

EM PACKET

Listed below are forms that require either a signature and/or other documentation that has been specified:

Request for Temporary Emergency Appointment

Acknowledgement of Emergency Employment Status

Maryland New Hire Registry Reporting Form

Authority to Release of Information

I-9 Form U.S. Department of Justice Employment Eligibility Verification (**attached copy of acceptable documents as required and listed on back of form**)

W-4 Form Withholding Allowance Certificate

Emergency Form

Health Statement of Ability for Sedentary and Light Duty Work

Employee Disclosure of Criminal History

Combined IRMA Policy Acknowledgement Form

DHMH Policies Acknowledgements

Should you have any questions or need assistance, please feel free to contact your Personnel Officer on 410-767-6403.

REQUEST FOR TEMPORARY EMERGENCY APPOINTMENT

UNIT'S NAME: _____

APPROPRIATION CODE: 32. _____
PROGRAM SUB-PROG FUND

REQUESTED CLASSIFICATION AND CLASSIFICATION CODE: _____

CLASSIFICATION GRADE AND REQUESTED STEP: _____
(If request is for a salary above base, complete attached Form)

FUNCTION TO BE PERFORMED BY POSITION: _____

REASON WHY AN EXISTING PERMANENT POSITION COULD NOT BE USED TO PERFORM THIS FUNCTION: _____

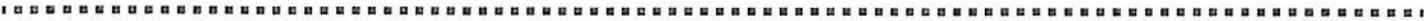
REASON/JUSTIFICATION FOR REQUEST TO HIRE VIA TEMPORARY EMERGENCY EMPLOYMENT: _____

SELECTED APPLICANTS NAME: _____ SS# _____

STARTING DATE (Must Have Prior Approval): _____

ENDING DATE (May Not Exceed 6 Months): _____

FULL TIME _____ PART TIME _____ % OF EMPLOYMENT _____



APPOINTING AUTHORITY/DESIGNEE SIGNATURE

DATE

PRINT NAME

PHONE NUMBER

FISCAL OFFICER'S SIGNATURE
Certification of the availability of source of funding for this reason

DATE

PRINT NAME

PERSONNEL OFFICER'S SIGNATURE

DATE

PRINT NAME

PHONE NUMBER

Attachment – State Application completed to include birthdate, race and sex.

APPLICANT SALARY REQUEST LETTER

NAME: _____

SS#: _____

DATE: _____

POSITION: _____

Complete One (Verification Required):

Current Salary _____/Hour

Previous Salary _____/Hour

Competing Job Offer Amount _____/Hour

The lowest salary I will accept if offered this position

_____.

Base _____/hour

Step 1 _____/hour

Step 2 _____/hour

Step 3 _____/hour

Step 4 _____/hour

Step 5 _____/hour

Step 6 _____/hour

Step 7 _____/hour

Step 8 _____/hour

Applicant's Signature & Date

ACKNOWLEDGEMENT OF EMERGENCY EMPLOYMENT STATUS

You have accepted an emergency appointment with the State of Maryland . Under Title 17, Subtitle 04, the following conditions apply to an employee in a emergency status:

EM Appointment

This kind of appointment is subject to the following conditions:

- A. You are entitled to be paid for hours worked based on the salary for the classification in which you are hired.
- B. You will receive overtime payment and shift differential, where permitted.
- C. You will not be entitled to the usual employee benefits such as paid holidays, leave, retirement, health insurance and salary increments.
- D. Your EM appointment cannot exceed six months.
- E. This appointment will not operate to place you in a favored position for any future hiring purposes. Consideration will be given to the experience you acquired during this emergency appointment in considering your qualifications.

I, the undersigned, certify that I have reviewed the foregoing "Acknowledgement OF Emergency Employment Status". Its contents have been explained to me by a member of the hiring agency's personnel unit and I understand the terms of my emergency employment with the (department) _____ effective _____

Date

Signature



STATE OF MARYLAND

DHMH

Maryland Department of Health and Mental Hygiene

Larry Hogan, Governor - Boyd Rutherford, Lt. Governor - Van Mitchell, Secretary

OFFICE OF HUMAN RESOURCES
AUTHORITY FOR RELEASE OF INFORMATION

As an applicant for a position with the Maryland Department of Health and Mental Hygiene, I have been asked to furnish information for use in reviewing my background and qualifications. In this connection, I hereby authorize the Department to investigate my past work history, character, education, military and police records to ascertain any and all information which may be pertinent to my employment qualifications.

I direct you to release such information upon request of the duly accredited representative of the Maryland Department of Health and Mental Hygiene regardless of any agreement I may have made with you previously to the contrary and regardless of any other legal obligation that you may be subject to regarding the release of such information.

I understand that the information you release is for official use by the Maryland Department of Health and Mental Hygiene, and that the Maryland Department of Health and Mental Hygiene may disclose the information you release as authorized by law.

I release any individual, including records custodians, from all liability for damages that may result to me on account of compliance or any attempts to comply with this authorization. This release is binding, now and in the future, on my heirs, assigns, associates, and personal representative(s) of any nature. Copies of this authorization that show my signature are as valid as the original release signed by me.

NAME:

PRINTED

DATE

SIGNATURE

WITNESS

DATE

NOTE:

Consequences for failing to grant this release or for fraudulent or irregular information may include, but are not limited to, non-selection, decertification, termination of employment in situations where employment has begun, notification to the Secretary, and criminal prosecution.

Toll Free 1-877-4MD-DHMH – TTY/Maryland Relay Service 1-800-735-2258

Web Site: www.dhmh.state.md.us

W-4 Form, visit

http://comptroller.marylandtaxes.com/Government_Services/State_Payroll_Services/State_Employees/Withholding_Form_Information/

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

Form I-9, Employment Eligibility Verification

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

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

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

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

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

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

- A citizen of the United States
- A noncitizen national of the United States (see instructions)
- A lawful permanent resident (Alien #) _____
- An alien authorized to work (Alien # or Admission #) _____ until (expiration date, if applicable - month/day/year)

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

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

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

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

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

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

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

A. New Name (if applicable)	B. Date of Rehire (month/day/year) (if applicable)
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C. If employee's previous grant of work authorization has expired, provide the information below for the document that establishes current employment authorization.

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

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

Read all instructions carefully before completing this form.

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

What Is the Purpose of This Form?

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

When Should Form I-9 Be Used?

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

Filling Out Form I-9

Section 1, Employee

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

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

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

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

Preparer/Translator Certification

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

Section 2, Employer

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

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

Employers must record in Section 2:

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

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

Paperwork Reduction Act

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

DEPARTMENT OF HEALTH & MENTAL HYGIENE

EMERGENCY FORM

SOCIAL SECURITY NUMBER: _____

NAME: _____
Last First Middle

SEX: _____ TELEPHONE NUMBER: _____

ASSIGNMENT WITHIN DHMH: _____
Program Division

IN CASE OF EMERGENCY NOTIFY: _____

RELATIONSHIP: _____

ADDRESS: _____
No. & Street City State Zip

TELEPHONE NUMBER: _____

DHMH 1491

MARYLAND STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE

HEALTH STATEMENT OF ABILITY FOR
SEDENTARY AND LIGHT-DUTY WORK

I have read and/or have had explained to me the responsibilities, functions and work environment of a _____, the job which has been offered to me, and attest that, to the best of my knowledge, I am physically and mentally capable of the safe and effective performance of all job-related functions of this classification.

Signature of Employee

Date

In principle, State employees should be responsible for and required to have and maintain a state of health and fitness that allows them to carry out their required job-related tasks without detriment to the effectiveness of their employing agency or themselves.

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
OFFICE OF HUMAN RESOURCES

EMPLOYEE DISCLOSURE OF CRIMINAL HISTORY

A record of criminal conviction is not an automatic bar to employment. Each case is considered on its own merits. Factors such as job-relatedness, age at the time of conviction, nature of the offense, success of rehabilitation, number of convictions, and recentness of the conviction(s) are taken into consideration to determine whether a criminal record disqualifies a candidate for employment.

Background and criminal record checks to include fingerprinting are routinely completed for all appointments.

Discovery of fraudulent, irregular or inaccurate information will be reported to appropriate State agencies.

Falsification of this form, or any other employment application form, will result in automatic rejection of the employment application, withdrawal of commitment, or immediate dismissal from employment.

HAVE YOU EVER BEEN **CONVICTED**, RECEIVED A **PROBATION BEFORE JUDGMENT**, OR RECEIVED A **NOT CRIMINALLY RESPONSIBLE DISPOSITION** OF ANY CRIMINAL CASE OTHER THAN A MINOR TRAFFIC VIOLATION?

_____ YES (If YES, give complete details on the second page of this form.)

_____ NO

SIGNATURE (FULL NAME)

DATE

PRINT FULL NAME

SUPERVISOR'S SIGNATURE

Form 4503 (4/09)

EMPLOYEE DISCLOSURE OF CRIMINAL HISTORY continued

PLEASE PRINT

1. CRIME CONVICTED OF: _____

DATE OF INCIDENT: _____

DATE CONVICTED: _____

DISPOSITION OF CASE: _____

2. CRIME CONVICTED OF: _____

DATE OF INCIDENT: _____

DATE CONVICTED: _____

DISPOSITION OF CASE: _____

3. CRIME CONVICTED OF: _____

DATE OF INCIDENT: _____

DATE CONVICTED: _____

DISPOSITION OF CASE: _____

4. CRIME CONVICTED OF: _____

DATE OF INCIDENT: _____

DATE CONVICTED: _____

DISPOSITION OF CASE: _____

Applicant's Name: _____ Date: _____
Please Print

Applicant's Signature: _____

COMBINED IRMA POLICY ACKNOWLEDGMENT FORM

This document is a combined policy acknowledgment form for DHMH computer-related policies. Following consultation with your supervisor, please read and initial the appropriate acknowledgment sections, then sign the signature block below.

Acknowledgement Section

Employee Initials	Supervisor Initials °	Policy Number-Statement
		<p>02.01.01 Policy on the Use of DHMH Electronic Information Systems (EIS) I hereby acknowledge awareness of DHMH Policy 02.01.01, and that my use of these systems constitutes my consent to comply with this directive.</p>
		<p>02.01.02-Software Copyright Policy & the State of Maryland Software Code Of Ethics- Unauthorized duplication of copyrighted computer software violates the law and is contrary to the State's standards of conduct. The State disapproves of such copying and recognizes the following principles as a basis for preventing its occurrence.</p> <ol style="list-style-type: none"> 1. The State will not permit the making or using of unauthorized software copies under any circumstances. 2. The State will provide legally acquired software to meet its legitimate software needs in a timely fashion and in sufficient quantities to satisfy those needs. 3. The State will enforce internal controls to prevent the making or using of unauthorized software copies, including measures to verify compliance with these standards and appropriate disciplinary actions for violations of these standards. <p>I understand that making or using unauthorized software will subject me to appropriate disciplinary action. I understand further that making copies of, or using unauthorized software may also subject me to civil and criminal penalties. My signature below indicates that I have read and understand Policy 02.01.02- Software Copyright Policy and the State of Maryland Software Code of Ethics.</p>
		<p>02.01.06-Policy to Assure Confidentiality, Integrity and Availability of DHMH Information (IAP) I acknowledge that I am required to comply with the general applicable sections of this policy as it relates to my current job duties. I further acknowledge that should I breach this policy, I am subject to disciplinary, civil, and criminal consequences.</p> <p>.....</p> <p>02.01.06-IAP--"Specific Personnel" Acknowledgement If I am currently designated, or at any time my job duties require me to be designated as a Custodian, Data Steward, Designated Responsible Party, Database Administrator, and/or Network (System) Administrator, I acknowledge that I am required to comply with the corresponding responsibilities assigned to <i>specific personnel</i>. Likewise, if I am currently required, or if at any time my duties include the requirement for preparation or monitoring of contracts or memoranda of understanding, I acknowledge that I am required to comply with the <i>specific personnel</i> provisions of the IAP and guidance.</p>

Employee/User Signature Block

I hereby acknowledge that I have reviewed and understand the above-initialed policies.

Employee/User Signature: _____ DATE: _____

Employee/User Identification (Please Print)

NAME: _____ PIN # or CONTRACT#: _____

AGENCY/COUNTY: _____ ADMINISTRATION/UNIT: _____ LOCATION: _____

Supervisor's Verification

Supervisor Signature: _____ DATE: _____

°Supervisor verifies that the employee/user has acknowledged and initialed the appropriate policies for his/her position.

Maryland State Department of Health and Mental Hygiene

Section 1 – DHMH Policy on Sexual Harassment

I hereby acknowledge receipt of the DHMH Policy on Sexual Harassment.

Section 2 – Executive Order 01.01.01991.16 - Substance Abuse Policy

I hereby acknowledge receipt of the Substance Abuse Policy and the policy overview sheet.

Section 3 - DHMH Policy 02.09.01-Policy on Employee's Timely Reporting of Unexpected Absences – AWOL Policy

I hereby acknowledge receipt of the AWOL Policy.

Section 4 – General Rules for Drivers of State Vehicles

I hereby acknowledge receipt of the General Rules for Drivers of State Vehicles and I am aware that a violation of these rules would be just cause for disciplinary action under the State Merit System Law.

Section 5 – State Ethics Commission

I hereby acknowledge receipt of the Public Ethics Law, and I agree to abide by the provisions summarized within the law. I understand that this is a general summary only and should not be relied upon as a substitute for the Law itself. Additional information on each provision is available on the State Ethics Commission's web site, <http://ethics.gov.state.md.us>

Section 6 – Policy on Equal Employment Opportunity (EEO)

I hereby acknowledge receipt of the Equal Employment Opportunity Policy.

I understand that my signature indicates that I have received a copy of each of the policies listed above.

Employee Print Name: _____ **SS#:** _____

Employee Signature: _____ **Date:** _____

For future reference, this page will be maintained in the employee's personnel file.

c: personnel file