ACADEMIC NEW HIRE CHECKLIST

Please note: The SJSU Research Foundation is an E-Verify employer.

Your signature below confirms that you have been given a Human Resources/Payroll packet, which consists of the following information:

All of the above forms must be completed and returned to SJSURF Human Resources

1. I-9 Form—employment Eligibility Verification. Go to http://www.newi9.com/ to access the electronic I-9 Form and complete the section 1 (use Employer Code-14365). You must present “acceptable” documents within 3 days of your hire date to Human Resources or the assigned Location Specialist.
2. Appointment Form
3. CA Notice to Employee—only needs to be completed for non-exempt (hourly) employee, signed copy must be provided to employee.
4. Voluntary Self-Identification of Disability
5. Confidential Data Sheet
7. W-4 Form—employee’s Tax Withholding Allowance Certificate.
8. Direct Deposit Form (optional)
9. Executive Order Acknowledgement

Human Resources/Payroll packet includes the following documents:

- Payroll Calendar
- Academic Calendar
- Holiday Schedule
- Instructions for filling out your Timesheet
- Alcohol & Drug Abuse Policy Summary
- Injury & Illness Prevention Program Summary
- Harassment and Discrimination Policy Summary
- Workers’ Compensation Brochure and Pre-designation Form
- Executive Order 1083 Memo
- Acknowledgement of Mandated Reporter Status and Legal Duty to Report Child Abuse and Neglect
- Health Insurance Marketplace Coverage Options and Your Health Coverage
- Use of SJSU Gmail Address for Research Foundation Communications Memo

Acknowledgment of Receipt Form

I understand it is my responsibility to review and become familiar with the information provided, and to adhere to all rules and policies as a condition of my continued employment.

The policies are subject to change at any time, and as changes occur, information will be made available to employees through the usual channels of communication, including the Research Foundation website: http://www.sjsufoundation.org/

________________________________________  _______________________
Signature                                                Date

Print Name: ____________________________________________
Federal law requires Human Resources to attest, under penalty of perjury, that each new hire's (1) identity and (2) legal authority to work has been examined and verified. New employees must report within 3 business days of hire to the Foundation Human Resources with the appropriate documentation.

<table>
<thead>
<tr>
<th>Check</th>
<th>New Hire</th>
<th>New Account or Acct Change</th>
<th>Reappointment</th>
<th>Rehire</th>
<th>Change of Position</th>
<th>One Time Pay</th>
<th>Separation*</th>
<th>Other</th>
</tr>
</thead>
</table>

**NAME:**
Last
First
M.I.

Social Security No.

Street Address:

City: __________________ State & Zip: ____________

Email: __________________

Home Phone: ( )

U.S. Citizen: Yes □ No □ Type of Visa: __________________

 Permanent Address (if different from above)

Supervisor:

Work Location:

Work Phone: __________________

Have you previously worked for the Foundation?
□ Yes □ No If yes, when?

Do you have any relatives working for the Foundation?
□ Yes □ No If yes, whom?

**ANTICIPATED APPOINTMENT PERIOD**

<table>
<thead>
<tr>
<th>AY/SEM</th>
<th>Intersession</th>
<th>Summer</th>
<th>Other</th>
</tr>
</thead>
</table>

Start: ____________
End: ____________

(Maximum one year or termination of funding, if earlier)

□ Hourly Rate: $

%Time of Regular Hours: _____ %Time of Overload Hours: _____

Job/Working Title:

Pay Classification:

Account No.:

Program / Project Title:

For Information concerning working conditions/benefits, refer to the FDN Employee Handbook or call FDN Human Resources.

Employee Signature ______ Date ______

Faculty Affairs Signature ______ Date ______

Continuing Ed. Signature ______ Date ______

Foundation HR Signature ______ Date ______

**FOUNDATION EMPLOYEES ARE NOT STATE EMPLOYEES.**

Foundation employees who work on projects or programs funded by grants, contracts, gifts or fees are considered temporary employees under the meaning of Section 89900(c) of the California State Education Code.

**RECOMMENDATIONS**

The recruitment and appointment of this person is in conformity with affirmative action policy and/or this appointment conforms to Chancellor's Office policy on overload as specified in FSA79-30.

**PROJECT DIRECTOR/PROGRAM HEAD**

Signature ____________ Date ____________

**DEPT. CHAIR**

Signature ____________ Date ____________

**SCHOOL DEAN**

Signature ____________ Date ____________

**EMPLOYMENT ALLOCATION**

(Must be completed by the Department)

1. SJSU ____________ %

2. CONTINUING EDUCATION ______ %

3. SJSU FOUNDATION ______ %
   a. Straight Time
   (Fdn. Employee) ______ %
   b. Reimbursed Time
   (Univ. Employee) ______ %
   c. Overload (25% max.) ______ % ______ hrs

4. TOTAL ALLOCATION OF TIME ______ %

Reason for separation:

__________________________________________

__________________________________________

Date separation is effective: ______

Last date worked: ______
**NOTICE TO EMPLOYEE**
*Labor Code section 2810.5*

<table>
<thead>
<tr>
<th>EMPLOYEE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee Name: ____________________________</td>
</tr>
<tr>
<td>Start Date: ________________________________</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>EMPLOYER</th>
</tr>
</thead>
<tbody>
<tr>
<td>Legal Name of Hiring Employer: <strong>San Jose State University Research Foundation</strong></td>
</tr>
<tr>
<td>Is hiring employer a staffing agency/business (e.g., Temporary Services Agency; Employee Leasing Company; or Professional Employer Organization [PEO])? □ Yes □ No</td>
</tr>
<tr>
<td>Other Names Hiring Employer is &quot;doing business as&quot; (if applicable):</td>
</tr>
<tr>
<td>Physical Address of Hiring Employer’s Main Office: 210 N. Fourth St, 4th Floor, San Jose, CA 95112</td>
</tr>
<tr>
<td>Hiring Employer’s Mailing Address (if different than above):</td>
</tr>
<tr>
<td>Hiring Employer’s Telephone Number: 408-924-1400</td>
</tr>
<tr>
<td>If the hiring employer is a staffing agency/business (above box checked &quot;Yes&quot;), the following is the other entity for whom this employee will perform work:</td>
</tr>
<tr>
<td>Name: ____________________________</td>
</tr>
<tr>
<td>Physical Address of Main Office: ____________________________</td>
</tr>
<tr>
<td>Mailing Address: ____________________________</td>
</tr>
<tr>
<td>Telephone Number: ____________________________</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>WAGE INFORMATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rate(s) of Pay: ____________________________ Overtime Rate(s) of Pay: ____________________________</td>
</tr>
<tr>
<td>Rate by (check box): □ Hour □ Shift □ Day □ Week □ Salary □ Piece rate □ Commission □ Other (provide specifics): ____________________________</td>
</tr>
<tr>
<td>Does a written agreement exist providing the rate(s) of pay? (check box) □ Yes □ No</td>
</tr>
<tr>
<td>If yes, are all rate(s) of pay and bases thereof contained in that written agreement? □ Yes □ No</td>
</tr>
<tr>
<td>Allowances, if any, claimed as part of minimum wage (including meal or lodging allowances):</td>
</tr>
<tr>
<td>(If the employee has signed the acknowledgment of receipt below, it does not constitute a &quot;voluntary written agreement&quot; as required under the law between the employer and employee in order to credit any meals or lodging against the minimum wage. Any such voluntary written agreement must be evidenced by a separate document.)</td>
</tr>
<tr>
<td>Regular Payday: 10th and 26th of the month, see Payroll Calendar</td>
</tr>
</tbody>
</table>
WORKER’S COMPENSATION

<table>
<thead>
<tr>
<th>Insurance Carrier’s Name:</th>
<th>CSURMA/AORMA administered by Sedgwick CMS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address:</td>
<td>P.O. BOX 14479, Lexington, Kentucky 40512-4479</td>
</tr>
<tr>
<td>Telephone Number:</td>
<td>916-851-8058</td>
</tr>
<tr>
<td>Policy No.:</td>
<td>CSURMA/AORMA</td>
</tr>
</tbody>
</table>

□ Self-Insured (Labor Code 3700) and Certificate Number for Consent to Self-Insure: _______________

PAID SICK LEAVE

Unless exempt, the employee identified on this notice is entitled to minimum requirements for paid sick leave under state law which provides that an employee:

a. May accrue paid sick leave and may request and use up to 3 days or 24 hours of accrued paid sick leave per year;

b. May not be terminated or retaliated against for using or requesting the use of accrued paid sick leave; and

c. Has the right to file a complaint against an employer who retaliates or discriminates against an employee for
   1. requesting or using accrued sick days;
   2. attempting to exercise the right to use accrued paid sick days;
   3. filing a complaint or alleging a violation of Article 1.5 section 245 et seq. of the California Labor Code;
   4. cooperating in an investigation or prosecution of an alleged violation of this Article or opposing any policy
      or practice or act that is prohibited by Article 1.5 section 245 et seq. of the California Labor Code.

The following applies to the employee identified on this notice: (Check one box)

□ 1. Accrues paid sick leave only pursuant to the minimum requirements stated in Labor Code §245 et seq. with no
    other employer policy providing additional or different terms for accrual and use of paid sick leave.

✘ 2. Accrues paid sick leave pursuant to the employer’s policy which satisfies or exceeds the accrual, carryover, and
    use requirements of Labor Code §246.

□ 3. Employer provides no less than 24 hours (or 3 days) of paid sick leave at the beginning of each 12-month period.

□ 4. The employee is exempt from paid sick leave protection by Labor Code §245.5. (State exemption and specific
    subsection for exemption): ___________________________________________________________________

ACKNOWLEDGEMENT OF RECEIPT

(Optional)

(PRINT NAME of Employer representative) __________________________ (PRINT NAME of Employee) __________________________

(SIGNATURE of Employer Representative) __________________________ (SIGNATURE of Employee) __________________________

(Date) __________________________ (Date) __________________________

The employee’s signature on this notice merely constitutes acknowledgement of receipt.

Labor Code section 2810.5(b) requires that the employer notify you in writing of any changes to the information set forth in this Notice within seven calendar days after the time of the changes, unless one of the following applies: (a) All changes are reflected on a timely wage statement furnished in accordance with Labor Code section 226; (b) Notice of all changes is provided in another writing required by law within seven days of the changes.
Why are you being asked to complete this form?

Because we do business with the government, we must reach out to, hire, and provide equal opportunity to qualified people with disabilities. To help us measure how well we are doing, we are asking you to tell us if you have a disability or if you ever had a disability. Completing this form is voluntary, but we hope that you will choose to fill it out. If you are applying for a job, any answer you give will be kept private and will not be used against you in any way.

If you already work for us, your answer will not be used against you in any way. Because a person may become disabled at any time, we are required to ask all of our employees to update their information every five years. You may voluntarily self-identify as having a disability on this form without fear of any punishment because you did not identify as having a disability earlier.

How do I know if I have a disability?

You are considered to have a disability if you have a physical or mental impairment or medical condition that substantially limits a major life activity, or if you have a history or record of such an impairment or medical condition.

Disabilities include, but are not limited to:

- Blindness
- Deafness
- Cancer
- Diabetes
- Epilepsy
- Autism
- Cerebral palsy
- HIV/AIDS
- Schizophrenia
- Muscular dystrophy
- Bipolar disorder
- Major depression
- Multiple sclerosis (MS)
- Missing limbs or partially missing limbs
- Post-traumatic stress disorder (PTSD)
- Obsessive compulsive disorder
- Impairments requiring the use of a wheelchair
- Intellectual disability (previously called mental retardation)

Please check one of the boxes below:

- ☐ YES, I HAVE A DISABILITY (or previously had a disability)
- ☐ NO, I DON’T HAVE A DISABILITY
- ☐ I DON’T WISH TO ANSWER

__________________________                      __________________
Your Name                      Today’s Date
Federal law requires employers to provide reasonable accommodation to qualified individuals with disabilities. Please tell us if you require a reasonable accommodation to apply for a job or to perform your job. Examples of reasonable accommodation include making a change to the application process or work procedures, providing documents in an alternate format, using a sign language interpreter, or using specialized equipment.

1 Section 503 of the Rehabilitation Act of 1973, as amended. For more information about this form or the equal employment obligations of Federal contractors, visit the U.S. Department of Labor’s Office of Federal Contract Compliance Programs (OFCCP) website at www.dol.gov/ofccp.

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

In order for the San Jose State University Foundation to comply with Affirmative Action and Equal Employment Opportunity laws and regulations, we are required to solicit gender and ethnic identification and other information of all our employees. All information provided will be maintained in a confidential Foundation Human Resources file and will not be disclosed to other persons, agencies or organizations except with your written consent or as otherwise authorized by law.

<table>
<thead>
<tr>
<th>PERSONAL DATA</th>
<th>JOB/WORKING TITLE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social Security Number</td>
<td></td>
</tr>
<tr>
<td>Last Name</td>
<td>First Name</td>
</tr>
<tr>
<td>Street Address</td>
<td>County</td>
</tr>
<tr>
<td>City</td>
<td>State</td>
</tr>
<tr>
<td>Home Phone No. ( )</td>
<td>Department</td>
</tr>
<tr>
<td>Work Phone No. ( )</td>
<td>E-Mail</td>
</tr>
<tr>
<td>Gender</td>
<td>Date of Birth</td>
</tr>
<tr>
<td>Disabled: Yes No Will special accommodations be required? Yes No</td>
<td></td>
</tr>
<tr>
<td>Please explain:</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>MILITARY STATUS (Please check one)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not Applicable Vietnam Era Veteran Disabled Veteran Disabled Vietnam Veteran</td>
</tr>
<tr>
<td>Other (Specify) Service Date/s:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>EMERGENCY INFORMATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contact Name</td>
</tr>
<tr>
<td>Address</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>City</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>CHECK DESIGNEE (In case of death or incapacitation)</th>
<th>SS #</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name</td>
<td>Relationship</td>
</tr>
<tr>
<td>Address</td>
<td>Phone No. 1 ( )</td>
</tr>
<tr>
<td></td>
<td>Phone No. 2 ( )</td>
</tr>
<tr>
<td>City</td>
<td>State</td>
</tr>
</tbody>
</table>

Name of Employee’s Supervisor Dept. 
Employee’s Signature Date

FHR4: 2/00 White/Human Resources Yellow/Employee
Statement of Confidentiality and Non-Disclosure of Records

Information contained in or pertaining to the business operations of the San Jose State University Research Foundation must be maintained in a confidential manner at all times.

As an employee who has or may be granted access to records in computer information systems, including Human Resources, Payroll, Finance, IT or any other source data, you are required to maintain this information in a confidential manner. Unauthorized access to, modification, deletion or disclosure of information, either internally among employees or departments or externally to outside parties, may compromise the integrity of the Research Foundation’s business operations, violate individual rights of privacy, and/or constitute a criminal act.

The Research Foundation’s computer information systems, which include third party vendor payroll systems, are to be accessed by authorized users only. Reproduction or distribution of any record, document, or information outside of its intended and approved use either verbally, electronically or by hard copy is strictly prohibited and will result in disciplinary action, up to and including termination of employment.

Further, illegal access and/or misuse of this information may be punishable by fine and/or imprisonment in accordance with applicable local, state and federal laws.

I acknowledge that I have received this information, and agree to adhere accordingly.

__________________________
Print Employee Name

__________________________
Employee Signature

__________________________
Date

__________________________
Primary Department Assignment

__________________________
Temporary Department Assignment
Form W-4 (2015)

Purpose. Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay. Consider completing a new Form W-4 each year and when your personal or financial situation changes.

Exemption from withholding. If you are exempt, complete only lines 1, 2, 3, 4, and 7 and sign the form to validate it. Your exemption for 2015 expires February 16, 2016. See Pub. 505, Tax Withholding and Estimated Tax.

Note. If another person can claim you as a dependent on his or her tax return, you cannot claim exemption from withholding if your income exceeds $1,050 and includes more than $350 of unearned income (for example, interest and dividends).

Exceptions. An employee may be able to claim exemption from withholding even if the employee is a dependent, if the employee:
  • Is age 65 or older,
  • Is blind, or
  • Will claim adjustments to income; tax credits; or itemized deductions, on his or her tax return.

The exceptions do not apply to supplemental wages greater than $1,000,000.

Basic instructions. If you are not exempt, complete the Personal Allowances Worksheet below. The worksheets on page 2 further adjust your withholding allowances based on itemized deductions, certain credits, adjustments to income, or two-earners/multiple jobs situations.

Complete all worksheets that apply. However, you may claim fewer (or zero) allowances. For regular wages, withholding must be based on allowances you claimed and may not be a flat amount or percentage of wages.

Head of household. Generally, you can claim head of household filing status on your tax return only if you are unmarried and pay more than 50% of the costs of keeping up a home for yourself and your dependents or other qualifying individuals. See Pub. 501, Exemptions, Standard Deduction, and Filing Information, for information.

Tax credits. You can take projected tax credits into account in figuring your allowable number of withholding allowances. Credits for child or dependent care expenses and the child tax credit may be claimed using the Personal Allowances Worksheet below. See Pub. 505 for information on converting your other credits into withholding allowances.

Nonwage income. If you have a large amount of nonwage income, such as interest or dividends, consider making estimated tax payments using Form 1040-ES, Estimated Tax for Individuals. Otherwise, you may owe additional tax. If you have pension or annuity income, see Pub. 505 to find out if you should adjust your withholding on Form W-4 or W-4P.

Two earners or multiple jobs. If you have a working spouse or more than one job, figure the total number of allowances you are entitled to claim on all jobs using worksheets from only one Form W-4. Your withholding usually will be most accurate when all allowances are claimed on the Form W-4 for the highest paying job and zero allowances are claimed on the others. See Pub. 505 for details.

Nonresident alien. If you are a nonresident alien, see Notice 1309, Supplemental Form W-4 Instructions for Nonresident Aliens, before completing this form.

Check your withholding. After your Form W-4 takes effect, use Pub. 505 to see how the amount you are having withheld compares to your projected total tax for 2015. See Pub. 505, especially if your earnings exceed $130,000 (Single) or $180,000 (Married).

Future developments. Information about any future developments affecting Form W-4 (such as legislation enacted after we release it) will be posted at www.irs.gov/w4.

Personal Allowances Worksheet (Keep for your records.)

| A | Enter “1” for yourself if no one else can claim you as a dependent .................................................. A |
| B | Enter “1” if: • You are single and have only one job; or • You are married, have only one job, and your spouse does not work; or • You wages from a second job or your spouse’s wages (or the total of both) are $1,500 or less. B |
| C | Enter “1” for your spouse. But, you may choose to enter “0” if you are married and have either a working spouse or more than one job. (Entering “-0-” may help you avoid having too little tax withheld). C |
| D | Enter number of dependents (other than your spouse or yourself) you will claim on your tax return. D |
| E | Enter “1” if you will file as head of household on your tax return (see conditions under Head of household above). E |
| F | Enter “1” if you have at least $2,000 of child or dependent care expenses for which you plan to claim a credit (Note. Do not include child support payments. See Pub. 503, Child and Dependent Care Expenses, for details.) F |
| G | Child Tax Credit (including additional child tax credit). See Pub. 972, Child Tax Credit, for more information. • If your total income will be less than $65,000 ($100,000 if married), enter “2” for each eligible child; then less “1” if you have two or four eligible children or less “2” if you have five or more eligible children. • If your total income will be between $65,000 and $84,000 ($100,000 and $119,000 if married), enter “1” for each eligible child. G |
| H | Add lines A through G and enter total here. (Note. This may be different from the number of exemptions you claim on your tax return.) H |

For accuracy, complete all worksheets that apply.

W-4
Employee’s Withholding Allowance Certificate

Whether you are entitled to claim a certain number of allowances or exemption from withholding is subject to review by the IRS. Your employer may be required to send a copy of this form to the IRS.

<table>
<thead>
<tr>
<th>1</th>
<th>Your first name and middle initial</th>
<th>2</th>
<th>Your social security number</th>
</tr>
</thead>
</table>
| 3 | Single | Married | Married, but withhold at higher Single rate.
| Note. If married, but legally separated, or spouse is a nonresident alien, check the “Single” box. |

| 4 | If your last name differs from that shown on your social security card, check here. You must call 1-800-772-1213 for a replacement card. |

| 5 | Total number of allowances you are claiming (from line H above or from the applicable worksheet on page 2) |
| 6 | Additional amount, if any, you want withheld from each paycheck |
| 7 | I claim exemption from withholding for 2015, and I certify that I meet both of the following conditions for exemption. • Last year I had a right to a refund of all federal income tax withheld because I had no tax liability, and • This year I expect a refund of all federal income tax withheld because I expect to have no tax liability. If you meet both conditions, write “Exempt” here. |

Under penalties of perjury, I declare that I have examined this certificate and, to the best of my knowledge and belief, it is true, correct, and complete.

Employee’s signature (This form is not valid unless you sign it.) |

Date |

| 8 | Employer’s name and address (Employer: Complete lines 8 and 10 only if sending to the IRS.) |
| 9 | Office code (optional) |
| 10 | Employer identification number (EIN) |


For Privacy Act and Paperwork Reduction Act Notice, see page 2.

Cat. No. 10220Q Form W-4 (2015)
## Direct Deposit Authorization

<table>
<thead>
<tr>
<th>Date</th>
<th>Employee Name</th>
<th>Social Security #</th>
<th>Home Address</th>
<th>Home Phone</th>
<th>#1 Bank Name</th>
<th>Bank Phone</th>
<th>Checking</th>
<th>Yes / no</th>
<th>Savings</th>
<th>Yes / no</th>
<th>Transit Routing #</th>
<th>Account #</th>
<th>Full Deposit</th>
<th>Or Partial Deposit</th>
<th>$</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>#2 Bank Name</th>
<th>Bank Phone</th>
<th>Checking</th>
<th>Yes / no</th>
<th>Savings</th>
<th>Yes / no</th>
<th>Transit Routing #</th>
<th>Account #</th>
<th>Full Deposit</th>
<th>Or Partial Deposit</th>
<th>$</th>
</tr>
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<tbody>
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</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>#3 Bank Name</th>
<th>Bank Phone</th>
<th>Checking</th>
<th>Yes / no</th>
<th>Savings</th>
<th>Yes / no</th>
<th>Transit Routing #</th>
<th>Account #</th>
<th>Full Deposit</th>
<th>Or Partial Deposit</th>
<th>$</th>
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</tr>
</tbody>
</table>

I authorize San Jose State University Foundation to direct deposit my check to the above referenced back account/accounts.

__________________________________ ____________
SIGNATURE      date

NOTE: Please attach a voided check for each account (DEPOSIT SLIP IS NOT ACCEPTABLE).
INSTRUCTIONS FOR COMPLETING YOUR Electronic I-9 and E-Verify

U.S. law requires that employers must complete Form I-9 to document verification of the identity and employment authorization of each new employee hired after November 6, 1986, to work in the United States.

E-Verify is an Internet-based system administered by the U.S. Department of Homeland Security, USCIS, Verification Division, in partnership with the Social Security Administration. It compares information from an employee’s Form I-9, Employment Eligibility Verification, to data from U.S. Department of Homeland Security and Social Security Administration records to confirm employment eligibility.

Effective June 1, 2011, the San Jose State University Research Foundation is a designated E-Verify employer. In undertaking and administering this federal compliance initiative, the Research Foundation has partnered with Equifax. Equifax’s I-9 management service is fully compliant with government regulations and integrates seamlessly with the government’s E-Verify portal and program.

As a new hire to the Research Foundation, you must complete and sign (electronically) Section 1 of Form I-9 no later than the first day of employment. Please go to www.newi9.com to complete the employee section. The employer code is 14365. The location for on campus employees is Central office, NASA employees is NASA and MLML has three locations. If you do not know your location you can choose ‘default’.

Once you complete Section 1 in the I-9 portal, a complete list of acceptable documents will be accessible for your review. You must provide those original documents to your designated site specialist or to Human Resources for verification within three days of your employment.

If you have any questions or concerns, please feel free to call Research Foundation Human Resources at (408) 924–1460.
ACKNOWLEDGEMENT OF RESPONSIBILITY
I have read the above statement and will comply with the applicable reporting requirements. Please sign and return this page to the Research Foundation HR.

Employee’s Name: ________________________________ Dept: __________________

Signature: __________________________________________ Date: ______________

My signature above is also an acknowledgement of receipt of a link to the Executive Order 1083 which includes the following attachments:

Attachment A [THIS ACKNOWLEDGEMENT]
Attachment B [Certificate of Training Completion]
Attachment C [Copy of Penal code §§ 11165.7, 11166, and 11167]
Attachment D [Form SS 8572, Suspected Child Abuse Report Form]

NOTE: The original signed version of this Acknowledgement (Attachment A) as well as Attachment B should be retained in the Employee’s Official Personnel File. The employee should keep a copy for their own records.