Clear Form

Villanova University
New Employee Personal Information Form

Employee Name (as it appears on your social security card):	
Department:	Date of Hire:
Date of Birth:	Social Security Number:
Gender:	Marital Status:
US Citizen? Yes If no, Visa status/permanent resident #:	Veteran's Status: I am not a Protected Veteran

What is your ethnicity: ☐ Hispanic or Latino? ☐ Not Hispanic or Latino

Please select one or more races that describe how you consider yourself:
☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American
☐ Native Hawaiian or Other Pacific Islander ☐ White

Address and Phone Information:

Street Address:	
City, State Zip:	
Home telephone #:	Cell Phone #:

Emergency Contact Information:

Contact #1 Name:	Relationship:
Address, City, State, Zip:	
Phone #1:	Phone #2:
Contact #2 Name:	Relationship:
Address, City, State, Zip:	
Phone #1:	Phone #2:

Dependent information (required for tuition benefits, even if not electing health benefits)

Full Name (First, Middle, Last)	Social Security Number	Date of Birth (MM/DD/YYYY)	Gender (M or F)	Relationship (Spouse/Child)

_____ _____
Signature Date

VILLANOVA
UNIVERSITY

WORKERS' COMPENSATION
EMPLOYEE NOTIFICATION

I understand that the University is required to pay for all my reasonable and necessary medical services required as a result of a work-related injury. If I am involved in a work-related injury, I am to inform my department head or supervisor without delay. I understand that I am required to treat with a health care provider identified as a panel physician and a facility on the list posted by the University on employee bulletin boards, and on the Human Resources website. I further understand that this restriction does not apply to emergency treatment if I am faced with an immediate life-threatening medical emergency.

Furthermore, I understand that I am required to treat with a panel physician for the 90 day period from the date of first treatment, and that should I not do so, the University is then not responsible for paying for health care services that I receive from other sources during the initial 90 day period. During that 90 day period of treatment by the panel physician, should the panel physician recommend invasive surgery, I am entitled to seek a second opinion from a physician of my choice at the University expense. Should my physician's opinion differ from that of the panel physician, and I choose to follow my physician's opinion, the panel physician will treat me accordingly during the mandatory 90 day period.

I understand that I may seek treatment from a health care provider of my own choice after I have treated with a panel physician for the mandatory 90 day period. If I choose to do this, I understand that I must inform the Human Resources offices within 5 days of my first visit. If I do not inform the Human Resources office of my election to seek treatment from a health care provider of my choice within the 5 days following the first visit after the mandatory 90 day period of treatment by the panel physician, I understand the University is not responsible for payment for any services performed or ordered by this health care provider until I do inform the Human Resources office of my change to my own health care provider. I understand that, once I properly inform the Human Resources office that I am treating with a health care provider following my treatment by a panel physician, all reasonable and necessary health care services will be paid by the University if it is determined that they continue to be needed for treatment of a bona fide work-related injury.

I am further informed that the health insurance plans offered by the University for non-work-related medical needs will not pay for treatment which is a result of a work-related medical condition, either before, during, or after the 90 day time frame.

I acknowledge that I have been informed of these rights and duties and that I understand them.

_____	_____
Employee Name (please print)	Employee Signature
_____	_____
Employee Banner ID#	Date

Revised 01/13

WORKERS' COMPENSATION INFORMATION

The workers' compensation law provides wage loss and medical benefits to employees who cannot work, or who need medical care, because of a work-related injury.

Benefits are required to be paid by your employer through insurance provided by the University. The University is required to post the name of the company responsible for paying workers' compensation benefits at its primary place of business and at its sites of employment in a prominent and easily accessible place, including, without limitation, areas used for the treatment of injured employees or for the administration of first aid.

You should report immediately any injury or work-related illness to your supervisor.

Your benefits could be delayed or denied if you do not notify your supervisor immediately.

If your claim is denied by the University, you have the right to request a hearing before a workers' compensation judge.

The Bureau of Workers' Compensation cannot provide legal advice. However, you may contact the Bureau of Workers' Compensation for additional general information at:

Bureau of Workers' Compensation, 1171 South Cameron Street, Room 103, Harrisburg, Pennsylvania 17104-2501; telephone number within Pennsylvania (800) 482-2383; telephone number outside of the Commonwealth (717) 772-4447; TTY (800) 362-4228 (for hearing and speech impaired only); www.state.pa.us PA Keyword: workers' comp.

I hereby acknowledge receipt of the "WORKERS' COMPENSATION INFORMATION" form.

_____ _____

Employee Name (please print) Employee Signature

_____ _____

Employee Villanova ID# Date

Revised 01/13

Villanova University
Payroll Department
Direct Deposit Request

Clear This Form

Check all that apply:

_____ New Direct Deposit
_____ Additional Direct Deposit
_____ Change of account number(s)
_____ Change of dollar amount(s)
_____ Cancel Direct Deposit: Bank Name:_____ Account #:_____

If canceling current direct deposit please check one below:

☐ Keep existing deposit active until new request is active.
(Usually one full pay cycle)

☐ Terminate current direct deposit, listed above, immediately.
(You will receive a check until new deposit is active)

Note: If above is left blank, current direct deposit will be terminated.

I hereby authorize Villanova University to initiate credit entries to the account and financial institution listed below and to charge the same said account only to reverse any credit posted erroneously. This authorization is to remain in full force and effect until Villanova University has written notification from me of its termination in such time and manner as to afford a reasonable opportunity to act on it.

Please complete all applicable information:

	☐ Net to Checking or ☐ Net to Savings	$_____ to Checking or $_____ to Savings	$_____ to Checking or $_____ to Savings
Bank Name:			
Branch Address:			
Branch Phone:			
Account Number:			
ACH Routing Number:*	* Obtain from bank	* Obtain from bank	* Obtain from bank

** If possible, please attach a copy of a blank voided check from account.
*** Forward to Payroll Department, Financial Services Building
*** It generally takes two complete payroll periods to begin direct deposit.

Employee Name _____ ID #_____
Please Print

Employee signature _____ Date_____
required

dd.frm 11/2/99

Clear form

CLGS-32-6 (8-11)

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. 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.

EMPLOYEE INFORMATION - RESIDENCE LOCATION

NAME (Last Name, First Name, Middle Initial)			SOCIAL SECURITY NUMBER
STREET ADDRESS (**No** PO Box, RD or RR)			
SECOND LINE OF ADDRESS			
CITY	STATE	ZIP CODE	DAYTIME PHONE NUMBER
MUNICIPALITY (City, Borough or Township)			
COUNTY	RESIDENT PSD CODE		TOTAL RESIDENT EIT RATE

EMPLOYER INFORMATION - EMPLOYMENT LOCATION

EMPLOYER BUSINESS NAME (Use Federal ID Name)			EMPLOYER FEIN
Villanova University			231352688
STREET ADDRESS WHERE ABOVE EMPLOYEE REPORTS TO WORK (**No** PO Box, RD or RR)			
800 Lancaster Avenue			
SECOND LINE OF ADDRESS			
CITY	STATE	ZIP CODE	PHONE NUMBER
Villanova	PA	19085	(610) 519-4261
MUNICIPALITY (City, Borough or Township)			
Radnor Township			
COUNTY	WORK LOCATION PSD CODE		WORK LOCATION NON-RESIDENT EIT RATE
Delaward	230801		0.0%

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

Print all forms