UNC CHARLOTTE

Emergency Notification Information

This information will be used to make an appropriate notification in the event of an emergency involving a faculty or staff member.

Employee Name	Last 4 digits of SSN	UNC Charlotte ID

Department or Office Name	Department Phone Number

PERSON # 1 TO CONTACT IN THE EVENT OF AN EMERGENCY

Employee's Relationship to named contact								
		A – Aunt / Uncle		F – Father		P – Parents
		B – Sibling		G – Grandparents		R – Grandchild
		C – Child / Children		M – Mother		S – Spouse
		D – Domestic Partner		N – Friend / Neighbor		U – Guardian
		E - Embassy		O - Other		V – Advisor / Sponsor

LAST Name	FIRST Name	Middle Initial

Address Lines 1 & 2	City	State	Zip Code

Contact Telephone Numbers					
Home		Business		Mobile	

PERSON # 2 TO CONTACT IN THE EVENT OF AN EMERGENCY

Employee's Relationship to named contact								
		A – Aunt / Uncle		F – Father		P – Parents
		B – Sibling		G – Grandparents		R – Grandchild
		C – Child / Children		M – Mother		S – Spouse
		D – Domestic Partner		N – Friend / Neighbor		U – Guardian
		E - Embassy		O - Other		V – Advisor / Sponsor

LAST Name	FIRST Name	Middle Initial

Address Lines 1 & 2	City	State	Zip Code

Contact Telephone Numbers					
Home		Business		Mobile	

UNC CHARLOTTE

Personnel Profile

The information requested on this form will be used for the following purposes:

- To establish an employee record on the University's Human Resources System (which includes Payroll)
- Compliance with Equal Employment Opportunity and Affirmative Action reporting requirement provisions of State and Federal laws
- Compliance with State law regarding Military Selective Service

Name (first MI last)	**Casual Name (ex. Bob, Kathy, etc.)**	**Last 4 digits of SSN**

Employee's Street Address	**City**	**State**	**Zip Code**

Personal Telephone Number	**Department/Office**

	Please initial if you would like to omit your address/contact number from the Campus Directory. (Updates can be made on Banner Self Service.)

Do you have prior service with the State of North Carolina?		**Yes**		**No**

Demographic Information:

Race Category (Select One or More):

	B - Black		**A** - Asian		**I** - American Indian or Alaska Native
	W - White		**H** - Hispanic		**P -** Native Hawaiian/Pacific Islander

Date of Birth						**Gender**			
Month		Day		Year		Male		Female	

Military Selective Service Compliance
In accordance with General Statute 143b-421.1, I hereby certify, as a condition of employment, that I have complied with the requirements of the Military Selective Service Act. My specific compliance is as follows:

	I certify that I am registered with the Selective Service.

I certify that I am not required to be registered with the Selective Service because: (Please 'X' one of the following reasons)		I am female.
		I am in the armed services on active duty. (Members of the Reserves and National Guard are not considered on active duty).
		I am currently 26 years of age, or older.
		I am a permanent resident of the Trust Territory of the Pacific Island or the Northern Marina Islands.
		I am a non-immigrant alien.

Employee's Signature: **Date:**

Veteran's Status Form

Print Name _____

Veteran Status	Definition	(✓)
Pre-JVA veterans	an individual who is an employee of or applicant to a contractor with a contract of $25,000 or more entered into prior to December 1, 2003, and unmodified since to $100,000 or more, and who is a special disabled veteran, veteran of the Vietnam era, recently separated veteran, or other protected veteran.	☐
Disabled veterans	(1) A veteran of the U.S. military, ground, naval or air service 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 - (2) A person who was discharged or released from active duty because of as service-connected disability.	☐
Active duty wartime or campaign badge veterans (was Other Protected)	a veteran who served on active duty in the U.S. military, ground, naval or air service during a war or in a campaign or expedition for which a campaign badge has been authorized, under the laws administered by the Department of Defense.	☐
Armed forces service medal veterans	any veteran who, while serving on active duty in the U.S. military, ground, naval or air service, participated in a United States military operation for which an Armed Forces service medal was awarded pursuant to Executive Order 12985 (61 FR 1209).	☐
Recently separated veterans	any veteran during the three-year period beginning on the date of such veteran's discharge or release from active duty in the U.S. military, ground, naval or air service.	Discharge Date ____/____/_____
Not a Veteran	If you are not a US Veteran, please print your name at the top and check this box.	☐

UNC CHARLOTTE

Patent Agreement

Name	Casual Name (ex. Bob, Kathy, etc.)	Last 4 digits of SSN

Department or Office Name	Title / Position

In consideration of my appointment to the faculty/staff of the University of North Carolina at Charlotte, and as a condition of that appointment, I do hereby agree as follows:

1. I have read and understand the **Institutional Patent and Copyright Procedures** of the University of North Carolina at Charlotte (*University Policy Statement #301: *Patent Policy*)

2. I agree to abide by the *Patent Policy* and to communicate promptly to the UNC Charlotte Office of Research a full and complete disclosure of all inventions conceived or reduced to practice by me in connection with my duties supported in whole or part by UNC Charlotte.

3. I further agree that I will assign the inventions and all applications and patents relating thereto to UNC Charlotte, a sponsor, or the federal government as and when requested by UNC Charlotte.

4. I understand that unless otherwise specifically agreed in writing I shall receive my share of the gross revenues from the licensing or sale of my invention in accordance with the revenue distribution formula set forth under the *Patent Policy*.

5. I understand that UNC Charlotte will rely upon this Agreement in making research and licensing agreements with third parties.

This Agreement shall not apply to any invention which does not come within the scope of UNC Charlotte ownership as defined in the *Patent Policy*.

Signature	Date

*** University Policy Statement #301: Patent Policy can be found online at:** http://legal.uncc.edu/policies/up-301

North Carolina Total Retirement Plans

Certifying Employee Status Under Retirement Reemployment Laws

Please print or type in black ink.

Section A. Tell us about yourself.

FIRST NAME	MI	LAST NAME	SUFFIX	SSN (last 4 digits)
MAILING ADDRESS				MEMBER ID (if known)
CITY		STATE	ZIP CODE	DATE OF BIRTH
POSITION TITLE				TELEPHONE NUMBER

Section B. Please understand that retirees are subject to earnings restrictions.

Retirees may be subject to earnings restrictions upon returning to work. State return-to-work laws require suspension of retirement benefits when earnings from applicable employers exceed the allowable limit. Before returning to work, be sure that you understand the return-to-work laws that apply to the System from which you retired. For example, new retirees in the Teachers' and State Employees' Retirement System (TSERS) may not work with a TSERS employer, or make arrangements for future work, until the first six months of retirement have passed. A summary of return-to-work laws for the Local Government Employees' Retirement System and the Teachers' and State Employees' Retirement System is located in Guides B, C, and D.

Section C. Please tell us if you are receiving a monthly benefit from any of the systems below.

☐ YES, I am currently receiving a monthly benefit from the following: (check all that apply)

- ☐ Teachers' and State Employees' Retirement System (TSERS)
- ☐ Local Governmental Employees' Retirement System (LGERS)
- ☐ Consolidated Judicial Retirement System (CJRS)
- ☐ Legislative Retirement System (LRS)
- ☐ Disability Income Plan of North Carolina (DIPNC)

☐ NO, I am not currently receiving a monthly benefit from any of the above listed systems.

Section D. Please sign below.

I certify that I have read the Guides and the information I provided in Sections A and C is correct to the best of my knowledge. I understand that if my employment subsequently creates an overpayment of benefits from the Retirement Systems Division, I am fully responsible for the repayment of the said overpayment.

Member's Signature _____ **Date** _____

Section E. Please submit this form to your employer.

Please do not send this form to the Retirement Systems Division (RSD). Your employer should retain this form.

Thank you.

N.C. Department of State Treasurer, Retirement Systems Division
3200 Atlantic Avenue, Raleigh, North Carolina 27604
(919) 807-3050 in the Raleigh area or (877) 627-3287 toll free
www.myncretirement.com

Voluntary Self-Identification of Disability

OMB Control Number 1250-0005
Expires 05/31/2023

Name: _____ Date: _____

Employee ID: _____
(if applicable)

Why are you being asked to complete this form?

We are a federal contractor or subcontractor required by law to provide equal employment opportunity to qualified people with disabilities. We are also required to measure our progress toward having at least 7% of our workforce be individuals with disabilities. To do this, we must ask applicants and employees if they have a disability or have ever had a disability. Because a person may become disabled at any time, we ask all of our employees to update their information at least every five years.

Identifying yourself as an individual with a disability is voluntary, and we hope that you will choose to do so. Your answer will be maintained confidentially and not be seen by selecting officials or anyone else involved in making personnel decisions. Completing the form will not negatively impact you in any way, regardless of whether you have self-identified in the past. For more information about this form or the equal employment obligations of federal contractors under Section 503 of the Rehabilitation Act, visit the U.S. Department of Labor's Office of Federal Contract Compliance Programs (OFCCP) website at www.dol.gov/ofccp.

How do you know if you 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:*

- Autism
- Autoimmune disorder, for example, lupus, fibromyalgia, rheumatoid arthritis, or HIV/AIDS
- Blind or low vision
- Cancer
- Cardiovascular or heart disease
- Celiac disease
- Cerebral palsy
- Deaf or hard of hearing
- Depression or anxiety
- Diabetes
- Epilepsy
- Gastrointestinal disorders, for example, Crohn's Disease, or irritable bowel syndrome
- Intellectual disability
- Missing limbs or partially missing limbs
- Nervous system condition for example, migraine headaches, Parkinson's disease, or Multiple sclerosis (MS)
- Psychiatric condition, for example, bipolar disorder, schizophrenia, PTSD, or major depression

Please check one of the boxes below:

☐ Yes, I Have A Disability, Or Have A History/Record Of Having A Disability

☐ No, I Don't Have A Disability, Or A History/Record Of Having A Disability

☐ I Don't Wish To Answer

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.

For Employer Use Only

Employers may modify this section of the form as needed for recordkeeping purposes.

For example:

Job Title: _____ Date of Hire: _____

UNC CHARLOTTE

Prior Creditable State Service Verification Form

Section A:

Employee Prior North Carolina State Employment Designation	
Name:	**UNC Charlotte ID Number:**
I have been previously employed by a North Carolina state employer: **Yes** □ No □ **Previous Teachers & State Employees Retirement System Participation:** **Yes** □ No □ **Previous Optional Retirement Plan Participation:** **Yes** □ **No** □	
If Yes; Complete Section B of this form and forward to the Benefits Department for Processing.	
I certify that the above information is accurate and complete. **Employee Signature: _____** **Print Name: _____**	

Section B:

UNC Charlotte Employee Information	Former Employer Information
Employee Name:	**Name of Agency:**
Employee ID:	**Prior Position:**
SSN #: (last four)	**SHRA _____ EHRA_____9-Month Faculty_____**
Date of Hire at UNC Charlotte:	**Agency Address:**
Phone Number:	**Agency Phone Number:**

★ **Is your agency/institution subject to the State Human Resources Act?** Yes □ No □

Section C: *The employee above was formerly employed by your agency/institution as a "permanent" employee. Please verify the information below upon separation, including any breaks or leave without pay.*

Service Date From:	**To:**	**Part-Time or Full-Time:**		**Breaks in Service:**
Service Date From:	**To:**	**Part-Time or Full- Time:**		**Breaks in Service:**

List any periods of Leave without Pay:			Participation in HCFSA or DCFSA for current year: Yes □ No □ Amount elected for current plan year:		
Sick Leave Hours:			Longevity Eligible:	Yes □	No □
Annual Vacation Leave Hours:			Amount of Longevity: Last Paid (if applicable):		
Bonus Leave 9/2002-9/2014 Hours:	Special Annual Leave Bonus FY 18-19 Hours:	Special Bonus Leave FY 17-18 Hours:	Prior Retirement Plan Election: ORP ____TSERS____	Total NC State Service Years:	Months:

I certify that the above information is accurate and complete.

HR Signature: _____ **Print Name**: _____

Date: _____ **HR Title: _____** **Phone:_____**

Return To: **UNC Charlotte Benefits Office**
9201 University City Blvd, King 207
Charlotte, NC 28223
benefits@uncc.edu
Phone: (704) 687-8134

Questions: **Gina Ewart, Benefits Consultant**
Phone: (704) 687-0647
Fax: (704) 687-5254

Revised 3-11-2020