



WELCOME TO DOC'S VIRTUAL ON-BOARDING PROCESS

At the time of fingerprinting & background, you must submit the following compliance documents:

- Birth Certificate, Passport, Naturalization Certificate and/or Resident Alien Card
- Social Security Card
- Driver's License or Non-Driver's Photo ID
- High School Diploma, General Equivalency Diploma; or College Degree (s)/Official transcript
- \$9 and/or \$75 Money Order(s)
- Copy of military ID (active members) or a copy of your DD-214 Form (If applicable)
- Any certificates or licenses necessary for your job title/trade (if Applicable)
- Court Dispositions (if applicable)
- Driving Abstracts (if applicable)



LET'S GET STARTED!

Are all your compliance documents ready and available? Let's proceed... Click on the link below in order to complete the following forms. The next few slides mirror the online forms and have been highlighted to assist you with filling them. Please print and scan them back to your assigned Staffing Specialist.

<http://www1.nyc.gov/site/jointheboldest/civilian/new-hire-processing.page>



Personnel Data Forms

FORMS:

- Identification Card Input Sheet
- DCAS NYCAPS New Hire Packet - Personal Data
- DCAS Designation of Beneficiary
- Federal Tax Form W-4
- Employee Withholding Certificate Form IT-2104
- Social Security and Pension Form
- Oath of Office Agreement
- PREA
- NYCERS
- Direct Deposit
- Tenant Parking Information Form





IDENTIFICATION CARD INPUT SHEET

DATE: 00/00/0000

LAST NAME: DOE FIRST NAME: JANE MI: _____

SOCIAL SECURITY NUMBER: 000-00-0000

MARITAL STATUS: MARRIED/SINGLE

DATE OF BIRTH: 00/00/0000

GENDER: MALE ☒ FEMALE ☐

RACE/ETHNICITY : HISPANIC

SHIELD NUMBER: _____

DO YOU CARRY AN OFF-DUTY FIREARM? YES ☐ NO ☒

CIVIL SERVICE TITLE: COMMUNITY COORDINATOR

BLOOD TYPE: A+

PENSION
NUMBER: N/A

FACILITY/UNIT: HR

WEIGHT: 150 HEIGHT: 5'4 HAIR COLOR: BR EYE COLOR: BR

COMPLETE
HOME ADDRESS: 75-20 ASTORIA BLVD
EAST ELMHURST, NY 11355

TELEPHONE NUMBER: (000)-000-0000 ALTERNATE NUMBER: _____

CIVIL SERVICE STATUS:

PERMANENT
()
FULL-TIME
()

PROVISIONAL
()
PART-TIME
()

NON-COMPETITIVE
()

FOR HR USE ONLY
CIVILIANS ONLY:

ESCORT REQUIRED () NO ESCORT REQUIRED ()



NYCAPS New Hire Packet - Personal Data

Print Form

Page 1 of 6

(To be completed by the Employee)

ID Effective Date

Internal Use Only

Employee Initials: **J.D.**Date: **00/00/0000**First Name **JANE**MI **N/A**Last Name **DOE**Suffix

Add a Person Page

Biographical Details

Name

Prefix **MR./MS.**First Name **JANE I**Middle Name **N/A**Last Name **DOE**Suffix

Biographical Information

Date of Birth **00/00/0000**Highest Education Level **PHD**Marital Status **MARRIED/SINGLE**☐ Full-Time Student (check if applicable)

National ID

National ID (Social Security Number) **000-00-0000**

Contact Information

Address

Street* **75-20 NORTHERN BLVD**
(Address 1)Apt. No. **#320**
(Address 2)City **EAST ELMHURST**State **NY**Zip Code **11370**
(Postal)County **QUEENS**
(Required)

NYCAPS New Hire Packet - Personal Data

Page 2 of 6


(To be completed by the Employee)

ID <input type="text"/>	Internal Use Only	Employee Initials: <u>J.D</u>	Date: <u>00/00/0000</u>
Effective Date <input type="text"/>			

First Name <u>JANE</u>	MI <input type="text"/>
Last Name <u>DOE</u>	Suffix <input type="text"/>

Add a Person Page (cont)

Contact Information	Phone Information			
	Phone Type <u>HOME</u>	Telephone <u>(000)-000-0000</u>	Extension <input type="text"/>	<input checked="" type="checkbox"/> Preferred (check if applicable)
	Phone Type <u>CELL</u>	Telephone <u>(000)-000-0000</u>	Extension <input type="text"/>	<input checked="" type="checkbox"/> Preferred (check if applicable)
Email Addresses				
	Email Type <u>PERSONAL</u>	Email Address <u>JANE.DOE@DOC.NYC.GOV</u>		

Regional	History	
	 USA	
	Military Status	<u>N/A</u>
	Citizenship (Proof 1)	<u>U.S PASSPORT</u>
	Citizenship (Proof 2)	<input type="text"/>
<input checked="" type="checkbox"/> Eligible to Work in U.S. (check if applicable)		

Driver's License Page (if applicable)

Drivers License	Driver's License # <u>123-456-789</u>
	State <u>NY</u>
	Valid from <u>00/00/0000</u> Valid to <u>00/00/0000</u>
	License Type <u>E</u>



NYCAPS New Hire Packet - Personal Data

Page 3 of 6

(To be completed by the Employee)

ID <input type="text"/>	Internal Use Only	Employee Initials: <u>J.D</u>	Date: <u>00/00/0000</u>
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First Name <u>JANE</u>	MI <input type="text"/>
Last Name <u>DOE</u>	Suffix <input type="text"/>

Emergency Contacts Page

Contact Address/Phone	Contact Name <u>JANE DOE</u>
	Relationship to Employee <u>HUSBAND</u> <input checked="" type="checkbox"/> Primary Contact (check if applicable)
	Same Address as Employee? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No (If no, complete address fields below)
	Street (Address 1) <input type="text"/>
	Apt. No. (Address 2) <input type="text"/>
	State <input type="text"/> City <input type="text"/> Zip Code (Postal) <input type="text"/>
Contact Address/Phone	County (Required) <input type="text"/>
	Same Phone as Employee? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Contact Phone <input type="text"/>

Other Phone Numbers	Additional Phone Numbers for Contact: Phone Type <input checked="" type="checkbox"/> Cell <u>(000)-000-0000</u> <input type="checkbox"/> Business <input type="text"/>
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Contact Address/Phone	Contact Name <u>JANE DOE</u>
	Relationship to Employee <u>MOTHER</u>
	Same Address as Employee? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No (If no, complete address fields below)
	Street (Address 1) <input type="text"/>
	Apt. No. (Address 2) <input type="text"/>
	State <input type="text"/> City <input type="text"/> Zip Code (Postal) <input type="text"/>
Contact Address/Phone	County (Required) <input type="text"/>
	Same Phone as Employee? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Contact Phone <u>(000)-000-0000</u>

Other Phone Numbers	Additional Phone Numbers for Contact: Phone Type <input checked="" type="checkbox"/> Cell <u>(000)-000-0000</u> <input type="checkbox"/> Business <input type="text"/>
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I certify that I have personally completed this application, and everything I have written within is, to the best of my knowledge and belief, true and complete.

Employee Signature: Sign Here



EQUAL EMPLOYMENT OPPORTUNITY
SELF-IDENTIFICATION FORM

ID

Internal Use Only

The City of New York is an equal opportunity employer and is strongly committed to a policy of non-discrimination. Additionally, we are committed to recruiting a diverse and inclusive talent pool. All forms of illegal discriminatory actions against applicants for employment and City employees are prohibited. In order to comply with certain federal regulations, the City of New York invites applicants and employees to voluntarily respond to the following questionnaire. This information is confidential, will not be included in personnel files, or disclosed to individuals making employment decisions, and will only be used in accordance with the provisions of applicable laws, executive orders and regulations, including those that require the information to be summarized and reported to the federal government for civil rights enforcement purposes. When reported, data will not identify any specific individual. Refusal to provide this self-identification information will not subject you to any adverse treatment.

First Name Jane MI

Last Name Doe Suffix

Social Security Number 000-00-0000 Date of Birth 00/00/0000

Gender ☒ Female or woman ☐ Male or man ☐ Non-binary (not female/
woman or male/man) ☐ Other - A gender
not listed ☐ Unknown/I choose
not to disclose

Ethnicity (check, if applicable):

☒ Hispanic or Latino - A person of Cuban, Mexican, Puerto Rican, Dominican, South or Central American, or other Spanish culture or origin, regardless of race.

Race (check one):

☐ American Indian or Alaskan Native - A person having origins in any of the original peoples of North or South America (including Central America) who maintains cultural identification through tribal affiliation or community attachment.

☐ Asian - A person having origins in any of the original peoples of the Far East, Southeast Asia, the Indian Subcontinent, including for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, Vietnam.

☐ Black or African American - A person having origins in any of the Black racial groups in Africa.

☐ Native Hawaiian or other Pacific Islander - A person having origins in any of the peoples of Hawaii, Guam, Samoa, or other Pacific Islands.

☐ White - A person having origins in any of the original peoples of Europe, North Africa, or the Middle East.

☐ Two or more races - All persons who identify with more than one of the above races.

Veteran Status (check any that apply):

☐ Disabled Veteran - A veteran who is entitled to compensation (or who but for the receipt of military retired pay would be entitled to compensation) under laws administered by the Secretary of Veterans Affairs, or was discharged or released from active duty because of a service-connected disability.

☐ Recently Separated Veteran - Any veteran during the three-year period beginning on the date of such veteran's discharge or release from active duty.

☒ Other Protected Veteran - Any person who served on active duty during a war or in a campaign or expedition for which a campaign badge has been authorized, under laws administered by the Department of Defense.

☐ Armed Forces Service Medal Veteran - Any person who, while serving on active duty in the Armed Forces, participated in a United States military operation for which an Armed Forces service medal was awarded pursuant to Executive Order 12985.

I affirm that I have truthfully answered all of the questions above.

Signature of Employee:

Sign Here

Date:

00/00/0000



DESIGNATION OF BENEFICIARY FORM (FOR ALL EMPLOYEES)

As an employee of the City of New York, your family members or other persons of your choice may receive a cash benefit representing all or some of your unused annual leave, compensatory time or accrued sick leave in the event of your death. They may also receive a death benefit if your death results from an injury occurring in the course of your employment through no fault of your own. This form provides you an opportunity to designate as beneficiaries the persons who you wish to receive those payments.

If you do not designate a beneficiary on this form, any such payment will be paid to your "estate." That means that the money will be distributed in accordance with the instructions in your Will, if you have one, or pursuant to an order of a Court under the laws of the State in which you reside, if you do not have a Will.

For all Non-Managerial employees: Mayor's Executive Order No. 34 dated March 26, 1971, and Labor Relations Order No. 74/46 and its successors, describes the lump sum cash payment for accrued annual leave and accrued compensatory time and any Accidental Death Benefit of \$25,000 that are to be paid upon death.

For all Managerial employees: Personnel Order No. 88/5, as amended, describes the lump sum cash payment for accrued annual leave, accrued sick leave and accrued compensatory time and any Accidental Death Benefit of \$25,000 that are to be paid upon death.

Name (Print) JANE DOE		Employee Reference Number	
Title COMMUNITY COORDINATOR		Agency DOC	
I wish to name the following persons as beneficiaries to receive any payments for accrued leave, compensatory time or accidental death to be paid upon my death:			
1. Name and Address of Beneficiary	Date of Birth	Email and Telephone #	Relationship % of Benefit
JANE DOE	00/00/00	A@GMAIL.COM 000-000-0000	SPOUSE 100%
<p>(To designate additional beneficiaries see reverse side of form.)</p> <p>The total % of benefit must equal 100%</p>			
<p>2. I do not wish to name any beneficiaries. I understand that if I do not designate a named beneficiary, all benefits will be paid to my estate and distributed under my Will or by a court, if I do not have a will.</p>			



All previous designated beneficiaries are hereby cancelled and it is directed that payments be made upon my death as specified above.

SIGN HERE

Signature of Employee (DO NOT PRINT)

Signed at (City, State)

Signature of Witness (DO NOT PRINT)

Signed at (City, State)

75-20 ASTORIA BLVD

Address of Employee

TODAY'S DATE

Date Signed

Address of Witness

Date Signed

Note: It is your responsibility to submit a new designation of beneficiary whenever changes in personal circumstances make a beneficiary designation update necessary.

1. (List additional beneficiaries below, if needed.)

Name and Address of Beneficiary

Date of Birth

Email and Telephone #

Relationship

%of Benefit

[Redacted]

[Redacted]

[Redacted]

[Redacted]

[Redacted]

The total % of benefit must equal TO 100%



Form W-4 (2019)

Future developments. For the latest information about any future developments related to Form W-4, such as legislation enacted after it was published, go to www.irs.gov/FormW4.

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. You may claim exemption from withholding for 2019 if **both** of the following apply.

- For 2018 you had a right to a refund of all federal income tax withheld because you had **no** tax liability, and
- For 2019 you expect a refund of **all** federal income tax withheld because you expect to have **no** tax liability.

If you're exempt, complete **only** lines 1, 2, 3, 4, and 7 and sign the form to validate it. Your exemption for 2019 expires February 17, 2020. See Pub. 505, Tax Withholding and Estimated Tax, to learn more about whether you qualify for exemption from withholding.

General Instructions

If you aren't exempt, follow the rest of these instructions to determine the number of withholding allowances you should claim for withholding for 2019 and any additional amount of tax to have withheld. For regular wages, withholding must be based on allowances you claimed and may not be a flat amount or percentage of wages.

You can also use the calculator at www.irs.gov/W4App to determine your tax withholding more accurately. Consider

using this calculator if you have a more complicated tax situation, such as if you have a working spouse, more than one job, or a large amount of nonwage income not subject to withholding outside of your job. After your Form W-4 takes effect, you can also use this calculator to see how the amount of tax you're having withheld compares to your projected total tax for 2019. If you use the calculator, you don't need to complete any of the worksheets for Form W-4.

Note that if you have too much tax withheld, you will receive a refund when you file your tax return. If you have too little tax withheld, you will owe tax when you file your tax return, and you might owe a penalty.

Filers with multiple jobs or working spouses. If you have more than one job at a time, or if you're married filing jointly and your spouse is also working, read all of the instructions including the instructions for the Two-Earners/Multiple Jobs Worksheet before beginning.

Nonwage income. If you have a large amount of nonwage income not subject to withholding, such as interest or dividends, consider making estimated tax payments using Form 1040-ES, Estimated Tax for Individuals. Otherwise, you might owe additional tax. Or, you can use the Deductions, Adjustments, and Additional Income Worksheet on page 3 or the calculator at www.irs.gov/W4App to make sure you have enough tax withheld from your paycheck. If you have pension or annuity income, see Pub. 505 or use the calculator at www.irs.gov/W4App to find out if you should adjust your withholding on Form W-4 or W-4P.

Nonresident alien. If you're a nonresident alien, see Notice 1392, Supplemental Form W-4 Instructions for Nonresident Aliens, before completing this form.

Specific Instructions

Personal Allowances Worksheet

Complete this worksheet on page 3 first to determine the number of withholding allowances to claim.

Line C. Head of household please note: Generally, you may claim head of household filing status on your tax return only if you're unmarried and pay more than 50% of the costs of keeping up a home for yourself and a qualifying individual. See Pub. 501 for more information about filing status.

Line E. Child tax credit. When you file your tax return, you may be eligible to claim a child tax credit for each of your eligible children. To qualify, the child must be under age 17 as of December 31, must be your dependent who lives with you for more than half the year, and must have a valid social security number. To learn more about this credit, see Pub. 972, Child Tax Credit. To reduce the tax withheld from your pay by taking this credit into account, follow the instructions on line E of the worksheet. On the worksheet you will be asked about your total income. For this purpose, total income includes all of your wages and other income, including income earned by a spouse if you are filing a joint return.

Line F. Credit for other dependents. When you file your tax return, you may be eligible to claim a credit for other dependents for whom a child tax credit can't be claimed, such as a qualifying child who doesn't meet the age or social security number requirement for the child tax credit, or a qualifying relative. To learn more about this credit, see Pub. 972. To reduce the tax withheld from your pay by taking this credit into account, follow the instructions on line F of the worksheet. On the worksheet, you will be asked about your total income. For this purpose, total

Separate here and give Form W-4 to your employer. Keep the worksheet(s) for your records.

Form W-4 Department of the Treasury Internal Revenue Service		Employee's Withholding Allowance Certificate ▶ Whether you're 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.		OMB No. 1545-0074 2019	
1 Your first name and middle initial JANE		Last name DOE		2 Your social security number 000-00-0000	
Home address (number and street or rural route) 75-20 ASTORIA BLVD		3 <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Married, but withhold at higher Single rate. Note: If married filing separately, check "Married, but withhold at higher Single rate."			
City or town, state, and ZIP code ASTORIA, NY 11370		4 If your last name differs from that shown on your social security card, check here. You must call 800-772-1213 for a replacement card. ▶ <input type="checkbox"/>			
5 Total number of allowances you're claiming (from the applicable worksheet on the following pages)		6 Additional amount, if any, you want withheld from each paycheck		7 2 If applicable	
8 I claim exemption from withholding for 2019, 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 ▶ 7					
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.) ▶					
9 Employer's name and address (Employer: Complete boxes 8 and 10 if sending to IRS and complete boxes 8, 9, and 10 if sending to State Directory of New Hires.) sign here		Date ▶ 00/00/0000		10 Employer identification number (EIN)	



Employee's Withholding Allowance Certificate

New York State • New York City • Yonkers

IT-2104

First name and middle initial JANE		Last name DOE		Your social security number 000-00-0000	
Permanent home address (number and street or rural route) 75-20 ASTORIA BLVD				Apartment number	
City, village, or post office ELMHURST		State NY		ZIP code 11370	
Are you a resident of New York City? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Are you a resident of Yonkers? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>					
Complete the worksheet on page 3 before making any entries. 1 Total number of allowances you are claiming for New York State and Yonkers, if applicable (from line 20) 1 2 2 Total number of allowances for New York City (from line 35) 2 2					
Use lines 3, 4, and 5 below to have additional withholding per pay period under special agreement with your employer.					
3 New York State amount				3 if applicable	
4 New York City amount				4 if applicable	
5 Yonkers amount				5 if applicable	

I certify that I am entitled to the number of withholding allowances claimed on this certificate.

Employee's signature Sign Here	Date 00/00/0000
------------------------------------------	---------------------------

Penalty – A penalty of \$500 may be imposed for any false statement you make that decreases the amount of money you have withheld from your wages. You may also be subject to criminal penalties.

Employee: detach this page and give it to your employer; keep a copy for your records.

Employer: Keep this certificate with your records.

Mark an X in box A and/or box B to indicate why you are sending a copy of this form to New York State (see instructions):

A Employee claimed more than 14 exemption allowances for NYS A ☐

B Employee is a new hire or a rehire ... B ☐ First date employee performed services for pay (mm-dd-yyyy) (see instr.):

Are dependent health insurance benefits available for this employee? Yes ☐ No ☐

If Yes, enter the date the employee qualifies (mm-dd-yyyy):

Employer's name and address (Employer: complete this section only if you are sending a copy of this form to the NYS Tax Department.)	Employer identification number
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Instructions

Changes effective for 2019

Form IT-2104 has been revised for tax year 2019. Additional allowances are allowed for covered employees of employers who elected to pay the employer compensation expense tax and for employees who made contributions to a New York Charitable Gifts Trust Fund during 2018. The worksheet on page 3 and the charts beginning on page 4, used to compute withholding allowances or to enter an additional dollar amount on line(s) 3, 4, or 5, have been revised. If you previously filed a Form IT-2104 and used the worksheet or charts, you should complete a new 2019 Form IT-2104 and give it to your employer.

Who should file this form

This certificate, Form IT-2104, is completed by an employee and given to the employer to instruct the employer how much New York State (and New York City and Yonkers) tax to withhold from the employee's pay. The more allowances claimed, the lower the amount of tax withheld.

If you do not file Form IT-2104, your employer may use the same number of allowances you claimed on federal Form W-4. Due to differences in tax law, this may result in the wrong amount of tax withheld for New York State, New York City, and Yonkers. Complete Form IT-2104 each year and file it with your employer if the number of allowances you may claim

is different from federal Form W-4 or has changed. Common reasons for completing a new Form IT-2104 each year include the following:

- You started a new job.
- You are no longer a dependent.
- Your individual circumstances may have changed (for example, you were married or have an additional child).
- You moved into or out of NYC or Yonkers.
- You itemize your deductions on your personal income tax return.
- You claim allowances for New York State credits.
- You owed tax or received a large refund when you filed your personal income tax return for the past year.
- Your wages have increased and you expect to earn \$107,650 or more during the tax year.
- The total income of you and your spouse has increased to \$107,650 or more for the tax year.
- You have significantly more or less income from other sources or from another job.
- You no longer qualify for exemption from withholding.





NEW YORK CITY DEPARTMENT OF CORRECTION
Cynthia Brann, Commissioner
Nadene M. Pinnock, Deputy Commissioner
Claudette Wynter, Assistant Commissioner
Human Resources
75-20 Astoria Boulevard, Suite 320
East Elmhurst, New York 11370
718 • 546 • 3100
Fax 718 • 278 • 6084

MEMORANDUM

1. After six (6) months, all **PERMANENT** employees **MUST** join the New York City Retirement System (Pension). You may however, join immediately if you so desire.
2. Pension membership is optional for **PROVISIONAL** and **NON-COMPETITIVE** employees.
3. Once you join the Pension System you cannot withdraw unless you resign.
4. Are you currently a NYCERS Member? Yes ☒ No ☐
 - a) If Yes, please insert your pension number: **00000**
 - b) If No, would you like to join the pension: Yes ☒ No ☐
5. Current City Service? Yes ☒ No ☐
 - a) If Yes, which agency: **Name of the Agency if applicable**
 - b) City Start Date: **00/00/0000**
6. Prior City Services? Yes ☒ No ☐
 - a) If Yes, which agency: **Name of the Agency if applicable**
 - b) Dates employed: **From 00/00/0000 To 00/00/0000**

00/00/0000

DATE

Sign Here

SIGNATURE





NEW YORK CITY DEPARTMENT OF CORRECTION
Cynthia Brann, Commissioner
Nadene M. Pinnock, Deputy Commissioner
Claudette Wynter, Assistant Commissioner
Human Resources
75-20 Astoria Boulevard, Suite 320
East Elmhurst, New York 11370
Tel 718 • 546 • 3100
Fax 718.278.6084

A \$9.00 FEE IS REQUIRED FOR FILING THIS FORM WITH THE CITY CLERK.
(PAYABLE BY U.S. POSTAL MONEY ORDER ONLY)

I, **JANE DOE** do hereby pledge and declare that I will support the
(Please Print)

Constitution of United States and the Constitution of the State of New York, and that I will
faithfully discharge the duties of the Position of **COMMUNITY COORDINATOR**
(Title of Position)

in the Department of Personnel of the City of New York, according to the best of my ability.

Sign Here
(Signature)

SUBSCRIBED AND SWORN BEFORE ME THIS

_____ Day of _____, 20_____

AND FILED IN THE OFFICE OF THE CITY CLERK, THIS _____ DAY
OF _____ CITY CLERK.





Employment Eligibility Verification

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

USCIS
Form I-9

OMB No. 1615-0047
Expires 03/31/2016

► **START HERE.** 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 documentation presented has a future expiration date may also constitute illegal discrimination.

Section 1. Employee Information and Attestation *(Employees must complete and sign Section 1 of Form I-9 no later than the first day of employment, but not before accepting a job offer.)*

Last Name (Family Name) DOE	First Name (Given Name) JANE	Middle Initial	Other Names Used (if any)		
Address (Street Number and Name) 75-20 ASTORIA BLVD		Apt. Number #320	City or Town EAST ELMHURST	State NY	Zip Code 11370
Date of Birth (mm/dd/yyyy) 00/00/0000	U.S. Social Security Number 000-00-0000	E-mail Address JANE.DOE@GMAIL.COM		Telephone Number (000)-000-0000	

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 Registration Number/USCIS Number): _____
- ☐ An alien authorized to work until (expiration date, if applicable, mm/dd/yyyy) _____. Some aliens may write "N/A" in this field. *(See instructions)*

For aliens authorized to work, provide your Alien Registration Number/USCIS Number **OR** Form I-94 Admission Number:

1. Alien Registration Number/USCIS Number: _____

OR

2. Form I-94 Admission Number: _____

If you obtained your admission number from CBP in connection with your arrival in the United States, include the following:

Foreign Passport Number: _____

Country of Issuance: _____

Some aliens may write "N/A" on the Foreign Passport Number and Country of Issuance fields. *(See instructions)*

3-D Barcode
Do Not Write in This Space

Signature of Employee: Sign Here	Date (mm/dd/yyyy): 00/00/0000
-----------------------------------------	--------------------------------------

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.





**CORRECTION DEPARTMENT
CITY OF NEW YORK**
**HUMAN RESOURCES CHECKLIST
RELATING TO PRISON RAPE ELIMINATION ACT
(PREA) (2003)**

FORM:
HR-PREA-2016

REF: PREA
28 CFR Part 115.17

Effective: 12/01/2016



NAME OF EMPLOYEE: **JANE DOE**

POSITION TITLE: **COMMUNITY COORDINATOR** DATE OF REVIEW **00/00/0000**

I, **JANE DOE**, was interviewed by _____
CANDIDATE (PRINT NAME)

_____, on _____
INTERVIEWER'S NAME TODAY'S DATE

for the position of **COMMUNITY COORDINATOR**

THE BELOW QUESTIONS ARE PREMISED ON PREA, 28 CODE OF FEDERAL REGULATIONS (CFR) § 115.17:
HIRING AND PROMOTION DECISIONS. EACH APPLICANT'S CASE IS INDEPENDENTLY CONSIDERED AND
EVALUATED BASED ON THE TOTALITY OF THE APPLICANT'S VERIFIABLE ACCUMULATED INFORMATION:
E.G., BACKGROUND CHECKS, REFERENCES, PRIOR WORK EXPERIENCE, QUALITY OF INTERVIEWS,
ETC., IN RELATION TO THE DUTIES AND RESPONSIBILITIES OF THE POSITION(S) FOR WHICH THE
APPLICANT APPLIED.

28 CFR § 115.17: HIRING AND PROMOTION DECISIONS

(a) The agency shall not hire or promote anyone who may have contact with inmates, and shall not enlist the services of any contractor who may have contact with inmates, who -

(1) Has engaged in sexual abuse in a prison, jail, lockup, community confinement facility, juvenile facility, or other institution (as defined in 42 U.S.C. 1997);

(2) Has been convicted of engaging or attempting to engage in sexual activity in the community facilitated by force, overt or implied threats of force, or coercion, or if the victim did not consent or was unable to consent or refuse; or

(3) Has been civilly or administratively adjudicated to have engaged in the activity described in paragraph (a)(2) of this section.

(b) The agency shall consider any incidents of sexual harassment in determining whether to hire or promote anyone, or to enlist the services of any contractor, who may have contact with inmates.

(c) Before hiring new employees who may have contact with inmates, the agency shall:

(1) Perform a criminal background records check; and

(2) Consistent with Federal, State, and local law, make its best efforts to contact all prior institutional employers for information on substantiated allegations of sexual abuse or any resignation during a pending investigation of an allegation of sexual abuse.

(d) The agency shall also perform a criminal background records check before enlisting the services of any contractor who may have contact with inmates.

(e) The agency shall either conduct criminal background records checks at least every five years of current employees and contractors who may have contact with inmates or have in place a system for otherwise capturing such information for current employees.

(f) The agency shall ask all applicants and employees who may have contact with inmates directly about previous misconduct described in paragraph (a) of this section in written applications or interviews for hiring or promotions and in any interviews or written self-evaluations conducted as part of reviews of current employees. The agency shall also impose upon employees a continuing affirmative duty to disclose any such misconduct.





BASED ON THE ABOVE LAW, I AFFIRM THE FOLLOWING:

1. I have not intentionally, recklessly, or negligently materially omitted or withheld any relevant, important, or required information regarding past misconduct, which may serve as grounds for termination or forfeiture of my employment with the Department. True ☒ False ☐ Initial. **JD**
2. I have not provided any materially false information that may be discovered in the course of my employment with the Department that may serve as grounds for termination or forfeiture of my employment with the Department. True ☒ False ☐ Initial. **JD**
3. I am aware that I have an affirmative duty to inform the Department if I engage or have engaged in sexual abuse in a prison, jail, lock up, community confinement facility, juvenile facility, other institution, or in the community. True ☒ False ☐ Initial. **JD**
4. I have never been convicted of engaging or attempting to engage in sexual activity in the community facilitated by force, overt or implied threats of force, or coercion, or if the victim did not consent or was unable to consent or refuse. True ☒ False ☐ Initial. **JD**
5. I have never been civilly or administratively adjudicated to have engaged in or attempted to engage in sexual activity in the community facilitated by force, overt or implied threats of force, or coercion, or if the victim did not consent or was unable to consent or refuse. True ☒ False ☐ Initial. **JD**
6. I have never been involved in incidences or accused of sexual harassment. True ☒ False ☐ Initial. **JD**
7. I do not currently have any pending or unresolved offenses against the law. True ☒ False ☐ Initial. **JD**
8. I have never engaged in sexual abuse in a prison, jail, lockup, community confinement facility, juvenile facility, or other institution (42 U.S.C. §1997(1) defines "institution" as any facility or institution which is owned, operated, or managed by, or provides services on behalf of any State or political subdivision of a State; and which is (i) for persons who are mentally ill, disabled, or retarded, or chronically ill or handicapped; (ii) a jail, prison, or other correctional facility, (iii) a pretrial detention facility; (iv) for juveniles held awaiting trial; residing in such facility or institution for purposes of receiving care or treatment; or residing for any State purpose in such facility or institution (other than a residential facility providing only elementary or secondary education that is not an institution in which reside juveniles who are adjudicated delinquent, in need of supervision, neglected, place in State custody, mentally ill or disabled, mentally retarded, or chronically ill or handicapped); or (v) providing skilled nursing, intermediate or long-term care, or custodial or residential care). True ☒ False ☐ Initial. **JD**

I HEREBY CERTIFY THAT I **JANE DOE**, TITLE, _____ HAVE READ THE FOREGOING DOCUMENT AND ANSWERED ALL QUESTIONS TRUTHFULLY. I ALSO CERTIFY THAT I WAS ADVISED OF MY DUTY AND ON-GOING OBLIGATION TO CONFORM TO PREA (2003) AND INFORM THE DEPARTMENT IF ANY OF THE ABOVE ANSWERS CHANGE. MATERIAL OMISSIONS REGARDING THE TYPES OF MISCONDUCT DESCRIBED HEREIN, OR THE PROVISION OF MATERIALLY FALSE INFORMATION, SHALL BE GROUNDS FOR MY TERMINATION.

Sign Here

CANDIDATE'S SIGNATURE

00/00/0000

DATE

INTERVIEWER'S SIGNATURE

DATE



NYCERS USE ONLY

F103

--

Application for Membership For NYCERS-Eligible Employees

This application is for City employees who wish to apply for NYCERS membership. You are to also nominate a beneficiary for a death benefit payable if you die while in City Service. Please read the Instructions Page before completing this form. You must submit this ENTIRE form, even if you intentionally leave some of the sections blank. Should you have any questions regarding this application, please contact our Call Center at 347-643-3000.

Social Security Number	Date of Birth (MM/DD/YYYY)	Daytime Phone Number	Email Address
000-00-0000	00 / 00 / 0000	(000)-000-0000	ABC@GMAIL.COM
First Name	MI.	Last Name	Sex (M or F)
JANE		DOE	F
In Care of (if applicable)			
Address		Apt. Number	
ENTER YOUR ADDRESS			
City	State	Zip Code	
FLUSHING	NY	11355	
Agency	Pass Number (Transit Only)		
DOC			
Your job title as it appears on payroll	Date of Appointment (MM/DD/YYYY)	Civil Service Appointment Date	
COMMUNITY COORDINATOR	00 / 00 / 0000	00 / 00 / 0000	

Classification (Check one) ☐ Competitive ☐ Exempt ☐ Labor ☐ Non-Competitive ☐ Provisional

Beneficiary Selection: A designated beneficiary is the person who is on file at NYCERS to receive a survivor benefit upon the death of a member in active service.

I understand that should I nominate more than one beneficiary, my death benefit will be paid in accordance with the percentages I have indicated on this form (combined percentages should total 100%). If no percentage is indicated, the death benefit will be shared equally. I understand that should I survive the beneficiary(ies), the benefit will then be payable to my estate.

The beneficiary(ies) whom I wish to nominate to receive my death benefit is:

Primary Beneficiary	First Name	MI.	Last Name
	JANE JR.		DOE
	Full Social Security Number	Date of Birth (MM/DD/YYYY)	Relationship
	000-00-0000	00 / 00 / 0000	DAUGHTER
	Address		Apt. Number
	City	State	Zip Code
	SAME AS ABOVE		

☒ If this beneficiary is a minor, check here and complete the guardian information on Form 137

Percentage %



THE CITY OF NEW YORK
PAYROLL MANAGEMENT SYSTEM
**Direct Deposit of Net Pay
Enrollment**

SUBMIT COMPLETED FORM TO:
YOUR AGENCY DIRECT DEPOSIT COORDINATOR OR
YOUR PAYROLL OFFICE

www.NYC.gov/payroll

TYPE OF
ACTION



NEW
ENROLLMENT

Attach a voided check or most recent savings statement.

EMPLOYEE SECTION

EMPLOYEE
IDENTIFICATION

FIRST

J A N E

M.I.

LAST

D O E

REFERENCE NUMBER

0 0 0 0 0 0 0

WORK TELEPHONE

0 0 0 0 0 0 0 0 0 0 0

AGENCY

D O C

ENROLLMENT

PERSON(S) NAMED ON ACCOUNT (PRINT EXACTLY - INCLUDE TRUSTEE OR JOINT OWNER)

PERSON 1

J A N E D O E

PERSON 2

ABA NUMBER*

0 0 0 0 0 0 0 0 0

ACCOUNT NUMBER**

0 0 0 0 0 0 0 0 0 0 0 0 0

ACCOUNT TYPE

(CHECK ONLY ONE)



SAVINGS



CHECKING

*ABA BANK NUMBER:

CHECKING ACCOUNTS -- The ABA number is the first nine (9) numbers prior to the account number at the bottom left corner of the check.

SAVINGS ACCOUNTS -- Contact your bank for ABA number, if not known.

(**See check, passbook or account statement for account number)

EMPLOYEE AUTHORIZATION

I hereby authorize The City of New York to deposit my net pay directly into my checking or savings account as requested. I also grant authorization for the reversal of a credit to my account in the event the credit was made in error. I understand that, under the "National Automated Clearing House Association" operating guidelines and rules, The City of New York can only reverse the amount of the incorrect direct deposit. I agree that this authorization will remain in effect until I provide to my agency a written cancellation to terminate the service.

EMPLOYEE
SIGNATURE

Sign Here

MONTH DAY YEAR
0 0 / 0 0 / 0 0

AGENCY PAYROLL SECTION

DOCUMENT #

CHECK DIGIT

JSN

PAYROLL #

ENROLLMENT
REJECTION REASONS



INACTIVE
LEAVE STATUS



OTHER

MANAGER/ SUPERVISOR

Name

(Please Print)

Signature

MONTH DAY YEAR
0 0 / 0 0 / 0 0

ENTERED INTO PMS

Name

Signature

MONTH DAY YEAR
0 0 / 0 0 / 0 0



Bulova Corporate Center
75-20 Astoria Boulevard
Tenant Parking Information Form

Tenant/Company Name: NYC Dept. of Correction

Employee Name: JANE DOE

Employee Unit: HUMAN RESOURCE

Employee Title: COMMUNITY COORDINATOR

Employee Contact Phone #: 000-00-0000

=====

Vehicle Information

Make: LEXUS

Model: 2019

Color: WHITE

License Plate #: ABC000

Reserved Parking: **NO**



Citywide Policies

FORMS:

- Federal Drug Free Workplace Act
- DCAS Agreement Under Section 1127 NYC Charter
- Charter 1136
- Charter 2603
- Mayor's Executive Order 16





NOTICE TO EMPLOYEES

Pursuant to the requirements of the Federal Drug-Free Workplace Act of 1998, the unlawful manufacture, distribution, dispensation, possession, or use of a controlled substance is prohibited in the workplace. Violations of this policy will subject an employee to discipline up to and including discharge.

The Federal Drug-Free Workplace Act of 1998 also requires that any employee convicted for a criminal drug offense, occurring in the workplace, notify the agency within five days of the conviction. The Federal Drug-Free Workplace Act requires that such notification be made a condition of employment. Accordingly, employees must notify the agency head and agency personnel officer within five days of conviction for a criminal drug offense occurring in the workplace. A conviction includes a finding of guilt, a no contest plea ("nolo contendere"), or the imposition of a sentence by any judicial body charged with determining violations of any criminal statute involving the manufacture, distribution, dispensation, use, or possession of any controlled substance.

This is to certify that I have read and received this notice.

JANE DOE

Name of Employee (Print or Type)

Sign Here

Signature of Employee

00/00/0000

Date

Signature of Individual
Witnessing Employee Signature

Date

Name and Title of Individual
Witnessing Employee Signature (Print or Type)

Date



AGREEMENT UNDER SECTION 1127 OF THE NEW YORK CITY CHARTER*

Under the provisions of Section 1127 of the New York City Charter, every person seeking employment with the City of New York (the "City") or any of its agencies, must sign an agreement as a condition precedent to such employment to the effect that if such person is or becomes a nonresident individual as defined in Section 11-1705(b) (Note: the City Charter incorrectly refers to Section 11-1706) of the Administrative Code of the City of New York ("the Code") or any similar provision of the Code at any time during such employment, the person will pay to the City an amount by which a City personal income tax on residents computed and determined as if such person was a resident individual during such employment exceeds the amount of any City earnings tax and City personal income tax imposed on such person for the same period.

In furtherance of this requirement and as a condition precedent to employment, I hereby agree that if I am or become a City Nonresident Individual as defined below:

1. I will pay to the City an amount by which a City personal income tax on residents computed and determined as if I were a resident individual, as defined in Section 11-1705(b) of the Code, during my employment, exceeds the amount of any City earnings tax and City personal income tax imposed on me for the same taxable period.
2. The City may, at each payroll period, deduct and withhold from my wages or compensation, an amount equal to the amount it would be required to withhold for City personal income tax on residents if I were a resident individual as defined in such section, to be credited to my City earnings and/or income tax liability and to my liability under this agreement and said Section 1127 of the New York City Charter.
3. Within ten days of filing them, I will furnish the Commissioner of Finance of the City with copies of my Federal income tax return and my State income tax return (if any).
4. Whenever my status as a nonresident individual or a resident individual changes, I will notify the head of the agency by which I am then employed, the City Personnel Director, and the Commissioner of Finance of such change.

Resident and Nonresident, as defined in the Administrative Code Section 11-1705(b):

1. City Resident Individual - For purposes of Section 1127 of the New York City Charter, City resident individual means an individual:
 - a. who is domiciled in this City, unless,
 - (i) he/she maintains no permanent place of abode in this City, maintains a permanent place of abode elsewhere, and spends in the aggregate not more than thirty days of the taxable year in this City, or
 - (ii) within any period of 548 consecutive days he/she is present in a foreign country or countries for at least 450 days, and during such period of 548 consecutive days he/she is not present in this City for more than 90 days and does not maintain a permanent place of abode in this City at which his/her spouse (unless such spouse is legally separated) or minor children are present for more than 90 days, and during any period of less than 12 months, which would be treated as a separate taxable period pursuant to Section 11-1754, and which period is contained within such period of 548 consecutive days, he/she is present in this City for a number of days which does not exceed an amount which bears the same ratio to 90 as the number of days contained in such period of less than 12 months bears to 548, or
 - b. who is not domiciled in this City but maintains a permanent place of abode in this City and spends in the aggregate more than 183 days of the taxable year in this City, unless such individual is in active service in the armed forces of the United States.
2. City Nonresident Individual - For purposes of Section 1127 of the New York City Charter, City nonresident individual means an individual who is not a City resident.

Signature: _____

Sign Here

Name (Print) _____

JANE DOE

Date: _____

04/08/16



**CERTIFICATION FOR CITY EMPLOYEES
PURSUANT TO CHARTER #1136**

Hon. Michael McSweeney
City Clerk
141 Worth Street
New York, NY 10013

Dear Mr. McSweeney:

Pursuant to Charter #1136, I hereby certify that I have read and shall conform to Chapter #49 of the Charter.

Sincerely,

JANE DOE

Name

COMMUNITY COORDINATOR

Title

N.Y.C. Department of Correction
Agency

00/00/0000

Date





Conflicts of Interest Board
2 Lafayette Street, Suite 1010
New York, NY 10007

RE: Charter§ 2603(b)(2) Certification

Pursuant to Charter§ 2603(b)(2), I hereby certify that I have read and shall conform to the provisions of Chapter 68 of the New York City Cha[No Title]

Sign Here

Signature

JANE DOE

Print Name

COMMUNITY COORDINATOR

Print Title

N.Y.C. Department of Correction
Agency

00/00/0000

Date





NEW YORK CITY DEPARTMENT OF CORRECTION

Cynthia Brann, Commissioner
Angel Villalona, First Deputy Commissioner
Nadene M. Pinnock, Deputy Commissioner
Claudette R. Wynter, Assistant Commissioner

Human Resources
75-20 Astoria Boulevard, Suite 320
East Elmhurst, New York 11370
Tel 718 • 546 • 3100

Mayor's Executive Order No. 16
Issued July 26, 1978

I JANE DOE hereby acknowledge receipt of a copy of
Name

Executive Order No. 16 on 00/00/0000
Date

I read and understand Mayor's Executive Order No. 16 Sign Here
Signature

Date 00/00/0000



CITYWIDE BENEFITS



New York City

Summary Program Description (SPD) Health Benefits Program



- City of New York employees hired on or after July 1, 2019, and their eligible dependents, will only be eligible to enroll in the EmblemHealth HIP HMO Preferred Plan, and must remain in the HIP HMO Preferred Plan for the first year (365 days) of employment.
- After 365 days of employment, the employee will have the option of either remaining in the HIP HMO Preferred Plan or selecting a different health plan within 30 days before the end of the 365 day period. If a new health plan is selected, the new plan will be effective on the 366th day.
- **NYCAPS (212) 487-0500**
- **Waiting period is 90 days**
- **Exceptions:**
 1. **City Transfer**
 2. **Civil Service List**
 3. **Non-Competitive Title**



The City of New York
Office of Labor Relations
Employee Benefits Program

HBP
Health Benefits Program

Summary Guide of 457 & 401(k) Plan Provisions



New York City
Deferred Compensation Plan 

New York City Deferred Compensation Plan

Welcome to the New York City Deferred Compensation Plan!

This booklet briefly describes the New York City Deferred Compensation Plan (NYCDCP), an umbrella program consisting of the 457 Plan and the 401(k) Plan. NYCDCP is a retirement savings plan which lets you save for the future through easy payroll deductions.

Contributions made on a pre-tax basis into the 457 and the 401(k) allow you to put aside a portion of your pay before federal, state, and local income taxes are taken out. Your taxes will be reduced as a result of the contributions you make, and your contributions and the earnings on them will accumulate tax-deferred.

Contributions made on an after-tax basis into the Roth 457 and the Roth 401(k) allow you to contribute a portion of your pay after taxes have been taken out and the earnings on your contributions may be tax-free upon withdrawal.

These programs contain many attractive features. They are tax-favored plans, where you have the choice of either creating your own investment portfolio using NYCDCP's core investment options or selecting a single professionally managed pre-arranged portfolio.

Within this booklet, you will find a comparison chart of the 457 and 401(k) programs, as well as information about NYCDCP's investment offerings. An Enrollment Form is attached. Please refer to the Summary Guide of 457 and 401(k) Plan Provisions, or visit NYCDCP online at nyc.gov/deferredcomp, for more information about the program and its investment offerings.

As you take the step to enroll, also consider consolidating your other retirement savings in the low-cost NYCDCP. Every dollar you don't pay in investment management fees results in one dollar more in investment return. The 401(k) Plan can accept rollovers from eligible retirement plans and IRAs. The 457 Plan can accept transfers from other employer 457 plans. Keeping track of your retirement assets is easier when they are all in the same place.

We are pleased to offer you these programs and feel they are an excellent opportunity for you to save now for the future.



New York City Deferred Compensation Plan
(212) 306-7760 • Outside NYC: 888-DCP-3113 • TTY: (212) 306-7707
Customer Service Center: 22 Cortlandt Street, 12 Fl, New York, NY 10007
nyc.gov/deferredcomp



FSA | *New York City*
Flexible Spending Accounts Program

**HCFA
DeCAP
MSC BUY-OUT
MSC PREMIUM**

Plan Year **2019**



The 55-a Program



Bill de Blasio
Mayor

Lisette Camilo
Commissioner
Department of Citywide
Administrative Services

Victor Calise
Commissioner
Mayor's Office for
People with Disabilities





You can contact DOC HR Help Desk
at 718-546-3100

Or

Contact your Staffing Specialist for
any question or concern.

