

NEW HIRE PAYROLL PACKET

This packet is to be completed by **full-time, benefits-eligible** employees prior to the first day of assignment at Frazier School District. A driver's license and Social Security card will also be required. Alternate documentation is acceptable according to the List of Acceptable Documents (Form I-9) enclosed. Please bring original, valid identification to the Business Office along with this packet so copies can be made.

Updated clearances are required in the Superintendent's Office if not provided at time of application.

Please contact 724-736-9507 Ext. 110 with questions.

FRAZIER SCHOOL DISTRICT

TO: _____

FROM: Erin Clausner, Payroll Clerk

SUBJECT: Benefits Paperwork

Congratulations on your new assignment with Frazier School District! As a full-time employee of the District, you are eligible to enroll in benefits as described below. Please complete the attached and return to me as soon as possible. Your eligibility is effective the first of the month following your full-time start date unless otherwise indicated. With a start date of _____, your eligibility will begin _____.

A few things to note:

- The ACSHIC enrollment form is for medical and prescription election.
- The Enrollment/Change Form is for dental and/or vision coverages.
- You may choose dental and/or vision coverages for yourself- dental only for dependents - regardless of your medical coverage election. This premium is paid by the District.
- Please provide copies of Social Security cards and marriage certificate for spousal coverage, Social Security cards and birth certificates for coverage of any/all dependent children. Other dependency documentation may be required.
- If you have the same or similar medical insurance elsewhere, please indicate your waiver of the offer and complete all sections of the ACSHIC form. This will constitute election of the medical allowance. Verification of coverage will be required.
- If you decline coverage at this time, unless you experience a defined qualifying event, the next opportunity to enroll will be for coverage effective **July 1, 2027**.
- UNUM forms are for disability insurance. This is coverage for the employee only and is paid for by the District.
- The Sun Life Employee Application is for life insurance coverage. Again, coverage is for the employee, paid by the District.
- The District offers voluntary enrollment in a healthcare flex benefit plan (FSA) through American Fidelity. This account is 100% funded by the employee. (Annual open enrollment for this plan will become effective again **July 1, 2027**.)
- Additional voluntary insurance products are available through American Fidelity/AF.
- Our American Fidelity representative will contact you to discuss these offers and to document your decision for the District's compliance records if you decline participation.
- Also, if you have/open an account with Fayette County School Employees' Federal Credit Union, you may have an amount of your choosing deducted and forwarded from your pay.
- Frazier School District utilizes the portal through Harris School Solutions (link on the District website) for paystub distribution. Access will be available on the date of your first district pay. Username is your first initial followed by your last name, all lower case, no space-- password will be the last 4 digits of your Social Security number. You are encouraged to change your password after the initial login.

If you have any questions, please contact me at 724-736-9507 Ext. 110. Best wishes in your new position.

Employee's Withholding Certificate

OMB No. 1545-0074

Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay.**Give Form W-4 to your employer.****Your withholding is subject to review by the IRS.****2026****Step 1:
Enter
Personal
Information**

(a) First name and middle initial	Last name	(b) Social security number
Address		Does your name match the name on your social security card? If not, to ensure you get credit for your earnings, contact SSA at 800-772-1213 or go to www.ssa.gov .
City or town, state, and ZIP code		
(c) ☐ Single or Married filing separately ☐ Married filing jointly or Qualifying surviving spouse ☐ Head of household (Check only if you're unmarried and pay more than half the costs of keeping up a home for yourself and a qualifying individual.)		
Caution: To claim certain credits or deductions on your tax return, you (and/or your spouse if married filing jointly) are required to have a social security number valid for employment. See page 2 for more information.		

TIP: Consider using the estimator at www.irs.gov/W4App to determine the most accurate withholding for the rest of the year if you: are completing this form after the beginning of the year; expect to work only part of the year; or have changes during the year in your marital status, number of jobs for you (and/or your spouse if married filing jointly), dependents, other income (not from jobs), deductions, or credits. Have your most recent pay stub(s) from this year available when using the estimator. At the beginning of next year, use the estimator again to recheck your withholding.

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

**Step 2:
Multiple Jobs
or Spouse
Works**

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

Do **only one** of the following.

- (a) Use the estimator at www.irs.gov/W4App for the most accurate withholding for this step (and Steps 3–4). If you or your spouse have self-employment income, use this option; **or**
- (b) Use the Multiple Jobs Worksheet on page 3 and enter the result in Step 4(c) below; **or**
- (c) If there are only two jobs total, you may check this box. Do the same on Form W-4 for the other job. This option is generally more accurate than Step 2(b) if pay at the lower paying job is more than half of the pay at the higher paying job. Otherwise, Step 2(b) is more accurate ☐

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

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

Exempt from withholding	I claim exemption from withholding for 2026, and I certify that I meet both of the conditions for exemption for 2026. See <i>Exemption from withholding</i> on page 2. I understand I will need to submit a new Form W-4 for 2027 . . . ☐		
Step 5: Sign Here	Under penalties of perjury, I declare that this certificate, to the best of my knowledge and belief, is true, correct, and complete.		
	Employee's signature (This form is not valid unless you sign it.)		Date
Employers Only	Employer's name and address	First date of employment	Employer identification number (EIN)

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Future Developments

For the latest information about developments related to Form W-4, such as legislation enacted after it was published, go to www.irs.gov/FormW4.

Purpose of Form

Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay. If too little is withheld, you will generally owe tax when you file your tax return and may owe a penalty. If too much is withheld, you will generally be due a refund. Complete a new Form W-4 when changes to your personal or financial situation would change the entries on the form. For more information on withholding and when you must furnish a new Form W-4, see Pub. 505, Tax Withholding and Estimated Tax.

Exemption from withholding. You may claim exemption from withholding for 2026 if you meet both of the following conditions: you had no federal income tax liability in 2025 and you expect to have no federal income tax liability in 2026. You had no federal income tax liability in 2025 if (1) your total tax on line 24 on your 2025 Form 1040 or 1040-SR is zero (or less than the sum of lines 27a, 28, 29, and 30), or (2) you were not required to file a return because your income was below the filing threshold for your correct filing status. If you claim exemption, you will have no income tax withheld from your paycheck and may owe taxes and penalties when you file your 2026 tax return. To claim exemption from withholding, certify that you meet both of the conditions by checking the box in the *Exempt from withholding* section. Then, complete Steps 1(a), 1(b), and 5. Do not complete any other steps. You will need to submit a new Form W-4 by February 16, 2027.

Your privacy. Steps 2(c) and 4(a) ask for information regarding income you received from sources other than the job associated with this Form W-4. If you have concerns with providing the information asked for in Step 2(c), you may choose Step 2(b) as an alternative; if you have concerns with providing the information asked for in Step 4(a), you may enter an additional amount you want withheld per pay period in Step 4(c) as an alternative.

When to use the estimator. Consider using the estimator at www.irs.gov/W4App if you:

1. Are submitting this form after the beginning of the year;
2. Expect to work only part of the year;
3. Have changes during the year in your marital status, number of jobs for you (and/or your spouse if married filing jointly), or number of dependents, or changes in your deductions or credits;
4. Receive dividends, capital gains, social security, bonuses, or business income, or are subject to the Additional Medicare Tax or Net Investment Income Tax; or
5. Prefer the most accurate withholding for multiple job situations.

TIP: Have your most recent pay stub(s) from this year available when using the estimator to account for federal income tax that has already been withheld this year. At the beginning of next year, use the estimator again to recheck your withholding.

Self-employment. Generally, you will owe both income and self-employment taxes on any self-employment income you receive separate from the wages you receive as an employee. If you want to pay these taxes through withholding from your wages, use the estimator at www.irs.gov/W4App to figure the amount to have withheld.

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

Specific Instructions

Step 1(c). Check your anticipated filing status. This will determine the standard deduction and tax rates used to compute your withholding.

Step 2. Use this step if you (1) have more than one job at the same time, or (2) are married filing jointly and you and your spouse both work. Submit a separate Form W-4 for each job.

Option (a) most accurately calculates the additional tax you need to have withheld, while option (b) does so with a little less accuracy.

Instead, if you (and your spouse) have a total of only two jobs, you may check the box in option (c). The box must also be checked on the Form W-4 for the other job. If the box is checked, the standard deduction and tax brackets will be cut in half for each job to calculate withholding. This option is accurate for jobs with similar pay; otherwise, more tax than necessary may be withheld, and this extra amount of tax withheld will be larger the greater the difference in pay is between the two jobs.



Multiple jobs. Complete Steps 3 through 4(b) on only one Form W-4. Withholding will be most accurate if you do this on the Form W-4 for the highest paying job.

Step 3. This step provides instructions for determining the amount of the child tax credit and the credit for other dependents that you may be able to claim when you file your tax return. To qualify for the child tax credit, the child must be under age 17 as of December 31, must be your dependent who generally lives with you for more than half the year, and must have the required social security number. You (and/or your spouse if married filing jointly) must have the required social security number to claim certain credits. You may be able to claim a credit for other dependents for whom a child tax credit can't be claimed, such as an older child or a qualifying relative. For additional eligibility requirements for these credits, see Pub. 501, Dependents, Standard Deduction, and Filing Information. You can also include **other tax credits** for which you are eligible in this step, such as the foreign tax credit and the education tax credits. To do so, add an estimate of the amount for the year to your credits for dependents and enter the total amount in Step 3. Including these credits will increase your paycheck and reduce the amount of any refund you may receive when you file your tax return.

Step 4.

Step 4(a). Enter in this step the total of your other estimated income for the year, if any. You shouldn't include income from any jobs or self-employment. If you complete Step 4(a), you likely won't have to make estimated tax payments for that income. If you prefer to pay estimated tax rather than having tax on other income withheld from your paycheck, see Form 1040-ES, Estimated Tax for Individuals.

Step 4(b). Enter in this step the amount from the Deductions Worksheet, line 15, if you expect to claim deductions other than the basic standard deduction on your 2026 tax return and want to reduce your withholding to account for these deductions. This includes both itemized deductions and other deductions such as for qualified tips, overtime compensation, and passenger vehicle loan interest; student loan interest; IRAs; and seniors. You (and/or your spouse if married filing jointly) must have the required social security number to claim certain deductions. For additional eligibility requirements, see Pub. 501.

Step 4(c). Enter in this step any additional tax you want withheld from your pay **each pay period**, including any amounts from the Multiple Jobs Worksheet, line 4. Entering an amount here will reduce your paycheck and will either increase your refund or reduce any amount of tax that you owe when you file your tax return.

Step 2(b)—Multiple Jobs Worksheet *(Keep for your records.)*

If you choose the option in Step 2(b) on Form W-4, complete this worksheet (which calculates the total extra tax for all jobs) on **only ONE** Form W-4. Withholding will be most accurate if you complete the worksheet and enter the result on the Form W-4 for the highest paying job. To be accurate, submit a new Form W-4 for all other jobs if you have not updated your withholding since 2019.

Note: If more than one job has annual wages of more than \$120,000 or there are more than three jobs, see Pub. 505 for additional tables; or, you can use the online withholding estimator at www.irs.gov/W4App.

- 1 **Two jobs.** If you have two jobs or you're married filing jointly and you and your spouse each have one job, find the amount from the appropriate table on page 5. Using the "Higher Paying Job" row and the "Lower Paying Job" column, find the value at the intersection of the two household salaries and enter that value on line 1. Then, **skip** to line 3 1 \$ _____

- 2 **Three jobs.** If you and/or your spouse have three jobs at the same time, complete lines 2a, 2b, and 2c below. Otherwise, skip to line 3.
 - a Find the amount from the appropriate table on page 5 using the annual wages from the highest paying job in the "Higher Paying Job" row and the annual wages for your next highest paying job in the "Lower Paying Job" column. Find the value at the intersection of the two household salaries and enter that value on line 2a 2a \$ _____
 - b Add the annual wages of the two highest paying jobs from line 2a together and use the total as the wages in the "Higher Paying Job" row and use the annual wages for your third job in the "Lower Paying Job" column to find the amount from the appropriate table on page 5 and enter this amount on line 2b 2b \$ _____
 - c Add the amounts from lines 2a and 2b and enter the result on line 2c 2c \$ _____

- 3 Enter the number of pay periods per year for the highest paying job. For example, if that job pays weekly, enter 52; if it pays every other week, enter 26; if it pays monthly, enter 12, etc. 3 _____

- 4 **Divide** the annual amount on line 1 or line 2c by the number of pay periods on line 3. Enter this amount here and in **Step 4(c)** of Form W-4 for the highest paying job (plus any other additional amount you want withheld) 4 \$ _____

Step 4(b)—Deductions Worksheet (Keep for your records.)

See the Instructions for Schedule 1-A (Form 1040) for more information about whether you qualify for the deductions on lines 1a, 1b, 1c, 3a, and 3b.

1	Deductions for qualified tips, overtime compensation, and passenger vehicle loan interest.	
a	Qualified tips. If your total income is less than \$150,000 (\$300,000 if married filing jointly), enter an estimate of your qualified tips up to \$25,000	1a \$ _____
b	Qualified overtime compensation. If your total income is less than \$150,000 (\$300,000 if married filing jointly), enter an estimate of your qualified overtime compensation up to \$12,500 (\$25,000 if married filing jointly) of the "and-a-half" portion of time-and-a-half compensation	1b \$ _____
c	Qualified passenger vehicle loan interest. If your total income is less than \$100,000 (\$200,000 if married filing jointly), enter an estimate of your qualified passenger vehicle loan interest up to \$10,000	1c \$ _____
2	Add lines 1a, 1b, and 1c. Enter the result here	2 \$ _____
3	Seniors age 65 or older. If your total income is less than \$75,000 (\$150,000 if married filing jointly):	
a	Enter \$6,000 if you are age 65 or older before the end of the year	3a \$ _____
b	Enter \$6,000 if your spouse is age 65 or older before the end of the year and has a social security number valid for employment	3b \$ _____
4	Add lines 3a and 3b. Enter the result here	4 \$ _____
5	Enter an estimate of your student loan interest, deductible IRA contributions, educator expenses, alimony paid, and certain other adjustments from Schedule 1 (Form 1040), Part II. See Pub. 505 for more information	5 \$ _____
6	Itemized deductions. Enter an estimate of your 2026 itemized deductions from Schedule A (Form 1040). Such deductions may include qualifying:	
a	Medical and dental expenses. Enter expenses in excess of 7.5% (0.075) of your total income	6a \$ _____
b	State and local taxes. If your total income is less than \$505,000 (\$252,500 if married filing separately), enter state and local taxes paid up to \$40,400 (\$20,200 if married filing separately)	6b \$ _____
c	Home mortgage interest. If your home acquisition debt is less than \$750,000 (\$375,000 if married filing separately), enter your home mortgage interest expense (including mortgage insurance premiums)	6c \$ _____
d	Gifts to charities. Enter contributions in excess of 0.5% (0.005) of your total income	6d \$ _____
e	Other itemized deductions. Enter the amount for other itemized deductions	6e \$ _____
7	Add lines 6a, 6b, 6c, 6d, and 6e. Enter the result here	7 \$ _____
8	Limitation on itemized deductions.	
a	Enter your total income	8a \$ _____
b	Subtract line 4 from line 8a. If line 4 is greater than line 8a, enter -0- here and on line 10. Skip line 9	8b \$ _____
9	Enter: $\left\{ \begin{array}{l} \bullet \$768,700 \text{ if you're married filing jointly or a qualifying surviving spouse} \\ \bullet \$640,600 \text{ if you're single or head of household} \\ \bullet \$384,350 \text{ if you're married filing separately} \end{array} \right\}$	9 \$ _____
10	If line 9 is greater than line 8b, enter the amount from line 7. Otherwise, multiply line 7 by 94% (0.94) and enter the result here	10 \$ _____
11	Standard deduction.	
Enter:	$\left\{ \begin{array}{l} \bullet \$32,200 \text{ if you're married filing jointly or a qualifying surviving spouse} \\ \bullet \$24,150 \text{ if you're head of household} \\ \bullet \$16,100 \text{ if you're single or married filing separately} \end{array} \right\}$	11 \$ _____
12	Cash gifts to charities. If you take the standard deduction, enter cash contributions up to \$1,000 (\$2,000 if married filing jointly)	12 \$ _____
13	Add lines 11 and 12. Enter the result here	13 \$ _____
14	If line 10 is greater than line 13, subtract line 11 from line 10 and enter the result here. If line 13 is greater than line 10, enter the amount from line 12	14 \$ _____
15	Add lines 2, 4, 5, and 14. Enter the result here and in Step 4(b) of Form W-4	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. Internal Revenue Code sections 3402(f)(2) and 6109 and their regulations require you to provide this information; your employer uses it to determine your federal income tax withholding. Failure to provide a properly completed form will result in your being treated as a single person with no other entries on the form; providing fraudulent information may subject you to penalties. Routine uses of this information include giving it to the Department of Justice for civil and criminal litigation; to cities, states, the District of Columbia, and U.S. commonwealths and territories for use in administering their tax laws; and to the Department of Health and Human Services for use in the National Directory of New Hires. We may also disclose this information to other countries under a tax treaty, to federal and state agencies to enforce federal nontax criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism.

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

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

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

Married Filing Jointly or Qualifying Surviving Spouse

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	\$0 - 9,999	\$10,000 - 19,999	\$20,000 - 29,999	\$30,000 - 39,999	\$40,000 - 49,999	\$50,000 - 59,999	\$60,000 - 69,999	\$70,000 - 79,999	\$80,000 - 89,999	\$90,000 - 99,999	\$100,000 - 109,999	\$110,000 - 120,000
\$0 - 9,999	\$0	\$0	\$480	\$850	\$850	\$1,020	\$1,020	\$1,020	\$1,020	\$1,020	\$1,020	\$1,020
\$10,000 - 19,999	0	480	1,480	1,850	2,050	2,220	2,220	2,220	2,220	2,220	2,220	2,620
\$20,000 - 29,999	480	1,480	2,480	3,050	3,250	3,420	3,420	3,420	3,420	3,420	3,820	4,820
\$30,000 - 39,999	850	1,850	3,050	3,620	3,820	3,990	3,990	3,990	3,990	4,390	5,390	6,390
\$40,000 - 49,999	850	2,050	3,250	3,820	4,020	4,190	4,190	4,190	4,590	5,590	6,590	7,590
\$50,000 - 59,999	1,020	2,220	3,420	3,990	4,190	4,360	4,360	4,760	5,760	6,760	7,760	8,760
\$60,000 - 69,999	1,020	2,220	3,420	3,990	4,190	4,360	4,760	5,760	6,760	7,760	8,760	9,760
\$70,000 - 79,999	1,020	2,220	3,420	3,990	4,190	4,760	5,760	6,760	7,760	8,760	9,760	10,760
\$80,000 - 99,999	1,020	2,220	3,420	4,240	5,440	6,610	7,610	8,610	9,610	10,610	11,610	12,610
\$100,000 - 149,999	1,870	4,070	6,270	7,840	9,040	10,210	11,210	12,210	13,210	14,210	15,360	16,560
\$150,000 - 239,999	1,870	4,100	6,500	8,270	9,670	11,040	12,240	13,440	14,640	15,840	17,040	18,240
\$240,000 - 319,999	2,040	4,440	6,840	8,610	10,010	11,380	12,580	13,780	14,980	16,180	17,380	18,580
\$320,000 - 364,999	2,040	4,440	6,840	8,610	10,010	11,380	12,580	13,860	15,860	17,860	19,860	21,860
\$365,000 - 524,999	2,720	5,920	9,390	12,260	14,760	17,230	19,530	21,830	24,130	26,430	28,730	31,030
\$525,000 and over	3,140	6,840	10,540	13,610	16,310	18,980	21,480	23,980	26,480	28,980	31,480	33,990

Single or Married Filing Separately

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	\$0 - 9,999	\$10,000 - 19,999	\$20,000 - 29,999	\$30,000 - 39,999	\$40,000 - 49,999	\$50,000 - 59,999	\$60,000 - 69,999	\$70,000 - 79,999	\$80,000 - 89,999	\$90,000 - 99,999	\$100,000 - 109,999	\$110,000 - 120,000
\$0 - 9,999	\$90	\$850	\$1,020	\$1,020	\$1,020	\$1,070	\$1,870	\$1,870	\$1,870	\$1,870	\$1,870	\$1,970
\$10,000 - 19,999	850	1,780	1,980	1,980	2,030	3,030	3,830	3,830	3,830	3,830	3,930	4,130
\$20,000 - 29,999	1,020	1,980	2,180	2,230	3,230	4,230	5,030	5,030	5,030	5,130	5,330	5,530
\$30,000 - 39,999	1,020	1,980	2,230	3,230	4,230	5,230	6,030	6,030	6,130	6,330	6,530	6,730
\$40,000 - 59,999	1,020	2,880	4,080	5,080	6,080	7,080	7,950	8,150	8,350	8,550	8,750	8,950
\$60,000 - 79,999	1,870	3,830	5,030	6,030	7,100	8,300	9,300	9,500	9,700	9,900	10,100	10,300
\$80,000 - 99,999	1,870	3,830	5,100	6,300	7,500	8,700	9,700	9,900	10,100	10,300	10,500	10,700
\$100,000 - 124,999	2,030	4,190	5,590	6,790	7,990	9,190	10,190	10,390	10,590	10,940	11,940	12,940
\$125,000 - 149,999	2,040	4,200	5,600	6,800	8,000	9,200	10,200	10,950	11,950	12,950	13,950	14,950
\$150,000 - 174,999	2,040	4,200	5,600	6,800	8,150	10,150	11,950	12,950	13,950	14,950	16,170	17,470
\$175,000 - 199,999	2,040	4,200	6,150	8,150	10,150	12,150	13,950	15,020	16,320	17,620	18,920	20,220
\$200,000 - 249,999	2,720	5,680	7,880	10,140	12,440	14,740	16,840	18,140	19,440	20,740	22,040	23,340
\$250,000 - 449,999	2,970	6,230	8,730	11,030	13,330	15,630	17,730	19,030	20,330	21,630	22,930	24,240
\$450,000 and over	3,140	6,600	9,300	11,800	14,300	16,800	19,100	20,600	22,100	23,600	25,100	26,610

Head of Household

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	\$0 - 9,999	\$10,000 - 19,999	\$20,000 - 29,999	\$30,000 - 39,999	\$40,000 - 49,999	\$50,000 - 59,999	\$60,000 - 69,999	\$70,000 - 79,999	\$80,000 - 89,999	\$90,000 - 99,999	\$100,000 - 109,999	\$110,000 - 120,000
\$0 - 9,999	\$0	\$280	\$850	\$950	\$1,020	\$1,020	\$1,020	\$1,020	\$1,560	\$1,870	\$1,870	\$1,870
\$10,000 - 19,999	280	1,280	1,950	2,150	2,220	2,220	2,220	2,760	3,760	4,070	4,070	4,210
\$20,000 - 29,999	850	1,950	2,720	2,920	2,980	2,980	3,520	4,520	5,520	5,830	5,980	6,180
\$30,000 - 39,999	950	2,150	2,920	3,120	3,180	3,720	4,720	5,720	6,720	7,180	7,380	7,580
\$40,000 - 59,999	1,020	2,220	2,980	3,570	4,640	5,640	6,640	7,750	8,950	9,460	9,660	9,860
\$60,000 - 79,999	1,020	2,610	4,370	5,570	6,640	7,750	8,950	10,150	11,350	11,860	12,060	12,260
\$80,000 - 99,999	1,870	4,070	5,830	7,150	8,410	9,610	10,810	12,010	13,210	13,720	13,920	14,120
\$100,000 - 124,999	1,870	4,270	6,230	7,630	8,900	10,100	11,300	12,500	13,700	14,210	14,720	15,720
\$125,000 - 149,999	2,040	4,440	6,400	7,800	9,070	10,270	11,470	12,670	14,580	15,890	16,890	17,890
\$150,000 - 174,999	2,040	4,440	6,400	7,800	9,070	10,580	12,580	14,580	16,580	17,890	18,890	20,170
\$175,000 - 199,999	2,040	4,440	6,400	8,510	10,580	12,580	14,580	16,580	18,710	20,320	21,620	22,920
\$200,000 - 249,999	2,720	5,920	8,680	10,900	13,270	15,570	17,870	20,170	22,470	24,080	25,380	26,680
\$250,000 - 449,999	2,970	6,470	9,540	12,040	14,410	16,710	19,010	21,310	23,610	25,220	26,520	27,820
\$450,000 and over	3,140	6,840	10,110	12,810	15,380	17,880	20,380	22,880	25,380	27,190	28,690	30,190



RESIDENCY CERTIFICATION FORM

Local Earned Income Tax Withholding

TO EMPLOYERS/TAXPAYERS:

This form is to be used by employers and taxpayers to report essential information for the collection and distribution of Local Earned Income Taxes to the local EIT collector. This form must be used by employers when a new employee is hired or when a current employee notifies employer of a name or address change. Use the Address Search Application at dced.pa.gov/Act32 to determine PSD codes, EIT rates, and tax collector contact information.

EMPLOYEE INFORMATION – RESIDENCE LOCATION			
NAME (Last Name, First Name, Middle Initial)		SOCIAL SECURITY NUMBER 	
STREET ADDRESS (No PO Box, RD or RR)			
ADDRESS LINE 2			
CITY	STATE	ZIP CODE	DAYTIME PHONE NUMBER
MUNICIPALITY (City, Borough or Township)			
COUNTY	RESIDENT PSD CODE 		TOTAL RESIDENT EIT RATE

EMPLOYER INFORMATION – EMPLOYMENT LOCATION			
EMPLOYER BUSINESS NAME (Use Federal ID Name)		EMPLOYER FEIN 	
FRAZIER SCHOOL DISTRICT			
STREET ADDRESS WHERE ABOVE EMPLOYEE REPORTS TO WORK (No PO Box, RD or RR)			
142 CONSTITUTION STREET			
ADDRESS LINE 2			
CITY	STATE	ZIP CODE	PHONE NUMBER
PERRYOPOLIS	PA	15473	724-736-9507
MUNICIPALITY (City, Borough or Township)			
PERRYOPOLIS BOROUGH			
COUNTY	WORK LOCATION PSD CODE 		WORK LOCATION NON-RESIDENT EIT RATE
FAYETTE	2 6 0 4 0 5		

CERTIFICATION	
Under penalties of perjury, I (we) declare that I (we) have examined this information, including all accompanying schedules and statements and to the best of my (our) belief, they are true, correct and complete.	
SIGNATURE OF EMPLOYEE	DATE (MM/DD/YYYY)
PHONE NUMBER	EMAIL ADDRESS

For information on obtaining the appropriate MUNICIPALITY (City, Borough, Township), PSD CODES, and EIT (Earned Income Tax) RATES, please refer to the Pennsylvania Department of Community & Economic Development website:

dced.pa.gov/Act32



Employment Eligibility Verification

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

USCIS
Form I-9

OMB No.1615-0047

Expires 05/31/2027

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

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

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

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

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

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

List A		OR	List B	AND	List C	
Document Title 1						
Issuing Authority						
Document Number (if any)						
Expiration Date (if any)						
Document Title 2 (if any)		Additional Information				
Issuing Authority						
Document Number (if any)						
Expiration Date (if any)						
Document Title 3 (if any)		☐ Check here if you used an alternative procedure authorized by DHS to examine documents.				
Issuing Authority						
Document Number (if any)						
Expiration Date (if any)						
Certification: I attest, under penalty of perjury, that (1) I have examined the documentation presented by the above-named employee, (2) the above-listed documentation appears to be genuine and to relate to the employee named, and (3) to the best of my knowledge, the employee is authorized to work in the United States.					First Day of Employment (mm/dd/yyyy):	
Last Name, First Name and Title of Employer or Authorized Representative				Signature of Employer or Authorized Representative		Today's Date (mm/dd/yyyy)
Employer's Business or Organization Name			Employer's Business or Organization Address, City or Town, State, ZIP Code			

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

LISTS OF ACCEPTABLE DOCUMENTS

All documents containing an expiration date must be unexpired.

* Documents extended by the issuing authority are considered unexpired.

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

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

LIST A Documents that Establish Both Identity and Employment Authorization	OR	LIST B Documents that Establish Identity	AND	LIST C Documents that Establish Employment Authorization
1. U.S. Passport or U.S. Passport Card 2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551) 3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa 4. Employment Authorization Document that contains a photograph (Form I-766) 5. For an individual temporarily authorized to work for a specific employer because of his or her status or parole: a. Foreign passport; and b. Form I-94 or Form I-94A that has the following: (1) The same name as the passport; and (2) An endorsement of the individual's status or parole as long as that period of endorsement has not yet expired and the proposed employment is not in conflict with any restrictions or limitations identified on the form. 6. Passport from the Federated States of Micronesia (FSM) or the Republic of the Marshall Islands (RMI) with Form I-94 or Form I-94A indicating nonimmigrant admission under the Compact of Free Association Between the United States and the FSM or RMI		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, sex, height, eye color, and address 2. ID card issued by federal, state or local government agencies or entities, provided it contains a photograph or information such as name, date of birth, sex, height, eye color, and address 3. School ID card with a photograph 4. Voter's registration card 5. U.S. Military card or draft record 6. Military dependent's ID card 7. U.S. Coast Guard Merchant Mariner Card 8. Native American tribal document 9. Driver's license issued by a Canadian government authority For persons under age 18 who are unable to present a document listed above: 10. School record or report card 11. Clinic, doctor, or hospital record 12. Day-care or nursery school record		1. A Social Security Account Number card, unless the card includes one of the following restrictions: (1) NOT VALID FOR EMPLOYMENT (2) VALID FOR WORK ONLY WITH INS AUTHORIZATION (3) VALID FOR WORK ONLY WITH DHS AUTHORIZATION 2. Certification of report of birth issued by the Department of State (Forms DS-1350, FS-545, FS-240) 3. Original or certified copy of birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal 4. Native American tribal document 5. U.S. Citizen ID Card (Form I-197) 6. Identification Card for Use of Resident Citizen in the United States (Form I-179) 7. Employment authorization document issued by the Department of Homeland Security For examples, see Section 7 and Section 13 of the M-274 on uscis.gov/i-9-central. The Form I-766, Employment Authorization Document, is a List A, Item Number 4. document, not a List C document.
Acceptable Receipts May be presented in lieu of a document listed above for a temporary period. For receipt validity dates, see the M-274.				
• Receipt for a replacement of a lost, stolen, or damaged List A document. • Form I-94 issued to a lawful permanent resident that contains an I-551 stamp and a photograph of the individual. • Form I-94 with "RE" notation or refugee stamp issued to a refugee.	OR	Receipt for a replacement of a lost, stolen, or damaged List B document.		Receipt for a replacement of a lost, stolen, or damaged List C document.

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



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

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

**USCIS
Form I-9
Supplement A**
OMB No. 1615-0047
Expires 05/31/2027

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

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

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

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

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

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

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

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

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

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



Supplement B,
Reverification and Rehire (formerly Section 3)

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

USCIS
Form I-9
Supplement B
OMB No. 1615-0047
Expires 05/31/2027

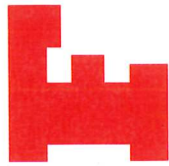
Last Name (Family Name) from Section 1.	First Name (Given Name) from Section 1.	Middle initial (if any) from Section 1.
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Instructions: This supplement replaces Section 3 on the previous version of Form I-9. Only use this page if your employee requires reverification, is rehired within three years of the date the original Form I-9 was completed, or provides proof of a legal name change. Enter the employee's name in the fields above. Use a new section for each reverification or rehire. Review the Form I-9 instructions before completing this page. Keep this page as part of the employee's Form I-9 record. Additional guidance can be found in the [Handbook for Employers: Guidance for Completing Form I-9 \(M-274\)](#)

Date of Rehire (if applicable)	New Name (if applicable)		
Date (mm/dd/yyyy)	Last Name (Family Name)	First Name (Given Name)	Middle Initial
Reverification: If the employee requires reverification, your employee can choose to present any acceptable List A or List C documentation to show continued employment authorization. Enter the document information in the spaces below.			
Document Title	Document Number (if any)	Expiration Date (if any) (mm/dd/yyyy)	
I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented documentation, the documentation I examined appears to be genuine and to relate to the individual who presented it.			
Name of Employer or Authorized Representative	Signature of Employer or Authorized Representative		Today's Date (mm/dd/yyyy)
Additional Information (Initial and date each notation.)			☐ Check here if you used an alternative procedure authorized by DHS to examine documents.

Date of Rehire (if applicable)	New Name (if applicable)		
Date (mm/dd/yyyy)	Last Name (Family Name)	First Name (Given Name)	Middle Initial
Reverification: If the employee requires reverification, your employee can choose to present any acceptable List A or List C documentation to show continued employment authorization. Enter the document information in the spaces below.			
Document Title	Document Number (if any)	Expiration Date (if any) (mm/dd/yyyy)	
I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented documentation, the documentation I examined appears to be genuine and to relate to the individual who presented it.			
Name of Employer or Authorized Representative	Signature of Employer or Authorized Representative		Today's Date (mm/dd/yyyy)
Additional Information (Initial and date each notation.)			☐ Check here if you used an alternative procedure authorized by DHS to examine documents.

Date of Rehire (if applicable)	New Name (if applicable)		
Date (mm/dd/yyyy)	Last Name (Family Name)	First Name (Given Name)	Middle Initial
Reverification: If the employee requires reverification, your employee can choose to present any acceptable List A or List C documentation to show continued employment authorization. Enter the document information in the spaces below.			
Document Title	Document Number (if any)	Expiration Date (if any) (mm/dd/yyyy)	
I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented documentation, the documentation I examined appears to be genuine and to relate to the individual who presented it.			
Name of Employer or Authorized Representative	Signature of Employer or Authorized Representative		Today's Date (mm/dd/yyyy)
Additional Information (Initial and date each notation.)			☐ Check here if you used an alternative procedure authorized by DHS to examine documents.

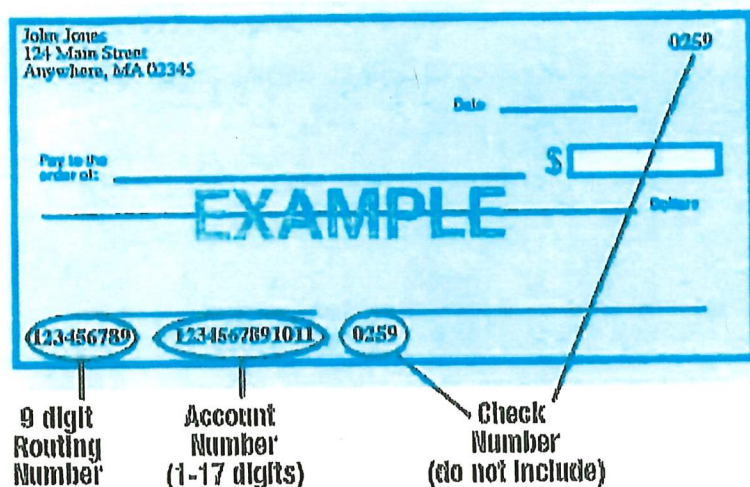


Frazier School District Payroll Schedule 2026-2027		
PAY DATE*	HOURS/DAYS WORKED	HOURS/DAYS WORKED
	FROM ...	TO ...
September 11, 2026	August 15, 2026	August 28, 2026
September 25, 2026	August 29, 2026	September 11, 2026
October 9, 2026	September 12, 2026	September 25, 2026
October 23, 2026	September 26, 2026	October 9, 2026
November 6, 2026	October 10, 2026	October 23, 2026
November 20, 2026	October 24, 2026	November 6, 2026
December 4, 2026	November 7, 2026	November 20, 2026
December 18, 2026	November 21, 2026	December 4, 2026
January 1, 2027	December 5, 2026	December 18, 2026
January 15, 2027	December 19, 2026	January 1, 2027
January 29, 2027	January 2, 2027	January 15, 2027
February 12, 2027	January 16, 2027	January 29, 2027
February 26, 2027	January 30, 2027	February 12, 2027
March 12, 2027	February 13, 2027	February 26, 2027
March 26, 2027	February 27, 2027	March 12, 2027
April 9, 2027	March 13, 2027	March 26, 2027
April 23, 2027	March 27, 2027	April 9, 2027
May 7, 2027	April 10, 2027	April 23, 2027
May 21, 2027	April 24, 2027	May 7, 2027
June 4, 2027	May 8, 2027	May 21, 2027
June 18, 2027	May 22, 2027	June 4, 2027
July 2, 2027	June 5, 2027	June 18, 2027
July 16, 2027	June 19, 2027	July 2, 2027
July 30, 2027	July 3, 2027	July 16, 2027
August 13, 2027	July 17, 2027	July 30, 2027
August 27, 2027	July 31, 2027	August 13, 2027
* Timesheet due date and/or pay date may be altered based on bank holiday(s) and/or district closures. Revisions to these dates will be communicated through district email.		

Direct Deposit Authorization Form

Please print and complete ALL the information below.

Employee Name: _____
Employee Social Security #: _____
Address: _____
City, State, Zip: _____



Name of Financial Institution: _____

Account #: _____

9-Digit Routing #: _____

Type of Account: Checking Savings (Circle One)

Please attach a voided check for the bank account to which funds should be deposited.

Frazier School District is hereby authorized to directly deposit my net pay in the account and financial institution indicated above. This authorization will remain in effect until I modify or cancel it in writing. Any such notification to my employer shall become effective following receipt, after a reasonable opportunity to act on it.

Employee Signature: _____

Date: _____



Frazier School District - Perryopolis (15473)
YOUR WORKERS COMPENSATION CLAIMS ARE MANAGED BY WORKPARTNERS
Send Bills To: PO Box 2971, Pittsburgh, PA 15230
Fax: (412) 454-8717
To Report a Claim Call: 1-800-633-1197
WC Policy: WC100-0006189
Policy Effective Date: 07/01/2026

NOTICE TO EMPLOYEES IN CASE OF WORK-RELATED INJURIES

1. If you suffer a work-related injury, your employer or its insurance company must pay for reasonable surgical and medical services and supplies, orthopedic appliances and prosthesis, including training in their use.
2. In order to insure that your medical treatment will be paid for by your employer or the insurance company, you must select from one of the following health care providers.
3. You must continue to visit one of the physicians listed below, if you need treatment, for ninety (90) days from the date of your first visit.
4. If one of the persons below refers you to another licensed specialist, your employer or their insurer will pay the bill for these services.
5. After this ninety- (90) day period, if you still need treatment and your employer has provided a list as set forth below, you may choose to go to another health care provider for treatment. You should notify your employer of this action within five days of your visit to said provider.
6. If a physician on the list prescribes invasive surgery, you may obtain a second opinion from any physician of your choice. If the second opinion is different than the listed physicians opinion, you may determine which course of treatment to follow; however, the second opinion must contain a specific and detailed treatment plan. If you choose the second opinion, the procedures in that opinion must be performed by one of the physicians on the list for the first ninety- (90) days. Therefore, in this situation, the employee may be required to treat with an employer-designated provider for up to 180 days.
7. If you are faced with a medical emergency, you may secure assistance from a hospital, physician, or health care provider of your choice for your work-related injury. However, when the emergency is resolved, you must seek treatment from a provider listed below.

Please contact your Claims Adjuster for any specialty need not listed on this panel.

<u>Name</u>	<u>Address</u>	<u>Scheduling</u>	<u>Area of Specialty</u>
St Clair Occupational Medicine (use Urgent Care after hours)	2000 Oxford Dr, Ste 100 Urgent Care: (412) 942-8800 Bethel Park, PA 15102	412-942-7115	Occupational Medicine
Independence Health WORKS - Greensburg	200 Village Dr Ste C Greensburg, PA 15601	724-765-1230	Occupational Medicine
*UPMC GoHealth Urgent Care LLC - Belle Vernon (All Locations)	860 Rostraver Rd Belle Vernon, PA 15012	724-243-2426	Urgent Care
*UPMC GoHealth Urgent Care LLC - Dunbar Twp/Morrell Ave (All Locations)	1440 Morrell Ave Connellsville, PA 15425	724-603-5022	Urgent Care
Mon-Vale Surgical Associates	800 Plaza Dr, Ste 140 Monongahela Valley Hospital HealthPlex Belle Vernon, PA 15012	724-929-4122	General Surgery
*UPP Dept of Neurosurgery - McKeesport	500 Hospital Way, Ste 6 John Painter Building McKeesport, PA 15132	412-647-3685	Neurosurgery
The Orthopedic Group - Belle Vernon	800 Plaza Dr, Ste 400 Belle Vernon, PA 15012	724-379-5802	Orthopedics
Penn Highlands Orthopedics & Sports Medicine - Uniontown	150 Wayland Smith Dr Uniontown, PA 15401	724-437-8200	Orthopedics
Martinelli Eye & Laser Center - Charleroi	303 First St Charleroi, PA 15022	724-483-3675	Ophthalmology
Associates in Medical Rehabilitation PLCC	1163 Country Club Rd Monongahela, PA 15063	724-258-1408	Physiatry (Musculoskeletal Injuries)
One Call Physical Therapy	Call Toll-Free for Closest Location	1-844-284-2525	Physical Therapy
One Call Chiropractic	Call Toll-Free for Closest Location	1-844-284-2525	Chiropractic
One Call Imaging Services	Call Toll-Free for Closest Location	1-844-284-2525	Diagnostic Imaging
One Call Durable Medical Equipment	Call Toll-Free for Supplier	1-844-284-2525	DME

in accordance with Section 306(f.1)(1)(i) of the Worker's Compensation Act AND 34 Pa. Code Section 127.753 Disclosure Requirements, this health care provider is employed, owned or controlled by UPMC.

**CONTACT THE BUSINESS MANAGER (EXT. 114) TO FILE A WORKER'S COMP. CLAIM
OR TO REQUEST AN UPDATED PANEL OF PROVIDERS.**

Panel updated: 6/9/2026



Frazier School District - Perryopolis (15473)

YOUR WORKERS COMPENSATION CLAIMS ARE MANAGED BY WORKPARTNERS

Send Bills To: PO Box 2971, Pittsburgh, PA 15230

Fax: (412) 454-8717

To Report a Claim Call: 1-800-633-1197

WC Policy:WC100-0006189

Policy Effective Date:07/01/2026

NOTICE TO EMPLOYEES IN CASE OF WORK-RELATED INJURIES

1. If you suffer a work-related injury, your employer or its insurance company must pay for reasonable surgical and medical services and supplies, orthopedic appliances and prosthesis, including training in their use.
2. In order to insure that your medical treatment will be paid for by your employer or the insurance company, you must select from one of the following health care providers.
3. You must continue to visit one of the physicians listed below, if you need treatment, for ninety (90) days from the date of your first visit.
4. If one of the persons below refers you to another licensed specialist, your employer or their insurer will pay the bill for these services.
5. After this ninety- (90) day period, if you still need treatment and your employer has provided a list as set forth below, you may choose to go to another health care provider for treatment. You should notify your employer of this action within five days of your visit to said provider.
6. If a physician on the list prescribes invasive surgery, you may obtain a second opinion from any physician of your choice. If the second opinion is different than the listed physicians opinion, you may determine which course of treatment to follow; however, the second opinion must contain a specific and detailed treatment plan. If you choose the second opinion, the procedures in that opinion must be performed by one of the physicians on the list for the first ninety- (90) days. Therefore, in this situation, the employee may be required to treat with an employer-designated provider for up to 180 days.
7. If you are faced with a medical emergency, you may secure assistance from a hospital, physician, or health care provider of your choice for your work-related injury. However, when the emergency is resolved, you must seek treatment from a provider listed below.

Please contact your Claims Adjuster for any specialty need not listed on this panel.

<u>Name</u>	<u>Address</u>	<u>Scheduling</u>	<u>Area of Specialty</u>
myMatrixx (an Express Scripts company)	Call Toll-Free for Closest Location BIN# 003858, Group# KYHA	1-800-945-5951	Pharmacy



WORKERS' COMPENSATION INFORMATION

To All Employees:

The workers' compensation law provides wage loss and medical benefits to employees who cannot work, or who need medical care, because of a work-related injury.

Benefits are required to be paid by your employer if self-insured, or through insurance provided by your employer. Your employer is required to post the name of the company responsible for paying workers' compensation benefits at its primary place of business and at its sites of employment in a prominent and easily accessible place. It is also required to be posted in any areas used for treatment of injured employees or for the administration of first aid.

You should report immediately any injury or work-related illness to your employer. Your benefits could be delayed or denied if you do not notify your employer immediately.

If your claim is denied by your employer, you have the right to request a hearing before a Workers' Compensation Judge.

The Bureau of Workers' Compensation cannot provide legal advice. However, you may contact the Bureau of Workers' Compensation for additional general information:

Department of Labor & Industry
Bureau of Workers' Compensation
651 Boas Street 8th Fl
Harrisburg, Pennsylvania 17121-0750
Telephone No. within Pennsylvania: 1-800-482-2383
Telephone No. outside of this Commonwealth: 717-772-4447
TTY: 1-800-362-4228 (for hearing and speech impaired only)
www.state.pa.us, PA keyword: workers' comp

For a complete list of panel physicians, please contact your employer. Please call 1-800-633-1197 with any additional questions.

I, _____, employee of _____,
(employer)

certify that I have been provided with, read, and understood the information set forth above consistent with the requirements of the Pennsylvania Workers' Compensation Act.

Date: _____

Fax this form to Workpartners (412-454-8717) if it is being completed as a result of a work injury; then place the original in the employee file. If this form is being completed for any reason other than in conjunction with an injury please do not fax to Workpartners, only place in the employee file.

Workpartners Claims Management Services PO Box 2971 Pittsburgh PA 15230



**EMPLOYEE'S ACKNOWLEDGEMENT FORM UNDER
SECTION 306(f)(1)(i) OF THE PENNSYLVANIA WORKER'S COMPENSATION ACT**

I recognize and agree that my employer has provided a list of at least six (6) designated health care providers, no more than two (2) of whom are coordinated care organizations and no fewer than three (3) of whom are physicians. Therefore, I acknowledge that I must treat with one of these health care providers for ninety (90) days from the date of my first visit. If I fail to treat with one of these designated health care providers, I understand that my employer will not be liable for the payment for services rendered during this ninety (90) day period. Subsequent treatment may be provided by any health care provider of my choice. However, I must advise my employer within five (5) days of my first visit to each and every non-designated health care provider. Failure to do so may affect whether my employer is liable for payment for services rendered prior to appropriate notice.

My employer has informed me of my rights and duties, and my signature acknowledges that I have been so informed and that I understand my rights and duties.

Employee's Signature

Date

Employee's Name (Print)

Employee Number

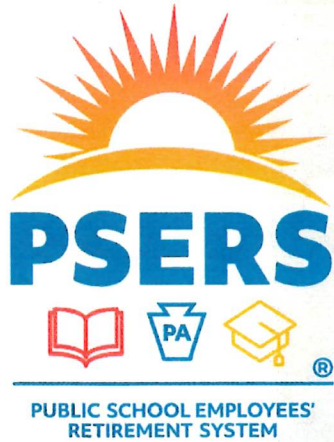
Employer

Department

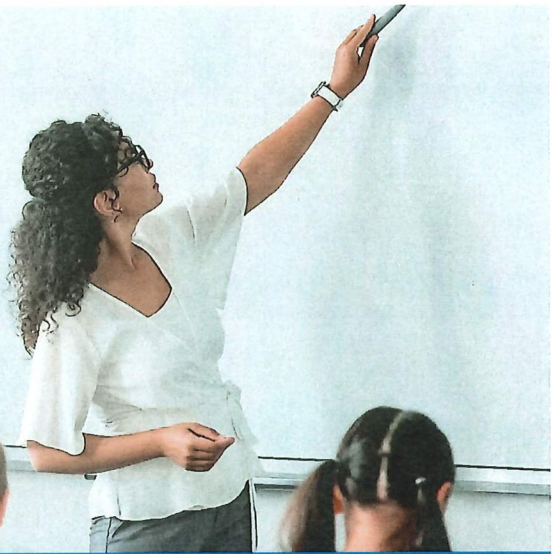
Witness' Signature

Date

Fax this form to Workpartners (412-454-8717) if it is being completed as a result of a work injury; then place the original in the employee file. If this form is being completed for any reason other than in conjunction with an injury please do not fax to Workpartners, only place in the employee file.



Information for New School Employees

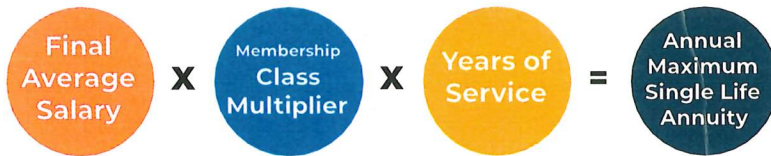


About PSERS

PSERS is a governmental, cost-sharing, multiple-employer pension plan to which public school employers, the Commonwealth, and school employees (members) contribute. Once you qualify for membership, you will have the option to elect one of two membership classes consisting of defined benefit (DB) and defined contribution (DC) components or a standalone DC membership class.

PSERS Defined Benefit (DB) Plan

In the DB plan, the retirement benefit is based on a formula that includes a pension multiplier, your credited years of service, and your final average salary.



PSERS Defined Contribution (DC) Plan

In the DC Plan, the retirement benefit is based on the amount of contributions made to the plan and the investment performance of those contributions. Your DC contributions and earnings, if any, are available for you to withdraw when you retire or leave employment. Class DC has only a DC component.



Class T-C, Class T-D, Class T-E, and Class T-F have only a DB component. Class T-G and Class T-H have both DB and DC components. Class DC has only a DC component.

With PSERS, you're on your way!

The Public School Employees' Retirement System (PSERS) and your school employer have partnered to assist you with planning and saving for your retirement.

When you become a PSERS member, you join one of the nation's largest public pension funds. That means you're now in good company with more than 500,000 fellow PSERS members.

PSERS has been proudly serving Pennsylvania public school employees for the past 100 years. In FY 2022 alone, PSERS disbursed more than \$6.6 billion to retirees. When it's your turn to retire, you can count on PSERS to be there for you and your retirement journey.

Access your retirement account online, anytime.

Sign up for PSERS Member Self-Service (MSS) Portal! Your PSERS MSS account provides you with 24-hour access to view correspondence and newsletters, update your address and beneficiaries, view pension payment history, generate retirement estimates, and more. Scan the QR Code before to register for your account today!

Questions?

PSERS Retirement Plan Information:

5 N 5th Street | Harrisburg PA 17101-1905
Toll-Free: 1.888.773.7748 (8 a.m. - 5p.m., M-F)
Harrisburg Local: 717.787.8540
Website: psers.pa.gov
Send us a Secure Message in Your MSS Account!

PSERS DC Plan Information:

Toll-Free: 1.833.432.6627 (8 a.m. - 8 p.m., M-F)
Participant Web: PSERSDC.voya.com



Qualifying for PSERS Membership

All full-time employees must become members of PSERS and must make retirement contributions starting their first day of employment. "Full-time," for retirement purposes with PSERS, is defined as employees who work 5 or more hours a day/5 days a week or its equivalent (25 or more hours a week), even if your employer considers you to be part-time.

Part-time salaried employees qualify for PSERS membership as of their first day of employment and must have retirement contributions withheld.

Part-time hourly and part-time per diem employees must meet minimum service requirements to qualify for PSERS membership (500 hours or 80 days). Once you meet membership requirements, subsequent service for any school employer is qualified service unless there is a break in membership. Refer to PSERS Active Member Handbook for more information.

Part-time employees may waive membership in PSERS. To qualify for the waiver, a part-time employee must have an Individual Retirement Account and request a waiver within 90 days of notification from PSERS that they qualify for PSERS membership. When you waive membership in PSERS, you forfeit all future rights to benefits for the waived time period.

Withheld Contributions

Your employer will withhold contributions beginning with your first day of qualifying PSERS service. If you are a full-time or part-time salaried employee, this will be your first day of employment.

If you are a part-time hourly or per diem employee, your employer can choose to withhold contributions for the PSERS DB plan. Any contributions withheld will be returned to you if you do not qualify for membership. Contributions cannot be withheld for the DC Plan until you qualify for membership. Once you meet PSERS membership eligibility requirements, your employer must withhold both DB and DC contributions.

The amount withheld is determined by your membership class. If you previously were a PSERS member, you will remain in your previous membership class and your employer will withhold contributions at the rate for that class.

Please visit [PSERS.pa.gov](https://psers.pa.gov) for the current member contribution rates.

Membership Class of Service

For school employees who become new members of PSERS on or after July 1, 2019, there are three membership classes with different retirement contribution rates and benefits with PSERS: Class T-G, Class T-H, and Class DC. New members are automatically enrolled as Class T-G, but have a one-time opportunity to elect Class T-H or Class DC membership.



Look for class election material from PSERS when your election period is open. Your election material will arrive through your PSERS Member Self-Service (MSS) account if you signed up or in the mail if you did not sign up for MSS. Additional information is also on the PSERS website. To assist you in deciding which membership class is right for you, take advantage of PSERS Membership Class Election Calculator online.

Retired Members Returning to Service

The Retirement Code restricts PSERS retirees from working for a public school in any capacity, full-time or part-time, qualifying or non-qualifying service, while receiving a PSERS retirement benefit except under limited circumstances. If you are a PSERS retiree and return to Pennsylvania public school service as a school employee, your monthly retirement benefit will be stopped unless a return to service exception is approved by the employer and PSERS. Please visit the PSERS website or contact PSERS for more information.

Your Responsibilities

Please refer to PSERS website for *PSERS Active Member Handbook* and other detailed information.

- ✓ **Read PSERS Communications:** Once qualified, new members will receive some important items such as the *Welcome Packet* and *Class Election Packet* (if applicable). If you have a PSERS Member Self-Service (MSS) account, you are automatically enrolled in Paperless Delivery which means that PSERS will deliver information to you electronically instead of through physical mail. You should check your account periodically to ensure you do not miss important information.
- ✓ **Nominate and Maintain Beneficiaries:** A beneficiary is the person(s) or entity(ies) you wish to receive your retirement benefits upon your death. You may nominate and change your beneficiary nomination electronically at any time through the MSS Portal. Alternatively, you may submit a *Nomination of Beneficiaries* (PSRS-187) form to PSERS. Please note that your most recently submitted Nomination of Beneficiaries will supersede previous nominations.
- ✓ **Review information on PSERS website and take advantage of available resources** such as free Foundations for Your Future (FFYF) programs conducted by PSERS retirement representatives.
- ✓ **Keep your email and mailing address current** through the MSS Portal.

Attached is the 2026 Plan Summary for Frazier School District from TSA Consulting Group, Inc. If you have any questions on your existing TSA plan contribution, or are interested in establishing one, please contact the appropriate vendor or representative below.

Cynthia L. Egan
Senior Financial Advisor
cegan@lincolninvestment.com

412-654-6149 (C)
412-883-3786 (W)
412-618-0036 (text)

Lincoln Investment
The Crane Building
40 24th St, 4th Floor
Pittsburgh, PA 15222

David Y. Pensyl
Financial Advisor
dpensyl@lincolninvestment.com
412-413-9395 (C/text)
412-520-3418 (F)

Kyle Bero
Financial Advisor
Kyle.bero@ascentpgh.com
Equitable Advisors
1900 Main St.
Suite 211
Canonsburg, PA 15317
724-766-7351 (C)

Invesco Oppenheimer Funds
(800)-959-4246

Douglas S. Waszo
Financial Advisor
dwaszo@4kmc.com
724-836-2800 (W)
724-286-7747 (C)

www.4kmc.com
Kades Margolis
319 S. Pennsylvania Avenue
Greensburg, PA 15601
724-836-5800 (fax)

Zach Vanhorn
Financial Advisor
zvanhorn@4mc.com
724-836-2800 (W)
724-691-7773 (C)

Domenic Santoleri
PA State Manager
Domenic.Santoleri@americanfidelity.com
American Fidelity Assurance Co.
877-518-2337 (W)
844-565-2235 (fax)

Tim Samolis
Senior Account Manager
tim.samolis@americanfidelity.com
412-337-3408 (C)

Daniel Hall
daniel.hall@horacemann.com
Horace Mann
412-925-6429

Bill Kuban
bill.kuban@horacemann.com
Horace Mann
412-559-6930

Security Benefits Group
(800) 888-2461

MEANINGFUL NOTICE / PLAN SUMMARY INFORMATION

403(b) PLAN

The 403(b) Plan is a valuable retirement savings option. This notice provides a brief explanation of the provisions, policies and rules that govern the 403(b) Plan offered.

Plan administration services for the 403(b) plan are provided by U.S. OMNI & TSACG Compliance Services (OMNI/TSACG). Visit the OMNI/TSACG website (<https://www.tsacg.com>) for information about enrollment in the plan, investment product providers available, distributions, enrollment, exchanges or transfers, 403(b) loans, and rollovers.

ELIGIBILITY

Most employees are eligible to participate in the 403(b) plan immediately upon employment; however, private contractors, appointed/elected trustees and/or school board members are not eligible to participate in the 403(b) plan. Verify if your employer allows student workers to participate in the 403(b) plan. Eligible employees may make voluntary elective deferrals to the 403(b) plan and are fully vested in their contributions and earnings at all times.

EMPLOYEE CONTRIBUTIONS

Traditional 403(b)

Upon enrollment, participants designate a portion of their salary that they wish to contribute to their traditional 403(b) account up to their maximum annual contribution amount on a pre-tax basis, thus reducing the participant's taxable income. Contributions to the participant's 403(b) account are made from income paid through the employer's payroll system. Taxes on contributions and any earnings are deferred until the participant withdraws their funds.

Roth 403(b)

Contributions made to a Roth 403(b) account are after-tax deductions from your paycheck. Income taxes are not reduced by contributions you make to your account. All qualified distributions from Roth 403(b) accounts are tax-free. Any earnings on your deposits are not taxed as long as they remain in your account for five years from the date that your first Roth contribution was made. Distributions may be taken if you are 59½ (subject to plan document provisions) or at separation from service.

The Internal Revenue Service regulations limit the amount participants may contribute annually to tax-advantaged retirement plans and imposes substantial penalties for violating contribution limits. OMNI/TSACG monitors 403(b) plan contributions and notifies the employer in the event of an excess contribution.

THE BASIC CONTRIBUTION LIMIT FOR 2026 IS \$24,500.

Additional provisions allowed:

2026 AGE-BASED ADDITIONAL AMOUNT

Participants who are age 50 to 59 or 64 or older by 12/31/2026 qualify to make an additional contribution of up to \$8,000 to their 403(b) accounts. Participants aged 60, 61, 62, or 63 on 12/31/2026 can contribute an additional amount of up to \$11,250.

THE SERVICE-BASED CATCH UP AMOUNT

The special catch-up provision allows participants to make additional contributions of up to \$3,000 if, as of the preceding calendar year, the participant has completed 15 or more full years of employment with the current employer, not averaged over \$5,000 per year in annual contributions, and has not utilized catch-up contributions in excess of the aggregate of \$15,000. For a detailed explanation of this provision, please visit <https://www.tsacg.com>.

ENROLLMENT

Employees who wish to enroll in the 403(b) plan must first select the provider and investment product best suited for their 403(b) account. Upon establishment of the account with the selected provider, a "Salary Reduction Agreement" (SRA) form and any disclosure forms must be completed and submitted to the employer. This form authorizes the employer to withhold 403(b) contributions from the employee's pay and send those funds to the Investment Provider on their behalf. An SRA must be completed to start, stop or modify contributions to a 403(b) account. Unless otherwise notified by your employer, you may enroll and/or make changes to your current contributions anytime throughout the year.

The total annual amount of a participant's contributions must not exceed the Maximum Allowable Contribution (MAC) calculation. For convenience, a MAC calculator is available at <https://www.tsacg.com>.

2026

INVESTMENT PROVIDER INFORMATION

A current list of authorized 403(b) Investment Providers and current employer forms are available on the employer's specific Web page at <https://www.tsacg.com>.

PLAN DISTRIBUTION TRANSACTIONS

Distribution transactions may include any of the following depending on the employer's Plan Document: loans, transfers, rollovers, exchanges, hardships, withdrawals or distributions. Participants may request these distributions by completing the necessary forms obtained from the provider and plan administrator as required. All completed forms should be submitted to the plan administrator for processing. Prior to taking a loan, participants should consult a tax advisor.

PLAN-TO-PLAN TRANSFERS

A plan-to-plan transfer is defined as the movement of a 403(b) account from a previous employer's plan and retaining the same account with the authorized investment provider under the new employer's plan.

ROLLOVERS

Participants may move funds from one qualified plan account, i.e. 403(b) account, 401(k) account or an IRA, to another qualified plan account at age 59½ or when separated from service. Rollovers do not create a taxable event.

DISTRIBUTIONS

Retirement plan distributions are restricted by IRS regulations. A participant may not take a distribution of 403(b) plan accumulations unless they have attained age 59½ or separated from service. In most cases, any withdrawals made from a 403(b) account are taxable in full as ordinary income.

EXCHANGES

Participants may exchange account accumulations from one 403(b) investment provider to another 403(b) investment provider that is authorized under the plan; however, there may be limitations affecting exchanges, and participants should be aware of any charges or penalties that may exist in individual investment contracts prior to exchange.

403(b) PLAN LOANS

Participants may be eligible to borrow their 403(b) plan accumulations depending on the provisions of their 403(b) account contract and provisions of the employer's plan. If loans are available, they are generally granted for a term of five years or less (general-purpose loans). Loans taken to purchase a principal residence can extend the term beyond five years depending on the provisions of their 403(b) account contract and provisions of the employer's plan. Details and terms of the loan are established by the provider. Participants must repay their loans through monthly payments as directed by the provider.

HARDSHIP WITHDRAWALS

Participants may be able to take a hardship withdrawal in the event of an immediate and heavy financial need. To be eligible for a hardship withdrawal according to IRS Safe Harbor regulations, you must certify and may be asked to provide evidence that the distribution is being taken for specific reasons. These eligibility requirements to receive a Hardship withdrawal are provided on the Hardship Withdrawal Disclosure form at <https://www.tsacg.com>.

EMPLOYEE INFORMATION STATEMENT

Participants in defined contribution plans are responsible for determining which, if any, investment vehicles best serve their retirement objectives. The 403(b) plan assets are invested solely in accordance with the participant's instructions. The participant should periodically review whether his/her objectives are being met, and if the objectives have changed, the participant should make the appropriate changes. Careful planning with a tax advisor or financial planner may help to ensure that the supplemental retirement savings plan meets the participant's objectives.

PLAN ADMINISTRATOR CONTACT INFORMATION

Transactions

P.O. Box 4037 | Fort Walton Beach, FL 32549
Toll-free: 1-888-796-3786 | <https://www.tsacg.com>

For overnight deliveries

73 Eglin Parkway NE, Suite 202 | Fort Walton Beach, FL 32548
Toll-free: 1-888-796-3786 | <https://www.tsacg.com>



A DAYBRIGHT FINANCIAL COMPANY



403(b) Plan Employee Universal Availability Notice

Frazier School District provides eligible employees the opportunity to voluntarily save for your retirement through a 403(b) plan. The Plan allows you to make pre-tax, or if available in the plan document post-tax Roth contributions, to a 403(b) savings account to help you save for retirement. All employee contributions are made through salary reduction and employees are always 100% vested in employee contributions. Plan contributions as well as any investment earnings are tax-deferred and therefore are not taxable until distributed. Because the plan is to help you save for retirement, distributions from the plan are only permissible under certain circumstances such as retirement or termination of employment.

Eligibility

All employees who receive compensation reportable on an IRS Form W-2 are eligible to participate in the plan, with the exception of those specifically excluded below. If no exclusions are indicated, then all employees are eligible to participate.

- Employees who participate in an eligible governmental plan under Code section 457(b)
- Employees who are non-resident aliens;
- Employees who are students performing certain services
- Employees who normally work fewer than 20 hours per week

Enrollment

Whether you desire to enroll in the plan, or you are already enrolled but wish to make a change to the amount you currently defer, you may accomplish this by establishing an account with one of our approved providers and completing a Salary Reduction Agreement for the plan. You may obtain a list of participating providers from Payroll at the District Office or under Employee Resources/Documents of Interest/Payroll Form on the Frazier website.

Contribution Limitations

- You may contribute up to \$24,500 for 2026 based on contribution limits set by federal tax law. If you attain age 50 during the calendar year of the deferral or are over age 50 you may make an additional \$8,000 contribution in 2026. These amounts are subject to change annually.

If you are age 50 or over with 15 or more years of service, additional catch-up contributions may be available.

Your participation in this plan is voluntary. Participation in and contributions to the plan may change or cease at any time, subject to the rules of the plan.

I, _____ the undersigned employee hereby attest that I have been made aware of my employers 403(b) Plan and the eligibility requirements thereof.

Employee Signature

Date



Mr. Michael V. Turek
Superintendent of Schools
mturek@fraziersd.org
724-736-9507 x116

Confidentiality Agreement

It is the policy of Frazier School District to provide our employees or students with a level of privacy and confidentiality with any information concerning any of our employees or students.

In the course of your work, you may have access to confidential information (oral, written or computer generated not otherwise available to the public at large) about employees or students, their families and/or personal business. School business information includes computer programs, software and supporting documentation, technology improvement plans, strategy plans, financial information and employee information (including but not limited to co-workers and their families).

THEREFORE, I AGREE that:

My right to enter or make use of confidential information is restricted to my need to know the data or information to perform my job responsibilities. I will keep my computer access password(s) confidential. If another method of accessing a computer system is used, I will restrict its use to myself. I will not discuss any confidential information in any public areas, hallways, gathering spaces, etc.

I will hold all confidential information of which I have knowledge in the truest confidence, as required by law. I agree to utilize confidential information obtained by me for the benefit of the employee or student or in performance of my job responsibilities.

Unauthorized disclosure, copying and/or misuse of confidential information is a serious breach of duty and will result in disciplinary action up to and including termination of employment or contract with Frazier School District. Further, this agreement mandates compliance extending beyond employment, contract, or association with Frazier School District as required by law.

I HAVE READ THIS CONFIDENTIALITY AGREEMENT AND AGREE TO ITS TERMS.

Employee Name (PRINT)

Employee Signature

Date

Please note...

- Required notices and additional information about Frazier School District's current medical plans can be found on the Allegheny County Schools Health Insurance Consortium (ACSHIC) website, acshic.com/your-benefits/plans-grids-summaries/#. Look for Member Benefit Grids and Summaries under the 'Your Benefits' dropdown.
- Visit the Optum Rx website at <http://welcome.optumrx.com/acshic/> to learn more about your prescription benefit and finding a network pharmacy.
- Frazier School District does not utilize ACSHIC's network for Dental and Vision plan coverages.
- Create an Account at unitedconcordia.com to access your dental summary of benefits or contact the Business Office for a paper copy of the Benefit Summary for your applicable group.
- Register at davisvision.com to access more information on your vision plan coverage or access their automated system at 1-800-999-5431. Your Social Security number is the Member ID.

Notice of Special Enrollment Rights

Pursuant to the Health Insurance Portability and Accountability Act ("HIPAA"), group health plans such as ACSHIC are required to provide active employees, their dependents and COBRA qualified beneficiaries with special enrollment opportunities for certain situations.

You may be able to enroll yourself or your dependents in this plan if you or your dependents lose eligibility for coverage under another plan, such as a spouse's plan. The following are some events that may trigger a Special Enrollment Event:

Loss of eligibility for other coverage

- o Due to divorce or legal separation;
- o Dependent loss of eligibility due to age under a parent's plan;
- o Death of an employee's spouse which leaves the spouse with no coverage;
- o Spouse's loss of employment that terminates insurance coverage; and
- o Spouse's no longer eligible for insurance coverage for other reasons.

You must request enrollment within 30 days after your or your dependents' other coverage ends.

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

If you or a dependent have exhausted entitlement to benefits under COBRA (usually after 18 or 36 months) you may be able to enroll yourself and/or your dependents. However, you must request enrollment within 30 days after the COBRA coverage ends.

Special enrollment rights also may exist in the following circumstances:

- o If you or your dependents experience a loss of eligibility for Medicaid or a state Children's Health Insurance Program (CHIP) coverage and you request enrollment within 60 days after that coverage ends; or
- o If you or your dependents become eligible for a state premium assistance subsidy through Medicaid or a state CHIP with respect to coverage under this plan and you request enrollment within 60 days after the determination of eligibility for such assistance.

You must notify your employer within the required period after a Special Enrollment Event takes place. Coverage will not be provided if the request is not made in a timely manner.

If you are enrolling in the Plan for the first time, you must complete an enrollment form and provide the supporting documentation for your Special Enrollment Event. If you are currently enrolled and adding a dependent, then a written request is required along with the supporting documentation.

Please contact **Erin Clausner** if you have any questions regarding the submittal of a Special Enrollment Request, 724-736-9507 Ext 110.

The Employee Benefits Security Administration offers more information on HIPAA on its Website, including Frequently Asked Questions for workers. To request assistance from a benefits advisor, contact EBSA electronically or call 1-866-444-3272.

ACSHIC Enrollment Form - Frazier School District

Effective Date:

LAST NAME		FIRST NAME		MI	
SOCIAL SECURITY NO.		DATE OF BIRTH		MARITAL STATUS ☐ SINGLE ☐ MARRIED	
ADDRESS		CITY		STATE ZIP CODE	
Coverage Type		Election		Coverage Level	
Medical/RX		☐ EPO ☐ PPO		☐ Parent/Children ☐ Employee/Spouse ☐ Family	

Dependent Election				RELATIONSHIP	
NAME	SSN	D.O.B.	GENDER		
1					
2					
3					
4					
5					
6					

Open Enrollment is the time that you can make changes to your benefits outside of a qualifying life event. For information on changes outside of open enrollment please see the HIPAA Notice of Special Enrollment Rights.

Waiving Coverage (continued on reverse, completion required to waive)

☐ I decline to enroll in medical coverage for myself and any/all dependents. By checking this box, I understand that I/we will not be enrolled in any of the above coverages. I understand that this waiver of coverage may affect my ability and that of any/all dependents to obtain coverage at a later date, specifically, except during applicable "Special Enrollment Periods". As a benefits-eligible employee waiving medical coverage through Frazier School District, completion of the reverse side of this form (and providing the necessary documentation) indicates my election of the applicable medical allowance in lieu of medical enrollment.

Enrollment Attestation

To the best of my knowledge, the information provided on these forms is true and correct. I understand that this form enrolls those eligible persons listed above in the selected plans and I authorize any payroll deductions required for the coverage I have selected. I also understand that I must select coverage for my dependents, or they will not be enrolled. By signing below, I also acknowledge contents of the HIPAA Notice of Special Enrollment Rights.

Employee Signature (Acceptance and Waiver)

Date

Authorized Employer Signature

Date

Waiving Coverage (continued from front)

The parties hereto agree that if the Frazier employee entitled to the health insurance benefits set forth on the reverse side of this form is insured by the same or a similar plan elsewhere, that employee shall so notify the District of that fact and make an election as to the insurance plan with which he/she will choose to be insured.

Employees covered by a spouse's insurance or other similar insurance coverage may choose not to be in the insurance program offered by the District. Employees making such a choice shall receive five hundred dollars (\$500) per month through payroll in lieu of the District plan enrollment-- unless specified elsewhere-- by providing the following.

If enrolled in spouse's coverage, please complete the following and provide documentation from the plan coordinator/employer verifying enrollment for yourself and any/all dependents. If enrolled in other similar coverage, complete the name of plan, account number of plan, and provide documentation.

Name of Employee	_____	Name of Plan	_____
Name of Employer	_____	Account Number of Plan	_____
Address of Employer	_____		

Employer Telephone Number	_____		

I hereby verify the statements set forth in this form are true and correct to the best of my knowledge, information and belief.

Employee Signature (Waiving Coverage)

Date

Enrollment/Change Form

United Concordia Dental / Davis Vision

School District _____

SECTION I - TO BE COMPLETED BY EMPLOYEE/RETIREE

Use this form to select/change a medical, dental and/or vision plan and coverage level. **Return this completed form within 31 days of your full-time date of hire or qualifying event, along with any required documentation i.e. marriage certificate, birth certificate, etc.**

Reason For Completing this Form: ☐ New Hire ☐ Current Employee Enrolling ☐ Change ☐ Termination

Type of change: ☐ Address ☐ Name ☐ Add or Remove Spouse/Dependent ☐ Waive Coverage

Hire Date: _____ Benefit Type (check all that apply): ☐ Dental ☐ Vision

Name	Social Security Number	Date of Birth	Male/Female	Add or Remove
Employee/Retiree			☐ M ☐ F	
Spouse			☐ M ☐ F	
Dep			☐ M ☐ F	
Dep			☐ M ☐ F	
Dep			☐ M ☐ F	

Street Address

City

State

Zip Code

Required Documentation Provide the required document along with this form. Refer to the Instructions for Benefit Elections/Changes to determine what documents you need to provide. Your benefits will not be updated until all documentation is received.

I certify that the above information is true and correct. For New Hire: By not enrolling in certain benefits at this time (within 31 days of full-time date of hire or within 31 days of a qualifying change in family status), I understand that I will be unable to enroll or make changes again until the next annual Open Enrollment period.

Signature of Employee/Retiree: _____

Date: _____

SECTION II - TO BE COMPLETED BY SCHOOL DISTRICT

District: _____

Representative: _____

Effective Date of Change: _____

Date Section I Received: _____

Group #(s)	Current (if applicable)	New	Coverage Level/Tier
Dental			☐ EE ☐ EE+CH ☐ EE+CHN ☐ EE+SP ☐ FAM
Vision			☐ EE ☐ EE+CH ☐ EE+CHN ☐ EE+SP ☐ FAM

Type of Activity (check all that apply):

☐ New Hire ☐ Remove Spouse/Dependent ☐ Waive Coverage
☐ Current Employee Enrolling ☐ Change of Address ☐ COBRA (check all that apply and indicate Qualifying Event below)
☐ Termination ☐ Name Change
☐ Add Spouse/Dependent ☐ Act 110 / Act 43 Eligible ☐ Dental ☐ Vision ☐ Other

Qualifying Event or Change of Family Status:

☐ Newborn ☐ Death ☐ Over Age Dependent
☐ Adoption ☐ Voluntary Resignation ☐ Medicare Entitlement
☐ Retirement ☐ Involuntary Resignation ☐ Other _____
☐ Marriage ☐ Legal Guardianship
☐ Divorce ☐ Court Ordered

Required documentation must be collected, reviewed and approved by district prior to enrollment. DO NOT send documentation to ReSo; keep at district for auditing purposes.

Signature of District Rep: _____

Date: _____

-required for processing -



GROUP INSURANCE ENROLLMENT FORM
Unum Life Insurance Company of America
2211 Congress Street, Portland, ME 04122

Please print legibly and complete this form in its entirety. Blank fields will cause significant delays in processing.

Policyholder Name

F R A Z I E R S C H O O L D I S T R I C

Policy No.

2 1 4 9 4 5

Division No.

0 0 1

Employee Social Security Number

- - - - -

Gender

M F

Date of Birth (mm/dd/yyyy)

/ /

Hours Worked Per Week

Employee First Name

M.I. Last Name

Employee Street Address

City

State

Zip Code

Original Date of Hire

/ /

Annual Salary

\$, ,

Occupation

- ☐ Exempt ☐ Non-Exempt
- ☐ Date entered into an eligible class (ex: part time to full time) or

☐ Rehire Date or

☐ Date of promotion to an eligible class

/ /

Spouse First Name (if coverage is selected)

Spouse Date of Birth (mm/dd/yyyy)

/ /

COVERAGE ELECTIONS: Your employer will inform you of available coverage. Check yes to enroll; check no if you decline or coverage is not available.

Life/AD&D ☐ Yes ☒ No Dependent Life ☐ Yes ☒ No LTD ☒ Yes ☐ No STD ☒ Yes ☐ No

AMOUNT OF COVERAGE SELECTED FOR:

LIFE/AD&D You: \$ X , X X X , X X X

Spouse: \$ X , X X X , X X X

Child: \$ X X , X X X

Note: If you have chosen coverage over the Guarantee Issue amount for you or your spouse, you will also need to complete an Evidence of Insurability form. The amount of coverage over your Guarantee Issue amount will be subject to medical underwriting and will become effective on the first of the month coincident with or next following the date Unum approves your Evidence of Insurability form. If you **DO NOT APPLY FOR** coverage for you or your dependent (s) during your or their initial enrollment period, you will need to complete an Evidence of Insurability form for all amounts of coverage. You may complete and electronically submit an Evidence of Insurability form—please see your Plan Administrator.

Beneficiary Information:

Name (last name, first, middle initial):	Relation to You:	Benefit %:
If the beneficiary(ies) named above are not living, then pay:		

Request for Signature and Certification: I understand that my coverage may be subject to exclusions, limitations, delayed effective dates and benefit offsets, as described in the enrollment materials or employee booklet(s) that have been provided to me by my employer. I certify that all statements are true to the best of my knowledge and belief and I understand that a copy of this form will be made available to me at my request. I authorize my employer to make the necessary deductions from my salary or wages to pay the premium when my insurance becomes effective. I understand that my payroll deduction amount will change if my coverage or costs change.

Employee Signature

Date

Work Phone

Home Phone

Unum is a registered trademark and marketing brand of Unum Group and its insuring subsidiaries.

AE-1107

RETAIN A COPY OF THIS FORM FOR YOUR RECORDS AND SEND A COPY TO YOUR EMPLOYER

Employee Application - LIFE INSURANCE

Please print clearly in blue or black ink.

ISSUE

Check one -- Employer Use

☒ New Employee ☐ Change ☐ COBRA

Employee Information -- Failure to accurately complete the questions on this application may affect the existence or amount of coverage. Please correct any errors in the information listed below.

Employee name (last, first, initial) | Employer | Employment location |
FRANK SCHOOL DISTRICT

Group policy/participant # | Account # or Bill Group Name | Cert. # | Employee SSN | Employee birthdate

Sex	Job title or position	Employee hire date	# hours per week	Earnings \$	Married	Children
☐ M				☐ Hourly ☐ Weekly	☐ Yes	☐ Yes
☐ F				☐ Monthly ☐ Yearly	☐ No	☐ No
				☐ Other		

Address | City | State | Zip

ELECTIONS ARE NOT VALID WITHOUT A SIGNATURE AT THE END OF THIS APPLICATION.

Dependent Information -- Required if Dependent coverage applies

Name (Last name, First Name) | Date of Birth | Gender | Relationship |

N/A

NOTE -- Coverage not elected will be assumed refused even if not specifically refused

Benefits

You may select the benefits below.

☒ Employee Life	☐ Voluntary Life Amount Electing _____	
	Have you used tobacco in any form in the last 12 months?	☐ Yes ☐ No
☒ Employee AD&D	☐ Voluntary AD&D Amount Electing _____	
☐ Dependent Life	☐ Voluntary Spouse Amount Electing _____	
	Name of Spouse _____	
	Date of birth _____	
	Has your spouse used tobacco in any form in the last 12 months?	☐ Yes ☐ No
☐ Short Term Disability	☐ Voluntary Child ☐ \$1,000 ☐ \$5,000 ☐ \$10,000	
☐ Long Term Disability	☐ Voluntary STD Amount Electing _____	
☐ Dental -- Employee	☐ Voluntary LTD Amount Electing _____	

Union Security Insurance Company
Mail to: P.O. Box 881824 El Paso, TX 79998-1824
Form 61(03/2010)

Page 1
KC4704 (7/2016)

- ☐ Dental – Employee + Spouse
☐ Dental – Employee + Child(ren)
☐ Dental – Employee + Family

Were you covered under another dental plan within the last 31 days? ☐ Yes ☐ No

If "Yes," termination date _____ Reason for termination of coverage _____

- ☐ Vision – Employee
☐ Vision – Employee + Spouse
☐ Vision – Employee + Child(ren)
☐ Vision – Employee + Family

- ☐ Critical Illness: ☐ Level 1 ☐ Level 2 (includes cancer option)

☐ Employee Critical Illness Amount Electing _____
 Have you used tobacco in any form in the past 12 months? ☐ Yes ☐ No

☐ Spouse Critical Illness Amount Electing _____
 Has your spouse used tobacco in any form in the past 12 months? ☐ Yes ☐ No

☐ Child(ren) Critical Illness Amount Electing _____

- ☐ Cancer:

☐ Level 1 ☐ Level 2

☐ Employee ☐ Employee + Spouse ☐ Employee + Child(ren) ☐ Family
 Have you used tobacco, in any form in the past 12 months? ☐ Yes ☐ No

- ☐ Accident

☐ Employee
☐ Spouse - Include Spouse Off the Job Disability Benefit? ☐ Yes ☐ No
☐ Child(ren)

Beneficiaries - Applies to all coverages for which a beneficiary designation is required

Last Name	First	MI	Relationship
* COMPLETE ATTACHED BENEFICIARY DESIGNATION FORM IN LIEU OF THIS SECTION.			

☐ Primary
☐ Secondary

☐ Primary
☐ Secondary

If beneficiary is not related to you, please provide Date of Birth, Social Security Number, and full address.

- 1) Give FULL names and relationships of each beneficiary.
- 2) Beneficiaries elected will apply to all coverage elected on this form for which a beneficiary designation is required.
- 3) If primary/secondary election is not noted, the beneficiary will be considered primary.
- 4) Proceeds will be paid in equal shares to those primary beneficiaries who survive you. If no primary beneficiaries survive you, the proceeds will be paid in equal shares to the surviving secondary beneficiaries.
- 5) If your designation does not fit in the above arrangement, or you want to specify a beneficiary by coverage, please contact Union Security Insurance Company for the appropriate forms.

MY SIGNATURE ON THIS APPLICATION CERTIFIES THAT I:

- (1) Apply for the coverages designated for which I am eligible under my employer's plan with Union Security Insurance Company.
- (2) Understand if coverages have been refused, I am not entitled to benefits under those coverages and that if I want to apply later, I must furnish at my own expense proof of good health satisfactory to Union Security Insurance Company. For Dental coverage, I understand that I will not be entitled to benefits until the expiration of any Late Entrant Limitation period specified in the policy.
- (3) Authorize any required deductions from my earnings.
- (4) Designate the beneficiary named on this application to receive any benefits payable in the event of my death.
- (5) Represent that all of the information on this application is complete, correct and true to the best of my knowledge and belief.
- (6) Understand that I must be actively at work the number of hours specified in the policy/participation agreement to remain insured.
- (7) Understand that I have the right to select any dental care provider of my choice.

- (8) Understand that the dental plan includes a pre-estimate provision that will advise me in advance of the benefits I may be eligible for if the procedure is performed.
- (9) Understand that coverages include waiting periods, limitations, and exclusions and a pre-existing conditions provision that may affect my entitlement to benefits.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Employee's signature _____ Date _____

AGENT, BROKER, AND/OR ENROLLER INFORMATION:

Agency Name: _____

Agent/Broker Name: _____

Enroller Name: _____



Beneficiary Tips

I want the money to pay my final expenses and to support my spouse and children. The easiest way is to name your spouse (by name) as the primary beneficiary ("Jane Doe, spouse," for example). You can also name a secondary beneficiary in case your spouse dies before you.

Be careful about naming your children as either primary or secondary beneficiaries if they are not yet 18. Minor beneficiaries pose special problems because a legal guardian of their estate must be appointed by a court – even if one of their parents is still living. Often, the money must be held until the child reaches 18.

Can I name more than one person as beneficiary? You can name as many beneficiaries as you want. Proceeds will be paid in equal shares unless you indicate percentages (not dollar amounts).

Proceeds will be paid first to the named primary beneficiaries who survive you. If no primary beneficiaries survive you, then proceeds will be paid to the named secondary beneficiaries.

What if I get divorced? If you named your prior spouse as the beneficiary and never changed the beneficiary designation, it depends on the terms of the divorce decree and applicable law whether your prior spouse will be the beneficiary. It is wise to check with your attorney.

The best way to avoid problems is to review your beneficiary designations whenever a life event (like marriage, divorce, birth of a child, etc.) occurs.

What if I don't have a spouse or children? You aren't required to name your spouse and children as beneficiaries. You can name any individual you like, including relatives, friends and/or most non-profit organizations. **Please note: You may not designate your employer as your beneficiary even in the event they are a non-profit organization.**

What if I don't designate a beneficiary? Our life insurance policy has a provision that details how the proceeds will be paid; we will use the provision to pay your surviving family. The order is 1 – current surviving spouse, 2 – your living children; including children by legal adoption (even if they are minors), 3 – parents and 4 – the estate of the insured.

Can I designate my estate as the beneficiary? In order for us to pay your estate, the estate must go through a probate court (unless waiver of administration laws apply) and someone must be appointed by the court as the legal representative.

What if we don't want to go through probate? In some states, we can pay under "waiver of administration" laws. These laws allow us to make the payment to the person who is handling the estate, if the amount is within the limits set by the state and with documentation required by the state.

What about payment to a trust? We can make payment to the trustee of a trust. Trusts can be complicated; therefore, you are strongly advised to seek an attorney's assistance to set one up correctly.

Can we pay according to directions left in a will? No. However, we can pay to your estate which is distributed in accordance with the instructions of a will. We can also pay to a trust created by a probated will, if we receive documentation within one year of your death that the trustee is legally authorized to receive payment. If this information is not received within one year of your death, we will pay the executors or administrators of your estate.

What about the other Sun Life coverages? If you have dependent life insurance, you are the beneficiary. The same is true if you qualify for the dismemberment provision under the Accidental Death & Dismemberment policy.

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Sun Life Administrative Office P.O. Box 981624 El Paso, Texas 79998-1624
T 800.733.7879 F 888.208.2323

KC4579B (11/2016)



CM Regent Solutions Beneficiary Designation

You may use this form to designate who will receive the Group Life Insurance proceeds in the event of your death. The designations you make on this form replace any prior beneficiary designations.

When applicable, designations apply to any Basic, Optional, Voluntary, Accidental Death and Dismemberment ("AD&D"), or other Group Life Insurance you have under the Group Policy shown in Section 1.

See Page 3 of this form for sample beneficiary designations and more information.

1 Employee and employer information

Name of employee (first, middle initial, last)		Social Security number	
Name of employer Frazier School District	Group policy number 932135	Billing group number	

2 Beneficiary designation

For primary beneficiaries, indicate who should receive the group life or AD&D insurance proceeds in the event of your death.

For secondary, (also known as contingent) beneficiaries, indicate who should receive the group life insurance proceeds in the event that ALL of your primary beneficiaries are not living at the time of your death.

Please make your beneficiary designation(s) below. If you need more space, attach another sheet to this form.

You may designate more than one Primary or Secondary Beneficiary. If you do, make sure to indicate the percentage share each should receive. The total within each class (Primary and Secondary) must equal 100%. If you do not specify percentages, surviving beneficiaries within the class will share proceeds equally.

Primary Beneficiary(ies)

Percent share
of proceeds*

1 Name (First, M.I., Last)	Relationship to employee	Social Security number	%
Address	Phone number	Date of birth	
2 Name (First, M.I., Last)	Relationship to employee	Social Security number	%
Address	Phone number	Date of birth	
3 Name (First, M.I., Last)	Relationship to employee	Social Security number	%
Address	Phone number	Date of birth	
4 Name (First, M.I., Last)	Relationship to employee	Social Security number	%
Address	Phone number	Date of birth	

2 Beneficiary designation, continued

Secondary Beneficiary(ies)

Percent share
of proceeds*

1 Name (First, M.I., Last)	Relationship to employee	Social Security number	%
Address	Phone number	Date of birth	
2 Name (First, M.I., Last)	Relationship to employee	Social Security number	%
Address	Phone number	Date of birth	
3 Name (First, M.I., Last)	Relationship to employee	Social Security number	%
Address	Phone number	Date of birth	
4 Name (First, M.I., Last)	Relationship to employee	Social Security number	%
Address	Phone number	Date of birth	

* The total within each class (Primary and Secondary) must equal 100%.

3 Signature

You must sign and date this form for your designation to become effective. Make a copy for your records and **return the signed original to your employer.**

Name of employee (first, middle initial, last)	Date
--	------

4 Beneficiary wording alternatives

Proposed Beneficiary(ies)	Suggested Wording
1. Estate	Estate
2. One beneficiary	Martha Doe, wife
3. More than one beneficiary in equal shares	Jane Doe, Mary Doe and Richard Doe, children, or survivor(s) of them, in equal shares.
4. Two beneficiaries, in succession	Primary: Martha Doe, wife; Secondary: Richard Doe, son. <i>(Richard will only receive proceeds if Martha Doe is not living at the time of the employee's death.)</i>
5. One beneficiary followed by two beneficiaries in equal shares	Primary: Martha Doe, wife; Secondary: Jane Doe and Mary Doe, children in equal shares, or the survivor of them. <i>(Jane and Mary will only receive proceeds if Martha Doe is not living at the time of the employee's death.)</i>
6. More than one Beneficiary in equal shares per descendent order	Jane Doe, Mary Doe and Richard Doe, or the survivor(s) of them, in equal shares. However, if any of my children predecease me and leave issue who survive me, the issue of the deceased child will receive their parents' share in equal shares.
7. One or more minor children	John Smith, as custodian for Jane Doe, a minor, under the Uniform Transfers to Minors Act (UTMA) so that proceeds can be paid before the child reaches the age of maturity.
8. To a church or non-profit organization	Name and address of the beneficiary organization.
9. Beneficiaries shown in percentages	John Smith, brother - 40%, or in the event of his death, to my estate; Alan Smith, brother 60%, or in the event of his death, to my estate.
10. Trust under Last Will and Testament	Proceeds to be paid to the Trustee under my Last Will and Testament.
11. Existing Trust	Jane Doe, Trustee of the Doe Family Trust, dated 1/1/2001.

Please Note: You cannot name your Employer as a beneficiary for Group Life Insurance proceeds under the Group Policy. Unless you specifically instruct otherwise, your beneficiary designation will be revocable.

Dependent Life Insurance benefits are payable to the Employee. If the Employee does not survive the Dependent, Dependent Life Insurance benefits will be paid to the Employee's estate.

Sun Life Assurance Company of Canada is not a tax or legal advisor and the above information is provided as general information only. Before making beneficiary designations, you may want to consult with your tax or legal advisor.

Contact us



By mail
CM Regent Solutions
300 Sterling Parkway, Suite 100
Mechanicsburg, PA 17050



By fax
866.691.6291



By e-mail
EBSS@cmregent.com

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SCHOOL PERSONNEL HEALTH RECORD
(FOR USE AFTER OFFER OF EMPLOYMENT HAS BEEN MADE)

I. INFORMATION

School Position Offered _____

Last Name	First	MI	Sex	Date of Birth
-----------	-------	----	-----	---------------

Home Phone	Cell Phone	Work Phone
------------	------------	------------

Mailing Address: Street	City	State	Zip
-------------------------	------	-------	-----

Emergency Contact

Name:	Relationship:
-------	---------------

Address:

Telephone number: (Home)	(Work)	(Cell)
-----------------------------	--------	--------

II. IMMUNIZATION HISTORY (Recommended, but not mandated by law)

VACCINE Check appropriate box	Enter Month, Day, and Year Each Immunization DOSE Was Given				
	1	2	3	4	5
Diphtheria, Tetanus with Pertussis ☐ Td ☐ Tdap					
Hepatitis B					
Measles-Mumps-Rubella (MMR)			Rubella Serology/Date/Titer Mumps disease diagnosed by a physician: Date Measles Serology/Date/Titer		
Varicella ☐ Vaccine ☐ Disease ☐ Serology Date: Neg/Pos					
Influenza					

III. TUBERCULOSIS SKIN TEST RESULTS (Testing required per Regulations of the Department of Health)

DATE GIVEN	SITE: LA / RA	GIVEN BY:	ANTIGEN NAME	MANUFACTURER / LOT # / EXP DATE	SIGNATURE
DATE READ	RESULTS in MM		READ BY SIGNATURE		

OR

IGRA TEST RESULTS

DATE COLLECTED	TEST NAME (QFT-GIT, T-SPOT, etc)	POSITIVE	NEGATIVE	INDETERMINATE	QUANTITATIVE RESULT

DATE TEST COMPLETED _____ SIGNATURE _____

Previously known/new positive reactors: _____

Chest X-ray: _____ Date: _____ Results: _____ Other: _____ Date: _____ Results: _____
(Attach a copy of the report.) (Attach a copy of the report.)

Preventive Anti-Tuberculosis Chemotherapy ordered: ☐ No ☐ Yes Date: _____

IF SIGNIFICANT REACTION WAS REPORTED, THE PRIMARY CARE PROVIDER REPORT MUST STATE THAT THE APPLICANT IS CURRENTLY FREE FROM TUBERCULOSIS DISEASE.

IV. MEDICAL CONDITIONS (✓)

	Yes	No	If Yes, Explain:
Allergies	☐	☐	
Asthma.....	☐	☐	
Cardiac.....	☐	☐	
Chemical Dependency	☐	☐	
Drugs	☐	☐	
Alcohol	☐	☐	
Diabetes Mellitus	☐	☐	
Gastrointestinal Disorder	☐	☐	
Hearing Disorder	☐	☐	
Hypertension.....	☐	☐	
Neuromuscular Disorder.....	☐	☐	
Orthopedic Condition	☐	☐	
Respiratory Illness	☐	☐	
Seizure Disorder	☐	☐	
Skin Disorder	☐	☐	
Vision Disorder.....	☐	☐	
Other (Specify)	☐	☐	

V. PHYSICAL EXAMINATION (✓)

	NORMAL	ABNORMAL	NOT EXAMINED	COMMENTS
Height (inches)				
Weight (pounds)				
Pulse				
Blood Pressure				
Hair/Scalp				
Skin				
Eyes – Visual Acuity: RL				
Eyes – Color Vision				
Ears – Hearing (dB) RL				
Nose and Throat				
Teeth and Gingiva				
Lymph Glands				
Heart – Murmur, etc...				
Lungs – Adventitious Findings				

Abdomen				
Genitourinary				
Neuromuscular System				
Extremities				

Are there any special medical problems or chronic diseases which require restriction of activity, medication which might affect his/her work role? If so, specify

Are there any special equipment or accommodations needed to enable this person to perform their duties? If so, specify

Physician Name (Print) Signature of Examiner

Date

Physician Address

The statements and answers as recorded above are full, complete and true to the best of my knowledge and belief. I understand that any false or misleading statements may cause termination of my employment.

I authorize the physician or other person to disclose any knowledge or information pertaining to my health to the employing authority for whom this examination is performed.

Signature of Employee

Date