



Welcome to UTMB



New Hire Instructions

Prior to your first day of employment you must visit the Benefits Services Office with a **completed** New Hire Packet. In addition, you will be required to provide supporting documentation for I-9 Employment Eligibility Verification which is required by Department of Homeland Security, U.S. Citizenship and Immigration Services. Benefits Services office hours are **8 a.m. – 5 p.m.**, Monday through Friday located at, **301 University Blvd., Room 2.208 Administration Building.**

Types of Identification:



I-9 Employment Eligibility Verification Form (click to print I-9 Form)

You must provide acceptable documents from List A or from List B and List C **Failure to comply by your 3rd day of employment can result in termination.**



Social Security Card

Requested for verification of name and SSN, and accurate payroll reporting under the Code of Federal Regulations, the U.S. Code, the Department of Labor and the Internal Revenue Service. If you require a Social Security card, visit: www.ssa.gov/ssnumber.



Photo ID

Required by the UTMB Police Dept for identification to create your ID badge



Copy of Resume or CV

Required to assist in the verification of previous employment and longevity

New Hire Packet forms:

All items requiring completion are located within, including the Non-Disclosure and Direct Deposit forms. ***Please click the hyperlink above to print the I-9 Form.***

All new employees are set up with a W-4 Status of Single status with zero allowances, which is the standard set forth by the Internal Revenue Service. As a UTMB employee you may update your information via the Employee Self Service option found on UTMB intranet website (<http://intranet.utmb.edu/iutmb/>), once you have been given your login authorization (utmb-usersm access). Instructions are located at **Completing a W-4.**

International Applicants: You must visit the International Affairs Office **first** at 301 University Blvd., Room 1.120, Rebecca Sealy Building.



Bring all documents pertaining to your Visa



You may visit their website: www.utmb.edu/international/ or call (409) 747-8822

Important Notice: All applicants are required to submit to a Security and Drug screening prior to employment. **Clinic hours for drug testing are from 7:30 a.m. to 3:00 p.m.** Applicants completing their Employment Eligibility Verification in Benefits Services after the clinic hours will be asked to return to complete the drug screening. Forward any questions to Benefits Services Office at (409) 772-2630.

CRIMINAL BACKGROUND CHECK
THE UNIVERSITY OF TEXAS MEDICAL BRANCH AT GALVESTON
THIS FORM TO BE COMPLETED BY THE APPLICANT / EMPLOYEE / VOLUNTEER
UNDER CONSIDERATION FOR HIRE OR PROMOTION
(See IHOP Policy 3.3.2, "Security Clearance for New Employees")

OFFICE OF HUMAN RESOURCES
NOTICE ABOUT INFORMATION LAWS AND PRACTICES

WITH FEW EXCEPTIONS, YOU ARE ENTITLED UPON YOUR REQUEST TO BE INFORMED ABOUT THE INFORMATION THE UNIVERSITY OF TEXAS MEDICAL BRANCH COLLECTS ABOUT YOU. UNDER SECTIONS 552.021 AND 552.023 OF THE *TEXAS GOVERNMENT CODE*, YOU ARE ENTITLED TO HAVE UTMB CORRECT INFORMATION ABOUT YOU THAT IS HELD BY US AND IS INCORRECT, IN ACCORDANCE WITH THE PROCEDURES SET FORTH IN THE UTMB BUSINESS PROCEDURES MEMORANDUM 32. THE INFORMATION THAT UTMB COLLECTS WILL BE RETAINED AND MAINTAINED AS REQUIRED BY TEXAS RECORDS RETENTION LAWS (SECTION 441.180 ET SEQ. OF THE *TEXAS GOVERNMENT CODE*) AND RULES. DIFFERENT TYPES OF INFORMATION ARE KEPT FOR DIFFERENT PERIODS OF TIME. PART OF THIS INFORMATION WILL BE OBTAINED BY ACXION INFORMATION SERVICES, 6111 OAK TREE BOULEVARD, 4TH FLOOR, INDEPENDENCE, OHIO 44131, TELEPHONE (800) 853-3228.

PLEASE PRINT ALL INFORMATION REQUESTED

FALSIFICATION OF ANY INFORMATION ON THIS FORM WILL VOID YOUR APPLICATION FOR EMPLOYMENT AND ANY ACTIONS BASED ON IT. THE INFORMATION ON THE APPLICATION FOR EMPLOYMENT, TOGETHER WITH ANY ATTACHMENTS, IS THE PROPERTY OF THE UNIVERSITY OF TEXAS MEDICAL BRANCH.

NAME: _____
 FIRST NAME **MIDDLE NAME** **LAST NAME** **SSN***

LIST ANY FORMER NAMES USED:

DRIVER'S LICENSE NUMBER AND ISSUING STATE: _____

DATE OF BIRTH: _____ MAIDEN NAME: _____

CURRENT AND PREVIOUS ADDRESSES : _____

RACE: _____ GENDER: _____ HEIGHT: _____ WEIGHT: _____

I HEREBY AUTHORIZE ANY LAW ENFORCEMENT AGENCY TO FURNISH THE UNIVERSITY OF TEXAS MEDICAL BRANCH OR ITS AGENT INFORMATION RELATED TO MY CRIMINAL HISTORY. I HEREBY RELEASE UTMB AND ALL ITS AGENTS AND EMPLOYEES, THE LAW ENFORCEMENT AGENCY AND ALL EMPLOYEES OF LAW ENFORCEMENT AGENCIES FURNISHING INFORMATION, FROM ALL LIABILITY RESULTING FROM THE FURNISHING OF THIS INFORMATION TO UTMB. IN ADDITION, I AUTHORIZE UTMB OR ITS AGENT TO VERIFY INFORMATION RELATED TO EDUCATION. I CERTIFY THAT THE STATEMENTS MADE BY ME ON THIS FORM ARE TRUE, COMPLETE, AND CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF AND ARE MADE IN GOOD FAITH. I UNDERSTAND THAT ANY FALSE STATEMENTS MADE HEREIN WILL VOID MY APPLICATION FOR EMPLOYMENT AND ANY ACTIONS BASED ON IT.

SIGNATURE _____ DATE _____

*DISCLOSURE OF YOUR SOCIAL SECURITY NUMBER (SSN) IS REQUIRED BY UTMB IN ORDER TO PROCESS A CRIMINAL HISTORY BACKGROUND CHECK. NO STATE OR OTHER AUTHORITY REQUIRES THAT YOU DISCLOSE YOUR SSN FOR A CRIMINAL HISTORY BACKGROUND CHECK. FAILURE TO PROVIDE YOUR SSN FOR A CRIMINAL HISTORY BACKGROUND CHECK, HOWEVER, MAY RESULT IN YOUR NOT BEING CONSIDERED FOR HIRE. FURTHER DISCLOSURE OF YOUR SSN IS GOVERNED BY THE PUBLIC INFORMATION ACT (CHAPTER 552 OF THE TEXAS GOVERNMENT CODE) AND OTHER APPLICABLE LAW.
REVISED 5/15/2009

**THE UNIVERSITY OF TEXAS MEDICAL BRANCH GALVESTON,
TEXAS**

Standards and Regulations for University Employment

To: THE UNIVERSITY OF TEXAS MEDICAL BRANCH

*I hereby certify that I have been furnished a copy of the following:
(Copies available on-line or at Benefits Services)*

1. Excerpts from Current Appropriations Bill. "Political Aid and Legislative Influence Prohibited."
2. Standards of Conduct for State Officers and Employees (Excerpts from Acts 1973, 63rd. Legislature, Page 1086, Chapter 421, Effective January 1, 1974.)
3. House Bill 1673, Article 8, Acts 66th. Legislature, 1979, Regular Session, State Purchasing and General Services-Property Accounting.
4. The General Policy statement of the Patent Policy Regulations of the University of Texas System as established in Part II, Chapter 5, and Subsection 2.4 of the Regents' Rules and Regulations.
5. Current Appropriations Bill, Article V, Section 9, statement on "Dual Employment with the state."
6. The University of Texas Medical Branch at Galveston Employee Guide can be accessed from the UTMB home page or at www.utmb.edu/policy/ihop

Employee Signature _____ **Date**

Printed Name _____ **SSN** _____

DRUG FREE WORKPLACE POLICY STATEMENT

The University of Texas Medical Branch at Galveston is required by the Drug-Free Workplace Act of 1988 (41 U.S.C.A. Paragraphs 701-707), to notify all employees that the University prohibits the unlawful manufacture, sale, distribution, possession or use of a controlled substance by any employee in the workplace or in the course and scope of his/her employment. A controlled substance is any substance so defined by federal or state statute or regulations. Exceptions shall apply to the extent that the employee is using such a substance pursuant to a valid prescription of other uses authorized by law.

Any employee who is found guilty (including a plea of no contest) or has a sentence fine or other penalty imposed by a court of competent jurisdiction under criminal statute for an offense involving a controlled substance that occurred in the workplace or in the course and scope of his/her employment shall report such action to the Employee Assistance Program within the Human Resources Department within five (5) days.

An employee who unlawfully manufactures, sells, distributes, possesses or uses a controlled substance in or on premises in the workplace or in the course and scope of his/her employment, regardless of whether such activity results in the imposition of a penalty under a criminal statute, will be subject to appropriate disciplinary action, including termination, or will be required to participate satisfactory in an approved drug assistance or rehabilitation program or both.

Employee Signature _____ Date _____

Printed Name _____ SSN _____

Political Aid, Legislative Influence, and Standards of Conduct
Provisions of the 1998 – 99 Appropriations Act

Employment provisions in Article IX. Sections 5 and 6 of the current *Appropriations Act* require that the following provisions be furnished to each employee. These sections also require that each employee acknowledge receipt of this information.

Sec. 5 Political Aid and legislative Influence Prohibited. None of the moneys appropriated by this Act, regardless of their source or character, shall be used for influencing the outcome of any election, or the passage or defeat of any legislative measure. This prohibition shall not be construed to prevent any official or employee of the state from furnishing to any Member of the Legislature or committee upon request, or to any other state official or employee or to any citizen information in the hands of the employee or official not considered under law to be confidential information. Any action taken against an employee or official for supplying such information shall subject the person initiating the action to immediate dismissal from state employment.

No funds under the control of any state agency or institution, including but not limited to state appropriate funds, may be used directly or indirectly to hire employees or in any other way fund or support candidates for the legislative, executive, or judicial branches of government of the State of Texas or the government of the United States.

None of the funds appropriated by this Act shall be expended in payment of the salary for full-time employment of any state employee who is also the paid lobbyist of any individual, firm, association or of a part-time employee who is required to register as a lobbyist by virtue of the employee's activities for institution for which the person is employed. A part-time employee may serve as a lobbyist on behalf of industry, a profession or association as long as such entity is not related to the agency with which he or she is employed.

Except as authorized by law, none of the funds appropriated by this Act shall be expended in payment of membership dues to an organization on behalf of the agency or an employee of an agency if the organization pays all or part of the salary of a person required to register under Chapter 305, Government code.

No employee of any state agency shall use any state-owned automobile except on official business of the state, and such employees are expressly prohibited from using such automobile in connection with any political campaign or any personal or recreational activity.

None of the moneys appropriated by this Act shall be paid to any official or employee who violated any of the provisions of this section.

Sec. 6 Standards of Conduct for State Employees. None of the funds appropriated by this Act shall be expended to pay the salary of a state employee who:

- 1) accepts or solicits any gift, favor, or service that might reasonably tend to influence the employee in the discharge of official duties or that the employee knows or should know is being offered with the intent to influence the employee's official conduct;
- 2) accepts other employment or engages in a business or professional activity that the employee might reasonably expect would require or induce the employee to dissolve confidential information acquired by reason of the official position;
- 3) accepts other employment or compensation that could reasonably be expected to impair the employee's independence of judgment in the performance of the employee's official duties;
- 4) makes personal investments that could reasonably be expected to create a substantial conflict between the employee's private interest and the public interest; or
- 5) intentionally or knowingly solicits, accepts, or agrees to accept any benefit for having exercised the employee's official powers or performed the employee's official duties in favor of another.

Employee Signature _____ Date _____

Printed Name _____ SSN _____

The University of Texas Medical Branch

**AUTHORIZATION FOR PAYROLL DEDUCTION FOR OUT-OF-POCKET
INSURANCE COSTS**

Name (printed): _____

TO: BENEFITS CENTER

I understand that as a full time employee with the University of Texas Medical Branch my Medical coverage is provided at no cost to me; however, should I drop below 100% (full-time) status, the University will only pay a portion of my insurance.

The remainder of the premiums due, that the University will not pay, will be deducted from my paycheck.

If the status change occurs and I do not wish to keep my insurances, I must notify the Benefits department within 31 days of the status change.

Signature

Date

Teacher Retirement System of Texas/Optional Retirement Program
Confirmation of Prior Participation

Name: _____ SSN: _____ Emp#: _____

1. Have you ever worked in Texas for:

State supported universities, medical and dental schools, junior/community colleges, public schools, regional education service centers, certain charter schools? If yes, where?

If YES, please complete the remainder of the form.

2. Did you contribute to TRS during this period of employment? Yes ____ No ____

If YES, have you withdrawn your funds from TRS? Yes ____ No ____

If NO, are you currently receiving a monthly retirement check from TRS? Yes ____ No ____

3. Have you ever elected the Optional Retirement Plan (ORP) in the state of Texas in lieu of participating in TRS? Yes ____ No ____

If YES, please list places of employment and dates of participation:

Place of Employment	Dates
	to
	to
	to
	to
	to

Signature

Date



EMPLOYEE HEALTH QUESTIONNAIRE

Previous UTMB Employee No Yes Year _____

Date:		UTMB ID#:	
Last Name:		First Name:	MI:
Maiden Name:	Marital Status:	Date of Birth:	
Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Race:	UTMB Mail Route:	
Home Address:			
City:	State:	Zip:	
Home Phone #:	Birthplace:	Job Title:	
Department:	Duty Hours:	Work Telephone #:	
Supervisor:			
The scope of my duties with UTMB does ___/does not ___ include direct contact with human blood, body fluids, and/or tissues.			
The scope of my duties with UTMB does ___/does not ___ include direct interaction (that is, in the same airspace) with patients.			
The scope of my duties with UTMB does ___/does not ___ include direct contact with animals or chemicals (used for research), radiological, isotopes, and/or toxins (research).			
MEDICAL HISTORY:			
List any current medical problems that require treatment or follow up:			
List any current medications you take:			
List any Medication Allergies you have:			
List any Allergies other than to medications:			
List any Medication you cannot take because of side effects or intolerances (exclude allergies):			
List any surgeries/operations/or serious injuries you have had:			
Check (✓) any of the following you currently have, or ever had:			
<input type="checkbox"/> Epilepsy or Convulsions	<input type="checkbox"/> Fainting or Dizzy Spells	<input type="checkbox"/> Impaired Hearing	
<input type="checkbox"/> Abnormal Color Vision	<input type="checkbox"/> Asthma	<input type="checkbox"/> Heart Problem	
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Hernia	
<input type="checkbox"/> Chronic Pain	<input type="checkbox"/> Fainting after Shots	<input type="checkbox"/> Back Pain or Spine Disorder	
<input type="checkbox"/> Back Surgery	<input type="checkbox"/> Bone or Joint Problem	<input type="checkbox"/> Positive TB Skin Test	
<input type="checkbox"/> Tuberculosis Disease	<input type="checkbox"/> Chronic Infection	<input type="checkbox"/> Chicken Pox	
<input type="checkbox"/> Rubella (German Measles)	<input type="checkbox"/> Measles	<input type="checkbox"/> Chronic Skin Problem	
<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Other		
Comments: _____			
<p><i>I acknowledge the above answers and all other information otherwise given by me as true, complete, and not misleading in any way. I understand that any incorrect, incomplete, misleading or false statements furnished by me will result in discharge from UTMB if I am employed. All information will be held strictly confidential.</i></p>			
Signature:		Date:	

LIMITED POWER OF ATTORNEY AND AUTHORIZATION FOR DIRECT DEPOSIT

Fax this form with Attached Voided Check to Payroll Services at 409-747-7904

Please send original to UTMB Finance - Payroll Services, 1902 Harborside Drive - Route 0921, Galveston, TX 77555-0921

Effective Date (Month and Year)	Social Security Number
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Employee or Student Name

Employee Number if applicable	Department Phone Number
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Name of Financial Institution

Type of Account (checking, savings, etc.)

Account Number

Transaction Type: <input type="radio"/> New Direct Deposit set-up <input type="radio"/> Change Account Type <input type="radio"/> Change Account Number <input type="radio"/> Change Financial Institution
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Authorization
I hereby appoint the University of Texas Medical Branch at Galveston (UTMB) as my attorney-in-fact for the purpose of directly depositing my salary and/or student financial aid by electronic transfer and/or other means of direct deposit to the financial institution and in the account designated above to be effective on the date specified. This authorization and request to deposit my salary and/or student financial aid is not an assignment of my right to receive payment of my salary and/or student financial aid from the State of Texas.

I understand that UTMB reserves the right to stop making deposits of my salary and/or student financial aid by electronic transfer and/or other means of direct deposit without advanced notice. I also agree that my authorization to directly deposit my salary or student financial aid may not be withdrawn without at least a 14 day written notice to UTMB.

I hereby authorize UTMB to deduct from the designated account or from my subsequent salary or student financial aid all amounts deposited to the account in error. In the event my designated account is closed or contains an insufficient balance to allow a deduction for amounts deposited in error, then I agree that UTMB may withhold any payments owed to me by UTMB until such amount deposited in error is repaid.

SIGN HERE <small>Payee</small>	Date
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Cancellation
I cancel the authorization to deposit to my account by electronic transfer any payments owing to me by the State of Texas.

SIGN HERE <small>Payee</small>	Date
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FOR OFFICE USE ONLY (Do not write below this line)

--ATTACH A VOIDED OR COPY OF A VOIDED CHECK--

**THE UNIVERSITY OF TEXAS MEDICAL BRANCH AT GALVESTON INFORMATION
RESOURCES SECURITY ACKNOWLEDGMENT AND NONDISCLOSURE AGREEMENT
UTMB EMPLOYEE**

Ensuring the security and integrity of the University of Texas Medical Branch at Galveston's information and information resources is the responsibility of all UTMB faculty, students and staff. The importance of protecting the reliability and accuracy of these information resources cannot be over emphasized. UTMB's academic, business, clinical, and research functions have become increasingly dependent on automation to access, process, store, and transmit information. The success of this university's missions depends on this information. The security and integrity of this information depend on each of us.

UTMB calls on all faculty, students and staff to fulfill the obligation of protecting these valuable information resources.

1. I understand and agree to abide by the following:
 - a. ANY information concerning ANY person, system, or asset of UTMB that is obtained while performing my duties is of value to this university and may be confidential or sensitive, regardless of medium. I will NOT disclose any information to any individual, unless such release of information is directly related to the performance of my responsibilities.
 - b. ALL passwords to information resources including, but not limited to, mainframe applications, network systems, voice mail, copy machines or long distance telephone use that I receive or devise are confidential and are to be used only by me. I will NOT disclose to any unauthorized person any password(s) I am given or devise and I will NOT write such password(s) or post them where they may be viewed by unauthorized persons. Use of a password not issued specifically to me or to a group of which I am a member is expressly prohibited. I am responsible for all transactions performed as a result of access authorized by use of my password.
 - c. I will NOT attempt to circumvent the computer security system by using or attempting to use any transaction, software, files or resources that I am not authorized to use.
 - d. I will NOT alter or in any way change information except in the performance of the duties of my job.
2. I understand and will comply with all policies, standards, and procedures adopted to safeguard information and associated information resources. Further, I acknowledge that I have received, read and understand the security policies outlined above and in the Information Resources Security Manual.
3. I understand that failure to comply with any of the conditions noted herein may result in my being disciplined or terminated from my position. I further understand that the university retains the right to pursue prosecution when misuse of its information and/or information resources is suspected.

Sign agreement and return to: Information Resources Security Officer, Route: 0113

My signature below represents my acknowledgment that I have received, read, and understand the security policies as outlined in the Information Resources Security Manual.

NAME (PRINT):
EMPLOYEE NO:
DATE OF BIRTH:
OFFICE PHONE:
HOME PHONE:
ORGANIZATION:
JOB TITLE:
DATE OF SIGNATURE:
SIGNATURE: