# Table of Contents

- Additional/Reduce Pay Form ................................................................. 4
- Address Change Form.................................................................................. 8
- Affiliates@UND Form.................................................................................. 10
- Criminal History Background Check for Minors (Under 18 Years)................. 13
- Designated Medical Provider Form .......................................................... 19
- Determination of Worker Status............................................................... 23
- Direct Deposit Authorization....................................................................... 30
- Direct Deposit Exemption Form................................................................... 32
- Donated Leave Consent to Release Name .................................................. 34
- Donated Leave Form.................................................................................... 35
- Employee Tuition Waiver.......................................................................... 37
- Family Member Tuition Waiver................................................................. 41
- Employment and Age Certificate-Minors.................................................... 45
- Employment Change (Notice of)................................................................. 47
- Flex Comp Day Care Cost Verification ....................................................... 49
- Flex Comp Status Change Form................................................................... 50
- Flexplace Agreement.................................................................................... 52
- Flexplace Agreement Renewal..................................................................... 60
- Flexplace Agreement Evaluation................................................................. 62
- Foreign National Form UND ....................................................................... 63
- Foreign National Information System (FNIS) Request................................. 71
- HRMS Access Request Form........................................................................ 75
- In/Out Processing Checklist........................................................................ 78
- Job Data Change.......................................................................................... 80
- Leave Authorization/Payroll Deduction Agreement ....................................... 83
- Leave Without Pay/Workload Reduction Request ........................................ 85
- Long Term Leave Certification of Health Care Provider for Employee’s Serious Health Condition ................................................................. 89
- Long Term Leave Certification of Health Care for Family Member’s Serious Health Condition ............................................................................ 94
- Long Term Leave Certification of Qualifying Exigency for Military Family Leave ................................................................. 100
- Long Term Leave Certification for Serious Injury or Illness of a Current Servicemember ................................................................. 104
<table>
<thead>
<tr>
<th>Form Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Long Term Leave Certification for Serious Injury or Illness of a Veteran</td>
<td>110</td>
</tr>
<tr>
<td>Caregiver Leave</td>
<td></td>
</tr>
<tr>
<td>Long Term Leave Physician's Release to Return to Work Form</td>
<td>117</td>
</tr>
<tr>
<td>Long Term Medical (FMLA) Leave Request</td>
<td>119</td>
</tr>
<tr>
<td>Mandatory Furlough Notice</td>
<td>121</td>
</tr>
<tr>
<td>Name Change Form</td>
<td>123</td>
</tr>
<tr>
<td>North Dakota Withholding Change Form</td>
<td>125</td>
</tr>
<tr>
<td>Notification of Payroll Overpayment</td>
<td>127</td>
</tr>
<tr>
<td>Perceptive Content Access Request</td>
<td>129</td>
</tr>
<tr>
<td>Performance Evaluation Tool</td>
<td>131</td>
</tr>
<tr>
<td>Position Description Instructions</td>
<td>134</td>
</tr>
<tr>
<td>Position Request/Change Form</td>
<td>142</td>
</tr>
<tr>
<td>Reduction-in-Force Analysis worksheet</td>
<td>145</td>
</tr>
<tr>
<td>Remote Hire Form</td>
<td>148</td>
</tr>
<tr>
<td>Retroactive Distribution Request</td>
<td>150</td>
</tr>
<tr>
<td>Partial Retro Salary Correction</td>
<td>154</td>
</tr>
<tr>
<td>Transfer Form</td>
<td>156</td>
</tr>
<tr>
<td>Twelve Month Payment Request</td>
<td>159</td>
</tr>
</tbody>
</table>
Additional/Reduce Pay Form

If completing this form for a Reduce Pay, you must attach a Payroll Overpayment form signed by the employee.

<table>
<thead>
<tr>
<th>Field</th>
<th>Explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Type of Employee:</td>
<td>Check only one box that best identifies the type of employee, in their primary position, that will be receiving the additional pay. (Must be active, not EERC or Cont. Ed.)</td>
</tr>
<tr>
<td>2. Empl ID#:</td>
<td>Employee ID number</td>
</tr>
<tr>
<td>3. Empl Rcd #:</td>
<td>Empl Rcd #: Enter the Employee Record number of the position where the Additional Pay will be attached.</td>
</tr>
<tr>
<td>4. Employee Name:</td>
<td>Name of employee receiving Additional Pay</td>
</tr>
<tr>
<td>5. Position Number:</td>
<td>Position number employee is currently appointed and Additional Pay is being attached.</td>
</tr>
<tr>
<td>6. Department ID:</td>
<td>Department Number that is attached to above Position Number</td>
</tr>
<tr>
<td>7. Department Name:</td>
<td>Department Name attached to above Position Number</td>
</tr>
<tr>
<td>8. Job Code:</td>
<td>Job Code associated with this Position Number</td>
</tr>
<tr>
<td>9. Standard Hours Worked:</td>
<td>Enter the number of hours this employee is actually working, each week, in their primary position(s), during the time they are receiving this Additional Pay.</td>
</tr>
<tr>
<td>10. Payment will be Paid Over:</td>
<td>If this is a payment for only one payday, check One Pay Period. If this payment is to be spread over more than one payday, check Multiple Pay Periods.</td>
</tr>
<tr>
<td>11. Changes to Additional Pay:</td>
<td>This box is used to cancel an Additional Pay or change funding, prior to completion of payment. Submit a photocopy of the Add'l Pay that was previously submitted and check the appropriate box for this change. Enter the effective date as the first day of the pay period following the last day worked for either cancellations or fund changes. Highlight the change and route for signature authorization for your division. These signatures should be in red or blue ink.</td>
</tr>
<tr>
<td>12. Actual Earnings Begin Date:</td>
<td>Enter the actual date that the employee starts working for this Additional Pay.</td>
</tr>
<tr>
<td>13. Actual Earnings End Date:</td>
<td>Enter the actual date that the employee will complete work for this Additional Pay.</td>
</tr>
<tr>
<td>14. Actual Hrs Worked/Wk on Additional Pay:</td>
<td>If the Additional Pay is not payment for additional hours, enter NONE; Otherwise estimate the average number of hours a week that the employee will work for this Additional Pay.</td>
</tr>
<tr>
<td>15. Pay Period Begin Date:</td>
<td>Enter the first day of the pay period that payment will start.</td>
</tr>
</tbody>
</table>
16. Pay Period End Date: Enter the last day of the pay period that payment will end.

17. Amt/Pay Period: Dollar amount per semi-monthly pay period. If payment does not divide equally into the goal amount, always round UP one penny. If payment is for one pay period, Amount Per Pay Period will equal Goal Amount. **To reduce pay, either enter the amounts in parentheses (), precede number with a (-), or type the amount in red to indicate a negative number.**

18. Goal Amount: Total amount of Additional Pay to be paid. The Additional Pay will automatically stop when Goal Amount is reached.

19. Earnings Code List: Place a checkmark or “X” next to the appropriate earnings code. **A detailed explanation of each earning code follows:**

   - **HRP** Retro-Regular Pay - Used when paperwork was not submitted by pay period deadline. Must have department head/chair signature. Only to be used for Salaried employees. Hourly employees should just submit a timesheet.

   - **H02** Retro-Contract Pay - Used when paperwork was not submitted by pay period deadline for a <12 month, benefited employee. Must have department head/chair signature. Only to be used for Salaried, Contract employees. Hourly, Contract Employees should just submit a timesheet.

   - **HRO** Retro-Overtime Pay - Used when paperwork was not submitted by pay period deadline. Must have department head/chair signature. Only to be used for Salaried employees. Hourly employees should submit a timesheet.

   - **H04** Faculty Overload - An amount paid to faculty for teaching/working > 40 hours per week.

   - **H05** Summer Salary - Amount paid to a <12 month faculty/staff for summer work, outside of regular contract, other than teaching.

   - **H06** Summer School - Amount paid to <12 month faculty to teach summer school, outside of regular contract.

   - **H08** Distance Learning - Amount paid to faculty for teaching Distance Learning Classes.

   - **H09** Corporate/Continuing Education - Amount paid to faculty for teaching Corporate/Continuing Ed classes.

   - **H17** Special Projects - With Retirement - Payment for temporary projects - Must provide Add'l Information.

   - **H19** Department Chair Compensation - Additional compensation received for Department chair duties.

   - **H28** Staff Overload - An amount paid to an exempt staff employee for working/teaching >40 hours per week. Non-exempt staff must submit a timesheet using the Overtime earnings code.
H51  Special Projects - No Retirement - Payment for temporary projects - Must provide Add'l Information.

H60  Awards - Payment of approved awards.

H64  Acting/Interim Assignment - Payment for a temporary assignment.

Other (Explain)  Other (Explain) - For any Earnings Code not identified above - Enter Earnings code and description. H01-Regular and H02 Contract cannot be paid with an additional pay request.

20. Additional Information:  You are encouraged to enter an explanation of the payment. (optional)

21. Funding Information:  Check only one box for source of funding. If using the funding identified in the department budget table for the position, check Use Position Default Funding box. Overloads (You may not use Default funding for H04 or H28 Overload payments). If entering a funding source below, check Use Funding Source Identified Below. If this is a funding change and you have identified it as a change above in the Changes to Additional Pay - check Funding Change Only.

If you checked Use Funding Source Identified below, enter the fund code, department, project, program, and account, where the funding of this payment is actually being paid from. Account Code will automatically complete. Split funding will require the completion of more than one form.

22. Signature Authorization:  Obtain two signatures from Department/Dean/VP authorizing the Additional Pay. If using a position from another department, you will need one signature from that department. Then follow your signature authorizations per your division, prior to submission to Payroll.
# ADDITIONAL/REDUCE PAY REQUEST

**University of North Dakota**

---

**Job Data Information**
- That Additional Pay will be attached (must be active, not EERC or Continuing Ed)
- □ Faculty
- □ Staff
- □ Temp Staff
- □ Medical Resident
- □ Workstudy Student
- □ GTA/GRA/CSA
- □ Institutional Student

**EMPLOYER ID:**

**EMPLOYEE ID:**

**FIRST NAME:**

**LAST NAME:**

**FORM #**

**DEPT #**

**DEPT NAME**

**JOB CODE**

**STANDARD HOURS WORKED**

---

## ADDITIONAL PAY

**PAYMENT WILL BE PAID OVER**
- □ One Pay Period
- □ Multiple Pay Periods

**CHANGES TO ADDITIONAL PAY**
- □ Cancel Additional Pay Effective
- □ Funding Change Effective

**ACTUAL EARNINGS BEGIN DATE**

**ACTUAL EARNINGS END DATE**

**ACTUAL HRS WORKED/OH ON ADDITIONAL PAY**

**PAY PERIOD BEGIN DATE**

**PAY PERIOD END DATE**

**ACTUAL PAY PERIOD**

**TOTAL AMOUNT**

---

<table>
<thead>
<tr>
<th>Check Box</th>
<th>Earnings Code</th>
<th>Description (Refer to Instructions for a more detailed explanation)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>H01</td>
<td>Retro - Salaried Pay - Explain reason for late paperwork in Additional Information.</td>
</tr>
<tr>
<td></td>
<td>H02</td>
<td>Retro - Contract Pay - Explain reason for late paperwork in Additional Information.</td>
</tr>
<tr>
<td></td>
<td>H03</td>
<td>Retro - Overtime Pay - Explain reason for late paperwork in Additional Information.</td>
</tr>
<tr>
<td></td>
<td>H04</td>
<td>Faculty Overload (Faculty working teaching &gt; 100%)</td>
</tr>
<tr>
<td></td>
<td>H05</td>
<td>Summer School</td>
</tr>
<tr>
<td></td>
<td>H06</td>
<td>Continuing Ed/Corporate/Distance Ed - With Retirement</td>
</tr>
<tr>
<td></td>
<td>H07</td>
<td>Continuing Ed/Corporate/Distance Ed - Without Retirement</td>
</tr>
<tr>
<td></td>
<td>H17</td>
<td>Special Projects - With Retirement</td>
</tr>
<tr>
<td></td>
<td>H19</td>
<td>Department Chair Compensation</td>
</tr>
<tr>
<td></td>
<td>H28</td>
<td>Staff Overload (Exempt Staff working teaching &gt; 100%)</td>
</tr>
<tr>
<td></td>
<td>H51</td>
<td>Special Projects - No Retirement</td>
</tr>
<tr>
<td></td>
<td>H60</td>
<td>Awards</td>
</tr>
<tr>
<td></td>
<td>H64</td>
<td>Acting/Interim Assignment</td>
</tr>
<tr>
<td></td>
<td>H</td>
<td>Include Earnings Code and explain</td>
</tr>
</tbody>
</table>

---

**Additional Information**

---

**Funding Information**
- □ Use Position Default Funding (Cannot be used for H04 & H28)
- □ Use Funding Source Identified Below
- □ Funding Change Only

**FUND CODE**

**DEPT #**

**DEPT NAME**

**PROJECT/GRANTS**

**PROGRAM**

**ACCOUNT**

**Account Code:** #N/A

---

**Dept. Contact Name:**

**Phone:**

**Box:**

---

**Recommending Official Signature**

**Dept ID**

**Date**

**Additional Approving Signature**

**Dept ID**

**Date**

---

**Approving Official Signature**

**Dept ID**

**Date**

**Reviewing Authority**

**Date**
Address Change Form

This form is used to update current Home and/or Permanent address in the system.

1. Enter Name, Empl ID, Social Security Number.

2. Local Address: Enter street, city, state, zip, area code and telephone number

3. Permanent Address: Enter street, city, state, zip, area code and telephone number

4. Mailing Address: Enter street, city, state, zip, area code and telephone number

5. Sign the form and date

6. Indicate if you are a benefited or non-benefited employee

7. If benefited circle which of the following benefits you are enrolled in: NDPERS, TIAA, TIAA Supplemental, Dental, Vision. This is needed so the address change is forwarded to the plan administrators.

8. Provide the term date if terminating employment at UND

9. Return form to:
   Human Resources
   Twamley Hall Room 312
   264 Centennial Drive Stop 7127
   Grand Forks, ND 58202-7127
PAYROLL ADDRESS CHANGE FORM
University of North Dakota

NAME (Last, First, Middle)

Empl ID

Social Security Number:

LOCAL ADDRESS:

STREET

CITY

STATE

ZIP CODE

AREA CODE

TELEPHONE NO.

PERMANENT ADDRESS:
If Permanent is the same as local, write same
Note: Non-Residents aliens must enter foreign address

STREET

CITY

STATE

ZIP CODE

AREA CODE

TELEPHONE NO.

MAILING ADDRESS:
(USED FOR MAILING W-2)

STREET

CITY

STATE

ZIP CODE

AREA CODE

TELEPHONE NO.

EMPLOYEE'S SIGNATURE

DATE

BENEFITTED EMPLOYEE

NON-BENEFITTED EMPLOYEE

Circle those that you are enrolled in, if you are benefitted:

NDPERS  TIAA  TIAA SUPPLEMENTAL  DENTAL  VISION

If you are terminating, what is your termination date?

07/15
Affiliates@UND Form

An affiliate of UND is an individual brought to the campus at the request of a UND sponsoring department. The sponsoring department is required to fill out the Affiliates@UND form and obtain the appropriate signatures to ensure the affiliate is able to access the proper services. If a U Card is needed by the affiliate, the individual is responsible for payment of the U Card fee at the time of issuance. Please follow these line-by-line directions when filling out the form.

**Affiliates must have an ending date; we no longer allow indefinite ending dates. 12 months is usually sufficient.**

1. **Affiliate Name and Date of Birth:**
   Be sure to verify the correct spelling of the affiliate’s last, first and middle names and attain an accurate date of birth. In addition, and when appropriate, be sure to identify any other names by which the affiliate may have been known.

2. **EMPLID #:**
   The EMPLID # is the “key” to the affiliate being able to access services. This is always a 7 digit number that usually starts with a zero. If an affiliate has ever been employed by UND, another North Dakota University System institution, or state agency or has been a student at a North Dakota University System institution, they will already have an EMPLID #. If any of the answers to the questions are yes, the same EMPLID # will be used during the time the person is affiliated with campus. If the answer is no, a new EMPLID # will be assigned.

3. **Home (Local/Permanent) Address:**
   This is the home (local/permanent) address of the affiliate. If the affiliate has a cell phone #, it would be used for notification in case of a campus emergency.

4. **On Campus Address: (This is to be completed by the affiliates department)**
   Name of department, building name and room number, and campus phone # where the affiliate can be reached.

5. **Affiliation with UND:**
   Clearly state the purpose for affiliate to be on campus.
   For Emeritus Professor’s be sure to list department and Emeritus here.
   Ex. Communications Professor Emeritus.

6. **Dates Affiliate will be on campus:**
   Beginning date is the first date the affiliate will be on campus and will need access to services. The ending date is the final date the affiliate will be on campus and will need access to services. If the affiliate received an UCard, it will expire on this date. It is the obligation of the UND sponsoring department to ensure the affiliate’s status is terminated once their work on campus is complete. This is accomplished by providing an ending date on this form.

7. **Services Affiliate will be Utilizing:**
   Please check all that apply. Some services require the affiliate to have a U Card, for which the affiliate will be charged for the card. Further, some services are only available by purchasing them.
   1. Campus Libraries
a. U Card required
2. Dining Center Meal Plans
   a. U Card required.
   b. Meal plans must be purchased.
   c. Contact Dining Services at 7-3823 for arrangements.
3. Printing Labs
   a. U Card required.
   b. Funds must be deposited in U Cash prior to utilization.
   c. Contact U Card Office at 7-2071 for arrangements.
4. Wellness Center Membership
   a. U Card required.
   b. Membership plan must be purchased.
   c. Contact Wellness Center at 7-WELL for arrangements.
5. UND Housing
   a. Housing services must be purchased.
   b. Contact UND Housing at 7-4251.
6. UND Building Keys
   a. Key request form is available on the UND Facilities website at:
      http://www.und.edu/dept/facilities/forms/forms.htm
7. UND Parking Permit
   a. Permit application is available on the UND Parking website:
      http://und.edu/student-life/parking/purchase-permit.cfm
   b. Permit must be purchased.
8. UND Network Access
   a. Once EMPLID # is activated or assigned, affiliate will have network access.

Signatures must be obtained in order requested with the Vice President or designee being the final signature. Form will not be processed unless all signatures are obtained.

8. **Requested by (Sponsoring Department/Program/Unit):**
   Name of departmental contact sponsoring the affiliate, department name, department #, signature, phone # and date. This should be the name of the person to be contacted if there are questions or additional information is needed.

9. **Sponsoring Department/Program/Unit Chair/Head/ Contact:**
   Name, department name, signature, phone # and date. This is the department chair or head of the program or unit sponsoring the affiliate.

10. **Authorized By:**
    Vice President or Designee of the sponsoring department.

Vice President’s office will forward form to Human Resources and Payroll Services, Stop 8010 for approval and assignment of Emplid #, if required. Human Resources will forward to the U Card Office if a U Card is required for the affiliate to access services. Affiliate will be responsible for the payment of the U Card fee at the time of issuance. Affiliate will not be able to obtain a U Card until the U Card Office receives the completed form from Human Resources.
# AFFILIATES @ UND

Application for UND Affiliate Status

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
<th>Middle Name</th>
<th>Date of Birth (mm/dd/yy)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- Have you ever been employed by UND? If yes, when? (Yes/No)  
- Have you ever been employed by a ND University System Institution or State Agency? If yes, when? (Yes/No)  
- Have you ever been a student at a ND University System Institution? If yes, when? (Yes/No)  
- If applicable, what is your EMPL ID?  

<table>
<thead>
<tr>
<th>Address: Home (Local/Permanent)</th>
<th>Dept Address (Required)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Country</td>
<td>Country</td>
</tr>
<tr>
<td>Address 1</td>
<td>Address 1</td>
</tr>
<tr>
<td>Address 2</td>
<td>Address 2</td>
</tr>
<tr>
<td>City</td>
<td>City</td>
</tr>
<tr>
<td>State</td>
<td>State</td>
</tr>
<tr>
<td>Zip</td>
<td>Zip</td>
</tr>
<tr>
<td>Country</td>
<td>Home Phone</td>
</tr>
<tr>
<td></td>
<td>County</td>
</tr>
<tr>
<td></td>
<td>Permanent Phone</td>
</tr>
<tr>
<td>Cell Phone (For campus emergency notifications. Will not be published.)</td>
<td>Home E-mail</td>
</tr>
</tbody>
</table>

**Affiliation with UND**  
- Dates of Affiliation: Beginning Date  
- Ending Date  

- Indicate which services affiliate will be utilizing:  
  - Campus Libraries - Please indicate which library/libraries access is needed.  
  - Shelp Library  
  - Law Library  
  - Health Sciences Library  
  - UND Building Keys  
  - Dining Center Meal Plans  
  - Wellness Center Membership  
  - UND Parking Permit  
  - UND Housing  
  - UND Network Access  
  - Other - Please Specify  

**Requested By (Sponsoring Department/Program/Unit):**  
- Name  
- Department  
- Date  
- Signature  
- Phone  
- Date

**Sponsoring Department/Program/Unit Chair/Head/Contact:**  
- Name  
- Department  
- Date

**Authorized By:**  
- Name  
- Date

**HR Use Only**

EMPL ID: ____________
Criminal History Background Check for Minors (Under 18 Years)

1. Minor’s parent/legal guardian fills out the consent form.
   1. Enter Date
   2. Enter minor’s name
   3. Enter UND
   4. Parent signs and prints name

2. Department has the minor fill out the UND Criminal History Background Check Authorization Form.
   1. Department must complete the “Hiring Department” section of the form
   2. The Minor must complete the “Subject of Background Check” section thoroughly
   3. Check or no to question about Criminal Offense or Charges
   4. If yes to the question in #3, select the correct information from the dropdowns for each Offense or Charge
   5. Minor must sign and date the form
   6. Once the Department, Minor and Parent/Guardian has completed and signed the forms they must be turned into Human Resources for processing
   7. Fair reporting information is provided after the CHBC page

3. Human Resources will e-mail the completed forms to Sterling

4. Once Sterling has entered the authorization and information into the Sterling Criminal History Background Check system we will be able to see the Minor’s name in the Pending section of Sterling.

5. When the Criminal History Background Check has been completed UND Human Resources will get an e-mail indicating the completion.

6. Human Resources will then email the hiring department to indicate that the individual is approved to work and department may proceed with the hiring process.
I, the undersigned parent or legal guardian of ____________, do hereby consent, on behalf of myself and said child, to have a background report prepared by Sterling Infosystems, Inc. and delivered to ____________ for use for employment purposes consistent with the disclosure and authorization provided to said child.

Signature of Legal Parent or Guardian

Print Name
University of North Dakota
Criminal History Background Check
Authorization Form

To be completed by Hiring Department - it is the responsibility of the department to obtain a valid email address and notify subject of the records check they will be receiving an e-vite (except for those under 18) from UND Human Resources to electronically submit their background check.

Department #  Department name  Department contact name  Department contact phone #

Upon clearance of background check, the position the subject would be hired as:  [ ] Regular (Benefited)  [ ] Temporary (Non-Benefited)

Is subject under 18?  [ ] Yes  [ ] No  Subject's email address:

[ ] Faculty  [ ] Staff  [ ] GTA/GRA/GSA  [ ] Medical Resident  [ ] Other (Please describe):

Departmental signature:  X  Date:

Have candidate complete if they are under 18 years or DO NOT have a valid email address.

To be completed by Subject of Background Check - background checks will be used to evaluate candidates/employees for employment purposes and will not be used to discriminate on the basis of race, color, creed, national origin, religion, sex, sexual orientation, gender identity, genetic information, age, veterans status, marital status, political affiliation or physical, mental or medical disability.

Full name  Mailing address  Social Security Number

Date of birth (mm/dd/yyyy)  Do you have a valid Driver's License?  [ ] Yes  [ ] No  Driver's License Number  State  Sex  [ ] Male  [ ] Female

Address line 1  Day Phone (include area code)

Address line 2  Home/Cell Phone (include area code)

City  Date  County  Zip

Have you ever been convicted of a criminal offense or are there any other criminal charges now pending against you?  [ ] Yes  [ ] No  If yes, identify type of offense (federal, misdemeanor, unknown or warrant), description of offense, state & county where arrest/conviction took place, and date. If more than four, list on back or on a separate sheet of paper.

<table>
<thead>
<tr>
<th>Type</th>
<th>Description of Offense</th>
<th>State</th>
<th>County</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Choose One</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Choose One</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Choose One</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>4</td>
<td>Choose One</td>
<td></td>
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</tbody>
</table>

I hereby consent to the preparation by Sterling Infosystems, Inc. (“Sterling”), a consumer reporting agency located at 1 State Street, New York, NY 10001, (877) 424-2457, www.sterlinginfosystems.com, of background reports regarding me and the release of such reports to the University of North Dakota (UND) and its designated representatives, to assist UND in making an employment decision involving me at any time after receipt of this authorization and throughout my employment, to the extent permitted by law. To this end, I hereby authorize, without reservation, any state and federal law enforcement agency or court, educational institution, motor vehicle record agency, credit bureau or other information service bureau or data repository, or employer to furnish any and all information regarding me to Sterling and/or UND itself, and authorize Sterling to provide such information to UND. I have been advised that I have a right to review and challenge the accuracy and completeness of the information obtained through this process. A photo copy of this signed release shall have the same force and effect as the original release. Fabrication or failure to disclose relevant information will disqualify me from consideration. In compliance with the Federal Privacy Act of 1974, the disclosure of the individual’s social security number on this form is mandatory pursuant to ND Century Code 43-50-32. The individual’s social security number is used for identification purposes and the national database to determine eligibility for licensure and detect violations of law or regulations. Penalty for the applicant not including the Social Security Number on their application will cause the application to be not processed.

Acknowledgment receipt of a copy of the Consumer Financial Protection Bureau’s “A SUMMARY OF YOUR RIGHTS UNDER THE FAIR CREDIT REPORTING ACT.”

Signature:  X  Date:

For the use only

Sterling Infosystems
Box and/or FBI, ND, and Federal  Submitted By:

Date:

15
A Summary of Your Rights Under the Fair Credit Reporting Act

The federal Fair Credit Reporting Act (FCRA) promotes the accuracy, fairness, and privacy of information in the files of consumer reporting agencies. There are many types of consumer reporting agencies, including credit bureaus and specialty agencies (such as agencies that sell information about check writing histories, medical records, and rental history records). Here is a summary of your major rights under the FCRA. For more information, including information about additional rights, go to www.consumerfinance.gov/learnmore or write to: Consumer Financial Protection Bureau, 1700 G Street N.W., Washington, DC 20552.

- **You must be told if information in your file has been used against you.** Anyone who uses a credit report or another type of consumer report to deny your application for credit, insurance, or employment — or to take another adverse action against you — must tell you, and must give you the name, address, and phone number of the agency that provided the information.

- **You have the right to know what is in your file.** You may request and obtain all the information about you in the files of a consumer reporting agency (your “file disclosure”). You will be required to provide proper identification, which may include your Social Security number. In many cases, the disclosure will be free. You are entitled to a free file disclosure if:
  - a person has taken adverse action against you because of information in your credit report;
  - you are the victim of identity theft and place a fraud alert in your file;
  - your file contains inaccurate information as a result of fraud;
  - you are on public assistance;
  - you are unemployed but expect to apply for employment within 60 days.

In addition, all consumers are entitled to one free disclosure every 12 months upon request from each nationwide credit bureau and from nationwide specialty consumer reporting agencies. See www.consumerfinance.gov/learnmore for additional information.

- **You have the right to ask for a credit score.** Credit scores are numerical summaries of your credit-worthiness based on information from credit bureaus. You may request a credit score from consumer reporting agencies that create scores or distribute scores used in residential real property loans, but you will have to pay for it. In some mortgage transactions, you will receive credit score information for free from the mortgage lender.

- **You have the right to dispute incomplete or inaccurate information.** If you identify information in your file that is incomplete or inaccurate, and report it to the consumer reporting agency, the agency must investigate unless your dispute is frivolous. See www.consumerfinance.gov/learnmore for an explanation of dispute procedures.
- Consumer reporting agencies must correct or delete inaccurate, incomplete, or unverifiable information. Inaccurate, incomplete, or unverifiable information must be removed or corrected, usually within 30 days. However, a consumer reporting agency may continue to report information it has verified as accurate.

- Consumer reporting agencies may not report outdated negative information. In most cases, a consumer reporting agency may not report negative information that is more than seven years old, or bankruptcies that are more than 10 years old.

- Access to your file is limited. A consumer reporting agency may provide information about you only to people with a valid need—usually to consider an application with a creditor, insurer, employer, landlord, or other business. The FCRA specifies those with a valid need for access.

- You must give your consent for reports to be provided to employers. A consumer reporting agency may not give out information about you to your employer, or a potential employer, without your written consent given to the employer. Written consent generally is not required in the trucking industry. For more information, go to www.consumerfinance.gov/learnmore.

- You may limit “prescreened” offers of credit and insurance you get based on information in your credit report. Unsolicited “prescreened” offers for credit and insurance must include a toll-free phone number you can call if you choose to remove your name and address from the lists these offers are based on. You may opt out with the nationwide credit bureaus at 1-888-5-OPTOUT (1-888-5-67868).

- You may seek damages from violators. If a consumer reporting agency, or, in some cases, a user of consumer reports or a furnisher of information to a consumer reporting agency violates the FCRA, you may be able to sue in state or federal court.

- Identity theft victims and active duty military personnel have additional rights. For more information, visit www.consumerfinance.gov/learnmore.

States may enforce the FCRA, and many states have their own consumer reporting laws. In some cases, you may have more rights under state law. For more information, contact your state or local consumer protection agency or your state Attorney General. For information about your federal rights, contact:

<table>
<thead>
<tr>
<th>TYPE OF BUSINESS:</th>
<th>CONTACT:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1a. Banks, savings associations, and credit unions with total assets of over $10 billion and their affiliates</td>
<td>a. Consumer Financial Protection Bureau 1700 G Street, N.W. Washington, DC 20552</td>
</tr>
<tr>
<td>b. Such affiliates that are not banks, savings associations, or credit unions also should list,</td>
<td>b. Federal Trade Commission. Consumer Response Center – FCRA</td>
</tr>
</tbody>
</table>
2. To the extent not included in item 1 above:
   a. National banks, federal savings associations, and federal branches and federal agencies of foreign banks
   b. State member banks, branches and agencies of foreign banks (other than federal branches, federal agencies, and insured state branches of foreign banks), commercial lending companies owned or controlled by foreign banks, and organizations operating under section 25 or 25A of the Federal Reserve Act
   c. Nonmember insured banks, insured state branches of foreign banks, and insured state savings associations
   d. Federal Credit Unions

3. Air carriers
   Asst. General Counsel for Aviation Enforcement & Proceedings
   Aviation Consumer Protection Division
   Department of Transportation
   1200 New Jersey Avenue, S.E.
   Washington, DC 20590

4. Creditors Subject to the Surface Transportation Board
   Office of Proceedings, Surface Transportation Board
   Department of Transportation
   395 E Street, S.W.
   Washington, DC 20423

5. Creditors Subject to the Packers and Stockyards Act, 1921
   Nearest Packers and Stockyards Administration area supervisor

6. Small Business Investment Companies
   Associate Deputy Administrator for Capital Access
   United States Small Business Administration
   409 Third Street, S.W., 8th Floor
   Washington, DC 20416

7. Brokers and Dealers
   Securities and Exchange Commission
   100 F Street, N.E.

   Farm Credit Administration
   1501 Farm Credit Drive
   McLean, VA 22102-5000

9. Retailers, Finance Companies, and All Other Creditors Not Listed Above
   FTC Regional Office for region in which the creditor operates or Federal Trade Commission Consumer Response Center – FCRA
   Washington, DC 20580
   (877) 382-4357
Designated Medical Provider Form

Purpose of this form is to allow the employee to designate a specific provider for care if employee should be injured on the job.

Employees intending to see a medical provider other than the University’s DMP’s must designate this in writing before utilizing that provider’s services. Employee is not required to designate an additional DMP, but must sign and return this form regardless.

1. Complete the form by entering the Physician/Clinic name and the situation when this provider should be used. Ex. Physician/Clinic – Dentist, Situation – mouth injury, broken tooth.

2. Employee can list multiple providers for any type of care.

3. Print Employee Name, Empl ID, Department name, and Department ID.

4. Sign and Date the form. Return to the correct address at the bottom of the form.
MEMORANDUM

To: UND Employees

From: Terry Wynne, Associate Director for Safety, Office of Safety

Date: October 28, 2014

Re: Workers Compensation/Designated Medical Provider (DMP) Procedures

UND participates in the Workforce Safety and Insurance (WSJ) Risk Management Program. This allows the Risk Management Workers Compensation Program (RMWCP) to designate health care providers to treat your workplace injuries and illnesses. If you need to seek medical attention due to a work-related injury, you must see a designated medical provider (DMP). The attached UND Designated Medical Provider form has a listing of all UND designated medical provider areas.

Altru Occupational Health was selected by Risk Management because it has an occupational health services department with an occupational health physician as the attending physician. An occupational health physician specializes in work-related injuries/illnesses.

UND Student Health Services will no longer be listed as a designated medical provider for the University. Should an employee want to utilize UND Student Health for their work related injuries, employee must list Student Health on the DMP as you would any primary doctor, chiropractor, eye doctor, or dentist.

Employees intending to see a medical provider other than the University’s DMP must designate this in writing on the attached form. This now includes Student Health if you desire to utilize them for any work-related injury. This must be done prior to any injury. The form is also available at http://und.edu/finance-operations/environmental-health-and-safety/risk-management.cfm. The form must be on file at the Office of Safety prior to the injury. If your job should require you to be out-of-town for a short period, you are urged to seek an After-Hour Clinic or an Urgent Care facility. Additionally, if your job will require you to be away from North Dakota for more than 30 days whether out-of-state or overseas, you must fill out the Out-of-State Workers Compensation Coverage Form or the Travel Outside the U.S. Form and the Notification of Out-of-Country form and submit to the Office of Safety at Stop 9031 or email them to: und.safety@email.und.edu. Instructions for those traveling outside of North Dakota for more than 30 days are located on this website http://und.edu/finance-operations/environmental-health-and-safety/risk-management.cfm.

If you do not have a DMP on file or need to update your DMP, please fill out the attached form and submit to the Office of Safety. If updating the DMP form, please fill it out with all the medical providers you wish to utilize because the Office of Safety removes the previous and replaces it with the new DMP.

If you have any questions about the designated medical provider policy, please contact the Office of Safety at 777-3341.
Occupational Injury Guidelines

1) Determine the seriousness of the injury and if medical attention is needed. If the injury is an emergency, inform your supervisor and report to an emergency treatment facility. If an ambulance is needed, dial 911 IMMEDIATELY. Initial emergency care is exempt from Designated Medical Provider (DMP) requirements. Notify Office of Safety immediately regarding severe injuries that require ambulance response at 777-3341.

2) If medical attention is needed and it is not an emergency, contact UND’s DMP: Altru Occupational Health, 1300 Columbia Road So., Phone 780-1546.

   OR

   A DMP you have specifically identified in writing (prior to injury).

3) Complete online the Incident Reporting Form within 24 hours of the work-related injury. It is located on this web site: http://und.edu/finance-operations/environmental-health-and-safety/riskmanagement.cfm. Supervisor must also complete online the Incident Investigation Form within 24 hours and that is located on this web site as well. Instructions on how to complete the forms online are located on this web site as well.

4) Workers compensation claims are filed online by Office of Safety directly from the Incident Reporting Form. You will be contacted to sign your claim for benefits.

5) To sign your claim form, come to Office of Safety at 3851 Campus Road (second floor of University Police Department). If your injury limitations prevent you from coming to sign your claim, arrangements can be made to have the claim form brought to you. Once signed, Office of Safety will send the claim form to Workforce Safety & Insurance.

6) Contact Office of Safety at 777-3341 for any questions.

7/2014
UND DESIGNATED MEDICAL PROVIDER FORM

UND participates in the Workforce Safety and Insurance (WSI) Risk Management Program. This allows the Risk Management Workers Compensation Program (RMWCP) to designate health care providers to treat your workplace injuries and illnesses.

WSI may not pay for medical treatment to another provider unless you are either referred to this provider by the Designated Medical Provider, or unless you designated in writing prior to the injury that you wanted to be treated by a different medical provider. Emergency care is exempt from this requirement. UND employees working outside the State of North Dakota for more than 30 days must complete the Out of State Workers Compensation Coverage Form. UND employees working overseas must complete a Travel Outside the U.S. Form. If working overseas for more than 30 days, must also complete the Notification of Out of Country Form. All forms can be found on the Office of Safety’s web site: http://und.edu/finance-operations/environmental-health-and-safety/riskmanagement.cfm. These forms can be mailed to Stop 9031 or e-mailed to und.safety@email.und.edu. UND employees that are working in the state must seek medical treatment from one of the following if injured on the job and they are:

GRAND FORKS
DMP: Altru Occupational Health - 780-1546 (Phone) 1300 Columbia Rd. So., Altru Health Institute Bldg.

OUTSIDE GRAND FORKS
Sanford Health Occupational Health - Bismarck, with satellite clinics in Jamestown and Dickinson.
OR
OR
Sanford Health - Fargo, with satellite clinics in Enderlin, Hillsboro, Mayville, Wahpeton, Valley City, Edgeley, Lisbon, Jamestown, Grafton and Park River.
OR
Altru Health Occupational Medicine - Grand Forks, with satellite clinics in Drayton, Cavalier, and Lake Region in Devils Lake

OUTSIDE THE STATE OF NORTH DAKOTA OR OVERSEAS
If working outside the State of North Dakota for more than 30 days, but still in the United States, fill out the Out of State Workers Compensation Coverage Form. If working overseas for less than 30 days, complete the Travel Outside the U.S. Form and if working overseas for more than 30 days, must also complete the Notification of Out of Country Form and submit to the Office of Safety three weeks prior to travel. Send forms to Stop 9031 or e-mail it to und.safety@email.und.edu. All the forms and instructions are located on the web site: http://und.edu/finance-operations/environmental-health-and-safety/riskmanagement.cfm. Any questions, contact Office of Safety at (701) 777-3341.

Employees intending to see a medical provider other than the University’s DMPs must designate this in writing before utilizing that provider’s services. This is accomplished by filling in the blanks below. You are not required to designate an additional DMP, but you must sign and return this form regardless. If updating the DMP form, please fill it out with all the medical providers you wish to utilize because the Office of Safety removes the previous and replaces it with the new DMP.

I wish to designate the following provider as a designated provider to seek treatment from in the event of a workplace injury or illness (e.g. UND Student Health for work related injuries):

<table>
<thead>
<tr>
<th>Physician/Clinic</th>
<th>Situation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician/Clinic</td>
<td>Situation</td>
</tr>
<tr>
<td>Physician/Clinic</td>
<td>Situation</td>
</tr>
</tbody>
</table>

All designations take effect upon submission to Office of Safety. This designation does not cover any prior work-related injuries. This statement remains in effect until another form is submitted by the employee.

Employee Name (Please Print): ___________________________  EMPLID: ___________________________
Employing Dept: ___________________________  Dept. ID: ___________________________
Employee Signature: ___________________________  Date: ___________________________

Signing this statement means that you have read and understand the policy.

RETURN COMPLETED FORM TO:
New Employee: Submit to PAYROLL, Stop 7117 or FAX: 777-3721
For Form Revision: Submit to Office of SAFETY, Stop 9031, email: und.safety@email.und.edu, or FAX: 777-4159
Determination of Worker Status

Purpose of the form is for Federal Employment Taxes and Income Tax Withholding.

Instructions:

Worker Information

1. Indicate who is completing the form and the date.

2. Enter Name, Empl ID, Phone number, Department name, and Email address of the employee.

General Information

3. Indicate number of workers completing the same or similar work in the department.

4. Indicate how employee obtain this position.

5. Describe work done be the worker.

6. Explain if the worker is an employee or independent contractor.

7. Answer question if employee worked in any capacity for UND before and if so, the dates and explain.

8. If a written agreement attach a copy.

Behavioral Control

9. Describe any training or instruction provided to the worker.

10. Explain how worker receives their assignments.

11. Explain how assignments are performed.

12. List who worker should contact for problems or complaints and who is responsible for resolution.

13. Explain what types of reports are required from the worker.

14. Describe workers routine, schedule, hours.

15. List location(s) the worker performs services.

16. Describe required meetings and any penalties for not attending.

17. Answer questions: if personally provides services and explain if helpers are needed who will hire them. If so, is approval needed and if yes, by whom.

18. Explain who will pay the helpers.
19. Explain if worker is reimbursed if they pay the helper and if yes, who.

Financial Control

20. List supplies, equipment, and materials and who provides them.

21. List any expenses incurred by the worker.

22. Explain if expenses are to be reimbursed and by who.

23. Indicate how the worker is paid.

24. Indicate if worker is covered by worker’s compensation insurance.

25. Explain if any economic loss or financial risk can be incurred by worker other than salary.

Relationship of the Worker and Firm

26. List any benefits available to worker.

27. Indicate if worker can be terminated by either party with no liability or penalty.

28. Indicate if worker performed similar duties elsewhere during same time period and if yes, is worker required to get approval from department.

29. Describe and attach any agreements prohibiting competition between worker and UND.

30. Describe any advertising the worker does.

31. Indicate if worker assembles or processes products at home who provides materials and instructions or pattern.

32. Indicate what worker does with finished product.

33. Explain how UND represents the worker.

34. If worker no longer provides services to UND explain how relationship ended.

35. Read the information before signing.

36. Complete the Department name and phone, print name, title, and phone of person completing the form.

37. Use electronic signature and date. Save file, attach to an email and send to und.accountingservices@email.und.edu.

38. Or you can print, sign, date and mail to address on form.
# Determination of Worker Status

For purposes of federal employment taxes and income tax withholding

**Worker Information**

<table>
<thead>
<tr>
<th>Number</th>
<th>Field</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Worker ( ) Department ( )</td>
<td>Date:</td>
</tr>
<tr>
<td>2</td>
<td>Name:</td>
<td>Email ID:</td>
</tr>
<tr>
<td></td>
<td>Phone:</td>
<td>Department:</td>
</tr>
<tr>
<td></td>
<td>Email:</td>
<td></td>
</tr>
</tbody>
</table>

**General Information**

Total Number of workers in your department performing the same or similar services?  

How did the worker obtain the position within your department?  
- ☐ Application  - ☐ Bid  - ☐ Employment Agency  - ☐ Other [specify]

Describe the work done by the worker?

Explain why you believe the worker is an employee or an independent contractor?

Did the worker provide services for the University of North Dakota in any capacity before providing the services that are the subject of this determination?  
- ☐ Yes  - ☐ No

If yes, what were the dates of the prior service?  
- From:  
- To:

If yes, explain the differences, if any, between current and prior services.

If the work is done under a written agreement between the department and the worker, attach a copy. Describe the terms and conditions of the work arrangement.

**Behavioral Control**

What specific training and/or instruction has the worker been given by the University of North Dakota for the services being performed?

How does the worker receive assignments?
<table>
<thead>
<tr>
<th>Question</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Who determines the methods by which the assignments are performed?</td>
<td>11</td>
</tr>
<tr>
<td>Who is the worker required to contact if problems or complaints arise and who is responsible for their resolution?</td>
<td>12</td>
</tr>
<tr>
<td>What types of reports are required from the worker? Attach examples.</td>
<td>13</td>
</tr>
<tr>
<td>Describe the Worker's daily routine such as schedule, hours, etc...</td>
<td>14</td>
</tr>
<tr>
<td>At what location(s) does the worker perform services [e.g., firm's premises, own office, home, etc]? Indicate the appropriate percentage of time the worker spends in each location, if more than one.</td>
<td>15</td>
</tr>
<tr>
<td>Describe any meetings the worker is required to attend and any penalties for not attending [e.g., monthly meetings, staff meetings].</td>
<td>16</td>
</tr>
<tr>
<td>Is the worker required to provide the services personally? Yes No</td>
<td></td>
</tr>
<tr>
<td>If substitutes or helpers are needed, who hires them?</td>
<td>17</td>
</tr>
<tr>
<td>If the worker hires the substitutes or helpers, is approval required? Yes No</td>
<td></td>
</tr>
<tr>
<td>If “yes,” by whom?</td>
<td></td>
</tr>
<tr>
<td>Who pays the substitutes or helpers?</td>
<td>18</td>
</tr>
<tr>
<td>Is the worker reimbursed if the worker pays the substitutes or helpers? Yes No</td>
<td></td>
</tr>
<tr>
<td>If “yes,” by whom?</td>
<td>19</td>
</tr>
</tbody>
</table>
### Financial Control

List the supplies, equipment, materials, and property provided by each party:

- The University of North Dakota:

- The worker:

- Other party:

What expenses are incurred by the worker in the performance of services for the department?

Specify which, if any, expenses are reimbursed by:

- The University of North Dakota:

- Other party:

Type of Pay the worker receives:  
- Salary  
- Commission  
- Hourly Wage  
- Lump Sum  
- Other (specify)  

Other:

Does the University of North Dakota carry worker's compensation insurance on the worker?  
- Yes  
- No

What economic loss or financial risk, if any, can the worker incur beyond the normal loss of salary (e.g., loss or damage of equipment, material, etc.)?

### Relationship of the Worker and Firm

List the benefits available to the worker (e.g., paid vacations, sick pay, pensions, bonuses, paid holidays, personal days, insurance benefits).

Can the relationship be terminated by either party without incurring liability or penalty?  
- Yes  
- No

Did the worker perform similar services for other campuses or institutions during the same time period?  
- Yes  
- No

If "yes," is the worker required to get approval from the department?  
- Yes  
- No
Describe any agreements prohibiting competition between the worker and the University of North Dakota while the worker is performing services or during any later period. Attach any available documentation.

What type of advertising, if any, does the worker do (e.g., a business listing in a directory, business cards, etc.)? Provide copies, if applicable.

If the worker assembles or processes a product at home, who provides the materials and instructions or pattern?

What does the worker do with the finished product (e.g., return it to the University of North Dakota, provide it to another party, or sell it)?

How does the University of North Dakota represent the worker (e.g., employee, partner, representative, or contractor)?

If the worker no longer performs services for the University of North Dakota, how did the relationship end (e.g., worker quit or was terminated, job completed, contract ended, other)?

Continue to the next page
I understand that the proper status of the worker depends on the manner in which the work is performed and on the nature of the relationship between the worker and the University personnel responsible for the work being performed. Therefore, the status of the worker for federal employee tax withholding and related reporting purposes will be re-determined when the manner in which the work is performed or the relationship between the worker and the University changes sufficiently to alter the validity of this certification.

I hereby declare that the information provided in this document is true and correct and that I have sufficient knowledge of, authority, and responsibility for the work to be performed under this contract to effectively make this certification.

If the department is negligent in completing this document and the Internal Revenue Services (IRS) determines an employer/employee relationship exists; the department will be responsible for all taxes and penalties.

I declare that I have examined this request, including accompanying documents, and to the best of my knowledge and belief, the facts presented are true, correct, and complete.

<table>
<thead>
<tr>
<th>Department for whom services are to be performed</th>
<th>Telephone number</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Signature of person completing this form</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Print name and title</th>
<th>Telephone Number</th>
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</thead>
<tbody>
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<td></td>
<td></td>
</tr>
</tbody>
</table>

When finished filling out form please save, attach file, and e-mail to und.accountingservices@email.und.edu.

Or mail to Accounting Services, 264 Centennial Dr Stop #8356, Grand Forks, ND 58202.
Direct Deposit Authorization

1. Emplid: Enter EmplID, if known. Otherwise, enter Social Security Number
2. Enter Home Telephone Number, Last Name, First Name and Work Telephone Number
3. Complete Primary Account information: This is the account where your check will be deposited, or the remainder of your check will be deposited, if you have amounts or %’s going to other banks. This is also the account where your reimbursements will be deposited.
   a. Select whether this is a request a NEW account, CHANGE an account, or to CANCEL an account
   b. Indicate whether it is a checking or savings account
   c. Complete bank name, city and state where the account was originally opened
   d. Complete the Routing and Account Numbers. These numbers can be found on one of your check blanks. DO NOT use numbers from a deposit slip, when providing numbers for checking accounts – the numbers are not the same. The following is how to identify the numbers on your check blank:

   ![Routing # - Account # - Check #]

   e. Attach a voided check to the form.
4. Second/Third/Fourth Account: Only if you would like a specific dollar amount or a percentage of the net payment to go to a different savings or checking account(s), complete the information for the additional account(s) and enter a specific dollar amount or percentage of net pay. Continue completing for additional accounts, if needed. Attach a voided check for each account.
5. Read the information at the bottom of the form, sign and date. Be aware that this request supersedes any previous requests at any other North Dakota University System institution and will cause all payroll payments for any of those entities to be deposited according to this request.
6. Due to the time required for payroll and bank processing, allow one pay period for implementation
### Authorization for Direct Deposit of Employee Pay and Reimbursements

#### Employee Information

<table>
<thead>
<tr>
<th>EMP#</th>
<th>Enter SS# ONLY if EMP# unknown</th>
<th>SS#</th>
<th>HOME #</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>LAST NAME</th>
<th>FIRST NAME</th>
<th>MI</th>
<th>WORK PHONE #</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Enrollment or Change Authorization

(Complete this section for new enrollment, financial institution or account changes. All employees may select up to a maximum of ten accounts within six financial institutions. The employee should complete the additional page of the authorization form, if needed.)

- [ ] CHECK IF ADDITIONAL PAGE IS ATTACHED

##### Primary Account:

- (This is the account where your paycheck is deposited after % or $ amount is deducted. It is also the account where your reimbursements are deposited.)

- SELECT ONE: □ New Enrollment  □ Bank/Account Change  □ Cancel Direct Deposit

- ACCOUNT TYPE (CHECK ONE):
  - □ Checking  □ Savings

- BANK OR CREDIT UNION NAME
- CITY
- STATE

Please verify account information.

##### Second Account: % or $ of Net Distribution:

- □ New Enrollment  □ Change  □ Cancel Direct Deposit

- ACCOUNT TYPE (CHECK ONE):
  - □ Checking  □ Savings

- BANK OR CREDIT UNION NAME
- CITY
- STATE

Please verify account information.

##### Third Account: % or $ of Net Distribution:

- □ New Enrollment  □ Change  □ Cancel Direct Deposit

- ACCOUNT TYPE (CHECK ONE):
  - □ Checking  □ Savings

- BANK OR CREDIT UNION NAME
- CITY
- STATE

Please verify account information.

##### Fourth Account: % or $ of Net Distribution:

- □ New Enrollment  □ Change  □ Cancel Direct Deposit

- ACCOUNT TYPE (CHECK ONE):
  - □ Checking  □ Savings

- BANK OR CREDIT UNION NAME
- CITY
- STATE

Please verify account information.

I authorize the University of North Dakota, to initiate accounting transactions to deposit my employee pay and reimbursements directly to the account(s) indicated above and to correct any errors which may occur from these transactions. I also authorize the Financial Institution to post these transactions to these accounts. This authorization is to remain in force until North Dakota University System receives written notice from me to cancel or change this authorization. I understand that submission of this request will supersede any other deposit requests I have submitted to North Dakota University System. I understand that this agreement does not apply to Student Financial Aid or Student Account Services disbursements. A separate Direct Deposit Request must be filed with Student Account Services.

#### Submit To: Payroll Office

<table>
<thead>
<tr>
<th>BOX 7127, TYWALMAN ROOM 312</th>
</tr>
</thead>
<tbody>
<tr>
<td>EMPLOYEE SIGNATURE</td>
</tr>
<tr>
<td>DATE</td>
</tr>
</tbody>
</table>

**Important Notice:** Due to the time required for payroll and bank processing, allow one pay period for implementation.
Direct Deposit Exemption Form

The purpose of this form is to state the reason automatic direct deposit is not available for payroll funds.

1. Complete Name and Empl ID

2. Select which option is correct for current situation.
   - If no more than two pay checks will be received in a year select this option and sign and date.
   - If able to obtain a checking or savings account for some reason, select this option and have the financial institution representative complete: name of institution, signature and date. (If this option is selected, employee must reapply each year until able to obtain an account or is no longer working for the university.)
   - If employee is a Work Study student and is receiving financial aid funds only.
   - Special circumstances—must be significant and not due to lack of bank account. (This requires President or Vice-President approval)

3. Read statement at bottom of form.

4. Sign and date the form.

5. Submit the form to Payroll.
Direct Deposit Exemption

Name: ___________________________ Empl ID: ___________________________

I respectfully request to be exempt from the Mandatory Direct Deposit Policy, due to the following reason:

☐ I will not receive more than two pay checks in a calendar year.

☐ I am unable to obtain a checking or savings account (Must re-apply each calendar year)—Financial Institution representative must complete below. The above mentioned employee is unable to open a checking or savings account at this financial institution at this time.

Financial Institution: ___________________________

Signature of Authorizor Representative: ___________________________ Date: ___________________________

☐ I am a Work Study student receiving financial aid funds only.

☐ Special circumstances—must be significant and not due to lack of bank account (Requires President or Vice-President approval)

I hereby certify that all of the above information is true, complete and correct.

Signature: ___________________________ Date: ___________________________

Submit form to: Payroll Office, Twamley 312 or mail to: 254 Centennial Drive Stop 7127

Office Use Only
☐ Not Approved ☐ Approved Signature: ___________________________ Title: ___________________________

5/2012
Donated Leave Consent to Release Name

Purpose of this form is to give the university authorization to release employees’ name to the campus employees for the use of requesting donation of annual or sick leave hours.

1. Fill out first and last name on the line within the statement giving permission.
2. Sign and date the form.
3. Return this form along with the Long Term Medical Request Form to Human Resources.

Employee Consent To Release Name
For Donated Leave Purposes

1. ________________________________, hereby consent to the written or oral disclosure of my name to eligible donors for donated annual or sick leave purposes.

   ________________________________  ________________________________
   Signature of Employee            Date

Please return this form with the Long Term Medical Request Form

4/9/2013
Donated Leave Form

The purpose of the form is for employee use to donate annual leave or sick leave to an eligible co-worker that is in need of additional time off due to a qualifying reason. The employees in need of donations are listed in the University Letter or contact Human Resources to get a list of current names.

There are guidelines as to how much can be donated:

1. The donating employee may donate up to 5% of accrued sick leave hours.
2. The donating employee must retain a balance of 40 hours vacation leave.
3. The receiving employee may receive 693 hours in a 12-month period.
4. All donations must be in full-hour increments.

The donating employee should complete this form and send form to the supervisor of the receiving employee for final approval. Supervisor of receiving employee will keep track of donated hours for departmental purposes and route form to the Payroll Office, as leave is needed.

1. Enter the name of the employee you would like to donate to, their Empl ID and department name.

2. Enter donating employee's name, phone number, Empl ID, department name, number of vacation and/or sick leave hours being donated.

3. Donating employee signs and dates the form.

4. Supervisor of the receiving employee signs and dates the form.
University of North Dakota
Donation of Leave

The donating employee may donate up to 5% of accrued sick leave hours.
The donating employee must retain a balance of 40 hours vacation leave.
The receiving employee may receive 693 hours in a 12-month period.
All donations must be in full-hour increments.

_Instructions_: The donating employee should complete this form and send form to the supervisor of the receiving employee for final approval. Supervisor of receiving employee will keep track of donated hours for departmental purposes and route form to the Payroll Office, as leave is needed.

<table>
<thead>
<tr>
<th>Name of Receiving Employee</th>
<th>Empl ID #</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Department</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Name of Donating Employee</th>
<th>Phone #</th>
<th>Empl ID #</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Department</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Number of Vacation Hours Donated</th>
<th>For Payroll Use Only:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Number of Sick Leave Hours Donated</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

_I authorize the donation of leave indicated above._

<table>
<thead>
<tr>
<th>Donating Employee Signature</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

_Approval: (Supervisor of Receiving Employee)_

<table>
<thead>
<tr>
<th>Supervisor Signature</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

All Leave Donations Will Be Kept Confidential
Employee Tuition Waiver

Checklist of Eligibility for Employee Tuition/Assistance Waiver & Family Member Tuition Waiver

This checklist identifies the information that administrative offices will review for tuition waiver eligibility. Submit completed/signed Application for Tuition Waiver form to:

Human Resources & Payroll Services, Twamley Hall Room 313, Stop 8010.

A new application must be completed and submitted each semester.

Tuition waivers apply to all benefitted employees of UND and of affiliated organizations* of UND. Employee/Eligible Family Member Tuition Waiver Policy: http://UND.edu/finance-operations/_files/docs/3-4-employee-family-tuition-waivers.pdf

504 Residency for Tuition Purposes;
http://www.ndus.nodak.edu/makers/procedures/ndus/default.asp?PID=280&SID=57


For both Employee and Family Member the following applies:

Classes excluded from the tuition waiver program include professional programs Law (JD) and Medicine (MD). Internships, study abroad/exchange and other situations where the tuition flows to an outside entity are also excluded from this policy. Physical therapy and occupational therapy classes are not part of the medicine exclusion.

For Employees: Courses taken at the campus of employment regardless of delivery type: 100% tuition and fee waiver is provided, with the exception of the CND, NDSA, program and course fees which shall be paid by the employee. For courses taken at another NDUS campus, other than the campus of employment, regardless of delivery type: a system-wide fixed 50% employer paid tuition assistance, with the employee paying the remaining 50% of tuition and 100% of all fees.

For Family Members: Courses taken at the campus of employed parent regardless of delivery type: 50% tuition only waiver is provided.

For NDUS office and Core Technology Services (CTS) staff who do not have a campus of employment, the following applies:

a) 100% tuition and fee waiver shall be provided for a traditional course, taken at any NDUS campus, with the exception that the employee shall pay the CND, NDSA, program and course fees. Traditional Course is a face-to-face course offering on a campus, where the employee and instructor are physically face-to-face; and
b) Employer shall provide a system-wide fixed 50% tuition assistance payment with the employee paying the remaining 50% of tuition and 100% of all fees, for all other courses.

In accordance with IRS regulations, employee tuition waivers valued over $5,250 per calendar year and the value of all graduate classes for eligible family members will be taxed to the employee. Applicable federal, state and social security taxes will be deducted on the employee’s paycheck on a pro-rated basis during the semester. (Subject to change to comply with federal and state laws)

NDUS Procedure 504 allows an eligible family member of a NDUS employee to be eligible for the North Dakota resident tuition rate. To apply for North Dakota residency contact Student Account Services or visit http://und.edu/admissions/student-account-services/nd-residency.cfm for more information.

After 9% of the period of enrollment for a class is completed, no refund shall be made for a class which is dropped. Class will be counted as a waived class.
EMPLOYEE TUITION WAIVER:
1. Human Resources:
   a. Must receive completed Application for Tuition Waiver/Assistance form no later than the Last Day to Add a class for the semester for which waiver is being requested.
   b. Application for Tuition Waiver form must have all necessary signatures.
      - UND employee must sign.
      - Employee’s supervisor must sign.
   c. Must be able to verify UND employee will be actively employed as a regular (benefited) employee on the first day of the semester.
2. Registrar's Office:
   a. Must be admitted.
   b. Must not be on academic probation
3. Student Account Services:
   a. Employee does not have an overdue accounts receivable balance. (Charges of at least $10.00 and 30 days past due.)
   b. Has not reached the limit of 3 classes per calendar year.

FAMILY MEMBER TUITION WAIVER:
1. Human Resources:
   a. Must receive completed Application for Tuition Waiver form no later than 30 days prior to the start of the semester.
   b. Application for Tuition Waiver form must have all necessary signatures.
      - UND employee must sign.
      - Eligible Family Member must sign.
   c. Must be able to verify UND employee will be actively employed as a regular (benefited) employee on the first day of the semester.
   d. Must verify: Spouse of the employee (must be legally married as recognized by the State of North Dakota); children under the age of 26.
      - For further definition of dependent see Employee and Eligible Family Member Tuition Waiver and Tuition Assistance Policy.
   e. Must receive the following verification: Marriage license, birth certificate and/or legal documents to prove family member status.
3. Registrar's Office:
   a. Must be admitted.
   b. Must not be on academic probation.
4. Student Account Services:
   a. Employee and/or Eligible Family Member do not have an overdue accounts receivable balance. (Charges of at least $10.00 and 30 days past due.)


Instructions for the Application:
1. Complete the Employee information section with name, Empl ID, phone, email address, mailing address, campus name, campus of enrollment, NDUSO/CTS/Other if applicable, undergraduate/graduate, year of waiver/assistance, and term of waiver/assistance.

2. List the courses you are requesting the waiver for this semester.

3. Employee must sign and date.

4. Return form to your supervisor for signature.

5. Submit the form with appropriate documentation to Human Resource. HR’s address is on the form.
APPLICATION FOR EMPLOYEE TUITION WAIVER/ASSISTANCE


1. INFORMATION BELOW TO BE COMPLETED BY EMPLOYEE

<table>
<thead>
<tr>
<th>EMPLOYEE NAME</th>
<th>EMPLOYEE ID #</th>
<th>DAYTIME PHONE</th>
</tr>
</thead>
<tbody>
<tr>
<td>EMPLOYEE EMAIL ADDRESS</td>
<td>EMPLOYEE MAILING ADDRESS</td>
<td></td>
</tr>
<tr>
<td>CAMPUS OF EMPLOYMENT</td>
<td>CAMPUS OF ENROLLMENT</td>
<td></td>
</tr>
<tr>
<td>FOR NDUS/OTHER ONLY</td>
<td></td>
<td></td>
</tr>
<tr>
<td>STUDENT STATUS</td>
<td>YEAR OF WAIVER/ASSISTANCE</td>
<td></td>
</tr>
<tr>
<td>Undergraduate</td>
<td>Graduate</td>
<td></td>
</tr>
<tr>
<td>TERM OF WAIVER/ASSISTANCE</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

2. TUITION WAIVER/ASSISTANCE REQUESTED THIS SEMESTER

<table>
<thead>
<tr>
<th>Course</th>
<th>Dept</th>
<th>Title</th>
<th>Course #</th>
<th>Section</th>
<th>Day/Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>1st Course</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2nd Course</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>3rd Course</td>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

3. EMPLOYEE SIGNATURE (Employee signature required for all requests)

I certify that I have read and understand the Tuition Waiver/Assistance policy and procedures as referenced above. I certify under penalties of perjury and subject to disciplinary action, up to and including termination, that I am eligible for this tuition waiver. Further, I, as the employee and student authorize and/or acknowledge the following:

- the release of any employee or student information, pertinent to decide eligibility for this request, to appropriate NDUS institutions and departments.
- In accordance with IRS regulations, employee tuition waivers valued over $5,250 per calendar year may be taxable to the employee. Applicable federal, state and social security taxes will be deducted on the employee’s paycheck on a pro-rated basis during the semester. (Subject to change to comply with federal and state laws)
- in accordance with federal regulations, the tuition waiver or assistance may be used as a financial resource and become part of the student's financial aid package. Financial aid may need to be adjusted if the amount of the tuition waiver or assistance, along with other financial aid, exceeds the total cost of attendance.

EMPLOYEE SIGNATURE (Required) __________________________ Date: ______________

4. REQUIRED SUPERVISOR APPROVAL

SUPERVISOR/DEPT. HEAD NAME __________________________

SUPERVISOR/DEPT. HEAD SIGNATURE & DATE __________________________

5. SUBMISSION

Submit Completed Form to: UND Human Resources
264 Centennial Drive Stop 8510, Grand Forks, ND 58202-8010

Please submit waiver no later than the last day to add a class in the term for which the waiver/assistance is being requested.

6. ADDITIONAL INSTITUTIONAL APPROVALS

Human Resources Approval Signature and Date __________________________

Registrar Approval Signature and Date __________________________

Student Account Services Approval Signature and Date __________________________

Important: This is a standardized form for the use of all employees within the NDUS system. The Campus of Employment should populate the highlighted boxes in section 5 and 6 with appropriate contact and approval information. Please no additional changes.
Family Member Tuition Waiver

Checklist of Eligibility for Employee Tuition/Assistance Waiver & Family Member Tuition Waiver

This checklist identifies the information that administrative offices will review for tuition waiver eligibility. Submit completed/signed Application for Tuition Waiver form to:

Human Resources & Payroll Services, Twamley Hall Room 313, Stop 8010.

A new application must be completed and submitted each semester.

Tuition waivers apply to all benefitted employees of UND and of affiliated organizations* of UND.

Employee/Eligible Family Member Tuition Waiver Policy: http://UND.edu/finance-operations/_files/docs/3-4-employee-family-tuition-waivers.pdf

504 Residency for Tuition Purposes;
http://www.ndus.nodak.edu/makers/procedures/ndus/default.asp?PID=280&SID=57

For both Employee and Family Member the following applies:
Classes excluded from the tuition waiver program include professional programs Law (JD) and Medicine (MD). Internships, study abroad/exchange and other situations where the tuition flows to an outside entity are also excluded from this policy. Physical therapy and occupational therapy classes are not part of the medicine exclusion.

For Employees: Courses taken at the campus of employment regardless of delivery type: 100% tuition and fee waiver is provided, with the exception of the CND, NDSA, program and course fees which shall be paid by the employee. For courses taken at another NDUS campus, other than the campus of employment, regardless of delivery type: a system-wide fixed 50% employer paid tuition assistance, with the employee paying the remaining 50% of tuition and 100% of all fees.

For Family Members: Courses taken at the campus of employed parent regardless of delivery type: 50% tuition only waiver is provided.

For NDUS office and Core Technology Services (CTS) staff who do not have a campus of employment, the following applies:

a) 100% tuition and fee waiver shall be provided for a traditional course, taken at any NDUS campus, with the exception that the employee shall pay the CND, NDSA, program and course fees. Traditional Course is a face-to-face course offering on a campus, where the employee and instructor are physically face-to-face; and
b) Employer shall provide a system-wide fixed 50% tuition assistance payment with the employee paying the remaining 50% of tuition and 100% of all fees, for all other courses.

In accordance with IRS regulations, employee tuition waivers valued over $5,250 per calendar year and the value of all graduate classes for eligible family members will be taxed to the employee. Applicable federal, state and social security taxes will be deducted on the employee’s paycheck on a pro-rated basis during the semester. (Subject to change to comply with federal and state laws)

NDUS Procedure 504 allows an eligible family member of a NDUS employee to be eligible for the North Dakota resident tuition rate. To apply for North Dakota residency contact Student Account Services or visit http://und.edu/admissions/student-account-services/nd-residency.cfm for more information.

After 9% of the period of enrollment for a class is completed, no refund shall be made for a class which is dropped. Class will be counted as a waived class.
EMPLOYEE TUITION WAIVER:
1. Human Resources:
a. Must receive completed Application for Tuition Waiver/Assistance form no later than the Last Day to Add a class for the semester for which waiver is being requested.
b. Application for Tuition Waiver form must have all necessary signatures.
   ☐ UND employee must sign.
   ☐ Employee’s supervisor must sign.
c. Must be able to verify UND employee will be actively employed as a regular (benefited) employee on the first day of the semester.
2. Registrar’s Office:
a. Must be admitted.
b. Must not be on academic probation
3. Student Account Services:
a. Employee does not have an overdue accounts receivable balance. (Charges of at least $10.00 and 30 days past due.)
b. Has not reached the limit of 3 classes per calendar year.

FAMILY MEMBER TUITION WAIVER:
1. Human Resources:
a. Must receive completed Application for Tuition Waiver form no later than 30 days prior to the start of the semester.
b. Application for Tuition Waiver form must have all necessary signatures.
   ☐ UND employee must sign.
   ☐ Eligible Family Member must sign.
c. Must be able to verify UND employee will be actively employed as a regular (benefited) employee on the first day of the semester.
d. Must verify: Spouse of the employee (must be legally married as recognized by the State of North Dakota); children under the age of 26.
   ☐ For further definition of dependent see Employee and Eligible Family Member Tuition Waiver and Tuition Assistance Policy.
e. Must receive the following verification: Marriage license, birth certificate and/or legal documents to prove family member status.
3. Registrar’s Office:
a. Must be admitted.
b. Must not be on academic probation.
4. Student Account Services:
a. Employee and/or Eligible Family Member do not have an overdue accounts receivable balance. (Charges of at least $10.00 and 30 days past due.)

Instructions for the application:

1. Must attach verification: marriage certificate, birth certificate, and/or other legal documents.

2. Complete the employee information of name, Empl ID, phone, department name, campus stop number, email address, check if UND or other and list the institutions name, students name, students date of birth, student ID number, who waiver is for spouse or dependent, undergraduate/graduate, term waiver is for and the year.

3. Employee and the Family member must sign and date the form.

4. Need any applicable signatures.

5. Submit form to Human Resource address on form.
**APPLICATION FOR FAMILY MEMBER TUITION WAIVER**

Submit completed/signed form to Human Resources, Twamley Hall Room 313, Stop 8010

**Reminder:** Family Member Tuition Waiver Applications are due no later than 30 days prior to the start of the semester and one must be completed and submitted each semester.

Please refer to the policy for Waiver/Assistance guidelines: http://und.edu/finance-operations/files/docs/3-4-employee-family-tuition-waivers.pdf

**Verification documents must be attached to prove family member status:**
1. Marriage Certificate
2. Birth Certificate and/or
3. Other legal documents

<table>
<thead>
<tr>
<th><strong>1. INFORMATION BELOW TO BE COMPLETED BY EMPLOYEE</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>EMPLOYEE NAME</strong></td>
</tr>
<tr>
<td><strong>DEPARTMENT</strong></td>
</tr>
<tr>
<td><strong>EMPLOYER</strong></td>
</tr>
<tr>
<td><strong>STUDENT FULL NAME</strong></td>
</tr>
<tr>
<td><strong>WAIVER APPLIES TO (Check one):</strong></td>
</tr>
<tr>
<td>Spouse</td>
</tr>
<tr>
<td><strong>Year:</strong></td>
</tr>
</tbody>
</table>

**EMPLOYEE and FAMILY MEMBER SIGNATURES**

I certify that I have read and understand the Tuition Waiver policy as listed above in the Checklist of Eligibility. I certify under penalties of perjury and subject to disciplinary action, up to and including termination, that I and/or my family member are eligible for this tuition waiver.

I, as the employee and/or student, authorize the release of any employee or family member information pertinent to decide eligibility for this request to Human Resources, Registrar’s Office, and Student Account Services.

**EMPLOYEE SIGNATURE** (Required) ____________________________ Date ____________

**FAMILY MEMBER SIGNATURE** (Required) ____________________________ Date ____________

**IV. APPROVALS**

Affiliated Org/NDUS Signature required for Non-UND employees only:

**Affiliated Org/NDUS Institution Approval - please print**

**Affiliated Org/NDUS Institution Signature** ____________________________ Date ____________

**FOR OFFICE USE ONLY**

**Human Resource Approval Signature** ____________________________ Date ____________

**Registrar Approval Signature** ____________________________ Date ____________

**Student Account Services Approval Signature** ____________________________ Date ____________

(Official Use Only)

Form Updated 4/7/2016
Employment and Age Certificate-Minors

The purpose of the forms is to provide the rules for the 14 and 15 year old employees and the agreement between all parties to follow the rules. The brochure attached to the form covers the types of work allowed and not allowed and the hours they may work.

1. First section of the form is to be completed by the Minor. All fields should be filled out and the section signed and dated.

2. Second section of the form is to be completed by the Employer. All fields should be filled out and the section signed and dated.

3. Third section of the form is to be completed by the Parent or Guardian. All fields should be completed and the section signed and dated.

4. Completed form and a photocopy should be sent to the ND Department of Labor. The address is found at the bottom of the form.
# Employment and Age Certificate - Minors

## TO BE COMPLETED BY MINOR:

<table>
<thead>
<tr>
<th>Name of Minor</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address of Minor</td>
</tr>
<tr>
<td>Telephone Number</td>
</tr>
<tr>
<td>Age</td>
</tr>
<tr>
<td>Date of Birth</td>
</tr>
<tr>
<td>Name of School Minor Attends</td>
</tr>
</tbody>
</table>

Signature of Minor: ____________________________ Date Signed: __________

## TO BE COMPLETED BY EMPLOYER:

<table>
<thead>
<tr>
<th>Name of Minor's Employer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address of Employer</td>
</tr>
<tr>
<td>Type of Industry</td>
</tr>
<tr>
<td>Duties/Occupation of Minor</td>
</tr>
<tr>
<td>Type of Evidence of Age Accepted:</td>
</tr>
</tbody>
</table>

I certify that I have examined, approved, and will maintain evidence of age for this minor.

Signature of Employer: ____________________________ Date Signed: __________

## TO BE COMPLETED BY MINOR'S PARENT OR GUARDIAN:

<table>
<thead>
<tr>
<th>Name of Parent/Guardian</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address of Parent/Guardian</td>
</tr>
<tr>
<td>Telephone Number</td>
</tr>
</tbody>
</table>

I certify that I am the parent or legal guardian of this minor and approve of the employment of this minor.

Signature of Parent/Guardian: ____________________________ Date Signed: __________

---

North Dakota child labor laws apply to teens ages 16 and younger and establish rules related to the employment of teens in four general areas. Specifically, they:

- Establish a minimum age of 14 to be employed
- Restrict the hours that can be worked by teens ages 14 and 15
- Prohibit teens ages 14 and 15 from performing work deemed to be hazardous
- Require the completion and filing of an Employment and Age Certificate (work permit)

In addition, federal child labor laws further limit the types of work that can be performed by teens ages 14 and 15 and extend restrictions regarding work in hazardous occupations to teens ages 16 and 17.

A summary of both state and federal child labor laws can be found in the ND Department of Labor's brochure, *Youth Employment in North Dakota: State & Federal Regulations*. The full text of North Dakota's child labor laws can be found in N.D.C.C. 34-07.

## REQUIRED DISTRIBUTION:

Original completed form and one photocopy to be sent to: ND Department of Labor
600 East Boulevard Avenue, Dept 408
Bismarck ND 58505-0340
(701)328-2850 or ND toll-free 1-800-562-8032
E-mail: labor@nd.gov, Website: www.nd.gov/labor

The parent or guardian who certifies, or rejects, the employment certificate must file a completed copy with the Department of Labor, the employer, the principal of the school which the minor attends, or a principal in the municipality in which the minor resides, within ten days of certification or rejection. (N.D.C.C. 34-07-05)
Employment Change (Notice of)

Purpose of the form is for an employee that is changing jobs or terminating employment to notify Human Resources of these changes along with a change in address or telephone number if appropriate.

1. Fill out the department name employee is leaving and the last day of employment.
2. Mark the reason for leaving.
3. Enter the complete forwarding address and phone number if appropriate.
4. Sign, date, print name and Empl ID number.
5. Supervisor signs, dates and prints their name.
NOTICE OF EMPLOYMENT CHANGE
(To be Submitted with Job Data Change or Separation Form)

This is my official notice that my last day of work with the University of North Dakota in the department of __________________________ will be _________ (mm/dd/yyyy).

My reason for leaving is:

☐ Retirement
☐ Accepted new position off campus
☐ Transferring to another UND Dept: __________________________
☐ Transferring to another State Agency: __________________________
☐ Disability
☐ Other (please specify) _______________________________________

My forwarding Address is (Address to send W-2):

________________________________________________________________
________________________________________________________________
________________________________________________________________

New Telephone Number: __________________________

Signature __________________________ Date __________________________

Print your Name __________________________ EmplID __________________________

Signature of Supervisor Accepting Document __________________________ Date __________________________

Print Supervisor’s Name __________________________
Flex Comp Day Care Cost Verification

Purpose of the form is to submit paid or due day care costs for reimbursement through the Flex Spending account.

1. Fill out last, first, middle name and Empl ID.
2. Enter amount paid or due.
3. Enter from and to dates for the time care is/was provided.
4. Enter day care provider name and social security number or tax ID number.
5. Day care provider must sign and date the form.
6. Participant must sign and date the form.
7. Submit the form either online or mail/fax to WageWorks for reimbursement.

<table>
<thead>
<tr>
<th>Participant Name:</th>
<th>LAST</th>
<th>FIRST</th>
<th>MIDDLE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Empl ID No.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>AMOUNT PAID / DUE</th>
<th></th>
<th>FOR DATES CARE PROVIDED</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>$</td>
<td></td>
<td>FROM:</td>
<td>TO:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>DAY CARE PROVIDER NAME:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>DAY CARE PROVIDER SOCIAL SECURITY NO. / TAX ID NO.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>DAY CARE PROVIDER SIGNATURE</th>
<th>DATE</th>
<th>PARTICIPANT SIGNATURE</th>
<th>DATE</th>
</tr>
</thead>
</table>

WHITE - UND PAYROLL OFFICE ATTACH TO VOUCHER
Flex Comp Status Change Form

Purpose of form is to notify UND of any status change that may impact flex benefits.

Instructions:

1. Enter name, Empl ID, and date of the status change.

2. Indicate the type of change that is taking place.

3. Indicate the changes to the Annual Election Amounts. First the current amounts, then the new amounts.

4. Check if this is to Elect or Revoke for the Premium Conversion.

5. Sign and date.

6. Return to the address on the form for remaining signature.
Flexible Benefits
STATUS CHANGE FORM
This form must be submitted within 31 days of the event.

Employer: University of North Dakota  Employee’s Name
Employee ID#  of Status Change

Type of Status Change: (Please indicate one of the following)
You may request a change in your election to revoke the existing plan election and make a new election for the remainder of the plan year. Please complete the form and submit to the Payroll Office within 31 days of the change in status. The Payroll Office will review your request and make a determination as to whether the request is appropriate in accordance with IRS regulations. The date the change goes into effect must be prospective. Retroactive elections are not allowed.

☐ Change in legal marital status: Events that change in employee’s legal marital status, including the following: marriage, death of a spouse, divorce, legal separation, and annulment.

☐ Number of Dependents: Events that change an employee’s number of dependents including the following: birth, death, adoption, and placement for adoption. A dependent is formally defined to be a tax dependent under Code Section 152. This rule would not allow election changes for non-tax dependents such as parents, domestic partners and children of domestic partners.

☐ Dependent Satisfies or Ceases to Satisfy Eligibility Requirements: Events that cause an employee’s dependent to satisfy or cease to satisfy eligibility requirements for coverage on account of attainment of age, student status or any similar circumstance.

☐ Employment Status: Any of the following events that change the employment status of the employee, the employee’s spouse or the employee’s dependent: a termination or commencement of employment, a strike or lockout; a commencement of or return from an unpaid leave of absence; or a change in worksite. Also included is if an employee switches from salaried to hourly-paid with the consequence that the employee ceases to be eligible for the plan.

☐ Residence: A change in the place of residence of an employee, spouse or dependent.

☐ Adoption Assistance: For purposes of adoption assistance through a cafeteria plan, the commencement or termination of an adoption proceeding.

Other Allowed Change Events:
☐ Change in day care provider
☐ Change in cost of day care provider (Does not apply when the day care provider is a relative)

Based on the above Status Change, please change my annual election as follows:

Please indicate Flexible Spending Account Changes:

<table>
<thead>
<tr>
<th>Medical Spending Account</th>
<th>Previous Annual Election (Total)</th>
<th>New Annual Election (Total)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>Dependent Care Spending Account</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| Premium Conversion  ☐ Elect  ☐ Revoke

I have read and fully understand the regulations to the change my election. I understand that this Status Change Form must be completed within 31 days of the change in status event, and the election change I have requested must be consistent with the change in status event. I understand retroactive election changes are not allowed and that any election change will be effective on the later of the Election Date or Date of Status Change. I certify that the above information is true and correct, and agree to provide any necessary third-party documentation to verify the change in status event.

Requested by:
Participant’s Signature  Date

Reviewed by:
Employer Signature  Date

☐ Approved  ☐ Denied

Payroll Office; University of North Dakota; 264 Centennial Drive, Stop 7127; Grand Forks, ND 58202-7127
Revised (03/25/15)

51
Flexplace Agreement

Purpose of the form is to lay out the details of an employee that will work off campus and may have a flex work schedule.

Instructions:

Employee Information

1. Fill in name, title, department name, supervisor, hire date, FLSA status, and what type of request it is.

2. Read all information on the form.

3. Describe the business purpose of the work arrangement.

4. List the work schedule and start and end dates.

5. List any meetings, trainings, or events required to attend.

6. Read all information on the form.

7. Under work details answer all questions.

8. Read the information through page 5.


10. If any “no” answers must be rectified or clarified.

11. Read Agreement information.

12. Employee prints name, signs and dates form.

13. Route for all appropriate signatures as listed on the form.
FLEXPLACE AGREEMENT

Employee Information

Employee name:
Title:
Department Name:
Supervisor:
Hire date for current position:

FLSA status: ☐ Exempt ☐ Non-exempt
This is a: ☐ New request ☐ Renewal ☐ Modification of current arrangement

Flexplace Worksite

Location of flexplace worksite (worksite address):
The flexplace employee agrees to work at the designated site during the hours specified in the agreement as defined below. Any change must be approved in advance by the supervisor.

Business Purpose of Flexplace Work Arrangement

Describe the business purpose for the Flexplace arrangement being requested:

Flexplace Work Schedule and Hours

Agreement start date:
Agreement end date:

<table>
<thead>
<tr>
<th>Days employee will be commuting</th>
<th>Non-exempt employee meal time</th>
<th>Number of work hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monday</td>
<td>to</td>
<td>to</td>
</tr>
<tr>
<td>Tuesday</td>
<td>to</td>
<td>to</td>
</tr>
<tr>
<td>Wednesday</td>
<td>to</td>
<td>to</td>
</tr>
<tr>
<td>Thursday</td>
<td>to</td>
<td>to</td>
</tr>
<tr>
<td>Friday</td>
<td>to</td>
<td>to</td>
</tr>
<tr>
<td>Saturday</td>
<td>to</td>
<td>to</td>
</tr>
<tr>
<td>Sunday</td>
<td>to</td>
<td>to</td>
</tr>
</tbody>
</table>

Non-exempt employees are subject to FLSA regulations. Any hours worked over 40 in a work week must be authorized in advance by the supervisor, and the employee must be paid overtime. The supervisor will maintain a record of actual hours worked. Non-exempt employees working 8 hours in a row must have a defined meal period.
Flexplace employees are expected to attend meetings, training sessions, and similar events as required by the supervisor.

Schedule of Standing Meetings

<table>
<thead>
<tr>
<th>Meeting Day</th>
<th>Time</th>
<th>Location</th>
<th>Title/Purpose</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>5</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Attendance

Employees should notify their supervisor if they need to call in sick, and must also obtain supervisor approval before taking any annual leave, in accordance with established leave policies.

Employee Responsibilities and Obligations

1. All job responsibilities and conditions of employment apply as if the employee were working at the primary worksite.
2. The employee will comply with all University rules, policies, and procedures that would be in effect if the employee were working at the primary worksite. The employee must notify the supervisor immediately of any situation that interferes with his or her ability to perform the assigned job.
3. Work developed or produced during flexplace work away from the primary worksite remains the property of the University.
4. A flexplace arrangement is not a substitute for dependent care. The employee is required to make dependent care arrangements for the agreed-upon work hours. The supervisor may ask the employee to provide dependent care information.
5. The employee must certify that the flexplace work environment is safe and the same safety habits that would be used at the primary worksite are being practiced at the flexplace site.
6. The flexplace employee is encouraged to contact his or her insurance agent for any information regarding home worksites and coverage for equipment that is damaged, destroyed, or stolen.
7. An employee with a flexplace agreement is not entitled to reimbursement for travel mileage to attend work meetings at the primary worksite, unless specifically agreed to by the employer in this agreement.
8. Tax deductions (i.e., home office deductions) are not applicable if the arrangement is for the convenience of the employee. The employee should seek professional advice for any questions or concerns regarding tax issues.
9. Failure to follow policies, procedures, and practices may result in termination of the arrangement and/or disciplinary action.

Work Details

1. Employee telephone number where employee can be reached during work hours:
2. Employee email address from which the employee will be working:
3. Describe how calls received for the employee during the time out of the primary worksite will be handled.
4. Describe work assignments the employee will perform at the flexplace worksite.
5. Describe the job performance standards to be maintained.
6. Describe how the employee’s performance will be assessed and the frequency of assessments.

7. Describe how the employee and the supervisor will communicate.
8. Describe how communication with others at the University will be handled.
9. Describe how communication with customers will be handled.
10. Describe what University support services will be available to the flexplace employee.

11. If University-owned equipment fails at the flexplace site, describe how down time will be handled.

12. Describe the records and files the employee is allowed to keep at the flexplace site. Be sure to also describe measures that will be in place to maintain security of documents and data.

13. Identify what office or travel expenses/reimbursements will be provided by the institution during the period of this agreement. Expenses incurred that are not included below, or not previously approved by the department in writing, will not be covered by the institution.

**Workers’ Compensation**

The flexplace employee is covered by workers’ compensation for an injury or illness resulting from performing official duties at the designated site. The employee must authorize access to appropriate officials to perform safety inspections of the flexplace site and/or to investigate a workers’ compensation claim.

**Supplies and Furniture**

Authorization for any supplies and/or furniture must be approved by the supervisor and the department chair/head prior to purchase. The University may provide standard office supplies if approved by the department chair/head.

Unless otherwise specified in the flexplace agreement, the employee will be responsible for providing furniture at the flexplace site. The University is not responsible for loss, damage, or wear of employee-owned equipment and/or furniture. Repair and/or replacement costs and liability for privately owned equipment and furniture used for flexplace work is the responsibility of the employee.

**Property and Equipment**

Home worksite equipment shall generally be provided by the employee. In the event that equipment is provided by the University, such equipment shall be used by the employee exclusively for University business.

The employee agrees to take reasonable steps to protect any University property from theft, damage, or misuse. This includes maintaining data security and record confidentiality. The employee will comply with all copyrights and licensing agreements for all software owned by the University. Depending on the circumstances, the employee may be responsible for any damage to, or loss of, University property based on the discretion of the University.

The employee is responsible for maintenance and repair of these items unless other arrangements have been made in advance and in writing with the supervisor. The University assumes no responsibility for any damage to, depreciation of, or loss of the employee’s personal property that may be used at home (or another flexplace site) for University business. The University may pursue recovery from the employee for
University property that is deliberately, or through negligence, damaged or destroyed while in the employee’s care.

The employee will return University equipment, records, and materials upon request and/or termination of the flexible work agreement. The employee may be responsible for any costs necessary to return, repair, or replace University property. If University property is not returned upon request, at the end of a flexplace situation or upon termination, the employee (or former employee) will be responsible for all costs to replace any unreturned equipment.

If the employee is unable to meet work obligations due to equipment issues, the employee will notify his or her supervisor and may be required to travel to the primary worksite to perform his or her functions until the issues are resolved.

The employee agrees to report to the supervisor any instances of loss or damage to University property, or known unauthorized use or access to University systems or data.

Property Insurance

The University has an insurance program to insure its property where it is approved for use. In the case of any damaged or lost equipment, the Office of Safety must be contacted as soon as possible for assistance in filing a claim. Personal property used in connection with University employment is not covered under the University policy and should be covered by homeowner’s or renter’s insurance. The University is not liable for personal property.

Data Security

Employees may find the need to work with sensitive information at the flexplace site in either paper or electronic form. To ensure the security and confidentiality of sensitive information, employees must take appropriate safeguards (e.g., not sharing passwords, implementing screen savers, etc.) to prevent unauthorized disclosure.

External computers used to administer University resources or to access sensitive information must be properly configured and secured. Employees are required to connect to the University’s network through the Virtual Private Network (VPN) when accessing non-public sensitive data or systems. Use personal firewall software installed or enabled, and run current antivirus protection software. The employee and supervisor must work with their division’s IT personnel to ensure proper configuration and security.

When accessing sensitive data remotely, employees are prohibited from storing sensitive data (such as Social Security numbers, student records, and credit card numbers) on local hard drives, flash drives, or other external media (including laptops and smart phones). Employees should periodically save files to a server that is maintained by the University.

Employees must follow all University policies and procedures relating to the security and integrity of sensitive data. Refer to the North Dakota University System (NDUS) Data Classification and Information Security Standard for more information (see Related Information of the Remote Site (Flexplace) Work Locations Policy or http://www.ndus.edu/makers/procedures/ndus/default.asp?PID=4818&SID=62).

The flexplace employee will protect University information from unauthorized disclosure or damage and will comply with federal, state, and local laws, and University policies and procedures regarding disclosure of public and official records. Work done at the employee’s flexplace site is regarded as official University business. All records, documents, and correspondence, either in paper or electronic form, must be safeguarded for return to the primary worksite. Release or destruction of records should be done only in accordance with University policy and procedures and with the knowledge of the employee’s supervisor. Electronic and computer files are considered University records and must be protected as such.
University Records and Files

All University records and files temporarily stored at a flexplace work location remain the property of the University of North Dakota. Products, documents, and records that are used, developed, or revised must be copied and/or returned to the University when requested, at the end of the flexplace agreement, and/or at the termination of employment.

The employee will protect all confidential University documents from unauthorized access.

Personal Property Liability

The University will not be liable for damages to the flexplace employee’s property resulting from the flexplace agreement.

Flexplace Resources Checklist

<table>
<thead>
<tr>
<th>Equipment/Furniture/Supplies</th>
<th>Provided by Employees</th>
<th>Provided by UND</th>
<th>Insured by Employees</th>
<th>Insured by UND</th>
</tr>
</thead>
<tbody>
<tr>
<td>Telephone line</td>
<td>□</td>
<td>□</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>Telephone basic phone rate</td>
<td>□</td>
<td>□</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>Telephone calling options (voice mail, call waiting, teleconference, etc.)</td>
<td>□</td>
<td>□</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>Telephone long distance charges</td>
<td>□</td>
<td>□</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>Cell phone</td>
<td>□</td>
<td>□</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>Cell phone options: (email, internet access, etc.)</td>
<td>□</td>
<td>□</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>Internet</td>
<td>□</td>
<td>□</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>Computer (CPU, monitor, keyboard)</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Laptop</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Fax machine</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Scanner</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Printer</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Copier</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Software</td>
<td>□</td>
<td>□</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>Printer ink cartridges</td>
<td>□</td>
<td>□</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>Supplies</td>
<td>□</td>
<td>□</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>Furniture</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
</tbody>
</table>
Flexplace Safety Checklist

When setting up a flexplace work space, ergonomics and safety are of primary importance.

Work Station Set-up
Are the work station and equipment ergonomically appropriate?

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>Item</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Computer desk</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Component desk (if applicable)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Keyboard</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Chair</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Computer screen</td>
</tr>
</tbody>
</table>

For more detailed information on setting up an ergonomic computer workstation, visit http://www.osha.gov/SLTC/etools/computerworkstations/pdf/files/checklist1.pdf

Work Space Set-up

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>Item</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Work space is designated and developed to work needs.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Work space is separated from major family activity areas.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Work space is away from noise and distractions.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Work space illumination is adequate and appropriate for tasks.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Work space and property are secured.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Work documents, data, and confidential information are secured.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Air quality and ventilation are adequate.</td>
</tr>
</tbody>
</table>

Safety

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>Item</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Work space area accommodates all equipment and related materials.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Sufficient electrical outlets are available.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>All electrical, phone, cords, panels, and receptacles are in good condition.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Three-prong grounded outlets are used. Note: Two-prong outlets that require plug adapters do not provide adequate protection for computers.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Equipment is fitted with surge protectors and overload fuses.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Equipment is placed close to electrical outlets. Electrical cords/wires are configured so there are no tripping hazards. Note: extension cords should not be used.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>There is a working smoke detector in or near the work space.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>A home multipurpose fire extinguisher is available. Employee is familiar with use.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Heating and ventilation systems are adequate and in good repair.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>There is an established evacuation plan in the event of a fire.</td>
</tr>
</tbody>
</table>

Any items listed above as “no” must be rectified or require further clarification. Please list steps to be taken.
Agreement

By signing this agreement, I state that I have read and understand the flexible work options guidelines and the flexplace conditions, and I agree to the terms and conditions set forth by this agreement. I believe that my work can be completed within the above schedule and location with no loss of customer service or disruption to others in my department, the University, or external customers. I understand that it is my responsibility to make my flexible work arrangement a success. A supervisor or other staff member may terminate or modify the arrangement at any time within the guidelines of contractual obligations (if applicable). I also understand that a new flexplace work options form and flexplace agreement form must be submitted to my supervisor and the Office of Human Resources anytime I wish to make a continuing change to my schedule, including returning back to the regular work location.

I agree with the conditions for use of University equipment, furniture, and/or data, and the nature of the equipment, supplies, and expenses to be provided for or paid for by the University as outlined in this agreement. I understand that this flexplace agreement is not approved until approved and signed by the vice president.

Printed Employee Name  Employee Signature  Date

The following signatures are required for final approval:

☐ Approved  ☐ Denied  Department Chair/Director Signature  Date

Department Chair/Director Email Address  Department Chair/Director Phone Number

☐ Approved  ☐ Denied  Dean/AVP Signature  Date

☐ Reviewed with the vice president for finance and operations  VP Initials  Date

☐ Approved  ☐ Denied  Vice President Signature  Date

Routing of Form:
1. Employee and supervisor complete agreement.
2. Supervisor submits agreement to department chair/director for approval.
3. If approved, department chair/director submits agreement to dean/associate vice president for approval.
4. If approved, dean/associate vice president submits agreement to UND Human Resources for review.
5. UND Human Resources submits agreement to the respective vice president for approval (respective vice president consults with vice president for finance and operations prior to approving the agreement).
6. When approved/denied, vice president returns agreement to Human Resources. UND Human Resources will notify the department.

The University of North Dakota flexible workplace agreement and guidelines have been adapted from the forms developed by Michigan Technological University, with thanks to Cleveland State University, George Washington University, Cornell University, Lehigh University, University of Pennsylvania, University of Kentucky, University of Arizona, and MIT whose WorkLife websites were especially helpful and are quoted in these forms and guidelines.

created by KK: 10-2015  Page 7
Flexplace Agreement Renewal

Purpose of the form is to renew an existing and already approved Flexplace Agreement. This form must be resubmitted annually. If the Flexplace work location has changed or the reason for the request has changed, then a new Flexplace Agreement is required. The Flexplace renewal will not be sufficient.

Instructions:

Employee Information:
   1. Enter employee name, title, department name, supervisor name.
   2. Enter hire date and hire flexplace approval date.

Flexplace Worksite:
   3. Indicate the worksite address.

Business Purpose of Flexplace Work Arrangement:
   4. Describe the business purpose for the Flexplace arrangement.

Flexplace work Schedule and Hours
   5. Enter the start and end date.

Department Chair/director Approval
   6. Department chair/director checks approved or denied, signs and dates the form.
FLEXPLACE AGREEMENT RENEWAL

The purpose of this document is to renew an existing and already approved Flexplace Agreement. This form must be resubmitted annually.

Note: If the Flexplace work location has changed or the reason for request has changed, then a new Flexplace Agreement is required. The Flexplace renewal will not be sufficient.

Employee Information

Employee name:
Title:
Department Name:
Supervisor:
Hire date for current position:

Hire Flexplace approval date:

Flexplace Worksite

Location of flexplace worksite (worksite address):
The flexplace employee agrees to work at the designated site during the hours specified in the agreement as defined below. Any change must be approved in advance by the supervisor.

Business Purpose of Flexplace Work Arrangement

Describe the business purpose for the Flexplace arrangement being requested:

Flexplace Work Schedule and Hours

Agreement start date:
Agreement end date:

Department Chair/Director Approval

☐ Approved  ☐ Denied

Department Chair/Director Signature  Date
Flexplace Agreement Evaluation

Purpose of the form is for Human Resources to evaluate a flexplace agreement and pass along that evaluation to the Provost.

Instructions

1. Enter employee name, title, department name, department chair, city/country/state of flexplace location.

2. Check the correct boxes for current location, tax compliance.

3. Enter any comments.

4. Check reason for request and Human Resource recommendation.
Foreign National Form UND

Purpose of the form is for Non-Resident Aliens receiving honorariums, prizes, awards or other non-employee payments.

Instructions:

Basic Information
1. Complete last name, first name, middle name(s), title, post title.
2. Enter student type, trainee type, social security / individual tax identification number, answer questions yes or no indicating if you don’t have one of these numbers that you have applied for one.
3. Enter foreign taxpayer id, institution id number, department name, occupation institution.

Individual Information
1. Indicate date of birth and marital status.
2. Answer questions if spouse is in the USA and if so, are they working in the USA.
3. Complete the dependents section if applicable otherwise go to home telephone section.
4. Enter home telephone number in USA, day time telephone number in USA, fax number, email address.
5. Indicate the date first entered the USA.
6. Indicate an emergency telephone number and email address.

USA Local Address
1. Enter address, city, state, and zip code.

Foreign Residence Address
1. Enter address, city, postal code, province/region, regional postal code, and country.
1. Enter country of passport / citizenship, passport number, passport expiration date.

2. Answer question yes or no to indicate if a US citizen.

3. Select yes or no to indicate if you have submitted an application to become a US permanent resident.

4. Enter country of tax residence.

5. Select yes or no to indicate if you have proven to the IRS that you have a closer connection to a foreign country than to the USA.

Other Information

1. Answer yes or no to the listed questions:
   a. Do you have a USA office? If yes, indicate number of days a year it is available to you.
   b. Are you a recipient of a grant?
   c. Are you engaged in a full-time program?
   d. Do you wish to claim treaty benefits if they are available?

Visa Immigration Activity

1. List current visa status. List any F, J, M, or Q visa immigration activity since 1/1/85 or visa immigration activity in last 3 calendar years.

2. Use dropdowns to indicate the following:
   a. Immigration status
   b. J-1 subcategory
   c. Primary purpose of visit
   d. Tax Residence
   e. Treaty benefit taken as
   f. Visa number
   g. First day in US in this status
   h. Last day in US in this status

Signature Page

1. Read the authorization statements.

2. Sign and date.
BASIC INFORMATION

Last Name: 
First Name: 
Middle Name(s): 
Title: 
Post Title: Examples: Phd, Esq., MD 
Student Type: 
Trainee Type: 
Your SSN / ITIN: 
If you have no SSN / ITIN, have you applied for one? Yes ☐ No ☐ 
Foreign Taxpayer ID: 
Institution ID Number: 
Department at Institution: 
Occupation at Institution: 

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INDIVIDUAL INFORMATION

Date of Birth: [ ] Use 3-letter abbreviation for month in day-month-year format

Marital status:  ○ Married  ○ Single

Spouse here in USA?:  ○ Yes  ○ No  ○ Spouse working in USA?:  ○ Yes  ○ No

If you have no dependents (not including spouse) skip to Home Telephone in USA

Dependents (not including spouse):

If you are a national of American Samoa, the Northern Mariana Islands, or the US Virgin Islands, or are tax resident in Canada or Mexico, enter your total number of dependents: 0

If you are a tax resident of Japan or the Republic of Korea (South), enter your total number of dependents who were with you in the USA at some time in the calendar year: 0

If you are a resident of India who entered the USA for the primary purpose of studying, enter your dependents who are US citizens or residents: 0

If you are not from any of the above countries go to Home Telephone in USA

Home Telephone in USA: [ ] Extension: [ ]

Day Phone in USA: [ ] Extension: [ ]

Fax: [ ]

Email address: [ ]

Date First Ever Entered USA: [ ] Use 3-letter abbreviation for month in day-month-year format

Emergency Telephone: [ ] Extension: [ ]

Emergency Email Address: [ ]
### USA LOCAL ADDRESS

<table>
<thead>
<tr>
<th>Field</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address Line 1</td>
<td></td>
</tr>
<tr>
<td>Address Line 2</td>
<td></td>
</tr>
<tr>
<td>Address Line 3</td>
<td></td>
</tr>
<tr>
<td>City</td>
<td></td>
</tr>
<tr>
<td>State</td>
<td></td>
</tr>
<tr>
<td>Zip code</td>
<td></td>
</tr>
</tbody>
</table>

### FOREIGN RESIDENCE ADDRESS

<table>
<thead>
<tr>
<th>Field</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address Line 1</td>
<td></td>
</tr>
<tr>
<td>Address Line 2</td>
<td></td>
</tr>
<tr>
<td>Address Line 3</td>
<td></td>
</tr>
<tr>
<td>City</td>
<td></td>
</tr>
<tr>
<td>Postal Code</td>
<td></td>
</tr>
<tr>
<td>Province/Region</td>
<td></td>
</tr>
<tr>
<td>Regional Postal Code</td>
<td></td>
</tr>
<tr>
<td>Country</td>
<td></td>
</tr>
</tbody>
</table>

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COUNTRY

Country of Passport/Citizenship: ____________

Passport Number: ____________

Passport Expiration Date: ______/____/____ Use 3-letter abbreviation in day-month-year format

Are you also a U.S. citizen? □ Yes □ No

Has submitted application to become a US lawful permanent resident? □ Yes □ No

Country of Tax Residence: ____________

Have you proven to the IRS that you have a closer connection to a foreign country than to the USA? □ Yes □ No

OTHER INFORMATION

Do you have an office regularly available to you in the USA? □ Yes □ No

If yes, how many days in this calendar year is the office available to you? ______

Are you the recipient of a grant? (i.e. a non-service scholarship or fellowship) □ Yes □ No

Are you engaged in a full-time program? □ Yes □ No

Do you wish to claim treaty benefits if they are available? □ Yes □ No

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<table>
<thead>
<tr>
<th>For the First and Last Day in US fields, please use the 3-character abbreviation for month in day-month-year format.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Be sure to circle all the way through the field for the last day (last day in US).</td>
</tr>
<tr>
<td>In the following forms, list any F, J, or O visa immigration activity since 1/1/85 or visa immigration activity in last 3 calendar years.</td>
</tr>
<tr>
<td>Please list your current visa status in the first row.</td>
</tr>
</tbody>
</table>

**Visa Immigration Activity**

---

North Dakota University of
I hereby authorize the University of North Dakota to release information contained on the Foreign National Information Form to Windstar Technologies, Inc., P.O. Box 800; 1504 Providence Hwy., Suite 13; Norwood, MA 02062-0800 for the following purpose: technical software support for the International Tax Navigator$^TM$ system.

I hereby certify that all of the above information is true, complete and correct. I understand that if my status changes from that which I have indicated on this form I must submit a new Foreign National Information Form to the Payroll Department.

Signature: ________________________________ Date: ________________
Foreign National Information System (FNIS) Request

Purpose of the form is to provide information to determine the person’s status as a resident alien or a nonresident alien for tax purposes.

Instructions:

1. Enter first name, last name, email address.

2. Provide one of the following items:
   a. Date of Birth
   b. Social security number
   c. Employee ID #

3. Check yes or no to the question, “If this is your first visit to the US?”

4. Read all information about the policies and regulations for international students in F-1 or J-1 student status.

5. If agreeing to the policies and regulations sign, date and provide empl id number.

6. Read all information on the last page and keep for future reference.
Request for Foreign National Information System (FNIS)

Request for FNIS

All international employees and students that receive payroll payments from the University of North Dakota are required to enter immigration data on UND's Foreign National Information System (FNIS).

Note: Not completing the online FNIS form may require UND to withhold taxes you may not owe.

After completing this form, you will receive an email with your FNIS logon and password. The personal and immigration information entered will make the paperwork process faster and easier. The Payroll Office needs sufficient information to determine your status as a resident alien or a nonresident alien for tax purposes. When entering data into FNIS, you will need your passport, visa, I-94 card, social security card and one of the following: I-20, DS2010, or I-797B. Note: please provide copies of those documents to the UND Payroll Office.

Forward this completed form to: UND Payroll Office, Twamley Hall Room 312, 264 Centennial Drive, Stop 7127, Grand Forks, ND 58202-7127. Forms can be faxed to: 701-777-4721 or emailed to: kevin.kuntz@email.und.edu.

________________________________________
First Name (Given Name)

________________________________________
Last Name (Family Name or Surname)

E-Mail Address

*Please be sure email address is clear and legible

Provide one of the following:

Date of Birth

Social Security Number

Employee ID# 

☐ Yes  ☐ No  Is this your first visit to the United States?
MEMO OF UNDERSTANDING – UNIVERSITY OF NORTH DAKOTA

EMPLOYMENT POLICIES AND REGULATIONS FOR INTERNATIONAL STUDENTS IN F-1 OR J-1 STUDENT STATUS

As an international student holding F-1 or J-1 student status, I understand that the U.S. Code of Federal regulations\(^1\) states that I may work on-campus under the following conditions:

- I can work a maximum of only 20 \textbf{hours per work week}\(^2\) whenever classes are in session.

- I am allowed to work more than 20 \textbf{hours per work week}\(^2\) during official academic break weeks. Academic break weeks are those full weeks when classes are not being held.

\textbf{DEFINITION OF ACADEMIC BREAKS (More than 20 hours of employment PERMITTED)}

- Spring break week
- Any full week(s) between the Fall and Spring semesters
- Any full week(s) starting the week following commencement in May through the week before classes begin in the Fall

- These hour limitations are per week and apply regardless of the number of employers I have.

- I understand that it is my responsibility to keep track of the number of hours that I work in order to ensure that I do not exceed the work-hour limitations prescribed by U.S. immigration regulations and the international student employment policies of the University of North Dakota.

\begin{center}
\textbf{I understand and agree that I must follow these regulations. Failure to do so will result in:}
- Termination of my employment
- Termination of my I-20 or DS-2019 resulting in loss of legal non-immigrant student status in the United States
\end{center}

My signature below verifies that I have read and understand the policies and regulations listed below and I understand the consequences to my status should I fail to follow these policies.

\begin{center}
\textbf{Student Signature: \underline{\hspace{2.5cm}}} \textbf{Date: \underline{\hspace{2.5cm}}}
\end{center}

\textbf{EMPL ID: \underline{\hspace{2.5cm}}}

\footnotesize
\(^{1}\)F-1 Regulations: U.S. 8 C.F.R. 214.29(b)
\(^{2}\)J-1 Regulations: U.S. 22 C.F.R. 62.29(g)(2)(ii)

\footnotesize \(^{2}\) "The work week shall be from 12:01 a.m. Sunday through 12:00 midnight Saturday" (NDUS Human Resource Policy Manual 11.1)
FNIS Instructions

If you are an international student or scholar who is employed at the University of North Dakota and/or the recipient of a fellowship, scholarship or grant, you are required to enter specific data pertaining to your immigration and tax status into a computerized database called the Foreign National Information System (FNIS).

After completing and submitting the FNIS Request Form, you will receive a “Immigration Data Needed” email message. This message will contain your login and password to the FNIS website. If you have forgotten your password, please contact Kevin Kuntz at kevin.kuntz@email.und.edu.

To login to the FNIS site, go to: https://fnis.windstar.cc/UND/. Use the login and password provided to you in the “Immigration Data Needed” email.

You will be required to change your password the first time you login to the FNIS system.

The IRS requires we have your consent to receiving electronic forms before we can upload them your forms. To give consent, at the welcome screen click on the “consent” link.

To enter your information, click on “Data Entry” on the welcome screen. Complete the questions in as much detail as possible. You can “save with errors” if you are unsure of some of the fields. There are useful “help” buttons available as you move through the fields. You must fully complete the fifth page “Visa History.” Add visa records for all visas that you have used in the United States. You cannot have overlapping dates in your visa records.

You are required to confirm the accuracy of your data on the last page after you’ve finished entering your information.

- Click on the “View Data” button to verify your information. Print the page and sign. This page should be submitted to the UND Payroll Office. You should also bring with, your passport, visa, I-94 card, social security card and one of the following: I-20, DS-2019 or I-797B.
- Go back to the “Confirmation” page (page 6) and check the “Confirmation” box on the bottom of the page.
- After you click “Finish”, you will receive notification that your data has been received.

Your information is automatically forwarded to the UND Payroll Office for processing and tax analysis.

You will receive further emails with instructions as your file moves through the analysis. You will also receive email notification when your tax forms have been uploaded to the FNIS site for your review and signature.

Not completing the online FNIS form may require UND to withhold taxes you may not owe.

UND FNIS website address: https://fnis.windstar.cc/UND/

Complete FNIS Instructions: http://und.edu/finance-operations/payroll_files/docs/fnis-instructions.pdf

Email Communication

All e-mail communications from the FNIS system will have subject lines beginning with “UND Payroll:” In addition, all emails will originate from a UND e-mail address such as: kevin.kuntz@email.und.edu or pat.hanson@email.und.edu.
HRMS Access Request Form

Purpose of form is to be used for requests for access to HRMS environments. Please complete this form electronically, to enable it to be emailed and attached to a Help Ticket, as indicated below.

Instructions:

1. Indicate the environment that pertains to your request, by placing a check mark on Production or by listing the environment other than Production.

2. Indicate the request type needed. (Examples are a request to add a new user, a request to change a user’s access or a request to delete the user’s access.) For a change or delete indicate the reason, and the request date.

3. Indicate the requestor’s full legal name, including middle initial. (No nicknames such as Bob for Robert or Judy for Judith.) Indicate the requestor’s phone number, requestor’s Email address, requestor’s Employee (EmplID) number, requestor’s NDUS User id, if known

4. Indicate the requested date of completion for this request.

5. Indicate any special instructions.

6. Indicate the name of the Primary Permission list. (Examples are PPBSC, PPDSU, PPSCS, etc…)

7. Indicate the Row Level Data Permission list. (Examples are DPBS2100, DPDSU, DPSCS, etc.)

8. Indicate if Expert Entry is approved for the requestor.

9. Indicate the exact role names that are required. Indicate if the role(s) is to be added or deleted.

10. Indicate if requesting Query Manager Access; if so requestor signs and date. Requestor’s signature that Data Privacy training has been completed. (This will be verified by Campus Access Control Officer.) (If an electronic signature is not available, enter the requestor’s name.)

11. Indicate the OrgPlus role needed: (Only one role can be assigned)
   a. C Admin – Users assigned this role should have the NDU_C_Admin role in HRMS Production.
   b. D Admin – Users assigned this role should have the NDU_D_Admin role in HRMS Production.
   c. Domain Admin – This role is assigned to the user on each campus that is the OrgPlus Domain Administrator.
12. For approval for OrgPlus, email this form to your Campus OrgPlus Domain Administrator who if approving, will: sign the request (If an electronic signature cannot be obtained, indicate the Domain Administrator's name.)

13. Signature of approval must be provided by the Department Head before it is sent to the Campus Access Control Officer for approval. (If an electronic signature is not available, enter the Department Head's name.)

14. When the form has been completed and approved, the Campus Access Control Officer will:

   a. Sign the form electronically or indicate approval by entering his/her name on the form.
   b. Complete a Help Ticket and attach this completed form to the Help Ticket.
   c. Assign the Help Ticket to the NDUS Security group.
   d. If not approving, notify the requestor.

15. When the request has been processed, the user will be notified by email by the NDUS Security group and the originator of the Help Ticket will be notified by email.

To find the Roles see [http://und.edu/finance-operations/human-resources-payroll/_files/docs/cnd-hrms-roles-training.pdf](http://und.edu/finance-operations/human-resources-payroll/_files/docs/cnd-hrms-roles-training.pdf)
Access Request for HRMS:

**Environment:**
- Induction
- [ ] Other (specify):
  - Please list:

**Request Type:**
- [ ] New
- [ ] Change
- [ ] Delete

**Indicate Reason:**
- [ ] Please list:

**Requested Completion Date:**
- [ ] Requestor's Full Name:
- [ ] Requestor's Employee (fronit) #:
- [ ] Requestor's Phone:
- [ ] Requestor's NDUS User ID, if known:

**Special Instructions:**

**Primary Permission List (e.g., PPDCS, PPDSU, PPSCS, etc.):**
- [ ] PPUND

**Row Level Data Permission List (e.g., DPBD2000, DR051, DPSCS, etc.):**
- [ ] DDUN (Enter your DeptID here)

**Enable Expert Entry**
- [ ] Check this box if requestor is approved for using Expert Entry

**Roles Required:**
- [Exact Role Names Must Be Given] Use Drop Down List

<table>
<thead>
<tr>
<th>Role</th>
<th>Add</th>
<th>Delete</th>
</tr>
</thead>
<tbody>
<tr>
<td>NDU_D_Admin</td>
<td></td>
<td></td>
</tr>
<tr>
<td>NDU_D_CampusInfo</td>
<td></td>
<td></td>
</tr>
<tr>
<td>NDU_D_TimeEffort_D</td>
<td></td>
<td></td>
</tr>
<tr>
<td>NDU_D_DevFab</td>
<td></td>
<td></td>
</tr>
<tr>
<td>NDU_D_Recruit</td>
<td></td>
<td></td>
</tr>
<tr>
<td>NDU_Process_Monitor</td>
<td></td>
<td></td>
</tr>
<tr>
<td>NDU_Report_Manager</td>
<td></td>
<td></td>
</tr>
<tr>
<td>NDU_D_Ops</td>
<td></td>
<td></td>
</tr>
<tr>
<td>NDU_D_Finance</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Requesting Query Manager access for HRMS?**
- [ ] YES
- [ ] NO

**NDUS-CNO-016_02 Query Statement of Understanding form must be submitted when requesting Query Manager access.**

**Signature:**
- [ ] I have completed Data Privacy training, (Required)
- [ ] I have completed the NDUS-CNO-016_Query Statement of Understanding Form, (Required for Query Manager)

**OrgPlus Roles:**
- [Select only one]

<table>
<thead>
<tr>
<th>Role</th>
<th>Add</th>
<th>Delete</th>
</tr>
</thead>
<tbody>
<tr>
<td>C Admin</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D Admin</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Domain Admin</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**ORACLE DBA ADMINISTRATOR’S SIGNATURE**

**Approval Section:**
- [ ] I have verified that Data Privacy training has been completed.
- [ ] I have verified that Query training has been completed. (Required for Query Manager)
In/Out Processing Checklist

Purpose of the form is to provide a checklist of items that the employee and department contact must do when starting or stopping employment with UND.

Instructions:

1. Department Contact fills out the employee's name, empl id, department name, first and last day of work, indicate if benefited employee, and forwarding address.

2. When employee is hired go down the list of items and employee will initial all items received in the Item Rec’d-Employee Initials column and will date.

3. When employee terms employment with UND, department contact/supervisor will use the same checklist and will initial all items returned by the employee in the Completed-Supervisor Initials column and will date.

4. Employee and Department Contact will sign and date the form.
## University of North Dakota
### In/Out Processing Checklist

#### Employment Items

<table>
<thead>
<tr>
<th>Item</th>
<th>How to Request</th>
<th>Item Rec'd - Employee Initials</th>
<th>Date</th>
<th>Upon Termination</th>
<th>Completed Supervisor Initials</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Department Keys/Passports</td>
<td>EE-Request from DC</td>
<td>EE-Return to DC</td>
<td></td>
<td>EE-Return to DC</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Desk</td>
<td>EE-Request from DC</td>
<td>EE-Return to DC</td>
<td></td>
<td>EE-Return to DC</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. P.O. Box</td>
<td>EE-Request from DC</td>
<td>EE-Return to DC</td>
<td></td>
<td>EE-Return to DC</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Security Badge</td>
<td>EE-Return to DC</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. UND Keys/Password: Building/Office</td>
<td>DC-Complete Facilities Key Request</td>
<td>EE-Return to Facilities/DC</td>
<td></td>
<td>EE-Return to DC</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Inside Door(s)</td>
<td>DC-Complete Facilities Key Request</td>
<td>EE-Return to Facilities/DC</td>
<td></td>
<td>EE-Return to DC</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Safe Combination</td>
<td>EE-Request from DC</td>
<td>DC-Request Combination Change</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Passwords</td>
<td>EE-Request from DC</td>
<td>DC-Change Password</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. Personal Computer</td>
<td>DC-Complete New User Request form for each printer as needed</td>
<td>DC-Compltes New User Request form, indicating deletion of access</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. Email/Network Login</td>
<td>Activate Outlook/Active Directory via contacting ITS or Dept IT person.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11. Voice Mail/Calling Card/Telephone Code</td>
<td>DC-Contact Telephone Counselor</td>
<td>DC-Contact Telephone Counselor</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12. Perceptive Content</td>
<td>DC - Completes New User Request form for each printer as needed</td>
<td>DC-Compltes New User Request form, indicating deletion of access</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13. PeopleSoft Access: Finance/HRMS/Student Admin</td>
<td>DC-Complete CNO Security Request form for each system access needed</td>
<td>Access is automatically terminated with submission of the termination</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14. Signature Authorization List</td>
<td>Send Departmental Authorization Sheet to ACCT Services</td>
<td>Authorization List Form to ACCT Services</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15. Gas Card for State Fleet Vehicles</td>
<td>Card in State Vehicle/cab turned in to office</td>
<td>DC-Use Driver ID Renewal Form</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>16. ND State Driver ID Card</td>
<td>Refer to Transportation Website</td>
<td>N/A</td>
<td></td>
<td>DC-Use Driver ID Renewal Form</td>
<td></td>
<td></td>
</tr>
<tr>
<td>17. Service Vehicle Placard</td>
<td>DC-Request from UND Parking Office</td>
<td>EE-Return to DC</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>18. Pager</td>
<td>EE-Request from DC</td>
<td>EE-Return to DC</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>19. Name Tag and/or Security Badge</td>
<td>EE-Request from DC</td>
<td>EE-Return to DC</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>20. UND Travel Card</td>
<td>N/A</td>
<td>EE-Return to DC</td>
<td></td>
<td>DC-Cut in half and send to ACCT Services Step 8550</td>
<td></td>
<td></td>
</tr>
<tr>
<td>21. UND Faculty/Staff ID Card</td>
<td>EE-After Employee issued, obtain from UND</td>
<td>EE-Return to DC</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>22. UND Parking Permit</td>
<td>Purchased from Parking Office</td>
<td>EE-Return to UND Parking Office Step 8550</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>23. UND Purchasing Card</td>
<td>DC-Submit application to Purchasing</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>24. Cell Phone</td>
<td>EE-Request from DC, DC-Contact</td>
<td>EE-Return to DC</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>25. Computer/Networking Computer</td>
<td>EE-Request from DC</td>
<td>EE-Return to DC</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>26. Library Materials</td>
<td>EE-Library checkout using UND ID Card</td>
<td>EE-Return to DC</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>27. Uniforms/Linens</td>
<td>EE-Request from DC</td>
<td>EE-Return to DC</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>28. Notebook Research, Workpapers</td>
<td>EE-Request from DC, includes those enlarged by DE</td>
<td>EE-Return to DC</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>29. Other Equipment/Supplies (Specify below)</td>
<td>EE-Request from DC</td>
<td>EE-Return to DC</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Human Resource/Payroll Items When Terminating Employment

<table>
<thead>
<tr>
<th>Items to be Completed</th>
<th>How to Complete</th>
<th>Completed Supervisor Initials</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Termination</td>
<td>Enter the termination in the HRMS Manager Self Service</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Separation Form or Letter</td>
<td>Send with Work Date Change form. If needed, template available on Human Resources website.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Annual leave forms, prior to payment of final</td>
<td>Send to Payroll with Signatures</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Department mail last pay advice or pick up last pay advice at department</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. IMPORTANT: Employee closes all accounts prior to last check being deposited. If necessary to close, contact Payroll Office prior to receiving last check.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Employee Signature**

Department Contact Signature

---

79
Job Data Change

Purpose of the form is to make changes to an employees pay rate, standard hours, functional title, or to request or return an employee from a leave of absence.

Instructions:

You can make **more than one change** to an employee at the same time on the one JDC form.

1. Select type of employee and benefited or non-benefited.
2. Enter emplid, last name, first name, middle name, dept id and dept name.
3. Use Job Data in HRMS to complete position #, standard hours, job code and empl id rec #.
4. Enter effective date of the change.
5. **Pay Rate Changes**-Check the box and make sure you indicate:
   a. The From amount (what they are currently making)
   b. Indicate if it is annual, hourly, or monthly
   c. The To amount (what the rate changed to)
   d. Indicate if it is annual, hourly, or monthly
   e. In the reason box be sure to state the reason for the increase or decrease. Ex. Promotion, Responsibility increase.
   f. Indicate if the funding sources have been checked. If any changes need to be made to the funding sources, submit a Position Funding Form as well.

**If this is a salaried position and the paperwork is late and they have missed pay periods, submit an additional pay for the pay periods missed. See Additional Pays for help completing this form.

**If it is an hourly person, paper time slips can be sent over for the missed pay periods.

6. **Leave of Absence**-Indicate if salary and benefits will continue to be paid while on leave.

7. **Reason**-Example for leave reasons may include: Medical leave, Military leave, Maternity leave, etc. **Pay Rate**-If going on unpaid leave enter the current salary in From salary and enter $0 in the To salary in #5.

8. **Return Date**-Indicate the date expected to return.

9. **Return from Leave of Absence**-When the employee returns complete another form and complete this section. **Pay Rate**-When returning from unpaid leave enter the current pay rate as $0 in the From salary and the original in the To salary.

10. **Blank box next to “Return from Leave”**-Enter the return date and comp rate.
11. **Standard Hours Worked/Week**- Indicate how many hours they were working in the From box and what they will be working in the To box.

12. **Reason**- Indicate the reason. Ex. Decreased hours due to school work load, went from ¼ time to ½ time position.

13. **Other**- This would be for any other change that is not specifically indicated on this form. Ex. Changing the labor code for TLAB.

14. **Additional Information**- You can state any information here that you feel would be helpful or pertinent to the change being made on this form. Also, if there is something that you want documented in their files that pertains to the change, this is a good place to enter that.

15. **Dept Contact Name**- Enter the contact person’s name and number. This is the person who filled out the form or would be the one to answer any questions about the form.

Route for the appropriate signatures. If a work study or institutional student must go to Career Services for signature. Graduate students need to route to the Graduate Office.
# JOB DATA CHANGE

**University of North Dakota**

**HRMS**

**GREY SHADeD FIELDS MUST BE COMPLETED**

Check One: Faculty  Staff  Temp Staff  Medical Resident  Workstudy Student  GTA/GRA/GSA  Institutional Student

Check One: Benefited  Non-benefited

For Internal Use Only: UNB  UNC  UNN

---

## Current Information

<table>
<thead>
<tr>
<th>EMPLOYEE#</th>
<th>FULL NAME</th>
<th>FIRST NAME</th>
<th>MIDDLE NAME</th>
<th>POSITION</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>DEPT CODE</th>
<th>DEPT NAME</th>
<th>STANDARD HOURS</th>
<th>JOB CODE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**EFFECTIVE DATE**

Complete only those AREAS that you are requesting to change!

**Change (Select Type of Action and Enter Correct Information)**

- **Pay Rate Change**
  - FROM $\ldots$
  - TO $\ldots$
  - PER Annual Month Hour

- **Begin Leave of Absence**
  - SALARY PAID? Yes No
  - BENEFITS PAID? Yes No
  - REASON FOR LEAVE OF ABSENCE

- **Return from Leave of Absence**

- **Standard Hrs Worked/Wk**
  - FROM $\ldots$
  - TO $\ldots$

- **Other**
  - FROM $\ldots$
  - TO $\ldots$

## Additional Information:

- NOTE: A change in position number, requires this form to terminate the current position no. and a Job Data Hire form to hire into the new position no.

Dept. Contact Name: ____________________________

Phone: ____________________________

Box: ____________________________

---

Recommending Official Signature: ____________________________  Date: ____________________________

Additional Approving/Reviewing Signature Date: ____________________________

Approving Official Signature: ____________________________  Date: ____________________________

Reviewing Authority: ____________________________  Date: ____________________________

---

LAST UPDATED: 02/27/2014
Leave Authorization/Payroll Deduction Agreement

Purpose of the form is to document the number of hours and dollar amount an employee will be taking that will put them in the negative. This assures that the university will be able to get that money back if the employee terms before they earn enough leave time back to cover the time taken.

Instructions:

1. Enter the employee’s name, department name, and position/title.

2. Indicate the number of sick and/or annual leave that will be taken and the dates the time will be used on.

3. Fill in the leave balances and the amount of pay to be taken from employee’s final paycheck if they should term. Make sure to read the entire paragraph.

4. Employee will sign and date.

5. Department head and Human Resources director must sign and date.
LEAVE AUTHORIZATION/PAYROLL DEDUCTION AGREEMENT
University of North Dakota

Employee Name:______________________________________________________

Employees Department:______________________________________________

Position/title:_______________________________________________________

I request approval to take

______ hours of sick leave and/or

______ hours of annual leave

on these dates:______________________________________________________

My leave balances are ______ hours sick leave and ______ hours annual leave. Accordingly, approval to take leave in advance of accumulation is required. I understand such approval is at the discretion of the department head, with approval of the appropriate institution or agency officer. I also understand that any leave taken in advance of accumulation must be paid back if employment is terminated before I have accumulated enough leave to make up any negative leave balance. As a condition of approval to take leave in advance of accumulation, I request and authorize a deduction from my final paycheck in the amount of $__________ (value of approved leave in advance) or such lesser amount required to pay off the balance of any unearned leave taken that remains on the date employment is terminated.

Date:________________________

Employee

Approved:

Department head

Director of Human Resources

Date:________________________

Date:________________________

Date:________________________
Leave Without Pay/Workload Reduction Request

Purpose of form is to request either leave without pay or to request a reduction in hours for a specified time frame.

Section 1 is to be completed by the employee request the leave:

- Last name
- First name
- Middle initial
- EmplID
- Department name
- Contact phone #
- Reason for the requested leave
- Indicate the type of request
- Leave start date
- Return to work date
- Indicate if leave is intermittent leave or a reduced schedule
- Indicate current hours worked per week (FTE)
- Indicate the requested hours per week (FTE)
- List current # of months/year
- List requested # of months/year
- Read statement and if in agreement sign and date form
- Return completed form to supervisor

Section 2 is to be completed for the employees’ supervisor:

- Supervisor should indicate if they do or do not approve of the request
- If approved forward to department chair/director
- If denied return a copy to the employee and indicate in the comment box the reason for the denial
- Sign and date the form

Section 3 is to be completed by the department chair/director:

- Indicates if leave is for 21 days or more and if it is approved
  - If approved attach the request to a job data change form and forward to division Vice President/President for approval
  - If denied make copy for file and return denial to supervisor
- Indicates request is for less than 21 working day or is for workload reduction and if is approved
  - If approved notify supervisor/employee and attach request to job data change form and submit to Human Resources. Make copy for file
  - If denied make copy for file and return denial to supervisor
- For denials indicate the reason in the comments box
- If approved indicate if UND will continue to pay Employer-Paid benefits during the
leave

- Chair/Director must sign and date
- Dean/AVP/Additional Approver must sign and date

Section 4 is to be completed by the Vice President or President

- Indicate if the request for leave without pay of 21 working days or more is approved
  - If approved forward to Human Resources
  - If denied enter reason in comments box
- Vice president or President must sign and date form
# University of North Dakota 
**Leave Without Pay/Workload Reduction Request**

*(If leave being requested is Long Term Medical Leave, please complete a Long Term Medical Leave Request, instead of Leave without Pay)*

**TO BE COMPLETED BY EMPLOYEE** (Type or Print)

<table>
<thead>
<tr>
<th>1. LAST NAME</th>
<th>2. FIRST NAME</th>
<th>3. MIDDLE INITIAL</th>
<th>4. EMPLID</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>5. DEPARTMENT NAME</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>6. CONTACT PHONE #</th>
</tr>
</thead>
</table>

| 7. REASON FOR REQUESTED LEAVE: |

<table>
<thead>
<tr>
<th>8. TYPE OF REQUEST</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Short Term</td>
</tr>
<tr>
<td>□ Limited Time</td>
</tr>
<tr>
<td>□ Permanent</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>9. LEAVE START DATE</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>10. RETURN TO WORK DATE</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>11. LEAVE IS BEING REQUESTED ON AN INTERMITTENT OR REDUCED SCHEDULE:</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Yes (if yes, please attach a proposed work schedule)</td>
</tr>
<tr>
<td>□ No</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>12. CURRENT HOURS/WEEK (PTE)</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>13. REQUESTED HOURS/WEEK (PTE)</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>14. CURRENT # OF MONTHS/YEAR</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>15. REQUESTED # OF MONTHS/YEAR</th>
</tr>
</thead>
</table>

I acknowledge this request is voluntary on my part and, if accepted by the University, I agree to the terms as listed above. I also understand the University reserves the right to accept or deny this request, at its discretion.

**Signature of Employee**

**Date**

---

**To be Completed by Supervisor:**

I recommend the approval of this Leave without Pay Request/Workload Reduction Request.

| □ Yes |
| □ No  |

If approved: Forward to Department Chair/Director.

If denied: Return copy to employee.

(If no reason for denial, if more work is needed, please attach additional pages)

**Signature of Supervisor**

**Date**

---

**To be Completed by Department Chair/Director:**

1. Leave request is 21 working days or more. I recommend approval of this request. *(See NDUS HR Policy 21)*

   | □ Yes |
   | □ No  |

   If approved: Attach this request to the Job Data Change form and forward to your division Vice President/President for approval.

   If denied: Make copy for files, return denial to Supervisor.

2. Leave request is for less than 21 working days or for workload reduction. I approve this request.

   | □ Yes |
   | □ No  |

   If approved: Notify Supervisor/Employee. Attach request to the Job Data Change form and submit to Human Resources. Make copy for files.

   If denied: Make copy for files, return denial to Supervisor.

(If no reason for denial, if more work is needed, please attach additional pages)

**Signature of Department Chair/Head**

**Date**

**Dean/AVP/Additional Approving Signature(s)**

**Date**

---

UND will continue to pay for Employer-Paid benefits during the Leave without Pay.

| □ Yes |
| □ No  |

Employees must notify Payroll Services of their intention to continue benefits during leave and provide payment no later than the first of each month.

**Signature of Department Chair/Head**

**Date**
<table>
<thead>
<tr>
<th><strong>To be Completed by Vice President or President:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>I approve this request for leave without pay of 21 working days or more.</td>
</tr>
<tr>
<td>If no, reason for denial. (If more room is needed, please attach additional pages)</td>
</tr>
<tr>
<td>If yes, forward to the Office the Human Resources</td>
</tr>
</tbody>
</table>

*Signature of Vice President, President or President's designee*  
*Date*
Long Term Leave Certification of Health Care Provider for Employee’s Serious Health Condition

Purpose of this form is to provide confirmation from the health care provider of a serious health condition requiring the employee to take extended leave.

Instructions:

Be sure to read all information on the form before filling it out.

Section 1- To be completed by the employer

A. Enter Employer name and contact.

B. Enter Employee’s job title, work schedule, and essential job function.

Section 2- To be completed by the employee

A. Enter first, middle and last name.

Section 3- To be completed by the Health Care Provider

A. Enter Provider name and business address.

B. Indicate the type of practice/medical specialty.

C. Enter telephone and fax number.

4. Complete Part A
   a. Answer questions about the condition and the possible time frame for the illness, date condition started, dates of treatment.
   b. Indicate if medication needed, if employee was referred elsewhere, and is illness pregnancy related.
   c. Use information from Section 1 to answer questions about job duties.
   d. Describe medical facts to support the leave.

5. Complete Part B
   a. Answer question about time unable to work.
   b. Indicate if there will be follow-up appointments. Give details.
   c. Indicate if this be a reoccurring illness and how often it may reoccur.

6. The health care provider must sign and date. Return the form to the patient.
Certification of Health Care Provider for Employee’s Serious Health Condition
(Family and Medical Leave Act)

DO NOT SEND COMPLETED FORM TO THE DEPARTMENT OF LABOR; RETURN TO THE PATIENT

U.S. Department of Labor
Wage and Hour Division

SECTION I: For Completion by the EMPLOYER
INSTRUCTIONS to the EMPLOYER: The Family and Medical Leave Act (FMLA) provides that an employer may require an employee seeking FMLA protections because of a need for leave due to a serious health condition to submit a medical certification issued by the employee’s health care provider. Please complete Section I before giving this form to your employee. Your response is voluntary. While you are not required to use this form, you may not ask the employee to provide more information than allowed under the FMLA regulations, 29 C.F.R. §§ 825.306-825.308. Employers must generally maintain records and documents relating to medical certifications, recertifications, or medical histories of employees created for FMLA purposes as confidential medical records in separate files/records from the usual personnel files and in accordance with 29 C.F.R. § 1630.14(c)(1), if the Americans with Disabilities Act applies, and in accordance with 29 C.F.R. § 1635.9, if the Genetic Information Nondiscrimination Act applies.

Employer name and contact: _____________________________________________

Employee’s job title: ______________________ Regular work schedule: __________

Employee’s essential job functions:

__________________________________________________________

Check if job description is attached:

SECTION II: For Completion by the EMPLOYEE
INSTRUCTIONS to the EMPLOYEE: Please complete Section II before giving this form to your medical provider. The FMLA permits an employer to require that you submit a timely, complete, and sufficient medical certification to support a request for FMLA leave due to your own serious health condition. If requested by your employer, your response is required to obtain or retain the benefit of FMLA protections. 29 U.S.C. §§ 2615, 2614(c)(3). Failure to provide a complete and sufficient medical certification may result in denial of your FMLA request. 29 C.F.R. § 825.313. Your employer must give you at least 15 calendar days to return this form. 29 C.F.R. § 825.305(b).

Your name: _________________________________________________________
First                      Middle                      Last

SECTION III: For Completion by the HEALTH CARE PROVIDER
INSTRUCTIONS to the HEALTH CARE PROVIDER: Your patient has requested leave under the FMLA. Answer, fully and completely, all applicable parts. Several questions seek a response as to the frequency or duration of a condition, treatment, etc. Your answer should be your best estimate based upon your medical knowledge, experience, and examination of the patient. Be as specific as you can; terms such as “lifelong,” “unknown,” or “indeterminate” may not be sufficient to determine FMLA coverage. Limit your responses to the condition for which the employee is seeking leave. Do not provide information about genetic tests, as defined in 29 C.F.R. § 1635.3(d), genetic services, as defined in 29 C.F.R. § 1635.3(e), or the manifestation of disease or disorder in the employee’s family members, 29 C.F.R. § 1635.3(b). Please be sure to sign the form on the last page.

Provider’s name and business address: __________________________________

Type of practice / Medical specialty: _________________________________

Telephone: __________ Fax: (________)
PART A: MEDICAL FACTS

1. Approximate date condition commenced: ____________________________

   Probable duration of condition: ____________________________

Mark below as applicable:
Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility?
   ___ No  ___ Yes. If so, dates of admission:

   ____________________________

Date(s) you treated the patient for condition:

   ____________________________

Will the patient need to have treatment visits at least twice per year due to the condition?
   ___ No  ___ Yes.

Was medication, other than over-the-counter medication, prescribed?
   ___ No  ___ Yes.

Was the patient referred to other health care provider(s) for evaluation or treatment (e.g., physical therapist)?
   ___ No  ___ Yes. If so, state the nature of such treatment and expected duration of treatment:

   4

2. Is the medical condition pregnancy?
   ___ No  ___ Yes. If so, expected delivery date:

3. Use the information provided by the employer in Section 1 to answer this question. If the employer fails to
   provide a list of the employee’s essential functions or a job description, answer these questions based upon
   the employee’s own description of his/her job functions.

   Is the employee unable to perform any of his/her job functions due to the condition?
   ___ No  ___ Yes.

   If so, identify the job functions the employee is unable to perform:

   ____________________________

4. Describe other relevant medical facts, if any, related to the condition for which the employee seeks leave
   (such medical facts may include symptoms, diagnosis, or any regimen of continuing treatment such as the use
   of specialized equipment):

   ____________________________

   ____________________________

   ____________________________

   ____________________________

   ____________________________

   ____________________________

Page 2  CONTINUED ON NEXT PAGE  Form WH-380-E. Revised May 2015
PART B. AMOUNT OF LEAVE NEEDED

5. Will the employee be incapacitated for a single continuous period of time due to his/her medical condition, including any time for treatment and recovery? __No __Yes.

If so, estimate the beginning and ending dates for the period of incapacity: ________________________

6. Will the employee need to attend follow-up treatment appointments or work part-time or on a reduced schedule because of the employee’s medical condition? __No __Yes.

If so, are the treatments or the reduced number of hours of work medically necessary? __No __Yes.

Estimate treatment schedule, if any, including the dates of any scheduled appointments and the time required for each appointment, including any recovery period:

______________________________________________________________

Estimate the part-time or reduced work schedule the employee needs, if any:

_____________ hour(s) per day; ____________ days per week from ___________ through ___________

7. Will the condition cause episodic flare-ups periodically preventing the employee from performing his/her job functions? __No __Yes.

Is it medically necessary for the employee to be absent from work during the flare-ups? __ No __Yes. If so, explain:

______________________________________________________________

Based upon the patient's medical history and your knowledge of the medical condition, estimate the frequency of flare-ups and the duration of related incapacity that the patient may have over the next 6 months (e.g., 1 episode every 3 months lasting 1-2 days):

Frequency: __________ times per ______ week(s) ______ month(s)

Duration: ______ hours or ___ day(s) per episode

ADDITIONAL INFORMATION: IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER:

______________________________________________________________

______________________________________________________________

______________________________________________________________

______________________________________________________________

______________________________________________________________

Page 9 CONTINUED ON NEXT PAGE Form WH-380-E Revised May 2015
Long Term Leave Certification of Health Care for Family Member’s Serious Health Condition

Purpose of this form is to provide confirmation from the health care provider of a serious health condition of a family member requiring the employee to take extended leave.

Instructions:
Be sure to read all information on the form before filling it out.

Section 1- To be completed by the employer
   A. Enter employer name and contact.

Section 2- To be completed by the employee
   A. Enter first, middle and last name.
   B. Indicate first, middle and last name of family member needing care and their relationship.
   C. Describe type of care providing and estimated time off needed.
   D. Employee is to sign and date.

Section 3- To be completed by the health care provider
   A. Enter provider’s name and business address.
   B. Indicate type of practice/medical specialty.
   C. Enter the telephone and fax number.
   
3. Complete Part A
   a. Answer questions about the condition and the possible time frame for the illness, date condition started, dates of treatment.
   b. Indicate if medication needed, if employee was referred elsewhere, and is illness pregnancy related
   c. Use information from Section 1 to answer questions about job duties.
   d. Describe medical facts to support the leave.

4. Complete Part B
   a. Answer the questions about treatment and recovery.
   b. Explain the care that will be provided.
   c. Indicate if follow-up treatments are needed and give schedule.
   d. Explain the care and why medically necessary.
   e. Indicate if care is required on an intermittent or reduced basis and list
schedule.
f. Explain the care needed by the patient and why medically necessary.
g. Indicate if this be a reoccurring illness and how often it may reoccur.

5. Health care provider must sign and date the form. Return form to the patient.
SECTION I: For Completion by the EMPLOYER

INSTRUCTIONS to the EMPLOYER: The Family and Medical Leave Act (FMLA) provides that an employer may require an employee seeking FMLA protections because of a need for leave to care for a covered family member with a serious health condition to submit a medical certification issued by the health care provider of the covered family member. Please complete Section I before giving this form to your employee. Your response is voluntary. While you are not required to use this form, you may not ask the employee to provide more information than allowed under the FMLA regulations. 29 C.F.R. §§ 825.305-825.306. Employers must generally maintain records and documents relating to medical certifications, recertifications, or medical histories of employees' family members, created for FMLA purposes as confidential medical records in separate files/records from the usual personnel files and in accordance with 29 C.F.R. § 1630.14(c)(1), if the Americans with Disabilities Act applies, and in accordance with 29 C.F.R. § 1635.9, if the Genetic Information Nondiscrimination Act applies.

Employer name and contact: ________________________________

SECTION II: For Completion by the EMPLOYEE

INSTRUCTIONS to the EMPLOYEE: Please complete Section II before giving this form to your family member or his/her medical provider. The FMLA permits an employer to require that you submit a timely, complete, and sufficient medical certification to support a request for FMLA leave to care for a covered family member with a serious health condition. If requested by your employer, your response is required to obtain or retain the benefit of FMLA protections. 29 U.S.C. §§ 2613, 2614(c)(3). Failure to provide a complete and sufficient medical certification may result in a denial of your FMLA request. 29 C.F.R. § 825.313. Your employer must give you at least 15 calendar days to return this form to your employer. 29 C.F.R. § 825.305.

Your name: ________________________________

First        Middle        Last

Name of family member for whom you will provide care: ________________________________

First        Middle        Last

Relationship of family member to you: ________________________________

If family member is your son or daughter, date of birth: ________________________________

Describe care you will provide to your family member and estimate leave needed to provide care: ________________________________

______________________________
Employee Signature  Date

Page 1 CONTINUED ON NEXT PAGE Form WH-380-F Revised May 2015
SECTION III: For Completion by the HEALTH CARE PROVIDER

INSTRUCTIONS to the HEALTH CARE PROVIDER: The employee listed above has requested leave under the FMLA to care for your patient. Answer fully and completely, all applicable parts below. Several questions seek a response as to the frequency or duration of a condition, treatment, etc. Your answer should be your best estimate based upon your medical knowledge, experience, and examination of the patient. Be as specific as you can. Terms such as "lifetime," "unknown," or "indeterminate" may not be sufficient to determine FMLA coverage. Limit your responses to the condition for which the patient needs leave. Do not provide information about genetic tests, as defined in 29 C.F.R. § 1635.3(f), or genetic services, as defined in 29 C.F.R. § 1635.3(c). Page 3 provides space for additional information, should you need it. Please be sure to sign the form on the last page.

Provider’s name and business address: ____________________________

Type of practice / Medical specialty: ____________________________

Telephone: (__________) __________________ Fax: (__________)

PART A: MEDICAL FACTS

1. Approximate date condition commenced: ____________________________

   Probable duration of condition: ____________________________

   Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility?       ______ No ______ Yes. If so, dates of admission: ____________________________

   Date(s) you treated the patient for condition: ____________________________

   Was medication, other than over-the-counter medication, prescribed? ______ No ______ Yes.

   Will the patient need to have treatment visits at least twice per year due to the condition? ______ No ______ Yes

   Was the patient referred to other health care provider(s) for evaluation or treatment (e.g., physical therapist)? ______ No ______ Yes. If so, state the nature of such treatments and expected duration of treatment: ____________________________

2. Is the medical condition pregnancy? ______ No ______ Yes. If so, expected delivery date: ____________________________

3. Describe other relevant medical facts, if any, related to the condition for which the patient needs care (such medical facts may include symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment): ____________________________

Page 1  CONTINUED ON NEXT PAGE  Form WH-310-F  Revised May 2015
PART B: AMOUNT OF CARE NEEDED: When answering these questions, keep in mind that your patient’s need for care by the employee seeking leave may include assistance with basic medical, hygienic, nutritional, safety or transportation needs, or the provision of physical or psychological care.

4. Will the patient be incapacitated for a single continuous period of time, including any time for treatment and recovery? ___No ___Yes.
   Estimate the beginning and ending dates for the period of incapacity: ______________________________
   During this time, will the patient need care? ___No ___Yes.
   Explain the care needed by the patient and why such care is medically necessary:
                                                                                       
                                                                                       
                                                                                       
                                                                                       

5. Will the patient require follow-up treatments, including any time for recovery? ___No ___Yes.
   Estimate treatment schedule, if any, including the dates of any scheduled appointments and the time required for each appointment, including any recovery period:
                                                                                       
                                                                                       
                                                                                       
                                                                                       
   Explain the care needed by the patient, and why such care is medically necessary: _____________________
                                                                                       
                                                                                       
                                                                                       
                                                                                       

6. Will the patient require care on an intermittent or reduced schedule basis, including any time for recovery? ___No ___Yes.
   Estimate the hours the patient needs care on an intermittent basis, if any:
   _____ hour(s) per day; _____ days per week from ___________ through ___________
   Explain the care needed by the patient, and why such care is medically necessary:
                                                                                       
                                                                                       
                                                                                       
                                                                                       
                                                                                       

Page 3  CONTINUED ON NEXT PAGE  Form WH-100-F Revised May 2015
7. Will the condition cause episodic flare-ups periodically preventing the patient from participating in normal daily activities?  

   No  Yes.

Based upon the patient’s medical history and your knowledge of the medical condition, estimate the frequency of 
flare-ups and the duration of related incapacity that the patient may have over the next 6 months (e.g., 1 episode 
every 3 months lasting 1–2 days):

Frequency: _____ times per _____ week(s) _____ month(s)

Duration: _____ hours or ____ day(s) per episode

Does the patient need care during these flare-ups?  

   No  Yes.

Explain the care needed by the patient, and why such care is medically necessary: ____________________________

__________________________________________

__________________________________________

__________________________________________

ADDITIONAL INFORMATION: IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER:
__________________________________________

__________________________________________

__________________________________________

__________________________________________

Signature of Health Care Provider  

Date

PAPERWORK REDUCTION ACT NOTICE AND PUBLIC BURDEN STATEMENT

If submitted, it is mandatory for employers to retain a copy of this disclosure in their records for three years. 29 U.S.C. § 2616; 
29 C.F.R. § 825.500. Persons are not required to respond to this collection of information unless it displays a currently valid OMB 
collection number. The Department of Labor estimates that it will take an average of 20 minutes for respondents to complete this 
collection of information including the time for reviewing instructions, searching existing data sources, gathering and maintaining 
the data needed, and completing and reviewing the collection of information. If you have any comments regarding this burden estimate 
or any other aspect of this collection information, including suggestions for reducing this burden, send them to the Administrator, 
Wage and Hour Division, U.S. Department of Labor, Room S-3502, 200 Constitution Ave., NW, Washington, DC 20210. 
DO NOT SEND COMPLETED FORM TO THE DEPARTMENT OF LABOR; RETURN TO THE PATIENT.
Long Term Leave Certification of Qualifying Exigency for Military Family Leave

Purpose of the form is for a military family member to request leave due to an urgent matter.

Instructions:
Be sure to read all information on the form before filling it out.

Section 1- To be completed by the employer
A. Enter employer name and contact information.

Section 2- To be completed by the employee
A. Enter first, middle and last name.
B. Indicate the first, middle and last name of the military member on or being called to active duty.
C. Indicate relationship.
D. Enter the period of military member’s active duty.
E. Read the statement and check one of the statements indicated and attach the documentation.

3. Complete Part A
   a. Describe reason requesting leave.
   b. Read statement and check the correct box.

4. Complete Part B
   a. Indicate the approximate date to start leave and possible duration.
   b. Answer the questions about the time requesting for leave.
   c. Enter schedule if periodic time off will be needed.

5. Complete Part C
   a. Read the statement and provide the information for the individual and organization involved.

6. Complete Part D
   a. Employee signs and dates the form. Return the form to employer.
Certification of Qualifying Exigency
For Military Family Leave
(Family and Medical Leave Act)

U.S. Department of Labor
Wage and Hour Division

SECTION I: For Completion by the EMPLOYER

INSTRUCTIONS to the EMPLOYER: The Family and Medical Leave Act (FMLA) provides that an employer may require an employee seeking FMLA leave due to a qualifying exigency to submit a certification. Please complete Section I before giving this form to your employee. Your response is voluntary, and while you are not required to use this form, you may ask the employee to provide more information than allowed under the FMLA regulations, 29 CFR 825.309.

Employer name: ________________________________
Contact information: ________________________________

SECTION II: For Completion by the EMPLOYEE

INSTRUCTIONS to the EMPLOYEE: Please complete Section II fully and completely. The FMLA permits an employer to require that you submit a timely, complete, and sufficient certification to support a request for FMLA leave due to a qualifying exigency. Several questions in this section seek a response as to the frequency or duration of the qualifying exigency. Be as specific as you can; terms such as “unknown” or “indeterminate” may not be sufficient to determine FMLA coverage. Your response is required to obtain a benefit: 29 CFR 825.310. While you are not required to provide this information, failure to do so may result in a denial of your request for FMLA leave. Your employer must give you at least 15 calendar days to return this form to your employer.

Your Name: ________________________________
First Middle Last

Name of military member on covered active duty or call to covered active duty status:

First Middle Last

Relationship of military member to you: ________________________________

Period of military member’s covered active duty: ________________________________

A complete and sufficient certification to support a request for FMLA leave due to a qualifying exigency includes written documentation confirming a military member’s covered active duty or call to covered active duty status. Please check one of the following and attach the indicated document to support that the military member is on covered active duty or call to covered active duty status:

A copy of the military member’s covered active duty orders is attached.

Other documentation from the military certifying that the military member is on covered active duty (or has been notified of an impending call to covered active duty) is attached.

I have previously provided my employer with sufficient written documentation confirming the military member’s covered active duty or call to covered active duty status.
PART A: QUALIFYING REASON FOR LEAVE

1. Describe the reason you are requesting FMLA leave due to a qualifying exigency (including the specific reason you are requesting leave):

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

2. A complete and sufficient certification to support a request for FMLA leave due to a qualifying exigency includes any available written documentation which supports the need for leave; such documentation may include a copy of a meeting announcement for informational briefings sponsored by the military; a document confirming the military member’s Rest and Recuperation leave; a document confirming an appointment with a third party, such as a counselor or school official, or staff at a care facility; or a copy of a bill for services for the handling of legal or financial affairs. Available written documentation supporting this request for leave is attached.

Yes ☐ No ☐ None Available ☐

PART B: AMOUNT OF LEAVE NEEDED

1. Approximate date exigency commenced: ____________________________

Probable duration of exigency: ____________________________

2. Will you need to be absent from work for a single continuous period of time due to the qualifying exigency?  

Yes ☐ No ☐

If so, estimate the beginning and ending dates for the period of absence:

________________________________________________________________________

3. Will you need to be absent from work periodically to address this qualifying exigency?  Yes ☐ No ☐

Estimate schedule of leave, including the dates of any scheduled meetings or appointments:

________________________________________________________________________

Estimate the frequency and duration of each appointment, meeting, or leave event, including any travel time (i.e., 1 deployment-related meeting every month lasting 4 hours):

Frequency: _____ times per _____ week(s) _____ month(s)

Duration: _____ hours _____ day(s) per event.
PART C

If leave is requested to meet with a third party (such as to arrange for childcare or parental care, to attend counseling, to attend meetings with school, childcare or parental care providers, to make financial or legal arrangements, to act as the military member’s representative before a federal, state, or local agency for purposes of obtaining, arranging or appealing military service benefits, or to attend any event sponsored by the military or military service organizations), a complete and sufficient certification includes the name, address, and appropriate contact information of the individual or entity with whom you are meeting (i.e., either the telephone or fax number or email address of the individual or entity). This information may be used by your employer to verify that the information contained on this form is accurate.

Name of Individual: ____________________________ Title: ____________________________

Organization: _____________________________________________________________

Address: _________________________________________________________________

Telephone: (_____) __________________________ Fax: (_____) __________________________

Email: _________________________________________________________________

Describe nature of meeting: _________________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

PART D

I certify that the information I provided above is true and correct.

Signature of Employee ____________________________ Date ________________

PAPERWORK REDUCTION ACT NOTICE AND PUBLIC BURDEN STATEMENT

If submitted, it is mandatory for employers to retain a copy of this disclosure in their records for three years. 29 U.S.C. 2616; 29 CFR 825.500. Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number. The Department of Labor estimates that it will take an average of 20 minutes for respondents to complete this collection of information, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, send them to the Administrator, Wage and Hour Division, U.S. Department of Labor, Room 5-3502, 200 Constitution Ave. N.W., Washington, DC 20210. DO NOT SEND THE COMPLETED FORM TO THE WAGE AND HOUR DIVISION; RETURN IT TO THE EMPLOYER.
Long Term Leave Certification for Serious Injury or Illness of a Current Servicemember

Purpose of the form is for a military family member to request leave due to an illness of a servicemember.

Instructions:

Be sure to read all information on the form before filling it out.

Section 1- To be completed by the employee and/or the current servicemember

A. Must be completed first before the healthcare provider completes the form.

B. Complete Part A
   a. Enter name and address of employer.
   b. Enter first, middle and last name of both the employee and the current servicemember.
   c. Indicate the relationship to the servicemember.

C. Complete Part B
   a. Answer the questions about the servicemember.

D. Complete Part C
   a. Describe the care to be provided to the servicemember and an estimate of leave time needed.

Section II- To be completed by a United States Department of Defense health Care Provider or a Health Care Provider who is either; (1) a United States Department of Veterans Affairs (“VA”) health care provider; (2) a DOD TRICARE network authorized private health care provider; (3) a DOD non-network TRICARE authorized private health care provider; or (4) a health care provider as defined in 29 CFR 825.125.

A. Complete Part A
   a. Enter the health care providers name and address.
   b. Indicate the type of practice/medical specialty.
   c. State which provider you are from the list provided.
   d. Enter telephone and fax numbers and email address.

B. Complete Part B
   a. Check which classification of medical condition is appropriate for servicemember.
   b. Answer the questions if the condition was due to active duty.
   c. Indicate the approximate start date of condition and probable duration.
   d. Indicate it receiving services for the condition and describe the treatment.

C. Complete Part C
   a. Answer questions if care for a single continuous period of time and give estimate
of beginning and ending dates.
b. Indicate if follow-up treatment is required and list schedule if yes.
c. Answer if the follow-up is medically necessary.
d. Indicate if there will be follow-up needed for flare-ups and estimate the frequency possible.

3. Health care provider is to sign and date the form. Return the form to the patient.
Notice to the EMPLOYER:

INSTRUCTIONS to the EMPLOYER: The Family and Medical Leave Act (FMLA) provides that an employer may require an employee seeking FMLA leave due to a serious injury or illness of a current servicemember to submit a certification providing sufficient facts to support the request for leave. Your response is voluntary. While you are not required to use this form, you may not ask the employee to provide more information than allowed under the FMLA regulations, 29 CFR 825.310. Employers must generally maintain records and documents relating to medical certifications, recertifications, or medical histories of employees or employees' family members created for FMLA purposes as confidential medical records in separate files or records from the usual personnel files and in accordance with 29 CFR 1630.14(c)(1), if the Americans with Disabilities Act applies, and in accordance with 29 CFR 1635.9, if the Genetic Information Nondiscrimination Act applies.

SECTION I: For Completion by the EMPLOYEE and/or the CURRENT SERVICEMEMBER for whom the Employee Is Requesting Leave

INSTRUCTIONS to the EMPLOYEE or CURRENT SERVICEMEMBER: Please complete Section I before having Section II completed. The FMLA permits an employer to require that an employee submit a timely, complete, and sufficient certification to support a request for FMLA leave due to a serious injury or illness of a servicemember. If requested by the employer, your response is required to obtain or retain the benefit of FMLA-protected leave. 29 U.S.C. 2013, 2614(c)(3). Failure to do so may result in a denial of an employee's FMLA request. 29 CFR 825.310(c). The employer must give an employee at least 15 calendar days to return this form to the employer.

SECTION II: For Completion by a UNITED STATES DEPARTMENT OF DEFENSE (“DOD”) HEALTH CARE PROVIDER or a HEALTH CARE PROVIDER who is either: (1) a United States Department of Veterans Affairs (“VA”) health care provider; (2) a DOD TRICARE network authorized private health care provider; (3) a DOD non-network TRICARE authorized private health care provider; or (4) a health care provider as defined in 29 CFR 825.125

INSTRUCTIONS to the HEALTH CARE PROVIDER: The employee listed on Page 2 has requested leave under the FMLA to care for a family member who is a current member of the Regular Armed Forces, the National Guard, or the Reserves who is undergoing medical treatment, recuperation, or therapy, is otherwise an outpatient status, or is otherwise on the temporary disability retired list for a serious injury or illness. For purposes of FMLA leave, a serious injury or illness is one that was incurred in the line of duty on active duty in the Armed Forces or that existed before the beginning of the member’s active duty and was aggravated by service in the line of duty on active duty in the Armed Forces that may render the servicemember medically unfit to perform the duties of his or her office, grade, rank, or rating.

A complete and sufficient certification to support a request for FMLA leave due to a current servicemember’s serious injury or illness includes written documentation confirming that the servicemember’s injury or illness was incurred in the line of duty on active duty or if not, that the current servicemember’s injury or illness existed before the beginning of the servicemember’s active duty and was aggravated by service in the line of duty on active duty in the Armed Forces, and that the current servicemember is undergoing treatment for such injury or illness by a health care provider listed above. Answer, fully and completely, all applicable parts. Several questions seek a response as to the frequency or duration of a condition, treatment, etc. Your answer should be your best estimate based upon your medical knowledge, experience, and examination of the patient. Be as specific as you can; terms such as “lifetime,” “unknown,” or “indeterminable” may not be sufficient to determine FMLA coverage. Limit your responses to the servicemember’s condition for which the employee is seeking leave. Do not provide information about genetic tests, as defined in 29 CFR 1635.3(f), or genetic services, as defined in 29 CFR 1635.3(e).
SECTION 1: For Completion by the EMPLOYEE and/or the CURRENT SERVICEMEMBER for whom the Employee Is Requesting Leave:

(This section must be completed first before any of the below sections can be completed by a health care provider.)

Part A: EMPLOYEE INFORMATION

Name and Address of Employer (this is the employer of the employee requesting leave to care for the current servicemember):

Name of Employee Requesting Leave to Care for the Current Servicemember:


First  Middle  Last

Name of the Current Servicemember (for whom employee is requesting leave to care):


First  Middle  Last

Relationship of Employee to the Current Servicemember:

Spouse □  Parent □  Son □  Daughter □  Next of Kin □  [ ]

Part B: SERVICEMEMBER INFORMATION

(1)  Is the Servicemember a Current Member of the Regular Armed Forces, the National Guard or Reserves?

Yes □  No □

If yes, please provide the servicemember’s military branch, rank and unit currently assigned to:

______________________________

Is the servicemember assigned to a military medical treatment facility as an outpatient or to a unit established for the purpose of providing command and control of members of the Armed Forces receiving medical care as outpatients (such as a medical hold or warrior transition unit)?

Yes □  No □

If yes, please provide the name of the medical treatment facility or unit:

______________________________

(2)  Is the Servicemember on the Temporary Disability Retired List (TDRL)?

Yes □  No □

Part C: CARE TO BE PROVIDED TO THE SERVICEMEMBER

Describe the Care to Be Provided to the Current Servicemember and an Estimate of the Leave Needed to Provide the Care:

______________________________

107
SECTION II: For Completion by a United States Department of Defense ("DOD") Health Care Provider or a Health Care Provider who is either: (1) a United States Department of Veterans Affairs ("VA") health care provider; (2) a DOD TRICARE Network Authorized Private Health Care Provider; (3) a DOD Non-Network TRICARE Authorized Private Health Care Provider; or (4) a Health Care Provider as defined in 29 CFR 825.125. If you are unable to make certain of the military-related determinations contained below in Part B, you are permitted to rely upon determinations from an authorized DOD representative (such as a DOD Recovery Coordinator).

(Please ensure that Section I above has been completed before completing this section. Please be sure to sign the form on the last page.)

Part A: HEALTH CARE PROVIDER INFORMATION

Health Care Provider’s Name and Business Address:

________________________________________________________________________

Type of Practice/Medical Specialty: __________________________________________

Please state whether you are either: (1) a DOD health care provider; (2) a VA health care provider; (3) a DOD TRICARE network authorized private health care provider; (4) a DOD non-network TRICARE authorized private health care provider, or (5) a health care provider as defined in 29 CFR 825.125:

________________________________________________________________________

Telephone: ( ) ______________ Fax: ( ) ______________ Email: ____________________

PART B: MEDICAL STATUS

(1) The current Servicemember’s medical condition is classified as (Check One of the Appropriate Boxes):

☐ (VSII) Very Seriously Ill/Injured – Illness/Injury is of such severity that life is imminently endangered. Family members are requested at bedside immediately. (Please note this is an internal DOD casualty assistance designation used by DOD healthcare providers.)

☐ (SI) Seriously Ill/Injured – Illness/injury is of such severity that there is cause for immediate concern, but there is no imminent danger to life. Family members are requested at bedside. (Please note this is an internal DOD casualty assistance designation used by DOD healthcare providers.)

☐ OTHER Ill/Injured – a serious illness or injury that may render the Servicemember medically unfit to perform the duties of the member’s office, grade, rank, or rating.

☐ NONE OF THE ABOVE (Note to Employee: If this box is checked, you may still be eligible to take leave to care for a covered family member with a “serious health condition” under § 825.113 of the FMLA. If such leave is requested, you may be required to complete DOL Form WH-380-F or an employer-provided form seeking the same information.)

(2) Is the current Servicemember being treated for a condition which was incurred or aggravated by service in the line of duty on active duty in the Armed Forces? Yes ☐ No ☐

(3) Approximate date condition commenced: _________________________________

(4) Probable duration of condition and/or need for care: ______________________

Page 3

Form WH-383 Revised May 2013
(5) Is the servicemember undergoing medical treatment, recuperation, or therapy for this condition? Yes □ No □
If yes, please describe medical treatment, recuperation or therapy:

PART C: SERVICEMEMBER’S NEED FOR CARE BY FAMILY MEMBER

(1) Will the servicemember need care for a single continuous period of time, including any time for treatment and recovery? Yes □ No □
If yes, estimate the beginning and ending dates for this period of time:

(2) Will the servicemember require periodic follow-up treatment appointments? Yes □ No □
If yes, estimate the treatment schedule:

(3) Is there a medical necessity for the servicemember to have periodic care for these follow-up treatment appointments? Yes □ No □

(4) Is there a medical necessity for the servicemember to have periodic care for other than scheduled follow-up treatment appointments (e.g., episodic flare-ups of medical condition)? Yes □ No □
If yes, please estimate the frequency and duration of the periodic care:

Signature of Health Care Provider: ____________________________ Date: ____________________

PAPERWORK REDUCTION ACT NOTICE AND PUBLIC BURDEN STATEMENT
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Long Term Leave Certification for Serious Injury or Illness of a Veteran for Military Caregiver Leave

Purpose of the form is for requesting military caregiver leave due to a serious injury or illness of a covered veteran.

Instructions:
Be sure to read all information on the form before filling it out.

Section 1- To be completed by employee or the Veteran whom employee is requesting leave

A. Complete Part A
   a. Enter name and address of employer.
   b. Enter first, middle and last name of employee.
   c. Enter the first, middle and last name of the veteran.
   d. Check the box next to the relationship to veteran.

B. Complete Part B
   a. Enter the veteran’s discharge date.
   b. Answer if veteran was dishonorably discharged.
   c. Provide the veteran’s military branch, rank and unit at discharge.
   d. Answer if veteran is receiving treatment for an injury or illness.

C. Complete Part C
   a. Describe care provided to the veteran and the estimated leave time needed.

Section 2- To be completed by (1) a United States Department of Defense (“DOD”) health care provider; (2) a United States Department of Veterans Affairs (“VA”) health care provider; (3) a DOD TRICARE network authorized private health care provider; (4) a DOD non-network TRICARE authorized private health care provider; or (5) a health care provider as defined in 29 CFR 825.125.

3. Complete Part A
   a. Enter the health care providers name and address.
   b. Enter telephone and fax numbers and email address.
   c. Indicate the type of practice/medical specialty.
   d. State which provider you are from the list provided.

4. Complete Part B
   a. Choose which statement describes the veteran’s medical condition.
   b. Answer question if condition was related to active duty.
   c. Indicate start date of condition and the estimated duration of the condition and/or need for care.
d. Answer if veteran is receiving treatment for an injury or illness. If yes, please describe treatment.

5. Complete Part C
   a. Indicate if veteran will need care for a continuous period of time. If yes, indicate estimated period of time.
   b. Answer if the veteran will need follow-up treatment. If yes, list estimate of treatment schedule.
   c. Indicate if follow-up is medically necessary.
   d. Indicate if care will be needed due to flare-ups. If yes, estimate frequency and duration of care.

Certification for Serious Injury or Illness of a Veteran for Military Caregiver Leave (Family and Medical Leave Act)

U.S. Department of Labor
Wage and Hour Division

Notice to the EMPLOYER

The Family and Medical Leave Act (FMLA) provides that an employer may require an employee seeking military caregiver leave under the FMLA leave due to a serious injury or illness of a covered veteran to submit a certification providing sufficient facts to support the request for leave. Your response is voluntary. While you are not required to use this form, you may not ask the employee to provide more information than allowed under the FMLA regulations, 29 CFR 825.310. Employers must generally maintain records and documents relating to medical certifications, recertifications, or medical histories of employees or employees’ family members, created for FMLA purposes as confidential medical records in separate files or records from the usual personnel files and in accordance with 29 CFR 1630.14(c)(1), if the Americans with Disabilities Act applies, and in accordance with 29 CFR 1655.9, if the Genetic Information Nondiscrimination Act applies.

SECTION I: For completion by the EMPLOYEE and/or the VETERAN for whom the employee is requesting leave

INSTRUCTIONS to the EMPLOYEE and/or VETERAN: Please complete Section I before having Section II completed. The FMLA permits an employer to require that an employee submit a timely, complete, and sufficient certification to support a request for military caregiver leave under the FMLA leave due to a serious injury or illness of a covered veteran. If requested by the employer, your response is required to obtain or retain the benefit of FMLA-protected leave. 25 U.S.C. 2613, 2614(c)(3). Failure to do so may result in denial of an employee’s FMLA request. 29 CFR 825.310(e). The employer must give an employee at least 15 calendar days to return this form to the employer.

(This section must be completed before Section II can be completed by a health care provider.)

Part A: EMPLOYEE INFORMATION

Name and address of employer (this is the employer of the employee requesting leave to care for a veteran):

________________________

Name of employee requesting leave to care for a veteran:

First Middle Last

________________________

Name of veteran (for whom employee is requesting leave):

First Middle Last

________________________

Relationship of employee to veteran:

Spouse ☐ Parent ☐ Son ☐ Daughter ☐ Next of Kin ☐ (please specify relationship):
Part B: VETERAN INFORMATION

(1) Date of the veteran’s discharge:

(2) Was the veteran dishonorably discharged or released from the Armed Forces (including the National Guard or Reserves)? Yes ☐ No ☐

(3) Please provide the veteran’s military branch, rank and unit at the time of discharge:

(4) Is the veteran receiving medical treatment, recuperation, or therapy for an injury or illness? Yes ☐ No ☐

Part C: CARE TO BE PROVIDED TO THE VETERAN

Describe the care to be provided to the veteran and an estimate of the leave needed to provide the care:
SECTION II: For completion by: (1) a United States Department of Defense ("DOD") health care provider; (2) a United States Department of Veterans Affairs ("VA") health care provider; (3) a DOD TRICARE network authorized private health care provider; (4) a DOD non-network TRICARE authorized private health care provider; or (5) a health care provider as defined in 29 CFR 825.125.

INSTRUCTIONS to the HEALTH CARE PROVIDER: The employee named in Section I has requested leave under the military caregiver leave provision of the FMLA to care for a family member who is a veteran. For purposes of FMLA military caregiver leave, a serious injury or illness means an injury or illness incurred by the servicemember in the line of duty on active duty in the Armed Forces (or that existed before the beginning of the servicemember’s active duty and was aggravated by service in the line of duty on active duty in the Armed Forces) and manifested itself before or after the servicemember became a veteran, and is:

(i) a continuation of a serious injury or illness that was incurred or aggravated when the covered veteran was a member of the Armed Forces and rendered the servicemember unable to perform the duties of the servicemember’s office, grade, rank, or rating; or
(ii) a physical or mental condition for which the covered veteran has received a U.S. Department of Veterans Affairs Service Related Disability Rating (VASRD) of 30 percent or greater, and such VASRD rating is based, in whole or in part, on the condition precipitating the need for military caregiver leave; or
(iii) a physical or mental condition that substantially impairs the covered veteran’s ability to secure or follow a substantially gainful occupation by reason of a disability or disabilities related to military service, or would do so absent treatment; or
(iv) an injury, including a psychological injury, on the basis of which the covered veteran has been enrolled in the Department of Veterans Affairs Program of Comprehensive Assistance for Family Caregivers.

A complete and sufficient certification to support a request for FMLA military caregiver leave due to a covered veteran’s serious injury or illness includes: written documentation confirming that the veteran’s injury or illness was incurred in the line of duty on active duty or existed before the beginning of the veteran’s active duty and was aggravated by service in the line of duty on active duty, and that the veteran is undergoing treatment, recuperation, or therapy for such injury or illness by a health care provider listed above. Answer fully and completely all applicable parts. Several questions ask a response as to the frequency or duration of a condition, treatment, etc. Your answer should be your best estimate based upon your medical knowledge, experience, and examination of the patient. Be as specific as you can, terms such as "life-time," "unknown," or "indeterminate" may not be sufficient to determine FMLA military caregiver leave coverage. Limit your responses to the veteran’s condition for which the employee is seeking leave. Do not provide information about genetic tests, as defined in 29 CFR 1635.3(a), or genetic services, as defined in 29 CFR 1055.3(e).

(Please ensure that Section I has been completed before completing this section. Please be sure to sign the form on the last page and return this form to the employee requesting leave (See Section I, Part A above). DO NOT SEND THE COMPLETED FORM TO THE WAGE AND HOUR DIVISION.)

Part A: HEALTH CARE PROVIDER INFORMATION

Health care provider’s name and business address:

________________________________________________________________________

Telephone: ( ) __________ Fax: ( ) __________ Email: ________________

Type of Practice/Medical Specialty: ______________________________________________________________________

Please indicate if you are:

☐ a DOD health care provider

☐ a VA health care provider

☐ a DOD TRICARE network authorized private health care provider

☐ a DOD non-network TRICARE authorized private health care provider

☐ other health care provider
PART B: MEDICAL STATUS

Note: If you are unable to make certain of the military-related determinations contained in Part B, you are permitted to rely upon determinations from an authorized DOD representative (such as, DOD Recovery Care Coordinator) or an authorized VA representative.

(1) The Veteran’s medical condition is:

☐ A continuation of a serious injury or illness that was incurred or aggravated when the covered veteran was a member of the Armed Forces and rendered the servicemember unable to perform the duties of the servicemember’s office, grade, rank, or rating.

☐ A physical or mental condition for which the covered veteran has received a U.S. Department of Veterans Affairs Service Related Disability Rating (VASRD) of 50% or higher, and such VASRD rating is based, in whole or in part, on the condition precipitating the need for military caregiver leave.

☐ A physical or mental condition that substantially impairs the covered veteran’s ability to secure or follow a substantially gainful occupation by reason of a disability or disabilities related to military service, or would do so absent treatment.

☐ An injury, including a psychological injury, on the basis of which the covered veteran is enrolled in the Department of Veterans Affairs Program of Comprehensive Assistance for Family Caregivers.

☐ None of the above.

(2) Is the veteran being treated for a condition which was incurred or aggravated by service in the line of duty on active duty in the Armed Forces?  Yes ☐  No ☐

(3) Approximate date condition commenced:

(4) Probable duration of condition and/or need for care:

(5) Is the veteran undergoing medical treatment, recuperation, or therapy for this condition?  Yes ☐  No ☐

If yes, please describe medical treatment, recuperation or therapy:

PART C: VETERAN’S NEED FOR CARE BY FAMILY MEMBER

“Need for care” encompasses both physical and psychological care. It includes situations where, for example, due to his or her serious injury or illness, the veteran is unable to care for his or her own basic medical, hygienic, or nutritional needs or safety, or is unable to transport him or herself to the doctor. It also includes providing psychological comfort and reassurance which would be beneficial to the veteran who is receiving inpatient or home care.

(1) Will the veteran need care for a single continuous period of time, including any time for treatment and recovery?  Yes ☐  No ☐

If yes, estimate the beginning and ending dates for this period of time:

(2) Will the veteran require periodic follow-up treatment appointments?  Yes ☐  No ☐

If yes, estimate the treatment schedule:
(3) Is there a medical necessity for the veteran to have periodic care for these follow-up treatment appointments?  
Yes ☐ No ☐

(4) Is there a medical necessity for the veteran to have periodic care for other than scheduled follow-up treatment appointments (e.g., episodic flare-ups of medical condition)?  
Yes ☐ No ☐

If yes, please estimate the frequency and duration of the periodic care:

________________________________________

________________________________________

Signature of Health Care Provider: ______________________ Date: ______________________

PAPERWORK REDUCTION ACT NOTICE AND PUBLIC BURDEN STATEMENT

If submitted, it is mandatory for employers to retain a copy of this disclosure in their records for three years, in accordance with 29 U.S.C. 2015, 29 CFR 825.300. Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number. The Department of Labor estimates that it will take an average of 20 minutes for respondents to complete this collection of information, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding this burden estimate or any other aspect of this collection information, including suggestions for reducing this burden, send them to the Administrator, Wage and Hour Division, U.S. Department of Labor, Room S-3502, 200 Constitution Ave. NW, Washington, DC 20210. DO NOT SEND THE COMPLETED FORM TO THE WAGE AND HOUR DIVISION: RETURN IT TO THE EMPLOYEE REQUESTING LEAVE (As shown in Section I, Part “A” above).
Long Term Leave Physician’s Release to Return to Work Form

Purpose of form is the physician states employee is allowed to return to work and indicates if there are any restrictions, for how long, and what kind. Attach a copy of your job duties for the physician to review.

Instructions:

1. Employee fills out the first section with their name, the date, physician’s name and phone number. Bring the form to the indicated doctor to complete the form.

To be completed by Physician:

2. Physician chooses if patient is released for full duty (A) or if there will be some restrictions (B) and will indicate appropriate dates.

3. Physician chooses, from the list, which restrictions apply and the weight or time restriction for that restriction.

4. Physician will read the statement and if agrees with everything on the form will sign and date the form.

To be completed by employee:

5. Employee will read the statement and if agrees will sign and date.

6. Form is to be returned to employer.
Physician’s Release to Return to Work Form

To be completed by Physician

After reviewing the attached job description and the specific duties within the job description, please complete either (A) or (B), then sign and date below.

(A) The above named employee has been released by the above named physician as eligible to return to Full Duty as of [Date] with NO RESTRICTIONS.
(B) The above named employee has been released by the above named physician to return to work on [Date] with the following RESTRICTIONS through [Date].

Check applicable boxes and provide the limitations/restrictions. (Max weight in lbs)

<table>
<thead>
<tr>
<th>Activity</th>
<th>Limitation (lbs)</th>
<th>Hours per day</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lifting</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Repetitive Lifting</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Carrying</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pushing/pulling</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pinching/Gripping</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reaching over head</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reaching away from body</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Repetitive Motion Restrictions:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other Restrictions:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

These limitations/restrictions are:
- Temporary limitations/restrictions
- Permanent limitations/restrictions

If the above restriction requires modified duty and such duty is not available, it is assumed that the employee will be sent home instead of returning to work. My signature indicates that I have read and understand the employee’s job description and the listed tasks within the job description and my findings are based on my medical assessment of this employee’s physical and mental capabilities as compared to the essential functions of the job.

Physician’s Name (Please Print) [Signature]

I agree that I will follow through with all of the restrictions listed above. I will notify my supervisor of any departure from these restrictions.

Employee signature [Signature] Date

10/23/2015
Long Term Medical (FMLA) Leave Request

Purpose of the form is to request a long term medical leave for the employee or a dependent of the employee.

Section 1 - To be completed by the employee requesting leave.

1. Complete the following:
   a. Last Name
   b. First Name
   c. Middle Initial
   d. EmplID
   e. Department Name
   f. Contact Phone #

2. Indicate the reason for the leave.

3. Complete the leave dates and specifics:
   a. Approximate leave start date
   b. Approximate return to work date
   c. Indicate if leave is on an intermittent or reduced schedule. If so, attach a copy of the schedule
   d. Indicate if requesting use of donated leave if a staff member
   e. Indicate if long-term or short-term leave if a faculty member

4. Read the terms of agreement and if employee agrees to them, sign and date the form.

5. Return the form to the appropriate department for signature and approval.
# University of North Dakota

## LONG TERM MEDICAL (FMLA) LEAVE REQUEST

### TO BE COMPLETED BY EMPLOYEE (Type or Print)

<table>
<thead>
<tr>
<th>1. LAST NAME</th>
<th>2. FIRST NAME</th>
<th>3. MIDDLE INITIAL</th>
<th>4. EMPID#</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>5. DEPARTMENT NAME</th>
<th>6. CONTACT PHONE#</th>
</tr>
</thead>
</table>

### 7. REASON FOR REQUESTED LEAVE:

- **A.** For prenatal medical care, or childbirth, or incapacity due to pregnancy.  
  (May be required to provide a Certification of Health Care Provider form within 15 calendar days of this request)
- **B.** To care for the employee’s child after birth, or placement for adoption or foster care.  
  (May be required to provide a Certification of Health Care Provider form or other form of documentation for adoption/foster care within 15 calendar days of this request)
- **C.** To care for the employee’s spouse, child, or parent who has a serious health condition.  
  (Must provide a Certification of Health Care Provider form within 15 calendar days of this request)
- **D.** For a serious health condition that makes the employee unable to perform their job.  
  (Must provide a Certification of Health Care Provider form within 15 calendar days of this request)
- **E.** For a serious injury or illness of a covered service member for military leave.  
  (Must provide a Certification for Serious Injury or Illness of a Covered Service Member for Military Leave form within 15 calendar days of this request)
- **F.** For qualifying exigency for military family leave.  (Must provide a Certification of Qualifying Exigency for Military Family Leave within 15 calendar days of this request)

### 8. APPROX. LEAVE START DATE

### 9. APPROX. RETURN TO WORK DATE

### 10. LEAVES BEING REQUESTED ON AN INTERMITTENT OR REDUCED SCHEDULE:

- **No**
- **Yes**  
  (If yes, please attach a proposed work schedule)

### 11. Additional Requests

<table>
<thead>
<tr>
<th>Staff:</th>
<th>A. Donated Leave (See NDUS HR Policy 20.6)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>A. Long-Term Sick Leave</td>
</tr>
<tr>
<td></td>
<td>B. Short-Term Sick Leave Taken</td>
</tr>
</tbody>
</table>

I understand and agree that:

1. I will provide medical certification of the serious health condition from the appropriate health care provider.
2. I understand that my request may be delayed until applicable certification is provided.
3. I may be asked to provide a return to work statement from my physician prior to being allowed to resume work, if I have taken leave due to my own serious illness (reason 707 above). I also understand that my return to work may be delayed until this statement is provided.
4. My health benefits will be maintained during the period of long term sick leave under the same conditions as if I continued to work. I will continue to pay my share of any premium/benefits while I am on leave, unless I elect, in writing, to discontinue such coverage (dental, vision, medical life, etc).
5. I may be required to reimburse my employer for the cost of health benefits provided by the state during my leave, if I fail to return to work for reasons other than the continuation, recurrence, or onset of a serious health condition.
6. I will provide medical certification from the appropriate health care provider stating that I am unable to perform the functions of my position on or before the date that my leave expires.
7. I am required to exhaust all paid leave before I am allowed to go on leave without pay.
8. If leave is intermittent, documentation of leave taken must be submitted to your supervisor every 30 days.
9. If requesting donated leave, I agree to the release of my name for the purpose of requesting leave donations.

My signature signifies that I have read and agree to the terms and conditions outlined in this request.

<table>
<thead>
<tr>
<th>Signature of Employee</th>
<th>Printed Name</th>
<th>Date</th>
</tr>
</thead>
</table>

### Office Use Only:

<table>
<thead>
<tr>
<th>Certification Rec'd</th>
<th>FMLA Approved</th>
</tr>
</thead>
<tbody>
<tr>
<td>Y</td>
<td>N</td>
</tr>
</tbody>
</table>

### Approval for Faculty Long-Term Sick Leave

(Attach Job Data Change Form to reduce salary to 75%)

<table>
<thead>
<tr>
<th>VPAA or SMMS Signature</th>
<th>Printed Name</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>6/14/2016</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Medical Records Privacy Rights: All medical information must be handled in a confidential manner and is protected by the Health Insurance Portability and Accountability Act (HIPAA).
Mandatory Furlough Notice

Purpose of this form is to notify a full-time benefited employee that their scheduled hours will be reduced for a period of time.

To be completed by the supervisor:

1. Complete the following:
   a. Employee name
   b. EmplID
   c. Date
   d. Name of who the notice is from

2. Supervisor will complete the information in the work schedule.

3. Employee will review and discuss the schedule with the supervisor and if in agreement will sign the form.

4. Supervisor will sign the form.

5. This form must be signed no later than 2 weeks prior to the start of the furlough period.

6. Return the form to Human Resources prior to the start of the furlough period.
To: 
EmplID: 
Date: 

From: 

Re: Mandatory Furlough Notice

Due to a lack of funding, you are being placed on a temporary mandatory furlough. A mandatory furlough is necessary when funding for a benefited employee is not enough to support full-time hours during any workweek. Based on our discussion regarding available funding, you are hereby notified that your hours will be reduced according to the schedule below.

While in furlough status, you remain an employee of UND and you:

- Are eligible to remain on benefits, regardless of the number of hours worked
- Will be compensated for all hours worked or leave taken
- Will accrue leave based on the number of paid hours
- May not volunteer to work at this employing department, either with or without compensation
- Will automatically return to your normal work schedule at the end of the mandatory furlough period listed below, unless you are unable to return to work due to a non-job-related medical condition, failure to return, to work after the furlough period, may be considered a resignation or cause for dismissal.

<table>
<thead>
<tr>
<th>First Day of Workweek</th>
<th>Week 1</th>
<th>Week 2</th>
<th>Week 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Last Day of Workweek</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Funded hours to be Worked*</td>
<td></td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Paid Leave to be Taken</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Furloughed Hours (Unpaid)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Hours (Must match Standard Hours in Job Data)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*If any hours are actually worked during a work week for an exempt employee, compensation must be at least $455.00 per week. If there are no hours worked in a work week, compensation may be zero for the week.

Please sign below acknowledging that you have received this notice at least two weeks prior to the start of the mandatory furlough and that you have read and understand this form.

_________________________  _______________________
Employee Signature:        Date:                    

_________________________  _______________________
Supervisor Signature:      Date:                    

This form must be signed by employee and supervisor, no later than two weeks prior to the start of the furlough period. Submit this signed form to Human Resources, prior to the start of the Mandatory Furlough period.
Name Change Form

Purpose of the form is to verify the legal name change of an employee for updating the system.

To be completed by employee

1. Complete the following:
   a. Complete legal first name
   b. Middle name
   c. Last name
   d. Most recent former name
   e. Employee ID
   f. Social Security number
   g. Marital Status
   h. Date of name change
   i. Indicate if receiving benefits from UND and if so, which one
   j. Sign form

To be completed by the Notary

2. Complete the following:
   a. Enter the day, month and year
   b. View new social security card
   c. Sign and stamp the form
NAME CHANGE FORM

I hereby request that my name, as it appears on my current Social Security Card, be changed as indicated below:

Complete Legal First Name: ________________________________

Middle Name: ________________________________

Last Name: ________________________________

Most Recent Former Name: ________________________________

Employee ID: ________________________________

Social Security Number: ________________________________

My Marital Status: ☐ Single ☐ Married 1

Date of Name Change ________________________________

I am currently receiving benefits for UND: ☐ YES ☐ NO 

☐ TIAA ☐ NDPER

Note: If you are a benefitted employee, you will need to complete a name change packet!

Employee Signature: ________________________________

The foregoing instrument was acknowledged before me this

________ day of _________ 20 _________

I have examined and verified the name on the Social Security Card to be used for Payroll purposes.

__________________________________________

Notary Public
North Dakota Withholding Change Form

Purpose of the form is to change an employee’s North Dakota income tax withholding amount.

1. To be completed by the employee
   a. Name-enter Last, First and MI
   b. Employee ID
   c. Social Security number
   d. E-mail address
   e. Daytime Phone #

2. Date employee would like the change to take effect

3. Indicate the change:
   a. Change state withholding
   b. Change North Dakota withholding allowances (indicate #)
   c. Additional withholding per paycheck (indicate additional amount)

4. Sign and date the form and return to the Payroll Office
# North Dakota Withholding Change Form

<table>
<thead>
<tr>
<th>Name (Last, First, MI):</th>
<th>Employee ID:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>E-Mail address:</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Social Security Number:</td>
<td></td>
</tr>
<tr>
<td>Daytime Phone #:</td>
<td></td>
</tr>
</tbody>
</table>

**Effective Date:**

*Please note: depending on when received, the change may not be in effect for the next payday.*

- [ ] Change my state withholding to North Dakota
- [ ] Change my North Dakota withholding allowances
- [ ] Additional Withholding per paycheck

*This request replaces and cancels all previous requests on file.*

<table>
<thead>
<tr>
<th>N.D. Allowances (Must be equal to or less than federal)</th>
<th>Additional amount to be withheld from each paycheck $</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Signature: ___________________________  Date: ___________________________

Please send original to:

UND Payroll Office  
Twanley Hall, Room 312  
264 Centennial Drive, Stop 7127  
Grand Forks, ND 58202-7127

Revised: 5/12
Notification of Payroll Overpayment

Purpose of the form is to notify the employee that an overpayment has occurred and the amount needs to be repaid. Employee can select how they want to pay it back.

Top Section – To be completed by the Payroll Accountant

1. Complete the top section
   a. Date of Notice
   b. Enter who to return the form to
   c. Enter employee name
   d. Enter employee id number
   e. Indicate date(s) when overpayment occurred
   f. Indicate the amount of the overpayment
   g. Describe the statement of facts as to why the overpayment occurred

Bottom Section – To be completed by employee

2. Complete bottom section
   a. Choose the method desired for repayment of the overpayment
   b. Sign, indicate phone number and date
   c. Return the form to the information indicated in the top section
NOTIFICATION OF PAYROLL OVERPAYMENT

Date of Notice: ________________

Please sign and return this form within 5 calendar days to: ________________________
*Failure to return this form will result in amount due to be sent to the Business Office for collection procedures in full.

Employee Name: ___________________ Employee ID Number: ___________________

Pay Period(s) of Overpayment: ________________

Overpayment Amount: $__________________________ *

Statement of Facts:

AUTHORIZATION FOR PAYROLL DEDUCTION: I agree with the Statement of Facts section above and agree to repay the University of North Dakota by payroll deduction in the amounts shown below from my payroll check(s) in order to satisfy my overpayment.

☐ Please deduct the full amount of the overpayment from my next payroll payment.

☐ Please deduct $__________ (Note: this option of deduction amount must be pre-arranged and approved by the Payroll dept or your dept) from my payroll for the next and subsequent pay periods until the overpayment is fully repaid. Payments I receive for any overtime, retroactive pay, etc. may also be deducted up to the remaining unpaid debt balance. In the event I leave employment with UND, I authorize the overpayment balance to be deducted from my final payroll payment or annual leave payout.

Employee Signature: ___________________ Phone #: ______________ Date: __________

Please feel free to call me at (701) 777-6973 with any questions or concerns.

Trish Muir
Accountant
Payroll Department
Perceptive Content Access Request

Purpose of the form is to request access to Perceptive Content.

To be completed by the department requesting the access

1. Complete the requested information
   a. Date
   b. Requestor name
   c. Requestor phone number
   d. Requestor email address
   e. Name of new user
   f. New user employing department name
   g. New user employing department number
   h. New user active directory user id
   i. EmplID
   j. New User email address

2. Indicate which drawer access is needed

3. Indicate the department numbers needing access to

4. Specify what role the new user will need

5. Department head will print their name and then sign

6. Return the form to the name and address listed at the top of the form
PERCEPTIVE CONTENT ACCESS REQUEST

Please complete and return to Cheryl Arntz at Payroll, Stop 7127 or cheryl.arntz@und.edu

DATE:

REQUESTOR:

REQUESTOR PHONE NUMBER:

REQUESTOR EMAIL ADDRESS:

NAME OF NEW USER:

NEW USER EMPLOYING DEPARTMENT NAME:

NEW USER EMPLOYING DEPARTMENT NUMBER:

NEW USER ACTIVE DIRECTORY USER ID:

EMPLID:

NEW USER EMAIL ADDRESS:

PERCEPTIVE CONTENT ACCESS DESCRIPTION: Include specific drawers and department numbers that you need access to.

☐ Human Resources drawer- Option A: Includes Academic Records, Awards, Contracts, Disciplinary Correspondence, PMFs, Leave Requests, Full-time employment history and all Payroll forms (Job Data Hires, Job Data Changes, Additional Pay Forms, Payroll corrections).

☐ Human Resources drawer- Option B: Includes Academic Records, Awards, Contracts, PMFs, Leave Requests, Full-time employment history and all Payroll forms (Job Data Hires, Job Data Changes, Additional Pay Forms, Payroll corrections).

Department numbers:

Specify what role the new user will need

☐ Scanner Role: Scans, edits, views and prints documents

☐ User Role: Scans, edits, views, links and prints documents

☐ Viewer Role: View only.

DEPARTMENT HEAD APPROVING THE REQUEST:

DEPARTMENT HEAD SIGNATURE: ________________________________

Created 11/2016
Performance Evaluation Tool

Purpose of the form is to assist in the engagement and overall development of UND Staff; in addition to ensuring the goals of the university are advancing in a positive and successful manner.

How to Use This Document:

1. Major Responsibility:
These are the brief overview statements of work to be performed, found as general headings in the employee’s official UND Position Description. Each responsibility is a significant requirement of the job derived from an analysis of the position. These major headings should be imported (cut and paste) onto this tool under the “Major Duties/Responsibility” section. There is no need to import the specific tasks in each section, just the main statement of responsibility. All text boxes in this document are expandable.

2. Comments:
Each area of Major Responsibility must have comments to attribute how well the employee is performing or where an employee needs improvement. Again, EVERY area should have feedback provided for the employee regardless of rating.

3. Rating:
Each area of Major Responsibility should have a rating correlating to the specific comments/examples provided.

   • Where a one “1-2” or “4-5” is given, the rating must be justified with a brief narrative description in the comments section detailing what exactly made the performance exceed standards or not meet standards.
   • When a “1-2” is given, there should be a formal corrective action plan already in place, or one must be developed and attached to this document. This must include goals detailing what development will occur to assist the employee in being successful. Please work with Human Resources to accomplish the improvement plans.
   • Sections where there is a “3” “Performance Expectations Fulfilled”, there should still be comments made regarding the performance of those duties.

4. Complete the second to last page
   • Identify any areas where performance has improved or deteriorated
   • Employee Comments
   • List Goals and supporting information

5. Last page
   1. Indicate the correct position description statement
   2. Employee signs and dates
   3. Supervisor signs and dates
   4. Reviewer signs and dates
University of North Dakota Staff Performance Evaluation Tool

MAJOR DUTIES/RESPONSIBILITIES

1

RATING 5-1 (check box)

5 4 3 2 1

3

COMMENTS/EXAMPLES

2

MAJOR DUTIES/RESPONSIBILITIES

RATING 5-1 (check box)

5 4 3 2 1

COMMENTS/EXAMPLES

University of North Dakota Staff Performance Evaluation Tool

CY 2016
Discuss any areas where performance has significantly improved or deteriorated since the last evaluation:

Employee Comments:

4

Goal Development for 2017: This section is for documentation of goal development for the next year. Each goal should have a plan and measurement in addition to a specific due date. Progress and completion of goals will be used to assist in evaluation of performance in the next year.

<table>
<thead>
<tr>
<th>Goal Statement (what's to be accomplished)</th>
<th>Plan to Complete</th>
<th>Measurement of completion</th>
<th>Due Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
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<td></td>
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</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Position Description (Check One):

☐ Position Description has been reviewed and currently reflects the accountabilities and responsibilities of the position, and is in the current format.
☐ Position Description has been reviewed and revised (and in correct format) and will be sent to Human Resources for approval.

This performance evaluation has been discussed with me and I have had the opportunity to provide my input. I understand that I may include a written statement with this form that will be retained in my personnel file.

_________________________  ________________________
Employee’s Signature          Date

_________________________  ________________________  ________________________
Supervisor’s Signature        Date                     Reviewer’s Signature         Date

133
Position Description Instructions

Purpose of the form is used to accurately document the description of a position including:

a. job description
b. job family assignment
c. source document for recruitment
d. source document for performance evaluation and development
e. source document for worker’s compensation or disability accommodation issues

When the following information is completed, submit to your institution’s Human Resources/Personnel representative to initiate the classification/reclassification process.

A. Complete Part A:
   1. Name of Employee
      1a. EmplID #
   2. Position #
      2a. Dept ID #
   2b. Current or Recommended Salary:
      3. Band #/Title
      3a. Job Family #/Title
      4. Functional Title
      5. Please check all that apply
         5a. Type of Position, check FT or PT, indicate % if PT
         5b. Length of position, check 9, 10, 11, 12 month, or check and indicate if other # of months
         6. Institution is filled for you
         7. Division
         8. Department
         9. Unit
         10. Work Mailing Address
         11. Work Phone
         12. Name & Title of Supervisor
         12a. Supervisor Position #
         13. List what the function/mission of your department
         14. Indicate the purpose of the position
         15. Indicate if this position is essential during emergencies/closures

B. Complete Duties/Responsibilities

Completed detailed position description which accurately reflects the duties/responsibilities of the position.

1. Cover memo/statement indicating:
   * The applicable reason:
2. New responsibilities have been added to the existing organization’s mission/purpose and assigned to this position; or
3. Significant amount of new responsibilities have been reassigned/changed to this position with no substantial change in the organization’s mission/purpose; or
4. Position is assigned in a band and job family which has been revised by the NDUS Human Resource Council.
   * Contact person for the process.

5. Department (up to President) Organizational Chart representing reporting relationship used for the performance evaluation including each employee’s:
   ____ Name
   ____ Functional title
   ____ Position Number
   ____ Job Family Name

**EXAMPLES**

**Position:** Administrative Secretary /#0000

<table>
<thead>
<tr>
<th>Duty/Responsibility No: 1</th>
<th>Statement of duty/responsibility:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percent of Time:</td>
<td>For ADA compliance, see instruction. Responsibility is:</td>
</tr>
<tr>
<td></td>
<td>✧ Essential ~ Secondary (Please check one)</td>
</tr>
<tr>
<td>Statement of duty/responsibility:</td>
<td>Perform departmental receptionist responsibilities.</td>
</tr>
</tbody>
</table>

**Tasks involved in fulfilling above duty/responsibility (include description of physical demands for individual task):**
1. Answer department telephone, relay information or transfer calls to appropriate individuals.
2. Greet visitors, answer questions and/or direct them to appropriate individual(s).
3. Handle daily mail and correspondence for department.

<table>
<thead>
<tr>
<th>Duty/Responsibility No: 2</th>
<th>Statement of duty/responsibility:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percent of Time:</td>
<td>For ADA compliance, see instruction. Responsibility is:</td>
</tr>
<tr>
<td></td>
<td>✧ Essential ~ Secondary</td>
</tr>
<tr>
<td>Statement of duty/responsibility:</td>
<td>Perform departmental administrative activities.</td>
</tr>
</tbody>
</table>

**Tasks involved in fulfilling above duty/responsibility (include description of physical demands for individual task):**
1. Compose routine correspondence for department chair.
2. Key instructional materials (tests, syllabi, handouts, class schedules) for department faculty.
3. Make travel arrangements for all departmental faculty.

<table>
<thead>
<tr>
<th>Duty/Responsibility No: 3</th>
<th>Statement of duty/responsibility:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percent of Time:</td>
<td>For ADA compliance, see instruction. Responsibility is:</td>
</tr>
<tr>
<td></td>
<td>9 Essential ✧ Secondary (Please check one)</td>
</tr>
<tr>
<td>Statement of duty/responsibility:</td>
<td>Assist with department seminars.</td>
</tr>
<tr>
<td>Duty/Responsibility No: 4</td>
<td>Statement of duty/responsibility:</td>
</tr>
<tr>
<td>--------------------------</td>
<td>----------------------------------</td>
</tr>
<tr>
<td>Work Safely.</td>
<td></td>
</tr>
</tbody>
</table>

Percent of Time: 2%

For ADA compliance, see instruction. Responsibility is:

÷ Essential  ~ Secondary (Please check one)

Tasks involved in fulfilling above duty/responsibility (include description of physical demands for individual task):
1. Follow safety rules.
2. Help identify unsafe working conditions.
3. Stop co-workers who are working in an unsafe manner.
### POSITION DESCRIPTION
North Dakota University System

#### PART A - Identification, Duties/Responsibilities, and Task Inventory

1. Name of Employee:  
2. Position #:  
3. Dept. ID #:  
4. Current or Recommended Salary:  
5. Band #/Title: Choose an item.  
6. Job Family #/Title: Choose an item.  
7. Functional Title:  
8. Please check all that apply:  
   - Full time  
   - Part-time  
9. Length of Position:  
   - 9 month  
   - 10 month  
   - 11 month  
   - 12 month  
   - Other Month: _____  
10. Institution: University of North Dakota  
11. Department:  
12. Unit:  
13. Work Mailing Address:  
14. Work Phone:  
15. Name & Title of Supervisor:  
16. Supervisor Phone #:  
17. What is the function/mission of your department?  
18. What is the purpose of your position? (Why does the position exist, how does the position function within the work unit?)  
19. Is this position essential during emergencies/closures?  
   - Yes  
   - No  
   (Essential personnel may be required to work during emergencies and closures affecting UND depending on staffing levels required for that particular situation.)
PART A - 16. Duties/Responsibilities

⇒ Indicate Essential/Secondary. The following questions should be taken into consideration in the determination:
- Is the duty/responsibility the reason the job exists?
- Is this a highly specialized task or one that requires special education, training, licensure?
- If the answer is yes, the duty is “essential”.
- What is the percentage of time spent on the function?
  If the answer indicates a great % of time, the duty is probably “essential”.
- What are the consequences to others or the institution of a failure to perform the function?
  If the answer indicates a high level of accountability, the duty is “essential”.

NOTE: See Position Description Instructions and examples.

<table>
<thead>
<tr>
<th>Duty/Responsibility No.</th>
<th>Percent of Time</th>
<th>Statement of duty/responsibility (used for evaluation/review of performance):</th>
</tr>
</thead>
</table>
| For ADA compliance, see instruction. Responsibility is:  
  ☐ Essential ☐ Secondary  
  (Please check one) |

Tasks involved in fulfilling the above duties/responsibilities (include description for physical and mental/cognitive demands)

<table>
<thead>
<tr>
<th>Duty/Responsibility No.</th>
<th>Percent of Time</th>
<th>Statement of duty/responsibility (used for evaluation/review of performance):</th>
</tr>
</thead>
</table>
| For ADA compliance, see instruction. Responsibility is:  
  ☐ Essential ☐ Secondary  
  (Please check one) |

Tasks involved in fulfilling the above duties/responsibilities (include description for physical and mental/cognitive demands)
### PART B – Required Experience, Characteristics and Ability

1. **EDUCATION/KNOWLEDGE REQUIREMENT** - Minimum education required to perform adequately in position could reasonably be attained only by completing the following (if you were to recruit today, what qualification would you require?)

<table>
<thead>
<tr>
<th>REQUIRED EDUCATION/TRAINING (choose one)</th>
<th>Major field of study or degree emphasis (accounting, economics, etc...)</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ less than high school diploma</td>
<td></td>
</tr>
<tr>
<td>☐ high school diploma or OED</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>COLLEGE LEVEL (choose one)</th>
<th>Specialized subject knowledge (cost accounting, MACRO economics, etc.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ 1 year</td>
<td></td>
</tr>
<tr>
<td>☐ 2 year</td>
<td></td>
</tr>
<tr>
<td>☐ 3 year</td>
<td></td>
</tr>
<tr>
<td>☐ 4 year</td>
<td></td>
</tr>
<tr>
<td>☐ Associate’s</td>
<td></td>
</tr>
<tr>
<td>☐ Bachelor’s</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>GRADUATE LEVEL (choose one)</th>
<th>Minimum Qualifications:</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ 1 year</td>
<td></td>
</tr>
<tr>
<td>☐ 2 year</td>
<td></td>
</tr>
<tr>
<td>☐ post-graduate</td>
<td></td>
</tr>
</tbody>
</table>

☐ Valid Driver’s License
☐ Other License(s) or Certification(s) ____________________________

**Preferred Qualifications:**

Competencies required: (i.e. ability to..., demonstrated leadership skills, strong communication skills)
Work safety requirements:
- Follow safety rules and promote safe behavior
- Help identify unsafe working conditions and notify supervisor or Office of Safety
- Ensure the safety policies and procedures are being followed
- Report incidents and near misses to supervisor or Office of Safety within 24 hours
- Complete all required safety and other mandatory training requirements

Work habit requirements:
- Attendance and punctuality consistently maintained; follows correct procedures for notification
- Use work time appropriately for work activities; attend meetings promptly
- Demonstrate flexibility in scheduling and accepting work assignments
- Follow procedures for requesting leave and reporting absences; provide necessary documentation/releases
- Remain calm, professional, and collegial in all circumstances

<table>
<thead>
<tr>
<th>Position Number</th>
<th>Job Family and Title of Persons Supervised</th>
<th>FTE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>TOTAL</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

3. INDIRECT SUPERVISION:
Total number of classified positions indirectly supervised:

Total number of student employees or other non-classified employees indirectly supervised:

4. HAZARDOUS WORKING CONDITIONS
Unusual or hazardous working conditions related to performance of duties:

Precautionary measures taken to avoid those unusual or hazardous working conditions:

Frequency of occurrence of unusual or hazardous working conditions:
5. This position is classified as:  

<table>
<thead>
<tr>
<th>Executive</th>
<th>Administrative</th>
<th>Professional</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Meets FLSA Salary Requirements</td>
<td>☐ Meets FLSA Salary Requirements</td>
<td>☐ Meets FLSA Salary Requirements</td>
</tr>
<tr>
<td>☐ Primary duty is management of the enterprise or recognized department/supervision</td>
<td>☐ Primary duty is office/non-manual work related to management policies/general business operations</td>
<td>☐ Primary duty is work requiring knowledge of advanced type in science or learning</td>
</tr>
<tr>
<td>☐ Does the employee have the authority to hire or fire or provide suggestions/recommendations to hire, fire, promote or change status of other employees</td>
<td>☐ Work directly related to academic instruction or training</td>
<td>☐ Work is original and creative in a field of artistic endeavor</td>
</tr>
<tr>
<td>☐ Customarily and regularly directs the work of two or more other employees</td>
<td>☐ Customarily and regularly exercises discretion and independent judgment in matters of consequence</td>
<td>☐ Work requires consistent exercise of discretion and judgment</td>
</tr>
</tbody>
</table>
Position Request/Change Form

Purpose of this form is to request any change that needs to be made to an existing position or to request the creation of a new position.

New Position Request – To be completed by the employing department

1. Complete the following information if requesting setup of a new position:
   a. Department name
   b. Department number
   c. Location code (Building Name)
   d. Supervisor’s name
   e. Supervisor’s position number
   f. Occupancy
   g. Regular/temp status
   h. Full/part time
   i. Academic rank
   j. Term
   k. Standard hours per week (include number of hours worked per day)
   l. Compensation frequency
   m. Business title (Functional Title)
   n. Estimated base salary (exclude fringes)
   o. Explain why and when position is needed
   p. Explain how position will be funded (include fund, dept and position # if applicable)
   q. Brief description on duties and responsibilities for correct job family placement (Grad Assistant and Pooled positions only)

Position Data Change - To be completed by the employing department

2. Complete any of the following fields that need to be changed on existing position:
   a. Department name
   b. Department ID #
   c. Position number
   d. Current incumbent
   e. Change the following and include the From and To information and the effective date
      i. Reg/Temp Status
      ii. Full/Part time Status
      iii. Business (Functional) Title
      iv. Department ID #
      v. Department Name
      vi. Reports To Name
      vii. Reports To Posn #
      viii. Standard Hours
      ix. Occupancy
      x. Academic Rank
      xi. Term
xii. Contract Dates
xiii. Other

f. Other Information relating to the change

Departmental Approvals – For new positions must get Vice Presidential approval

3. Get all required signature and dates
4. Return completed form to Human Resources
### POSITION REQUEST/CHANGE

**New Position Request**

<table>
<thead>
<tr>
<th>DEPARTMENT NAME</th>
<th>DEPARTMENT NUMBER</th>
<th>LOCATION CODE (BUILDING NAME)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>SUPERVISOR'S NAME</th>
<th>SUPERVISOR'S POSITION NUMBER</th>
<th>OCCUPANCY</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>REGULAR/TEMPORARY STATUS</th>
<th>FULL/PART TIME</th>
<th>ACADEMIC RANK</th>
<th>TERM</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>STANDARD HOURS PER WEEK</th>
<th>MON</th>
<th>TUE</th>
<th>WED</th>
<th>THU</th>
<th>FRI</th>
<th>SAT</th>
<th>SUN</th>
</tr>
</thead>
<tbody>
<tr>
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<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>COMPENSATION FREQUENCY</th>
<th>BUSINESS TITLE (Functional Title)</th>
<th>ESTIMATED BASE SALARY [DO NOT INCLUDE FRINGES]</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

**List detailed when and why this position is needed:**

**Provide detail on how this new position will be funded** (Include Fund, Dept. and Position # if applicable)

**Provide brief description of duties and responsibilities for correct job family placement** (For Graduate Assistant and Positional positions only)

### Position Data Change

<table>
<thead>
<tr>
<th>DEPARTMENT NAME</th>
<th>DEPARTMENT ID #</th>
<th>POSITION NUMBER</th>
<th>CURRENT INCUMBENT</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>CHANGE:</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Reg/Temp Status</td>
</tr>
<tr>
<td>B. Full/Part Time Status</td>
</tr>
<tr>
<td>C. Business (Functional) Title</td>
</tr>
<tr>
<td>D. Department ID #</td>
</tr>
<tr>
<td>E. Department Name</td>
</tr>
<tr>
<td>F. Reports To Name</td>
</tr>
<tr>
<td>G. Reports To Rank #</td>
</tr>
<tr>
<td>H. Standard Hours</td>
</tr>
<tr>
<td>I. Occupancy</td>
</tr>
<tr>
<td>J. Academic Rank</td>
</tr>
<tr>
<td>K. Term</td>
</tr>
<tr>
<td>L. Contract Dates</td>
</tr>
<tr>
<td>M. Other</td>
</tr>
</tbody>
</table>

**Additional Information**

### Departmental Approval(s)

**Vice Presidential approval required on New Position Request.**

<table>
<thead>
<tr>
<th>Signature of Department Head</th>
<th>Date</th>
<th>Signature of Dean's Office</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Dept. Contact Name</th>
<th>Phone</th>
<th>Step #</th>
<th><strong>Signature of Vice President or Designated Official</strong></th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

### FOR HR USE ONLY

- [X] Approved
- [ ] Disapproved

<table>
<thead>
<tr>
<th>SALARY PLAN</th>
<th>GRADE</th>
<th>JOB CODE</th>
<th>POSITION NUMBER ASSIGNED</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Effective Date</th>
<th>Signature of Human Resources Approval</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Reduction-in-Force Analysis worksheet

Purpose of the form is to identify positions that must be a Reduction-in-Force and to document the steps taken to identify and carry out the Reduction.

To be completed by department and approved by the Vice President

1. Enter department name and division/unit
2. List all benefited staff positions with the same job code. Include:
   a. Name
   b. Empl ID
   c. Position #
   d. Job Code & Title
   e. Hire Date
3. Attach additional sheets if necessary
4. Answer yes or no to the question about probationary or temporary employees performing similar duties. If yes, explain.
5. Read the NDUS Policy and Additional Policy Sections
6. List the person(s) and position(s) identified to be RIF’d
7. Identify how RIF’d position work duties will be covered. Be specific and include name(s) and department(s) if moving duties to others.
8. Appointing Authority needs to sign and date
9. Vice President needs to sign and date
# Reduction-in-Force Analysis Worksheet

<table>
<thead>
<tr>
<th>Department</th>
<th>1</th>
</tr>
</thead>
</table>

In the space below, all benefited staff positions within the department or workgroup that fall into the same position (example: 3105001) must be listed to determine which positions have been identified for reduction in force.

<table>
<thead>
<tr>
<th>Name</th>
<th>Exp ID</th>
<th>Position #</th>
<th>Job Code &amp; Title</th>
<th>Hire Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(attach additional sheets if necessary)

Are there any probationary or temporary employees performing similar duties in the department?  [ ] Yes  [ ] No

### NDUS Policy 24 Reduction in Force

24.1 When necessary to achieve a reduction in force, institutions may terminate or reduce from full to part-time or hours worked of any staff employee due to an organizational or procedural change, diminished workload, lack of funds, or other exigency. The employee shall be given at least two weeks written notice of the reduction. At the institution's discretion, employees who are terminated may be given two weeks pay in lieu of the two weeks notice.

24.2 Institutions shall not subject regular staff employees (see Section 2.2) to a reduction in force while there are temporary or probationary employees engaged in the same work, serving at the same work unit.

24.3 Institutions shall conduct reductions in force in a non-discriminatory manner (see Section 1.2) and shall not use such actions as a substitute for disciplinary measures.

24.4 Based upon departmental need and work to be performed, the department head shall determine which employees will be subject to reduction in force. In determining which employees shall be affected, the department shall consider the following:

1. An analysis of the acquired knowledge, demonstrated skills, and versatility of its employees compared to the work to be done and the available funding. Employees lacking the necessary skills and versatility should be considered for reduction.

2. An analysis of the level of demonstrated work performance, with having a consistently low level of performance should be considered for reduction.

3. A review of the length of service of its employees. Employees with the fewest years of service should be considered for reduction.

4. An analysis of the extent of required training needed to train a reassigned employee to full productivity in a different position. Employees requiring substantial retraining should be considered for reduction.

5. Any documented understandings concerning the position in place at the beginning of employment.

24.5 The department shall maintain written documentation of the required analysis and review in Section 24.4

### Additional Policy Considerations

24.6 Ranking of employees terminated or reducing hours worked shall be in the reverse order of the reduction in force when a similar job becomes available in their former department within two years of the date of the action.

24.7 Employees not on probation when terminated as a result of a reduction in force shall, for two years following the reductions, be provided the following additional services:

1. To the extent possible, institutions will assist terminated employees in searching for other employment.

2. The Human Resource Council will maintain a list of employees, including their qualifications, who were terminated due to a reduction in force. This list shall be made available to all institutions for employment considerations. Individuals from this list shall be treated as internal applicants by the hiring institution.

3. To assist in retraining efforts, employees terminated due to a reduction in force may continue to utilize the North Dakota University System's employee tuition waiver as outlined in Section 33 of this manual.

List person(s)/position(s) identified to be RIF:

How will work duties of RIF's position(s) be covered (i.e. eliminated, assigned to another employee, moved to another department, etc.)? Be specific and identify names(s) and department(s) if moving duties to others:

146
| I certify that I have considered the written analysis and comparison required as per NDUS Policy 24 in arriving at this Reduction-in-Force decision. |
|---|---|
| Appointing Authority | Date |
| Vice President | Date |
Remote Hire Form

Notary/Authorized Representative I-9 Instruction Sheet

1. The University of North Dakota is requesting you to act as our representative to examine the identification papers for a new employee. Because the U.S. Citizenship and Immigration Services (USCIS) requires us to verify the right of our employees to work in the United States, we are asking you to serve as our representative in this matter by examining the individual’s paperwork and completing certain sections of the attached USCIS Form I-9 for UND.

2. Please find the attached Form I-9 and the Remote Hire Notice Form. Verify that the employee has completed Section 1 of the Form I-9 prior to completing Section 2.

3. The employee must present appropriate documentation of their identity and eligibility to work in the U.S. as given on the “List of Acceptable Documents” on the back of the Form I-9. The employee must present one document from List A, OR, one document from List B and one document from List C. All documents presented MUST be originals – ONLY original Social Security cards with name and Social Security number printed on the front are allowed. Any other information printed on the front of the Social Security card, makes it invalid for I-9 purposes.

4. Please complete Section 2 with the information of each document presented. Be sure that the document information is entered in the column corresponding to the appropriate list of documents on the back of the I-9.

5. We also need you to complete the Certification section of the Form I-9. The employment start date is provided to you on the Remote Hire Request Form. Please complete the Certification section as follows:
   a. Enter the employee’s date of employment (see Remote Hire Request Form)
   b. Sign, print your name and date in the designated fields.
   c. Do NOT complete the Business or Organization Name and Address.
   d. Attach a photocopy of the front and back of all documents the employee has presented to you.

6. If you have any questions or concerns regarding the completion of the Form I-9, please contact the Payroll Office at (701) 777-4890.

7. Return the Remote Hire Request Form and the completed I-9 Form to the new employee.

8. Any applicable fees for this service are the responsibility of the employee.

Prior to the date of employment, the new Employee must fax the Remote Hire Request Form and the completed I-9 form to (701) 777-4721. Mail the originals to:

UND Payroll Office, 264 Centennial Drive Stop 7127, Grand Forks, ND 58202-7127.
REMOTE NOTICE FORM

Information Sheet to be completed by employing department and provided to the Notary with I-9 and Instruction Sheet for the purpose of completing an I-9 remotely when an employee is unable to physically present their documents at an E-Verify site at UND.

Name: Last:_________________________ First:_________________________ Middle:__________

Department Contact:
Name: ______________________________
Department Name:____________________
Title: ________________________________
Phone: ______________________________

Employee’s Date of Employment: ________________ (This date must be entered into the Certification section of the Form I-9 by the Notary, so it must be completed when the employee presents it to the Notary with the instruction sheet.)

Type of New Employee Packet Required: ____Non-Benefited ____NDPERS ____TIAA

This form must be completed and given to the Notary or Authorized Representative before the Form I-9 is completed. This will ensure that the correct employment date is entered on the I-9 form.

Fax the completed Remote Hire Form and completed I-9 form immediately to (701) 777-4721 Attn: Anita. Mail the original Remote Hire Form and I-9 form to the UND Payroll Office, no later than the employee’s date of employment.

Employees Signature __________________________ Date ______________________

Notary/Authorized Representative Signature __________________________ Date ______

Notary/Authorized Representative Address

____________________________________

Notary/Authorized Representative Phone

____________________________________
Retroactive Distribution Request

Purpose of the form is to correct actuals distribution (payroll processing) data when it has been identified as incorrect AFTER it has been posted to PeopleSoft General Ledger. This process modifies the incorrect transactions and posts the changes to General Ledger. The process cannot be used to change any amounts paid to employees, vendors, or taxing authorities – it can only be used to change the combo code(s) of those transactions.

Retroactive Distribution Business Process

Upon determination of an actuals transaction posting to the General Ledger with an incorrect combo code, complete and remit the UND Retroactive Distribution Request form to the Payroll Office. This information must include:

1. **Date of request** and who is requesting the change
2. **Transaction Type**: A drop down menu will appear with the following choices. Please choose the one applicable to the change being made.
   - All (Earnings, Deductions & Taxes) Deductions & Taxes
   - Deductions
   - Earnings
   - Earnings & Taxes
   - Deductions Taxes
3. **Position Number**: Position number affected (000XXXXX)
4. **Pay Period Beginning Date / Pay Period Ending Date**: Enter the pay period beginning and end dates for the original transaction. Generally, this should be the beginning and ending dates of the pay period of the original earnings. For example, to retro distribute a transaction occurring for the pay period of 12-16-06 to 12-31-06 (for the paycheck issued on 01-15-07) the Pay Period Beginning Date would be 12-16-06 and the Pay Period End Date would be 12-31-06. Please remember to complete the form for each incorrect pay period.
5. **Employee ID**: Empl ID number
6. **Employee Name**: Employee’s name as it appears in PeopleSoft
7. **Employee Rcd # from HE Actuaxls**: Choose one from the drop-down menu. The number of employee’s job – usually zero unless the employee holds more than one job concurrently on campus or in the ND HRMS system. Be sure to choose the record number associated with the job for which the correction is being made.
8. **Combo Code**: The combo code information that was incorrect: (Ex. U12345-6789-UND0004444-05432-R)
   - Business Unit – U (for UND1) Fund Code – fund number Dept ID – department number
   - Project – grant and contract information
Program Code – leading 0 and four digits  
Account – Single Letter (previously the TCC); see account below

9. **Account:**
   - 511002 Salary – regular benefited R
   - 511005 Staff Overload S
   - 512005 Salary – Other O
   - 513005 Temp Salaries – Non-benefited T
   - 514005 Overtime V
   - 515005 Salary – Faculty F
   - 515010 Faculty Overload P
   - 517005 Grad Assistants G

**DETAILS OF REDISTRIBUTION (correct funding source):**

10. **Redistribution Combo Code:** The **corrected** combo code string information: (Ex. U12366-5576-UND0004300-05415-T)
    - Business Unit – U (for UND1)
    - Fund Code – fund number
    - Dept ID – department number
    - Project – grant and contract information
    - Program Code – leading 0 and four digits
     Account – Single Letter (previously the TCC); see account below:

11. **Redistribution Account:**
    - 511002 Salary – regular benefited R
    - 511005 Staff Overload S
    - 512005 Salary – Other O
    - 513005 Temp Salaries – Non-benefited T
    - 514005 Overtime V
    - 515005 Salary – Faculty F
    - 515010 Faculty Overload P
    - 517005 Grad Assistants G

12. **Total Redistribution Amount:** The total dollar amount of the transaction being corrected.

13. **Reason for Change:** Please include any additional relevant information.

14. **Along with the form please print out and attach:**
    HE Actuals Report:
    Payroll for North America > Payroll Processing USA > Pay Period Reports > HE Actuals Report

15. **Please remember to complete the** Department contact name and phone number. All appropriate signatures must be obtained on the form prior to submitting to the Payroll Office. If Grant and Contract Funds are involved, the appropriate Grants Officer must sign off on the correction before submitting to the Payroll Office.

**NOTE:**
After the following payroll cycle has been posted, you will be able to re-run your HE Actuals report. Another report that may help you in determining that the payroll is correct is the Gross and Fringe
Report (Payroll for North America>Payroll Distribution>GL Interface Reports>Gross and Fringe). The Corrections made to the General Ledger will be dated the month the retroactive distribution was completed. It will not affect prior month actuals.
# UND RETROACTIVE DISTRIBUTION REQUEST

Submit this form to the Payroll Office to request that payroll distributions previously posted to General Ledger be modified in the HRMS system. The modified distributions will be posted to General Ledger along with the posting of the next on-cycle payroll.

For grant and contract funds: The reason for the change must include the who, what, why, when and where. If the cost transfer is > 90 days, the Cost Transfer and Justification form must be completed in addition to the Redistribuition form.

<table>
<thead>
<tr>
<th>DATE OF REQUEST</th>
<th>REQUESTED BY:</th>
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<tbody>
<tr>
<td>1</td>
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<table>
<thead>
<tr>
<th>DETAILS OF ORIGINAL TRANSACTION</th>
<th>(incorrect combo code used)</th>
</tr>
</thead>
<tbody>
<tr>
<td>TRANSACTION TYPE: Earnings</td>
<td>POSITION #: 2</td>
</tr>
<tr>
<td>EMPLOYEE NAME:</td>
<td>6</td>
</tr>
<tr>
<td>ACCOUNT: 514005</td>
<td>9</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>DETAILS OF REDISTRIBUTION</th>
<th>(Correct combo code to be used)</th>
</tr>
</thead>
<tbody>
<tr>
<td>REDISTRIBUTION COMBO CODE: U</td>
<td>10</td>
</tr>
<tr>
<td>REDISTRIBUTION ACCOUNT:</td>
<td>11</td>
</tr>
</tbody>
</table>

<table>
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<tr>
<th>REASON FOR CHANGE:</th>
</tr>
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<tr>
<td>13</td>
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</tbody>
</table>

Dept. Contact Name: _____________________________ Phone #: ________ Box #: ________

Requestor Signature: __________________________ Date: __________ Reviewing Authority: __________________ Date: __________

Department Signature: __________________________ Date: __________ Reviewing Authority: __________________ Date: __________

PI/Other Authorized Signature (in ink): __________________ Date: __________

Required for grant and contract funds

PLEASE ATTACH HE ACTUAL REPORT 14
Partial Retro Salary Correction

(This is used only on rare occasions)

If only a portion of the transaction is to be transferred to a new combo code, the Retro Partial Salary Correction form must also be included. (Ex: A transaction was applied to a given combo code. One half of this amount now needs to be redirected to a different combo code after the transaction is posted to GL).

When completing the Partial Salary Correction form please follow the following:

1. Employee ID, Employee Name and Employee RCD# must be filled in. A partial retro form needs to be completed for each pay period and for each employee affected. Enter the Begin and End Earnings Date.
2. The original transaction should be listed in the Total Earnings/Ded/Tax line. Amounts from the HE Actualls Report should be recorded under the appropriate account category.
3. The combo code to which dollars are being transferred is listed on the “Dollar amount to be redirected line.
   a. Enter the combo code to which a portion of the original transaction is being transferred.
   b. Enter dollar amounts under the appropriate heading for those accounts where changes need to be made.
   c. If the distribution is being made to more than one additional combo code, contact the Payroll Office (777-4226) for assistance.
4. The amount remaining in the combo code for the original transaction will calculate in the bottom row. Be sure to enter the original transaction combo code in the row labeled “Dollar Difference”.
5. When completed, this form is attached to a completed UND Retroactive Distribution Request form, and both forms are forwarded to the Payroll Office for processing.
This is used for Partial Salary Corrections ONLY

<table>
<thead>
<tr>
<th>Employee ID:</th>
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<tbody>
<tr>
<td>Employee Name:</td>
<td></td>
</tr>
<tr>
<td>Employee RCD#</td>
<td>1</td>
</tr>
<tr>
<td>Earnings Begin Date:</td>
<td></td>
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<tr>
<td>Earnings End Date:</td>
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Earnings Begin Date should always start with the first day of the month or the 16th.

Please watch account - some individuals are on State and some TIAA.

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</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>U4350010</td>
<td>1,028.06</td>
<td>3.27</td>
<td>276.57</td>
<td>0.71</td>
<td>0.14</td>
<td>0.45</td>
<td>114.76</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>65.88</td>
<td>11.41</td>
<td>0.00</td>
<td>1,503.65</td>
</tr>
</tbody>
</table>

Dollar amount to be redirected: U4350010/00/00000113

Example of Combo Code as: U4350010/00/000000000000000F

Dollar Difference: U4350010/00/00000109F

| Dollar Difference | U4350010/00/00000109F | 276.06 | 0.88 | 74.52 | 0.19 | 0.04 | 0.12 | 30.88 | 0.00 | 0.00 | 0.00 | 17.72 | 3.15 | 0.00 | 404.56 |
Transfer Form

Purpose of the form is to allow an active employee to transfer from one position another without having to go through the Manager Self Service system.

Form can be used by a department to transfer an employee from one position to another within that department or another department within the same college.

1. Complete the top portion with correct information:
   - Effective date
   - Last name
   - First name
   - Middle initial
   - EmplID #

2. From section is to be completed by the terming department:
   - Indicate type of employee
   - Department ID number
   - Department name
   - Position number
   - Rec #
   - Job code
   - Pay rate
   - Standard hours
   - Supervisor position #
   - Supervisor name
   - Functional title
   - Additional information
   - Signatures from appropriate levels for the terming department

3. To section to be completed by the hiring department:
   - Indicate the type of employee
   - Department ID number
   - Department name
   - Position number
   - Job code
   - Pay rate
   - Standard hours
   - Supervisor position #
   - Supervisor
   - Functional title
   - Additional information
   - Indicate if background check is needed: Yes if needed, N/A if not, if one is on file choose Yes and indicate the Completed date
• Enter the new campus address the employee will be employed by
• Enter the employee's new work phone number
• Signatures from the appropriate departments
• Route form to HR/Payroll
Twelve Month Payment Request

Purpose of the form is to allow contract employees to request contract payments over 12 months instead of over contract length.

1. Enter name and emplid

2. Employee must meet the qualifications to be able to request 12 month payments.
   1. Must be benefited
   2. Not planning to terminate employment prior to the end of the 12 month period following the contract start date
   3. Base Academic Year Salary less than $162,000.00
   4. This form will be completed and in the Payroll Office no later than 15 days prior to the start of the contract period to which it applies

3. Employee must read the “I Understand that” section and indicate if they are starting participation or if they are discontinuing participation.

   This election renews automatically every year unless a request to discontinue is submitted.

   This form must be received 15 days prior to the start of the contract period for either authorization to start or to discontinue participation.

4. Employee must sign, date, and indicate contract start date.

5. Return the form to the Payroll Office
University of North Dakota
TWELVE MONTH PAYMENT REQUEST

Name (Please Print): ___________________________ Empl ID: ________________________

I certify that I meet the following qualifications:

1. Must be benefited
2. Not planning to terminate employment prior to the end of the 12 month period following the contract start date
3. Base Academic Year Salary less than $70,000.00
4. This form will be completed and in the Payroll Office no later than 15 days prior to the start of the contract period to which it applies

I understand that:

This election will automatically renew each year, unless I submit a request, in writing to the Payroll Office, no later than 15 days prior to the start of the next contract period.

Per IRS regulations, an employee’s election to be paid over twelve months is irrevocable with respect to the remainder of the twelve month period. This means that if you sign up for payment over twelve months, or allow your election to automatically renew, we are not allowed to let you change that payment schedule during the next year.

I hereby authorize UND to pay my salary over 24 pay periods, beginning with the first regular payday for the start of my appointment. Should there be a change in my employment status that affects my pay schedule, I authorize UND to deduct from my paycheck(s) amounts sufficient to ensure full payment of any unpaid voluntary deductions due and owing. I understand that payment over 24 pay periods will automatically renew each year, unless I notify the Payroll Office, in writing, no later than 15 days prior to the start of the new appointment period. I understand that this election is irrevocable with respect to the academic period that I am enrolling and continuing into the future, unless I notify Payroll at least 15 days prior to the start of my next appointment period.

I wish to discontinue my participation Twelve Month Payment program effective with the start of my next Academic Year appointment. This election MUST be in the Payroll Office no later than 15 days prior to the start of your next appointment period.

__________________________  _______________________  ________________________
Signature                    Date                      Contract Start Date

Hand Deliver to: UND Payroll Office, Twamley Hall Room 312
Or Mail to: UND Payroll Office
264 Centennial Drive Stop 7127
Grand Forks, ND 58202-7127