASE SALARY | | |
| NAME AND TITLE OF SUPERVISOR | \$ _____ | \$ _____ | |
| REASON FOR LEAVING | FIRST | LAST | DID YOU SUPERVISE ANYONE? YES NO |

| SCHOOLS | NAME & ADDRESS OF SCHOOL | DATES | INDICATE HIGHEST LEVEL COMPLETED | MAJOR OR TYPE OF PROGRAM | TYPE OF DEGREE OR CERTIFICATE AND DATE |
|-------------------------------|--------------------------|-------|----------------------------------|--------------------------|--|
| HIGH SCHOOL OR GRADE SCHOOL | | | | | |
| COLLEGE | | | | | |
| GRADUATE SCHOOL | | | | | |
| VOCATIONAL OR BUSINESS SCHOOL | | | | | |

SPECIAL QUALIFICATIONS AND SKILLS (OFFICE MACHINES OPERATED, INCLUDING EQUIPMENT, FOREIGN LANGUAGES SPOKEN, ETC.)

| U.S. MILITARY SERVICE | TYPE OF DISCHARGE | DATE OF ENTRANCE | DATE OF DISCHARGE |
|--------------------------------------|-------------------|------------------|-------------------|
| DESCRIBE YOUR DUTIES IN THE MILITARY | | | |

If your answer is yes to any of the following questions, please explain in the box to the right.

- a. Have you ever worked for the University System of Maryland or the State of Maryland? Yes No
- b. Have you ever been convicted in court for Other than a misdemeanor or a minor traffic Violation? Yes No
- c. Are you under 18 years of age? Yes No

Additional Comments (For additional information you wish to submit)

I certify that all information on this application is accurate and recognize it is subject to verification and that my employment and/or continuance thereof is contingent upon its accuracy. I understand that an offer of employment, if made, may be contingent upon the satisfactory result of a post-offer medical examination or medical inquiry. I understand that employment by UMCES is subject to the policies and practices adopted by or applicable to the University of Maryland System or UMCES.

Signature of Applicant _____ Date _____

Do Not Write Below this Line _____

Interview's Comments
Date



CENTER ADMINISTRATION

Post Office Box 775
Cambridge, MD 21613-0075
(410) 228-9250
Fax: (410) 228-3843
<http://www.umces.edu>

ID Card Information

Name: _____

SSN: _____

Date of Birth: _____

Select One: Faculty Staff Student

Signature