PennState Health

NEW HIRE CHECKLIST

COMPLETE ALL FORMS AND BRING TO NEW EMPLOYEE ORIENTATION:

- □ Self-Identification Form
- □ Voluntary Self Identification of Protected Veterans
- □ Voluntary Self-Identification of Disability
- □ Worker's Compensation Employee Notification
- □ Penn State Intellectual Property Agreement (IPA Form)

BRING THE FOLLOWING <u>REQUIRED</u> DOCUMENTS WITH YOU TO ORIENTATION:

- □ Two forms of identification (please reference the list on Form I-9 (Employment Eligibility Verification) for all acceptable forms of ID. We are required by the Department of Justice to review these documents on all new employees within the first **3** days of employment.

PennState Health

EQUAL EMPLOYMENT OPPORTUNITY
SELF-IDENTIFICATION FORM
FOR
PENN STATE HEALTH EMPLOYEES

Penn State Health is an equal opportunity/affirmative action employer. As a federal contractor, we are required to keep records on the race, sex and ethnicity of our employees and to file periodic reports with the government. This information will be kept confidential.

EMPLOYEE NAME:	**EMPLOYEE ID#:** (Leave Blank)
JOB TITLE:	**WORK LOCATION/DEPT:** (Leave Blank)

The following designations are those used by the Federal government. No other designations are available at this time. Please mark only one sex and one race/ethnic group.

PART I - SEX (Please check only one)

❍ **Male**
❍ **Female**

PART II- RACE/ETHNICITY (Please check only one)

❍ **Hispanic or Latino** *(includes persons of Cuban, Mexican, Puerto Rican, South or Central America, or other Spanish culture or origin regardless of race).*

❍ **Black or African American, Not Hispanic or Latino** *(includes persons having origins in any of the black racial groups of Africa.)*

❍ **American Indian or Alaska Native, Not Hispanic or Latino** *(includes persons having origins in any of the original peoples of North and South America (including Central America), and who maintain tribal affiliation or community attachment.)*

❍ **Asian, Not Hispanic or Latino** *(includes persons having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian Subcontinent, including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.)*

❍ **Native Hawaiian or Other Pacific Islander, Not Hispanic or Latino (***includes persons having origins in any of the peoples of Hawaii, Guam, Samoa, or other Pacific Islands.)*

❍ **White, Not Hispanic or Latino (***includes persons having origins in any of the original peoples of Europe, the Middle East, or North Africa.)*

❍ **Two or More Races, Not Hispanic or Latino (***includes all persons who identify with more than one of the above five races.)*

❍ **I choose not to disclose.**

Penn State Health is an equal opportunity employer and does not discriminate on the basis of race, color, religion, sex, sexual orientation, national origin, age, disability, veteran status or marital status. Please direct all inquiries to the Human Resources Department.

PennState Health

VOLUNTARY SELF IDENTIFICATION OF PROTECTED VETERANS
Invitation to Self Identify
FOR
PENN STATE HEALTH EMPLOYEES

Penn State Health is a Government contractor subject to the Vietnam Era Veterans' Readjustment Assistance Act of 1974, as amended by the Jobs for Veterans Act of 2002, 38 U.S.C. 4212 (VEVRAA), which requires Government contractors to take affirmative action to employ and advance in employment: (1) disabled veterans; (2) recently separated veterans; (3) active duty wartime or campaign badge veterans; and (4) Armed Forces service medal veterans. These classifications are defined as follows:

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

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

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

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

Protected veterans may have additional rights under USERRA - the Uniformed Services Employment and Reemployment Rights Act. In particular, if you were absent from employment in order to perform service in the uniformed service, you may be entitled to be reemployed by your employer in the position you would have obtained with reasonable certainty if not for the absence due to service. For more information, call the U.S. Department of Labor's Veterans Employment and Training Service (VETS), tollfree, at **1-866-4-USA-DOL**.

As a Government contractor subject to VEVRAA, we are required to submit a report to the United States Department of Labor each year identifying the number of our employees belonging to each specified "protected veteran" category. If you believe you belong to any of the categories of protected veterans listed above, please indicate by checking the appropriate box below.

PennState Health

VOLUNTARY SELF IDENTIFICATION OF PROTECTED VETERANS
Invitation to Self Identify
FOR
PENN STATE HEALTH EMPLOYEES

EMPLOYEE ID#: (Leave Blank)	**Date:**
EMPLOYEE NAME:	

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

- ❑ DISABLED VETERAN
- ❑ RECENTLY SEPARATED VETERAN: Date of Separation ____/____/_____
- ❑ ACTIVE WARTIME OR CAMPAIGN BADGE VETERAN
- ❑ ARMED FORCES SERVICE MEDAL VETERAN

_____

- ❑ I am a protected veteran, but I choose not to self-identify the classifications to which I belong.
- ❑ I am NOT a protected veteran.

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

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

The information you submit will be kept confidential, except that (i) supervisors and managers may be informed regarding restrictions on the work or duties of disabled veterans, and regarding necessary accommodations; (ii) first aid and safety personnel may be informed, when and to the extent appropriate, if you have a condition that might require emergency treatment; and (iii) Government officials engaged in enforcing laws administered by the Office of Federal Contract Compliance Programs, or enforcing the Americans with Disabilities Act, may be informed.

Penn State Health is an equal opportunity employer and does not discriminate on the basis of race, color, religion, sex, sexual orientation, national origin, age, disability, veteran status or marital status. Please direct all inquiries to the Human Resources Department.

Voluntary Self-Identification of Disability

OMB Control Number 1250-0005
Expires 05/31/2023

Name: _____ Date: _____

Employee ID: _____
(if applicable)

Why are you being asked to complete this form?

We are a federal contractor or subcontractor required by law to provide equal employment opportunity to qualified people with disabilities. We are also required to measure our progress toward having at least 7% of our workforce be individuals with disabilities. To do this, we must ask applicants and employees if they have a disability or have ever had a disability. Because a person may become disabled at any time, we ask all of our employees to update their information at least every five years.

Identifying yourself as an individual with a disability is voluntary, and we hope that you will choose to do so. Your answer will be maintained confidentially and not be seen by selecting officials or anyone else involved in making personnel decisions. Completing the form will not negatively impact you in any way, regardless of whether you have self-identified in the past. For more information about this form or the equal employment obligations of federal contractors under Section 503 of the Rehabilitation Act, visit the U.S. Department of Labor's Office of Federal Contract Compliance Programs (OFCCP) website at www.dol.gov/ofccp.

How do you know if you have a disability?

You are considered to have a disability if you have a physical or mental impairment or medical condition that substantially limits a major life activity, or if you have a history or record of such an impairment or medical condition. *Disabilities include, but are not limited to:*

- Autism
- Autoimmune disorder, for example, lupus, fibromyalgia, rheumatoid arthritis, or HIV/AIDS
- Blind or low vision
- Cancer
- Cardiovascular or heart disease
- Celiac disease
- Cerebral palsy
- Deaf or hard of hearing
- Depression or anxiety
- Diabetes
- Epilepsy
- Gastrointestinal disorders, for example, Crohn's Disease, or irritable bowel syndrome
- Intellectual disability
- Missing limbs or partially missing limbs
- Nervous system condition for example, migraine headaches, Parkinson's disease, or Multiple sclerosis (MS)
- Psychiatric condition, for example, bipolar disorder, schizophrenia, PTSD, or major depression

Please check one of the boxes below:

☐ Yes, I Have A Disability, Or Have A History/Record Of Having A Disability

☐ No, I Don't Have A Disability, Or A History/Record Of Having A Disability

☐ I Don't Wish To Answer

PUBLIC BURDEN STATEMENT: According to the Paperwork Reduction Act of 1995 no persons are required to respond to a collection of information unless such collection displays a valid OMB control number. This survey should take about 5 minutes to complete.

For Employer Use Only

Employers may modify this section of the form as needed for recordkeeping purposes.

For example:

Job Title: _____ Date of Hire: _____

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UNIVERSITY INTELLECTUAL PROPERTY AGREEMENT (IPA)

Purpose: This IPA is required to be completed and signed by individuals first appointed or transferred to the following classification categories: (1a) executive, administrator, academic administrator, and academic throughout the University; (b) faculty, staff exempt, staff nonexempt, and technical service in academic or academic service units throughout the University; (2) for any existing employee in the above classification categories who has not previously signed this IPA; (3) graduate assistants/fellows/trainees at the time of their first appointment; and (4) undergraduate/graduate students, postdoctoral trainees/research associates, wage payroll employees, visiting scholars/scientists/students, emeritus/retired faculty and others who may be in a position to make, conceive or reduce to practice inventions or otherwise develop technology.

Instructions: The original signed IPA should be returned to the Office of Technology Management, 113 Technology Center, University Park, via your department of employment or matriculation.

In consideration of my employment/appointment/association, I agree to abide by the terms of the University's Intellectual Property Policies and Procedures currently in effect, as well as any subsequent revisions thereto. In so agreeing, I especially acknowledge my responsibilities:

(1) to assign and do hereby assign to the University (or its designee) all rights which I have or may acquire in inventions, discoveries, rights of patent therein, software or courseware which are conceived, reduced-to-practice, or authored by me to the extent specified in University policy:

   (a) with the use of University facilities or resources, or
   (b) in the field of expertise and/or within the scope of responsibilities covered by my employment/appointment/association with the University (hereafter PSU IP);

(2) to submit invention disclosures to the University promptly following the completion of conception or the first reduction-to-practice of any PSU IP;

(3) to do whatever is required to enable the University (or its designee), at its expense, to protect the PSU IP whether by patent, copyright or otherwise; including:

   (a) making myself available for meetings and providing necessary documentation, data and research results to support the filing or prosecution of patent applications covering PSU IP,
   (b) reviewing and signing documents from PSU or from patent attorneys retained by PSU (or its designee) to seek protection of PSU IP, and
   (c) assisting the University (or its designee) in seeking licensees to commercialize PSU inventions;

(4) to maintain laboratory documentation, including laboratory notebooks, where appropriate, to adequately demonstrate that inventions or discoveries were conceived or first reduced-to-practice by me including clear identification of any sponsorship;

(5) to provide to the University, prior to completion of my association with work contracted pursuant to contracts or grants, a complete disclosure of all software, inventions or discoveries conceived or first reduced-to-practice by me with the utilization of time, money or facilities charged to contracts or grants, and copyrightable works vested thereunder.

I acknowledge that I have been provided full access to all PSU policies governing intellectual property, and I agree it is my responsibility to read, understand and abide by all University policies governing intellectual property. I acknowledge that I have had all of my questions answered regarding those policies, and that it is my responsibility to seek any additional information that I require from the Office of Technology Management and the University Policy Manual.

I understand that this IPA is part of the terms of my employment/appointment/association; that any contract of employment or other legally binding agreement entered into by me with the University after the date of this IPA shall fully incorporate and include the terms of this IPA unless a provision of that subsequent contract of employment specifically modifies this IPA.

My responsibility set forth in Section (3), will continue after termination of my employment/appointment/ association with the University.

If I am now or hereafter become employed as a principal investigator or director of a University research, development, or other type of project, I will abide by the terms of this IPA and determine whether each person who performs any part of the research or development work on the project for which I am responsible has signed an appropriate Intellectual Property Agreement; and if not, will obtain such additional Intellectual Property Agreements as are necessary, and forward them to the Office of Technology Management, 113 Technology Center, University Park.

I intend to be legally bound by this IPA.

PLEASE CHECK CURRENT STATUS AND SIGN:

- ☐ FACULTY/STAFF
- ☐ GRAD ASST/FELLOW/TRAINEE
- ☐ GRADUATE STUDENT
- ☐ UNDERGRADUATE STUDENT
- ☐ POSTDOCTORAL TRAINEE/RESEARCH ASSOCIATE
- ☐ VISITING SCHOLAR/SCIENTIST/STUDENT
- ☐ EMERITUS/RETIRED FACULTY
- ☐ NON-DEGREE STUDENT
- ☐ OTHER _____

_____
PSU ID Number only

_____ _____
Last Name First Name

_____ _____
Signature

_____ _____
Date

_____ _____
College/Department/Administrative Unit

_____
Witness – Printed Name

_____
Signature

_____
Date

_____
College/Department/Administrative Unit

NOTICE: MEDICAL TREATMENT FOR YOUR WORK INJURY OR OCCUPATIONAL ILLNESS

Your employer has selected a list of 6 or more physicians and other health care providers who are available to treat your work-related injuries and illness during the first 90 days of treatment. If you are injured at work or suffer an occupational illness, you have certain legal RIGHTS and DUTIES under Section 306 (f.1) (I)(i) of the Workers' Compensation Act regarding your medical treatment. These rights and duties are summarized below.

MEDICAL TREATMENT: DURING THE FIRST 90 DAYS

- You have the RIGHT to receive reasonable and necessary medical treatment for your work injury or occupational illness. Your employer must pay for the treatment, as long as the treatment is by one of the listed providers.
- You have the RIGHT to choose which of the listed providers will treat you for your work injury or illness.
- You have the RIGHT to switch among any of the listed providers when you receive treatment; and if a listed provider refers you to a provider not on your employer's list, you have the RIGHT to receive treatment from the referral provider.
- You have the RIGHT to receive emergency medical treatment from any provider. However, non-emergency treatment must be given by a listed provider.
- If a listed provider prescribes surgery for you, you have the RIGHT to receive a second opinion from any provider of your choice. If that opinion is different from the opinion of the listed provider, you have the RIGHT to choose which course of treatment to follow. If you choose the treatment prescribed in the second opinion, you must receive the treatment from a listed provider for a period of 90 days after the date of your visit to the provider of the second opinion.
- You have the DUTY to visit one or more of the listed providers for the first 90 days of treatment for your work injury or illness if you expect your employer to pay for the medical treatment you receive.
- If you seek treatment for your work injury or illness from a provider who is not on the list, your employer may not have to pay for this medical treatment during this 90-day period. Therefore, you should talk to your employer before seeking treatment from a provider who is not on the list.

IMPORTANT: The requirements your employer must meet is to have a list of at least 6 providers. If the list does not meet these requirements, it is not a valid list, and you have the right to seek medical treatment for your work injury or occupational illness from any health care provider of your choice.

M EDICAL TREATMENT: AFTER THE FIRST 90 DAYS

- You have the RIGHT to receive treatment from any physician or other health care provider of your choice, wheather or not they are listed by your employer. Your employer must pay for this treatment, as long as it is reasonable and necessary for your work injury or occupational illness and has been properly documented by the physician or other health care provider.

You have the DUTY to notify your employer if you receive treatment from a physician or other health care provider who is not listed by your employer. You must notify your employer within five days of the first visit to any provider who is not on your employer's list. The employer may not be required to pay for treatment received until you have given this notice.

Your signature on this form indicates that you have been informed and you understand these rights and duties. **If you have questions, be sure you have your rights and duties explained to you before you sign this form.**

I have been informed of my medical treatment and duties with regard to work related injuries and illnesses. This notice was presented to me at (check one). ☐ TIME OF HIRE ☐ WHEN I WAS INJURED

EMPLOYEE: _____ DATE: _____

PRINT NAME: _____

(Rev. 10/1/09)