

Office of Human Resources

GRADUATE ASSISTANT PACKET

The following must be completed before you may begin working:

- Complete a background check issued by Human Resources
- Attend the GA Orientation session
- Completed attached Payroll Forms
- Stop in the Office of Human Resources located in 100 St Thomas Hall to return all completed Payroll forms and to complete a Form I9 which must be done in person. You will need to bring original, unexpired documents that prove your identity and employment eligibility. The Department of Homeland Security has provided a list <https://www.uscis.gov/i-9-central/form-i-9-resources/handbook-for-employers-m-274/120-acceptable-documents-for-verifying-employment-authorization-and-identity> to assist with meeting this requirement. **Please bring with you either one document from List A or one from List B AND one from List C.** Scans and pictures of these documents are not acceptable.

You will not be able to start employment until all above steps are completed.

Employee's Withholding Certificate

Department of the Treasury
Internal Revenue Service

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

2023

Step 1: Enter Personal Information	(a) First name and middle initial	Last name	(b) Social security number
	Address		Does your name match the name on your social security card? If not, to ensure you get credit for your earnings, contact SSA at 800-772-1213 or go to www.ssa.gov .
	City or town, state, and ZIP code		
	(c) <input type="checkbox"/> Single or Married filing separately <input type="checkbox"/> Married filing jointly or Qualifying surviving spouse <input type="checkbox"/> Head of household (Check only if you're unmarried and pay more than half the costs of keeping up a home for yourself and a qualifying individual.)		

Complete Steps 2-4 ONLY if they apply to you; otherwise, skip to Step 5. See page 2 for more information on each step, who can claim exemption from withholding, other details, and privacy.

Step 2: Multiple Jobs or Spouse Works

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

Do **only one** of the following.

(a) Reserved for future use.

(b) Use the Multiple Jobs Worksheet on page 3 and enter the result in Step 4(c) below; **or**

(c) If there are only two jobs total, you may check this box. Do the same on Form W-4 for the other job. This option is generally more accurate than (b) if pay at the lower paying job is more than half of the pay at the higher paying job. Otherwise, (b) is more accurate

TIP: If you have self-employment income, see page 2.

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

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

Step 5: Sign Here	Under penalties of perjury, I declare that this certificate, to the best of my knowledge and belief, is true, correct, and complete.		
	Employee's signature (This form is not valid unless you sign it.)		Date
Employers Only	Employer's name and address	First date of employment	Employer identification number (EIN)



RESIDENCY CERTIFICATION FORM

Local Earned Income Tax Withholding

TO EMPLOYERS/TAXPAYERS:

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

EMPLOYEE INFORMATION – RESIDENCE LOCATION							
NAME (Last Name, First Name, Middle Initial)		SOCIAL SECURITY NUMBER					
STREET ADDRESS (No PO Box, RD or RR)		<table border="1" style="width: 100%; height: 20px; border-collapse: collapse;"> <tr> <td style="width: 25px; height: 20px;"></td> <td style="width: 25px; height: 20px;"></td> <td style="width: 25px; height: 20px;"></td> <td style="width: 25px; height: 20px;"></td> </tr> </table>					
ADDRESS LINE 2							
CITY	STATE	ZIP CODE	DAYTIME PHONE NUMBER				
MUNICIPALITY (City, Borough or Township)							
COUNTY	RESIDENT PSD CODE	TOTAL RESIDENT EIT RATE					
	<table border="1" style="width: 100%; height: 20px; border-collapse: collapse;"> <tr> <td style="width: 25px; height: 20px;"></td> <td style="width: 25px; height: 20px;"></td> <td style="width: 25px; height: 20px;"></td> <td style="width: 25px; height: 20px;"></td> </tr> </table>						

EMPLOYER INFORMATION – EMPLOYMENT LOCATION												
EMPLOYER BUSINESS NAME (Use Federal ID Name)		EMPLOYER FEIN										
University of Scranton		<table border="1" style="width: 100%; height: 20px; border-collapse: collapse;"> <tr> <td style="width: 25px; height: 20px; text-align: center;">2</td> <td style="width: 25px; height: 20px; text-align: center;">4</td> <td style="width: 25px; height: 20px; text-align: center;">0</td> <td style="width: 25px; height: 20px; text-align: center;">7</td> <td style="width: 25px; height: 20px; text-align: center;">9</td> <td style="width: 25px; height: 20px; text-align: center;">5</td> <td style="width: 25px; height: 20px; text-align: center;">4</td> <td style="width: 25px; height: 20px; text-align: center;">9</td> <td style="width: 25px; height: 20px; text-align: center;">5</td> </tr> </table>		2	4	0	7	9	5	4	9	5
2	4	0	7	9	5	4	9	5				
STREET ADDRESS WHERE ABOVE EMPLOYEE REPORTS TO WORK (No PO Box, RD or RR)												
800 Linden St												
ADDRESS LINE 2												
CITY	STATE	ZIP CODE	PHONE NUMBER									
Scranton	PA	18510	570-941-7767									
MUNICIPALITY (City, Borough or Township)												
Scranton												
COUNTY	WORK LOCATION PSD CODE	WORK LOCATION NON-RESIDENT EIT RATE										
Lackawanna	<table border="1" style="width: 100%; height: 20px; border-collapse: collapse;"> <tr> <td style="width: 25px; height: 20px; text-align: center;">3</td> <td style="width: 25px; height: 20px; text-align: center;">5</td> <td style="width: 25px; height: 20px; text-align: center;">0</td> <td style="width: 25px; height: 20px; text-align: center;">9</td> <td style="width: 25px; height: 20px; text-align: center;">0</td> <td style="width: 25px; height: 20px; text-align: center;">1</td> </tr> </table>	3	5	0	9	0	1					
3	5	0	9	0	1							

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

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

www.newPA.com/Act32

DIRECT DEPOSIT AUTHORIZATION AGREEMENT

Reset Form

Complete, print, and Submit this form along with required document(s) to:

Human Resources
ST THOMAS HALL

Please direct any questions to the Payroll Department

Tel (570) 941-4066
Fax (570) 941-5937

Indicate that you are a: Student

Print Name: _____ Royal ID Number: _____

To elect entire amount into one primary account, please complete the section: PRIMARY ACCOUNT only.

Direct deposit information will be verified with your financial institution(s). You may receive a paper check until your direct deposit becomes active. This process can take up to 10 working days. Please contact the Payroll Department with any questions.

Primary Account - Mandatory - Entire Net Payroll will be deposited into this account.

Bank Transit/ Routing Number: (must be 9 digits)	Bank Name
Account Number:	Dollar Amount to be Deposited: <input type="text" value="100 %"/>
Type of Account: <input type="checkbox"/> Checking <input type="checkbox"/> Savings	Check One: <input type="checkbox"/> Start

I hereby authorize the University to initiate direct deposit into the account and financial institution listed above. Payroll direct deposits will be made to the account listed above until I choose to change this agreement by submission of a new Direct Deposit Authorization form.

You will receive notification of your electronic direct deposit advice via your official University e-mail. You may view, print or save this advice by visiting the Payroll Information menu on the Employee tab in your My.Scranton portal.

Please attach a voided personal check OR deposit form/letter from your financial institution(s) which includes the 9-digit transit/routing number.

Student Employee Signature: _____ Date: _____ Phone: _____

LOCAL SERVICES TAX – EXEMPTION CERTIFICATE

2023

Tax Year

APPLICATION FOR EXEMPTION FROM LOCAL SERVICES TAX

- A copy of this application for exemption from the Local Services Tax (LST), and all necessary supporting documents, must be completed and presented to your employer AND to the political subdivision levying the Local Services Tax where you are employed.
- This application for exemption from the Local Services Tax must be signed and dated.
- **No exemption will be approved until proper documentation has been received.**

Name: _____
Address: _____
City/State: _____

Soc Sec #: _____
Phone #: _____
Zip: _____

REASON FOR EXEMPTION

1. _____ MULTIPLE EMPLOYERS: Attach a copy of a current pay statement from each employer that shows the name of the employer, the length of the payroll period, the amount of Local Services Tax withheld, and total earnings. List all employers on the reverse side of this form. **You must notify your other employers of a change in principal place of employment within two weeks of the change.**

2. _____ EXPECTED TOTAL EARNED INCOME AND NET PROFITS FROM ALL SOURCES WITHIN _____ (municipality or school district) WILL BE LESS THAN \$ \$15,600.00 : Attach copies of your last pay statement(s) or your W-2 for the relevant year.

If you are self-employed, please attach a copy of your PA Schedule C, F, or RK-1 for the relevant year.

3. _____ ACTIVE DUTY MILITARY EXEMPTION: Please attach a copy of your orders directing you to active duty status. Annual training is not eligible for exemption. You are required to advise the tax office when you are discharged from active duty status.

4. _____ MILITARY DISABILITY EXEMPTION: Please attach copy of your discharge orders and a statement from the United States Veterans Administrator documenting your disability. Only 100% permanent disabilities are recognized for this exemption.

EMPLOYER: Once you receive this Exemption Certificate, you shall not withhold the Local Services Tax for the portion of the calendar year for which this certificate applies, unless you are otherwise notified or instructed by the tax collector to withhold the tax.

Tax Office: Scranton Single Tax Office
Address: 100 The Mall at Steamtown Unit 216
City/State: Scranton, PA

Phone #: (570) 963-6756 Ext. 3115
Zip: 18503

IMPORTANT NOTE TO EMPLOYERS

1. The municipality is required by law to exempt from the LST employees whose earned income from all sources (employers and self-employment) in their municipality is less than \$12,000 when the levied rate exceeds \$10.00.
2. The school district for the municipality in which your worksite(s) is located may or may not levy an LST. If it does, the income exemption provided may differ from the municipality and can be anywhere from \$0 to \$11,999.
3. Contact the tax office where your business worksites are located to obtain this information.

Employment Information: List all places of employment for the applicable tax year. Please list your PRIMARY EMPLOYER under #1 below and your secondary employers under the other columns. If self employed, write SELF under Employer Name column.

1. PRIMARY EMPLOYER 2. 3.

Employer Name	University of Scranton		
Address	800 Linden St		
Address 2			
City, State Zip	Scranton, PA 18510		
Municipality	Scranton		
Phone	(570) 941-4066		
Start Date			
End Date			
Status (FT or PT)	PT		
Gross Earnings			

4. 5. 6.

Employer Name			
Address			
Address 2			
City, State Zip			
Municipality			
Phone			
Start Date			
End Date			
Status (FT or PT)			
Gross Earnings			

PLEASE NOTE:

All information received by the Tax Collector is considered to be **CONFIDENTIAL** and is only used for official purposes relating to the collection, administration and enforcement of the **LOCAL SERVICES TAX**.

I DECLARE UNDER PENALTY OF LAW THAT THE INFORMATION STATED ON AND ATTACHED TO THIS FORM IS TRUE AND CORRECT:

SIGNATURE: _____ **DATE:** _____



AmTrust North America
An AmTrust Financial Company

Attached is a panel of Physicians for this address

SWC1370355 - 1 - University of Scranton
800 Linden St
Scranton, PA 18510

Date created: 01/04/2022

Scranton, PA 18510
Workers' Compensation Program: Designated Health Care Providers

The following procedures must be followed in case of work related injury or illness:

A. Immediately report the injury to your supervisor.

Any injury you sustain at work must be reported immediately to your supervisor. Failure to do so may delay your benefits or cause you to lose your rights to benefits. Supervisors must promptly report injuries to the appropriate personnel office.

B. Obtain medical care from a provider listed below.

DISA Global Solutions
Occupational Medicine Clinic
1000 Meade St
Dunmore, PA 18512
570-209-7160

† Express Urgent Care
Urgent Care
449 Scranton Carbondale Hwy
Scranton, PA 18508
(570)344-6000

Optum
Available at any major pharmacy
PHARMACY
866-599-5426

One Call Care
Requires adjuster approval
PHYSICAL THERAPY
866-672-3064

† Peairs, Randall
Ophthalmology
200 Mifflin Ave
Scranton, PA 18503
(570)342-3145

† Scranton Orthopaedic
Orthopedics
334 Main Street
Dickson City, PA 18503
(570) 307-1767

Dental Works
For the nearest location, please call the toll free number.
DENTIST
855-443-9872

Hospital
For Emergency Services, please go to the nearest hospital.
HOSPITAL
(FOR EMERGENCY SERVICES ONLY)

† Khan, Iqbal A
Neurology
210 Montage Mtn Rd
Moosic, PA 18507
(570)909-9411

† Roche, James
Surgery - General
743 Jefferson Avenue
Scranton, PA 18510
(570) 344-1231

One Call Medical Diagnostics
Requires adjuster approval
DIAGNOSTICS
800-872-2875

C. Medical Emergency:

If you are faced with a medical emergency, you may secure initial emergency treatment from any of the above mentioned emergency facilities or any other emergency facility. However, any follow-up care to the emergency treatment must be with a designated health care provider.

D. If you choose to treat with an out of state provider, you may be subject to balance billing.

E. For medical treatment to be paid by your employer:

1. You must select one of the physicians or physician groups listed above.
2. You must continue to visit one of the physicians listed above or any specialist to which that provider refers you, if you need treatment, for Ninety (90) days from the date of your first visit. This requirement is in conformance with the Pennsylvania Workers' Compensation Act, Section 306 (F) (1) (i).
3. After Ninety (90) days, if you still need treatment, you may continue with the same physician or you may choose to go to another physician or health care provider for treatment. If you decide to go to another provider, you must notify your employer of this action within five (5) days of your visit.
4. Your bills will be paid if your physician or healthcare provider reports as required (within ten days after your first visit and at least once a month as long as treatment continues). You must notify the new provider that these reports are to be submitted to the following address:

AmTrust North America
P O Box 94405
Cleveland, OH 44101
888-239-3909 Toll Free
678-258-8399 Fax

*For medical groups, all providers are eligible to render medical services.

Signature

Date