NAME:_____
(Please Print)

Office Use Only
Comp. Date: _____

LAY COACH – REQUIRED DOCUMENTS

For your convenience, all required employment forms are included in this packet. Upon completion, please return the completed packet to the Athletics/Activities Director.

Maumee City Schools accepts employment applications year-round. Teaching, substitute teaching, non-teaching and administrative positions must be applied for online at www.maumee.k12.oh.us. In addition to the online application, the forms included in this packet must be submitted. Upon completion, you must submit these documents to the Athletic/Activities Director before you may assume any duties involving students of the Maumee City School District.

I have read the above statement and agree to this employment arrangement. I understand that I will receive a 1-year limited contract upon approval by the Board of Education at its next regularly scheduled meeting.

Signed: _____ Date: _____

PAPERWORK CHECKLIST

_____ **Emergency Medical Information Card:** This information is kept on file at the Athletic Director's Office in case of injury or illness while working in one of our buildings. Please keep this information up to date.

_____ **Social Security Card:** Per a recent IRS ruling and Board policy, you must provide your original social security card for copying as part of your employment packet.

_____ Payroll Forms (all forms are required and must be completed in full):
- _____**W-4 Federal Tax Form**
- _____**IT-4 Ohio Withholding Certificate**
- _____**Direct Deposit Form:** Direct deposit is mandatory. Please attach a voided check.
- _____**School Employees Retirement System Form:** (or Reemployed Retiree Notification, if applicable)
- _____**Statement Concerning Employment in a Job Not Covered by Social Security (Form SSA-1945):** All state and local government employers are required to provide all prospective employees with this statement.

_____ **Annual 403(b) Plan Eligibility Notice (Optional):** Our district is required to include any employee that works in the district.

_____ **New Health Insurance Marketplace Coverage Options & Your Health Coverage:** Our district is required to provide this information. Please do not return this form.

_____ **Employment Eligibility Verification Form (Form I-9):** All employees, citizens and non-citizens, hired after November 6, 1986, must complete Section 1 of this form at the time of hire. Acceptable identification documents include, driver's license or state ID, and social security card. Complete list of acceptable documents is available on request.

_____ Signed Statements:
- _____**Drug-Free Workplace Policy**
- _____**Anti-Harassment Policy**
- _____**Auditor of State Fraud-Reporting System Information**
- _____**Hepatitis B Inoculations**

_____ **State and Federal Criminal Record Check Results (BCII/FBI):** All employees are required to be fingerprinted. To arrange fingerprinting with Maumee City Schools, please refer to the information sheet provided in this packet.

_____ **Pupil Activity Permit:** All lay coaches are required to have a Pupil Activity Permit. You must provide a copy of your Pupil Activity Permit to be included in your personnel file.

Emergency/Medical Information
CONFIDENTIAL

Today's Date: _____ Date of Birth _____

Last Name _____ First Name _____ Home/Cell Phone _____

Street Address _____ City _____ State _____ Zip _____

IN AN EMERGENCY, PLEASE CONTACT:

1) Name _____ Relationship _____

Home/Cell Phone _____ Work Phone _____

2) Name _____ Relationship _____

Home/Cell Phone _____ Work Phone _____

Doctor's Name _____ Office Phone _____

Doctor's Name _____ Office Phone _____

Insurance Provider _____ Known medical conditions (drug allergies, diabetes, heart problems, etc.) _____

_____

Medications taken regularly _____

_____

On reverse side, please state any other relevant information (medication side effects, religious restrictions, special requests, etc.)

Return completed form to Maumee City Schools, 716 Askin Street, Maumee, OH 43537.

11/02
Revised 4/08

Form W-4 (2016)

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 2016 expires February 15, 2017. 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 dependent(s) 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 1392, 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 2016. 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 • Your 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 $70,000 ($100,000 if married), enter "2" for each eligible child; then **less** "1" if you have two to four eligible children or **less** "2" if you have five or more eligible children. • If your total income will be between $70,000 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.

- If you plan to **itemize** or **claim adjustments to income** and want to reduce your withholding, see the **Deductions and Adjustments Worksheet** on page 2.
- If you are **single and have more than one job** or are **married and you and your spouse both work** and the combined earnings from all jobs exceed $50,000 ($20,000 if married), see the **Two-Earners/Multiple Jobs Worksheet** on page 2 to avoid having too little tax withheld.
- If **neither** of the above situations applies, **stop here** and enter the number from line H on line 5 of Form W-4 below.

---------- **Separate here and give Form W-4 to your employer. Keep the top part for your records.** ----------

Form **W-4**
Department of the Treasury
Internal Revenue Service

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.**

OMB No. 1545-0074

2016

1	Your first name and middle initial	Last name	2 **Your social security number**
	Home address (number and street or rural route)	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.	
	City or town, state, and ZIP code	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)	5	
6	Additional amount, if any, you want withheld from each paycheck	6	$
7	I claim exemption from withholding for 2016, 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.) ▶ **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)

Deductions and Adjustments Worksheet

Note: Use this worksheet *only* if you plan to itemize deductions or claim certain credits or adjustments to income.

1 Enter an estimate of your 2016 itemized deductions. These include qualifying home mortgage interest, charitable contributions, state and local taxes, medical expenses in excess of 10% (7.5% if either you or your spouse was born before January 2, 1952) of your income, and miscellaneous deductions. For 2016, you may have to reduce your itemized deductions if your income is over $311,300 and you are married filing jointly or are a qualifying widow(er); $285,350 if you are head of household; $259,400 if you are single and not head of household or a qualifying widow(er); or $155,650 if you are married filing separately. See Pub. 505 for details . . . **1** $

2 Enter: { $12,600 if married filing jointly or qualifying widow(er); $9,300 if head of household; $6,300 if single or married filing separately } . . . . . **2** $

3 **Subtract** line 2 from line 1. If zero or less, enter "-0-" . . . . . **3** $

4 Enter an estimate of your 2016 adjustments to income and any additional standard deduction (see Pub. 505) **4** $

5 **Add** lines 3 and 4 and enter the total. (Include any amount for credits from the *Converting Credits to Withholding Allowances for 2016 Form W-4* worksheet in Pub. 505.) . . . . . **5** $

6 Enter an estimate of your 2016 nonwage income (such as dividends or interest) . . . . . **6** $

7 **Subtract** line 6 from line 5. If zero or less, enter "-0-" . . . . . **7** $

8 **Divide** the amount on line 7 by $4,050 and enter the result here. Drop any fraction **8**

9 Enter the number from the **Personal Allowances Worksheet,** line H, page 1 . . . . . **9**

10 **Add** lines 8 and 9 and enter the total here. If you plan to use the **Two-Earners/Multiple Jobs Worksheet,** also enter this total on line 1 below. Otherwise, **stop here** and enter this total on Form W-4, line 5, page 1 **10**

Two-Earners/Multiple Jobs Worksheet (See *Two earners or multiple jobs* on page 1.)

Note: Use this worksheet *only* if the instructions under line H on page 1 direct you here.

1 Enter the number from line H, page 1 (or from line 10 above if you used the **Deductions and Adjustments Worksheet**) **1**

2 Find the number in **Table 1** below that applies to the **LOWEST** paying job and enter it here. **However,** if you are married filing jointly and wages from the highest paying job are $65,000 or less, do not enter more than "3" **2**

3 If line 1 is **more than or equal to** line 2, subtract line 2 from line 1. Enter the result here (if zero, enter "-0-") and on Form W-4, line 5, page 1. **Do not** use the rest of this worksheet **3**

Note: If line 1 is **less than** line 2, enter "-0-" on Form W-4, line 5, page 1. Complete lines 4 through 9 below to figure the additional withholding amount necessary to avoid a year-end tax bill.

4 Enter the number from line 2 of this worksheet **4**

5 Enter the number from line 1 of this worksheet **5**

6 **Subtract** line 5 from line 4 . . . . . **6**

7 Find the amount in **Table 2** below that applies to the **HIGHEST** paying job and enter it here . . . . **7** $

8 **Multiply** line 7 by line 6 and enter the result here. This is the additional annual withholding needed . . **8** $

9 Divide line 8 by the number of pay periods remaining in 2016. For example, divide by 25 if you are paid every two weeks and you complete this form on a date in January when there are 25 pay periods remaining in 2016. Enter the result here and on Form W-4, line 6, page 1. This is the additional amount to be withheld from each paycheck **9** $

Table 1

Married Filing Jointly		All Others	
If wages from **LOWEST** paying job are—	Enter on line 2 above	If wages from **LOWEST** paying job are—	Enter on line 2 above
$0 - $6,000	0	$0 - $9,000	0
6,001 - 14,000	1	9,001 - 17,000	1
14,001 - 25,000	2	17,001 - 26,000	2
25,001 - 27,000	3	26,001 - 34,000	3
27,001 - 35,000	4	34,001 - 44,000	4
35,001 - 44,000	5	44,001 - 75,000	5
44,001 - 55,000	6	75,001 - 85,000	6
55,001 - 65,000	7	85,001 - 110,000	7
65,001 - 75,000	8	110,001 - 125,000	8
75,001 - 80,000	9	125,001 - 140,000	9
80,001 - 100,000	10	140,001 and over	10
100,001 - 115,000	11		
115,001 - 130,000	12		
130,001 - 140,000	13		
140,001 - 150,000	14		
150,001 and over	15		

Table 2

Married Filing Jointly		All Others	
If wages from **HIGHEST** paying job are—	Enter on line 7 above	If wages from **HIGHEST** paying job are—	Enter on line 7 above
$0 - $75,000	$610	$0 - $38,000	$610
75,001 - 135,000	1,010	38,001 - 85,000	1,010
135,001 - 205,000	1,130	85,001 - 185,000	1,130
205,001 - 360,000	1,340	185,001 - 400,000	1,340
360,001 - 405,000	1,420	400,001 and over	1,600
405,001 and over	1,600		

Privacy Act and Paperwork Reduction Act Notice. We ask for the information on this form to carry out the Internal Revenue laws of the United States. Internal Revenue Code sections 3402(f)(2) and 6109 and their regulations require you to provide this information; your employer uses it to determine your federal income tax withholding. Failure to provide a properly completed form will result in your being treated as a single person who claims no withholding allowances; providing fraudulent information may subject you to penalties. Routine uses of this information include giving it to the Department of Justice for civil and criminal litigation; to cities, states, the District of Columbia, and U.S. commonwealths and possessions for use in administering their tax laws; and to the Department of Health and Human Services for use in the National Directory of New Hires. We may also disclose this information to other countries under a tax treaty, to federal and state agencies to enforce federal nontax criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism.

You are not required to provide the information requested on a form that is subject to the Paperwork Reduction Act unless the form displays a valid OMB control number. Books or records relating to a form or its instructions must be retained as long as their contents may become material in the administration of any Internal Revenue law. Generally, tax returns and return information are confidential, as required by Code section 6103.

The average time and expenses required to complete and file this form will vary depending on individual circumstances. For estimated averages, see the instructions for your income tax return.

If you have suggestions for making this form simpler, we would be happy to hear from you. See the instructions for your income tax return.

IT 4
Rev. 5/07

Notice to Employee

1. For state purposes, an individual may claim only natural dependency exemptions. This includes the taxpayer, spouse and each dependent. Dependents are the same as defined in the Internal Revenue Code and as claimed in the taxpayer's federal income tax return for the taxable year for which the taxpayer would have been permitted to claim had the taxpayer filed such a return.

2. You may file a new certificate at any time if the number of your exemptions ***increases.***

   You must file a new certificate within 10 days if the number of exemptions previously claimed by you ***decreases*** because:
   (a) Your spouse for whom you have been claiming exemption is divorced or legally separated, or claims her (or his) own exemption on a separate certificate.
   (b) The support of a dependent for whom you claimed exemption is taken over by someone else.
   (c) You find that a dependent for whom you claimed exemption must be dropped for federal purposes.

   The death of a spouse or a dependent does not affect your withholding until the next year but requires the filing of a new certificate. If possible, file a new certificate by Dec. 1st of the year in which the death occurs.

   For further information, consult the Ohio Department of Taxation, Personal and School District Income Tax Division, or your employer.

3. If you expect to owe more Ohio income tax than will be withheld, you may claim a smaller number of exemptions; or under an agreement with your employer, you may have an additional amount withheld each pay period.

4. A married couple with both spouses working and filing a joint return will, in many cases, be required to file an individual estimated income tax form IT 1040ES even though Ohio income tax is being withheld from their wages. This result may occur because the tax on their combined income will be greater than the sum of the taxes withheld from the husband's wages and the wife's wages. This requirement to file an individual estimated income tax form IT 1040ES may also apply to an individual who has two jobs, both of which are subject to withholding. In lieu of filing the individual estimated income tax form IT 1040ES, the individual may provide for additional withholding with his employer by using line 5.

please detach here

Ohio | Department of Taxation

Employee's Withholding Exemption Certificate

IT 4
Rev. 5/07

Print full name _____ Social Security number _____

Home address and ZIP code _____

Public school district of residence _____ School district no. _____
(See *The Finder* at tax.ohio.gov.)

1. Personal exemption for yourself, enter "1" if claimed ..... _____
2. If married, personal exemption for your spouse if not separately claimed (enter "1" if claimed) ..... _____
3. Exemptions for dependents ..... _____
4. Add the exemptions that you have claimed above and enter total ..... _____
5. Additional withholding per pay period under agreement with employer ..... $ _____

Under the penalties of perjury, I certify that the number of exemptions claimed on this certificate does not exceed the number to which I am entitled.

Signature _____ Date _____

MAUMEE CITY SCHOOL DISTRICT

716 Askin Street
Maumee, Ohio 43537-3602
419-893-3200
Fax 419-891-5387
www.maumee.k12.oh.us

To: Substitutes, Lay Coaches, PAC & Misc. Employees

From: Paul Brotzki, Treasurer

RE: Email Notification of Direct Deposit

As a cost savings, Maumee City Schools now requires all substitutes, lay coaches, and PAC and miscellaneous employees to be on email notification of direct deposit. For security purposes, your social security number and account number will not be on the notification, only the last four digits of your account number and your account type, "checking" or "savings." The following are a couple reasons you may find notification of direct deposit beneficial to you:

- You will receive the email notification on Wednesday, instead of waiting until Friday's mail. Your monies will be deposited to your account on Friday as usual.
- You can keep the information stored on your computer, instead of storing paper direct deposit notifications.

A direct deposit form is attached for your convenience. If you wish to make any changes or have questions, please contact Linda Posadny at lposadny@maumeek12.org.

AUTHORIZATION AGREEMENT FOR DIRECT DEPOSIT AND OR EMAIL NOTIFICATION OF DIRECT DEPOSIT MAUMEE CITY SCHOOLS

All Maumee City Schools employees are required to be on direct deposit per contracts. All Substitute employees will also be required to be on direct deposit and Email notification of direct deposit as of November 1, 2012. Please complete this form and return to the Treasurer's Office as soon as possible. Thank you for your cooperation.

I hereby authorize the Maumee City Schools hereinafter referred to as DISTRICT, to initiate credit entries and to initiate, if necessary, debit entries and adjustments for any credit entries in error my account(s) listed below.

FINANCIAL INSTITUTION NAME | TRANSIT/ABA NO. (9 digit number) | ACCCOUNT NO

1._____ _____ _____Checking _____Savings_

City/State_____ _____% or amount $_____

2._____ _____ _____Checking _____Savings_

City/State_____ _____% or amount $_____

3._____ _____ _____Checking _____Savings_

City/State_____ _____% or amount $_____

4._____ _____ _____Checking _____Savings_

City/State_____ _____% or amount $_____

Email Address(s)_____
Check for email notification_____ Or email: **TO_MAUMEE@NWOCA.ORG** your email address(s)

This Authority is to remain in force until the DISTRICT has received WRITTEN notification form me of its termination according to dates specified in the contract.

SSN:_____ NAMES: _____
(Please Print)

DATE:_____ SIGNATURE:_____

Example:

AUTHORIZATION AGREEMENT FOR DIRECT DEPOSIT AND
OR EMAIL NOTIFICATION OF DIRECT DEPOSIT
MAUMEE CITY SCHOOLS

All Maumee City Schools employees are required to be on direct deposit per contracts. All Substitute employees will also be require to be on direct deposit and Email notification of direct deposit as of November 1, 2012. Please complete this form and return to the Treasurer's Office as soon as possible. Thank you for your cooperation.

I hereby authorize the Maumee City Schools hereinafter referred to as DISTRICT, to initiate credit entries and to initiate, if necessary, debit entries and adjustments for any credit entries in error my account(s) listed below.

FINANCIAL INSTITUTION NAME	TRANSIT/ABA NO. (9 digit number)	ACCCOUNT NO
1. Maumee City Schools	241478851	11111111111 Checking X Savings
City/State Maumee, Ohio		% or amount $ 200.00
2. Toledo State Bank	241279387	2222222222 Checking __ Savings X
City/State Toledo, Ohio		% or amount $ 50.00
3. Maumee Credit Union	0412000144	0000 Checking __ Savings X
City/State Maumee, Oh		100 % or amount $

Email Address(s) JSMITH@YAHOO.COM
Check for email notification X Or email TO_MAUMEE@NWOCA.ORG with email address(s)

This Authority is to remain in force until the DISTRICT has received WRITTEN notification form me of its termination according to dates specified in the contract.

SSN: 111-11-111 NAMES: John Smith (Please Print)

DATE: 11/1/2012 SIGNAUTRE: _____

You must designate a percentage of pay that equals 100% or a fixed amount with the balance being deposited at 100%. Can place $ amounts on multiple lines but 1 line must have 100%.

Please attach a voided check to this form to insure that the account numbers of the financial institution and your personal account numbers are entered correctly.

Any changes made by you or your bank regarding your account must be provided to the treasurer in writing by completing a new authorization form and must be received 7 working days prior to the effective pay date. New or changed direct deposit form received will take place right away, first pay from receiving this notice. Contact Linda Posadny (419-893-3200) if you need further assistance.

SCHOOL EMPLOYEES RETIREMENT SYSTEM OF OHIO

300 East Broad Street, Suite 100, Columbus, Ohio 43215-3746
614-222-5853 • Toll-Free 1-800-878-5853 • www.ohsers.org

MEMBERSHIP RECORD

PART A - TO BE COMPLETED BY MEMBER

☐☐☐-☐☐-☐☐☐☐
SOCIAL SECURITY NUMBER

LAST NAME _____ FIRST _____ MIDDLE _____ MAIDEN _____

PERMANENT MAILING ADDRESS: STREET _____

CITY _____ STATE _____ ZIP _____

☐ MALE ☐ FEMALE

DATE OF BIRTH: _____ (MONTH DAY YEAR)

E-MAIL ADDRESS: _____

PHONE NUMBER: (_____) _____

☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED

FAMILY DATA

	LAST NAME	FIRST	MIDDLE OR MAIDEN	DATE OF BIRTH MONTH/DAY/YEAR
SPOUSE:				
CHILDREN:				
FATHER:				
MOTHER:				

JOB CLASSIFICATION *Mark one box only:*

☐ Administrative ☐ Clerical/Secretarial ☐ Custodial/Maintenance
☐ Educational Aide ☐ Food Service ☐ Transportation
☐ Supplemental (Coach, Advisor, Etc.) ☐ School Board Member ☐ Other_____

If an employee of the schools through an outside contract company:
Name of contract company:_____

MEMBERSHIP IN OTHER OHIO SYSTEM

For all of the following, check "yes" or "no" if you ever were a member of or received benefits from:

	MEMBER	BENEFIT
School Employees Retirement System of Ohio	☐ Yes ☐ No	☐ None ☐ Service ☐ Disability ☐ Survivor
State Teachers Retirement System of Ohio	☐ Yes ☐ No	☐ None ☐ Service ☐ Disability ☐ Survivor
Ohio Public Employees Retirement System	☐ Yes ☐ No	☐ None ☐ Service ☐ Disability ☐ Survivor
Ohio Police & Fire Pension Fund	☐ Yes ☐ No	☐ None ☐ Service ☐ Disability ☐ Survivor
Ohio State Highway Patrol Retirement System	☐ Yes ☐ No	☐ None ☐ Service ☐ Disability ☐ Survivor
Cincinnati Retirement System	☐ Yes ☐ No	☐ None ☐ Service ☐ Disability ☐ Survivor

Individuals receiving a Disability Benefit from SERS need to contact SERS before returning to work.

MEMBER CERTIFICATION

I hereby certify the information given here to be true to the best of my knowledge.

SIGNATURE: _____ DATE: _____
DO NOT PRINT

PART B - TO BE COMPLETED BY EMPLOYER

SCHOOL DISTRICT _____ COUNTY _____ ☐☐ COUNTY ☐☐☐ DISTRICT NO.

MEMBER'S FIRST DATE OF SERVICE THIS SCHOOL YEAR (July 1 - June 30): _____

I hereby certify that I have verified the employee's Social Security number, the job title, and the first date of service for the current employment.

AUTHORIZED OFFICER'S SIGNATURE:_____

Social Security Administration

Statement Concerning Your Employment in a Job Not Covered by Social Security

Employee Name _____ **Employee ID#** _____

Employer Name _____ **Employer ID#** _____

Your earnings from this job are not covered under Social Security. When you retire, or if you become disabled, you may receive a pension based on earnings from this job. If you do, and you are also entitled to a benefit from Social Security based on either your own work or the work of your husband or wife, or former husband or wife, your pension may affect the amount of the Social Security benefit you receive. Your Medicare benefits, however, will not be affected. Under the Social Security law, there are two ways your Social Security benefit amount may be affected.

Windfall Elimination Provision

Under the Windfall Elimination Provision, your Social Security retirement or disability benefit is figured using a modified formula when you are also entitled to a pension from a job where you did not pay Social Security tax. As a result, you will receive a lower Social Security benefit than if you were not entitled to a pension from this job. For example, if you are age 62 in 2013, the maximum monthly reduction in your Social Security benefit as a result of this provision is $395.50. This amount is updated annually. This provision reduces, but does not totally eliminate, your Social Security benefit. For additional information, please refer to Social Security Publication, "Windfall Elimination Provision."

Government Pension Offset Provision

Under the Government Pension Offset Provision, any Social Security spouse or widow(er) benefit to which you become entitled will be offset if you also receive a Federal, State or local government pension based on work where you did not pay Social Security tax. The offset reduces the amount of your Social Security spouse or widow(er) benefit by two-thirds of the amount of your pension.

For example, if you get a monthly pension of $600 based on earnings that are not covered under Social Security, two-thirds of that amount, $400, is used to offset your Social Security spouse or widow(er) benefit. If you are eligible for a $500 widow(er) benefit, you will receive $100 per month from Social Security ($500 - $400=$100). Even if your pension is high enough to totally offset your spouse or widow(er) Social Security benefit, you are still eligible for Medicare at age 65. For additional information, please refer to Social Security Publication, "Government Pension Offset."

For More Information

Social Security publications and additional information, including information about exceptions to each provision, are available at www.socialsecurity.gov. You may also call toll free 1-800-772-1213, or for the deaf or hard of hearing call the TTY number 1-800-325-0778, or contact your local Social Security office.

I certify that I have received Form SSA-1945 that contains information about the possible effects of the Windfall Elimination Provision and the Government Pension Offset Provision on my potential future Social Security Benefits.

Signature of Employee _____ **Date** _____

Information about Social Security Form SSA-1945 Statement Concerning Your Employment in a Job Not Covered by Social Security

New legislation [Section 419(c) of Public Law 108-203, the Social Security Protection Act of 2004] requires State and local government employers to provide a statement to employees hired January 1, 2005 or later in a job not covered under Social Security. The statement explains how a pension from that job could affect future Social Security benefits to which they may become entitled.

Form SSA-1945, **Statement Concerning Your Employment in a Job Not Covered by Social Security,** is the document that employers should use to meet the requirements of the law. The SSA-1945 explains the potential effects of two provisions in the Social Security law for workers who also receive a pension based on their work in a job not covered by Social Security. The Windfall Elimination Provision can affect the amount of a worker's Social Security retirement or disability benefit. The Government Pension Offset Provision can affect a Social Security benefit received as a spouse, surviving spouse, or an ex-spouse.

Employers must:

- Give the statement to the employee prior to the start of employment;
- Get the employee's signature on the form; and
- Submit a copy of the signed form to the pension paying agency.

Social Security will not be setting any additional guidelines for the use of this form.

Copies of the SSA-1945 are available online at the Social Security website, www.socialsecurity.gov/online/ssa-1945.pdf. Paper copies can be requested by email at ofsm.oswm.rqct.orders@ssa.gov or by fax at 410-965-2037. The request must include the name, complete address and telephone number of the employer. Forms will not be sent to a post office box. Also, if appropriate, include the name of the person to whom the forms are to be delivered. The forms are available in packages of 25. Please refer to Inventory Control Number (ICN) 276950 when ordering.

Employees,

As you may have heard, the IRS has issued new regulations that place additional administrative responsibilities on employers sponsoring a 403(b) plan. These responsibilities help ensure that 403(b) plans operate in accordance with the IRS rules, and they do change how our plan, the Maumee City Schools (403(b) Plan) operates.

To help keep our 403(b) Plan in compliance, **Maumee** Schools has entered into an administrative agreement with planwith**ease**.com. Some of you may have already been told by your 403(b) provider that certain requests (including loans, withdrawals, contract exchanges, transfers, rollovers, hardship withdrawals, purchase of service credit, and others) must now receive approval by the school district or plan administrator via signature before the transaction can be completed. As our plan administrator, planwith**ease**.com will review and authorize these requests electronically, instead of requiring you to secure a signature directly from the school district. Please note that planwith**ease**.com works 24 hours a day, so it's always ready when you need it.

We have provided planwith**ease**.com with basic information about each employee eligible to participate (or participating in) our 403(b) Plan, so that a profile on the site for each such employee could be created. When you log into the site for the first time, you will be asked to create your own unique user ID and password. We ask that you log in as soon as possible to create these items, and begin using the site. Please log in at: www.planwithease.com. The first time you log in, your User ID is your social security number, and your password is the month and year of birth in MMYY format. For example, a birth date of June 9, 1960 would be "0660". Once logged in, you will be prompted to change both your User ID and Password so that they are specific to you. You will also find a *Participant User's Guide* on the site that you can access online or print for reference. It is suggest that you complete this initial log in and become familiar with the site now and not wait until you want to use it!

To obtain approvals from planwith**ease**.com, start by obtaining the necessary paperwork from your 403(b) provider by calling them or going to their website for the forms needed to complete the transaction. This is the same process as always, as each provider will have unique transaction paperwork for that company. Next, log into www.planwith**ease**.com and, in the left-hand navigation column, click on the type of transaction being requested. The site will walk you through each step, prompting you for answers to basic questions and instructing you to provide any additional documentation needed to complete your request. Once you receive notice that your requested transaction is approved, you simply print the approval notice document (not the email or screen image!) and attach it to the paperwork you received from your provider. For example, if you requested a loan, you will attach the planwith**ease**.com approval notice to the loan application you received from your 403(b) provider and send both to your 403(b) provider, who will then process your request.

The planwith**ease**.com website also offers financial education information and calculators, which are available to all employees.

We realize change is never easy and most people don't like to make changes. These administrative changes were mandated by the IRS, and the district felt the best way to stay in compliance and provide the highest level of service to our employees was to utilize the services available with plawith**ease**.com. We are confident this system is easy to use, will speed transaction approvals and will keep any inconvenience to a minimum.

Should you have questions, please contact **Linda Posadny 419-893-3200**

Sincerely,

Paul Brotzki

Paul Brotzki
Treasurer

C09-0615-020

Annual 403(b) Plan Eligibility Notice

Maumee City Schools offers our eligible employees the opportunity to save for retirement by participating in the 403(b) plan. You can participate in this plan by making pre-tax contributions and Roth 403(b) after-tax contributions. You are eligible to participate in this plan, whether or not you are actively contributing to it.

Not yet contributing to the 403(b) plan?
To start your contributions to the 403(b) plan, complete and return a salary reduction agreement to Linda Posadny, 716 Askin St. Maumee, Oh 43537 (Administration office). Open enrollment is the first of **every** month. Please note that in addition to completing and returning a salary reduction agreement, you must also establish an account with the appropriate investment provider(s) that you have selected on the salary reduction agreement and you may also need to provide any additional information that may be required to enroll you in the 403(b) plan.

Already contributing the 403(b) plan? Great News! You have an opportunity to increase your contributions to the 403(b) Plan.
If you are already currently contributing to the 403(b) plan, you may be able to increase your pre-tax contributions and Roth 403(b) after-tax contributions. To change your contributions, complete and return a salary reduction agreement to Linda Posadny, 716 Askin St. Maumee, Oh 43537 (administration office). Open enrollment is the first of every month.

Of course, you can keep your contributions at their current level. In the alternative, if your current financial situation means that you need to lower you're saving for retirement, you can change your contribution rate by completing and returning a salary reduction agreement as described above.

How much can I contribute?
In general, you may contribute up to $17,500 in 2014. This amount may be adjusted annually. Also, if you are at least 50 years old and/or you have completed at least 15 years of service, you may also be able to make additional catch-up contributions. Each catch-up has its own limits.

This Notice is not intended as tax or legal advice. Neither your employer nor the investment providers offering retirement savings products under the plan can provide you with tax or legal advice. Employees are encouraged to contact their financial representative or tax professional with any questions

This sample universal availability notice is provided as a service to ING's 403(b) plan sponsors to assist you in meeting the requirement under the final 403(b) regulations of notifying your employees on an annual basis of their eligibility to participant in the plan.

planwithease.com℠
PO BOX 5054
Minot, ND 58702-5054

403(b) Salary Reduction Agreement

(Please Check One)

☐ Initial 403(b) Salary Reduction Agreement

☐ Change in Contribution Amount or Percentage, Investment Provider Allocation, and/or Money Source
(Supersedes any prior agreement)

☐ Terminate Agreement (Stop/Cancel) *Complete Employee and Employer information, sign, and return*

Employee and Employer Information

Employee Name (first, middle initial, last) _____ Social Security Number _____-__-_____

Employee Address (Street, City, State, ZIP Code) _____

Plan Number _____ Employer Name _____

403(b) Salary Reduction Allocation Election (Check one)

☐ Initial Salary Reduction Agreement

Effective Date: _____ *(allow for at least one pay cycle to be effective)*

I elect to reduce my salary by *(elect one)* $_____ or _____% each pay period on a **pre-tax basis**

☐ Change Salary Reduction Agreement

Effective Date: _____ *(allow for at least one pay cycle to be effective)*

I elect to amend my salary by *(elect one)* $_____ or _____% each pay period on a **pre-tax basis**

Money Source

☐ Employee Voluntary ☐ Employer Contribution

Please note: each money source change will require a separate form to be completed.

Investment Provider Allocation Election

- Allocation % total must equal 100%
- Whole Percentages only

Effective Date: _____ *(Employee is responsible for establishing an account with the Investment Provider before any amounts are contributed by the Employer to the Investment Provider)*

Investment Provider	Contract/Account Number	Allocation %
		Total:

Authorized Signatures

This Agreement is intended to meet the requirements of, and qualify under, Section 403(b) of the Internal Revenue Code of 1986, as amended, and of the plan adopted by Employer. The Employer and Employee agree that the employment agreement between Employer and Employee is being initiated or amended as stated above. This amendment is incorporated and made a part of the agreement as of the effective date above.

The terms of this Agreement are as follows: (1) The Agreement is a legal and binding contract and is irrevocable with respect to amount earned while it is in effect; and applies only to amounts earned while it is in effect; (2) It shall automatically apply to the employment agreement between Employer and Employee for each succeeding year unless amended or terminated by a written notice to Employer; (3) It is terminable at any time for amounts not earned; (4) A termination request remains in effect unless or until a new Agreement is submitted; (5) It replaces any previous Agreement and therefore includes all applicable contribution choices; (6) Employee irrevocably releases all present and /or future rights to receive payment of said sum/total earned from Employer while this agreement is in effect in exchange for the release of the money as pay it is being diverted to the employee account with the Investment Provider identified above.

The maximum amount of salary reduction may not exceed the limits of IRC 401(a)(30), 402(g)(1), 403(b)(1)(E), 415(c) and any other applicable IRC provisions.

In witness whereof, this Agreement has been executed by and on behalf of the parties this

_____ Day of _____, _____.

Employee Signature	Employer Signature and Title *(if required)*

EMPLOYEE PROVIDER LIST

	403B Provider							
Ded No	**Investment Provider**	**Contact Person**	**email**	**Address**	**City**	**State**	**Zip code**	**Phone #**
526	**American Fidelity**	Mike Managhan	mike.managhan@af-group.com	6860 Tylersville Rd Ste 10	Mason	Oh	45040	1-877-518-2337
500	**ING**	Matt Snyder	matthewsnyder@ingfa.com	2760 Centennial Rd	Toledo	Oh	43617	419-725-4470
		Mike Landolt	mikelandolt@ingfa.com	2760 Centennial Rd	Toledo	Oh	43617	419-534-4413
502	**Ameriprise**	Vedo Candiello	vedo.m.candiello@ampf.com	5217 Monroe St Ste B	Toledo	Oh	43623	419-842-8488
		Jeff Coutcher	jeffery.a.coutcher@ampf.com	5911 Renaissance	Toledo	Oh	43623	419-885-2980 option 4
		Rick Luedtke	richard.d.luedtke@ampf.com	5217 Monroe St Ste B	Toledo	Oh	43623	888-752-6403 888-PLAN-403b
		Kristin Gedert	kristin.l.gedert@ampf.com	836 W South Boundary Ste 2B	Perrysburg	Oh	43551	419-873-2332
511	**VALIC**	Thomas Menning	thomas.menning@aigretirement.com	509 W Wayne	Maumee	Oh	43537	419-708-5379
519	**MetLife Investors**	Brenda White	bwhite5@metlife.com	9200 S Hills Blvd Ste 145	Broadview H	Oh	44147	419-732-0414
554	**AXA Equitable**	Erin Morgan	erin.morgan@axa-advisors.com	1001 Lakeside Ave Suite 1650	Cleveland	Oh	44114	1-567-230-0317
		Brittan Bache	brittany.bache@axa-advisors.com	1001 Lakeside Ave Suite 1650	Cleveland	Oh	44114	419-271-6929
	Roth 403B Provider	**Contact Person**	**email**	**Address**	**City**	**State**	**Zip code**	**Phone #**
	American Fidelity	Mike Managhan	mike.managhan@af-group.com	6860 Tylersville Rd Ste 10	Mason	Oh	45040	1-877-518-2337
	ING	Matt Snyder	matthewsnyder@ingfa.com	2760 Centennial Rd	Toledo	Oh	43617	419-725-4470
		Mike Landolt	mikelandolt@ingfa.com	2760 Centennial Rd	Toledo	Oh	43617	419-534-4413
	Ameriprise	Vedo Candiello	vedo.m.candiello@ampf.com	5217 Monroe St Ste B	Toledo	Oh	43623	419-842-8488
		Jeff Coutcher	jeffery.a.coutcher@ampf.com	5911 Renaissance	Toledo	Oh	43623	419-885-2980 option 4
		Rick Luedtke	richard.d.luedtke@ampf.com	5217 Monroe St Ste B	Toledo	Oh	43623	888-752-6403 888-PLAN-403b
		Kristin Gedert	kristin.l.gedert@ampf.com	836 W South Boundary Ste 2B	Perrysburg	Oh	43551	419-873-2332
	VALIC	Thomas Menning	thomas.menning@aigretirement.com	509 W Wayne	Maumee	Oh	43537	419-708-5379
	AXA Equitable	Erin Morgan	erin.morgan@axa-advisors.com	1001 Lakeside Ave Suite 1650	Cleveland	Oh	44114	1-567-230-0317
		Brittan Bache	brittany.bache@axa-advisors.com	1001 Lakeside Ave Suite 1650	Cleveland	Oh	44114	419-271-6929
	457 Provider	**Contact Person**	**email**	**Address**	**City**	**State**	**Zip code**	**Phone #**
559	**ING**	Matt Snyder	matthewsnyder@ingfa.com	2760 Centennial Rd	Toledo	Oh	43617	419-725-4470
		Mike Landolt	mikelandolt@ingfa.com	2760 Centennial Rd	Toledo	Oh	43617	419-534-4413
563	**Ohio Deferred Compensation**		www.obg.ohio.gov	257 E Town St Ste. 400	Columbus	Oh	43215	877-644-6457
670	*ROTH Provider*	**Contact Person**	**email**	**Address**	**City**	**State**	**Zip code**	**Phone #**
	ING	Matt Snyder	matthewsnyder@ingfa.com	2760 Centennial Rd	Toledo	Oh	43617	419-725-4470
		Mike Landolt	mikelandolt@ingfa.com	2760 Centennial Rd	Toledo	Oh	43617	419-534-4413

You can use your own financial consultants as long as he/she has the proper licensers.

New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 11-30-2013)

PART A: General Information

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by your employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.[1]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution -as well as your employee contribution to employer-offered coverage- is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact Linda Posadny at 419-893-3200 or our Health Plan Advisor, Matt Holzemer at 419-725-7363

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

[1] An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer name	4. Employer Identification Number (EIN)	
Maumee Board of Education	34-6400846	
5. Employer address	6. Employer phone number	
716 Askins St	419-893-3200	
7. City	8. State	9. Zip code
Maumee	Ohio	43537
10. Who can we contact about employee health coverage at this job?		
Linda Posadny		
11. Phone number (if different from above)	12. Email address	
	lposadny@maumeek12.org	

Here is some basic information about health coverage offered by this employer:

- As your employer, we offer a health plan to:

☐ All employees. Eligible employees are:

☒ Some employees. Eligible employees are:

Employees who work 25 or more hours per week

- With respect to dependents:

☒ We do offer coverage. Eligible dependents are:

Spouses and children of eligible employees

☐ We do not offer coverage.

☒ If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, HealthCare.gov will guide you through the process.

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)*	First Name *(Given Name)*	Middle Initial	Other Names Used *(if any)*

Address *(Street Number and Name)*	Apt. Number	City or Town	State	Zip Code

Date of Birth *(mm/dd/yyyy)*	U.S. Social Security Number	E-mail Address	Telephone Number
	☐☐☐-☐☐-☐☐☐☐		

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:	Date *(mm/dd/yyyy)*:

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.

Signature of Preparer or Translator:			Date *(mm/dd/yyyy)*:
Last Name *(Family Name)*	First Name *(Given Name)*		
Address *(Street Number and Name)*	City or Town	State	Zip Code

STOP ***Employer Completes Next Page*** STOP

Section 2. Employer or Authorized Representative Review and Verification

(Employers or their authorized representative must complete and sign Section 2 within 3 business days of the employee's first day of employment. You must physically examine one document from List A OR examine a combination of one document from List B and one document from List C as listed on the "Lists of Acceptable Documents" on the next page of this form. For each document you review, record the following information: document title, issuing authority, document number, and expiration date, if any.)

Employee Last Name, First Name and Middle Initial from Section 1:

List A Identity and Employment Authorization	OR	List B Identity	AND	List C Employment Authorization
Document Title:		Document Title:		Document Title:
Issuing Authority:		Issuing Authority:		Issuing Authority:
Document Number:		Document Number:		Document Number:
Expiration Date *(if any)(mm/dd/yyyy)*:		Expiration Date *(if any)(mm/dd/yyyy)*:		Expiration Date *(if any)(mm/dd/yyyy)*:
Document Title:				
Issuing Authority:				
Document Number:				
Expiration Date *(if any)(mm/dd/yyyy)*:				
Document Title:				
Issuing Authority:				
Document Number:				
Expiration Date *(if any)(mm/dd/yyyy)*:				

3-D Barcode
Do Not Write in This Space

Certification

I attest, under penalty of perjury, that (1) I have examined the document(s) presented by the above-named employee, (2) the above-listed document(s) appear to be genuine and to relate to the employee named, and (3) to the best of my knowledge the employee is authorized to work in the United States.

The employee's first day of employment *(mm/dd/yyyy)*: _____ **(*See instructions for exemptions.*)**

Signature of Employer or Authorized Representative	Date *(mm/dd/yyyy)*	Title of Employer or Authorized Representative
Last Name *(Family Name)* First Name *(Given Name)*		Employer's Business or Organization Name Maumee City Schools
Employer's Business or Organization Address *(Street Number and Name)* 716 Askin St	City or Town Maumee	State OH	Zip Code 43537

Section 3. Reverification and Rehires *(To be completed and signed by employer or authorized representative.)*

A. New Name *(if applicable)* Last Name *(Family Name)* First Name *(Given Name)* Middle Initial	**B.** Date of Rehire *(if applicable) (mm/dd/yyyy)*:

C. If employee's previous grant of employment authorization has expired, provide the information for the document from List A or List C the employee presented that establishes current employment authorization in the space provided below.

Document Title:	Document Number:	Expiration Date *(if any)(mm/dd/yyyy)*:

I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented document(s), the document(s) I have examined appear to be genuine and to relate to the individual.

Signature of Employer or Authorized Representative:	Date *(mm/dd/yyyy)*:	Print Name of Employer or Authorized Representative:

Maumee City School District - Bylaws & Policies

3122.01 – Drug-Free Workplace – Professional Staff
4122.01 – Drug-Free Workplace – Operational Staff

The Board of Education believes that quality education is not possible in an environment affected by drugs or alcohol. It will therefore maintain an educational setting, which is not tainted by the use or evidence of use of any controlled substance or alcohol.

Illegal Drugs and Alcohol. The use, sale, purchase, manufacture, distribution, dispensation, possession and/or transfer of an illegal drug, drug paraphernalia and/or alcohol or being under the influence of an illegal drug and/or alcohol during work time, while involved in any District-related activity or event or at any time while on or using Board property, is prohibited.

A. "Illegal drug" means any narcotic, depressant, stimulant, hallucinogen, cannabinoid, or other substance subject to the Federal Controlled Substance Act, which is not lawfully prescribed or not lawfully obtained by an employee.
B. "Alcohol" includes, but is not limited to, distilled spirits, liquor, beer, wine, malt liquor, or any other intoxicant used as a beverage.
C. "Board property" includes, but is not limited to, premises owned, leased or used by the Board, including Board work sites, locations or Board owned, leased or operated vehicles and equipment.
D. Under the influence means being affected or impaired by a drug or alcohol, or the combination of a drug or alcohol, in any detectable manner.

Any staff member who violates this policy shall be subject to disciplinary action in accordance with District guidelines and the terms of collective bargaining agreements.

The Superintendent shall establish guidelines that ensure compliance with this policy and that each staff member is given a copy of the standards regarding unlawful possession, use, or distribution of illicit drugs and alcohol by staff and informed that compliance with this requirement is mandatory. Such guidelines shall provide for appropriate disciplinary actions, if and when needed, which comply with the terms of any negotiated agreement.

41 U.S.C. 701 et seq., Drug-Free Workplace Act of 1988
20 U.S.C. 3224A

Adopted 4/16/90, Revised 5/17/93, Revised 5/19/97, Revised 11/17/97

While the District does not maintain a drug/alcohol rehabilitation program, the District is concerned about any staff member who is a victim of drug or alcohol abuse, and will facilitate the process by which s/he receives help through programs and services available in the community. A staff member may contact her/his supervisor or the Superintendent's office whenever such help is needed.

I have read the Maumee City School District Policy regarding a Drug-Free Workplace (3122.01/4122.01). The district guidelines are available on request.

Employee Name (Printed)	Employee Signature	Date

Maumee City School District - Bylaws & Policies - 4362 - ANTI-HARASSMENT (for classified staff)

General Policy Statement
It is the policy of the Board of Education to maintain an education and work environment that is free from all forms of unlawful harassment, including sexual harassment. This commitment applies to all School District operations, programs, and activities. All students, administrators, teachers, staff, and all other school personnel share responsibility for avoiding, discouraging, and reporting any form of unlawful harassment. This policy applies to unlawful conduct occurring on school property, or at another location if such conduct occurs during an activity sponsored by the Board.

The Board will vigorously enforce its prohibition against discriminatory harassment based on race, color, national origin, sex (including sexual orientation and transgender identity), disability, age, religion, ancestry, or genetic information (collectively, "Protected Classes") that are protected by Federal civil rights laws (hereinafter referred to as "unlawful harassment"), and encourages those within the School District community as well as third parties, who feel aggrieved to seek assistance to rectify such problems. The Board will investigate all allegations of harassment and in those cases where unlawful harassment is substantiated, the Board will take immediate steps to end the harassment, prevent its reoccurrence, and remedy its effects. Individuals who are found to have engaged in unlawful harassment will be subject to appropriate disciplinary action.

For purposes of this policy, "School District community" means students, administrators, and professional and classified staff, as well as Board members, agents, volunteers, contractors, or other persons subject to the control and supervision of the Board.

For purposes of this policy, "third parties" include, but are not limited to, guests and/or visitors on School District property (e.g., visiting speakers, participants on opposing athletic teams, parents), vendors doing business with, or seeking to do business with, the Board, and other individuals who come in contact with members of the School District community at school-related events/activities (whether on or off School District property).

Other Violations of the Anti-Harassment Policy
The Board will also take immediate steps to impose disciplinary action on individuals engaging in any of the following prohibited acts:

A. Retaliating against a person who has made a report or filed a complaint alleging unlawful harassment, or who has participated as a witness in a harassment investigation.
B. Filing a malicious or knowingly false report or complaint of unlawful harassment.
C. Disregarding, failing to investigate adequately, or delaying investigation of allegations of harassment, when responsibility for reporting and/or investigating unlawful harassment charges comprises part of one's supervisory duties.

Anti-Harassment Compliance Officers
The Board designates the following individuals to serve as "Anti-Harassment Compliance Officers" for the District. They are hereinafter referred to as the "Compliance Officers".

Dr. Todd Cramer, Assistant Superintendent
716 Askin Street, Maumee OH 43537, 419-893-3200, tcramer@maumeek12.org

Nancy Sayre, Supervisor, Federal Programs, Communications & School Operations
716 Askin Street, Maumee OH 43537, 419-893-3200, nsayre@maumeek12.org

R.C. 4112.02, 20 U.S.C. 1400 et seq., The Individuals with Disabilities Education Improvement Act, of 2004 (IDEIA), 20 U.S.C. 1681 et seq., 29 U.S.C. 621 et seq., Age Discrimination in Employment Act of 1967, 29 U.S.C. 794, Rehabilitation Act of 1973, as amended, 29 C.F.R. Part 1635, 29 U.S.C. 6101, The Age Discrimination Act of 1975, 42 U.S.C. 12101 et seq., Americans with Disabilities Act of 1990, as amended, 42 U.S.C. 2000d et seq., 42 U.S.C. 2000e et seq., 42 U.S.C. 2000ff et seq., The Genetic Information Nondiscrimination Act, 42 U.S.C. 1983, National School Boards Association Inquiry and Analysis – May 2008

Adopt 4/16/90,Rev 4/29/96,Rev 6/19/00,Rev 12/17/01,Rev 3/20/06,Rev 1/22/07,Rev 1/21/10,Rev 10/18/10,Rev 12/9/13,Rev 8/11/14

I have read the Maumee City School District Policy regarding Anti-Harassment (4362). The district guidelines are available on request.

Employee Name (Printed)	Employee Signature	Date

MAUMEE CITY SCHOOL DISTRICT

716 Askin St
Maumee, Ohio 43537-3602
419-893-3200
Fax 419-891-5387
www.maumee.k12.oh.us

The Ohio Auditor of Ohio's office maintains a system for the reporting of fraud, including misuse of public money by any official or office. The system allows all Ohio citizens, including public employees, the opportunity to make anonymous complaints through a tool free number, the Auditor of State's website, or through the United States mail.

Auditor of State's fraud contact information:

US MAIL for written complaint:
Ohio Auditor of State's Office
Special Investigations Unit
88 East Broad Street
P.O. Box 1140
Columbus, OH 43215

CALL: SIU Fraud Hotline
1-866-FRAUD OH (1-866-372-8364)

WEBSITE: www.ohioauditor.gov

Acknowledgement of receipt of Auditor of State fraud-reporting system information

Pursuant to Ohio Revised Code 117.103(B)(1), a public office shall provide information about the Ohio fraud-reporting system and the means of reporting fraud to each new employee upon employment with the public office.

Each new employee has thirty days after beginning employment to confirm receipt of this information.

By signing below you are acknowledging Maumee City Schools provided you information about the fraud-reporting system as described by Section 117.103(A) of the Revised Code, and that you read and understand the information provided. You are also acknowledging you have received and read the information regarding Section 124.341 of the Revised Code and the protections you are provided as a classified or unclassified employee if you use the before-mentioned fraud-reporting system.

I, _____ have read the information provided by my employer regarding the fraud-reporting system operated by the Ohio Auditor of State's office. I further state that the undersigned signature acknowledges receipt of this information.

_____
PRINT NAME, TITLE, AND DEPARTMENT

_____ _____
PLEASE SIGN NAME DATE

ORC 117.103 - Auditor of state's system for reporting fraud

(A) The auditor of state shall establish and maintain a system for the reporting of fraud, including misuse and misappropriation of public money, by any public office or public official. The system shall allow Ohio residents and the employees of any public office to make anonymous complaints through a toll-free telephone number, the auditor of state's web site, or the United States mail to the auditor of state's office. The auditor of state shall review all complaints in a timely manner.

The auditor of state shall keep a log of all complaints filed under this section, which is a public record under section 149.43 of the Revised Code. The log shall include the date the complaint was received, a general description of the nature of the complaint, the name of the public office or agency with regard to which the complaint is directed, and a general description of the status of the review by the auditor of state. If section 149.43 of the Revised Code or another statute provides for an applicable exemption from the definition of public record for the information recorded on the log, that information may be redacted.

(B) (1) A public office shall provide information about the Ohio fraud-reporting system and the means of reporting fraud to each new employee upon employment with the public office. Each new employee shall confirm receipt of this information within thirty days after beginning employment. The auditor of state shall provide a model form on the auditor of state's web site to be printed and used by new public employees to sign and verify their receipt of information as required by this section. The auditor of state shall confirm, when conducting an audit under section 117.11 of the Revised Code, that new employees have been provided information as required by this division. (2) On the effective date of this section, each public office shall make all its employees aware of the fraud-reporting system required by this section. (3) Divisions (B)(1) and (2) of this section are satisfied if a public office provides information about the fraud-reporting system and the means of reporting fraud in the employee handbook or manual for the public office. An employee shall sign and verify the employee's receipt of such a handbook or manual.

Added by 129th General Assembly File No.73, HB 66, §1, eff. 5/4/2012

ORC 124.341 - Violation or misuse - whistleblower protection

(A) If an employee in the classified or unclassified civil service becomes aware in the course of employment of a violation of state or federal statutes, rules, or regulations or the misuse of public resources, and the employee's supervisor or appointing authority has authority to correct the violation or misuse, the employee may file a written report identifying the violation or misuse with the supervisor or appointing authority. In addition to or instead of filing a written report with the supervisor or appointing authority, the employee may file a written report with the office of internal audit created under section 126.45 of the Revised Code or file a complaint with the auditor of state's fraud-reporting system under section 117.103 of the Revised Code.

If the employee reasonably believes that a violation or misuse of public resources is a criminal offense, the employee, in addition to or instead of filing a written report or complaint with the supervisor, appointing authority, the office of internal audit, or the auditor of state's fraud-reporting system, may report it to a prosecuting attorney, director of law, village solicitor, or similar chief legal officer of a municipal corporation, to a peace officer, as defined in section 2935.01 of the Revised Code, or, if the violation or misuse of public resources is within the jurisdiction of the inspector general, to the inspector general in accordance with section 121.46 of the Revised Code. In addition to that report, if the employee reasonably believes the violation or misuse is also a violation of Chapter 102., section 2921.42, or section 2921.43 of the Revised Code, the employee may report it to the appropriate ethics commission.

(B) Except as otherwise provided in division (C) of this section, no officer or employee in the classified or unclassified civil service shall take any disciplinary action against an employee in the classified or unclassified civil service for making any report or filing a complaint as authorized by division (A) of this section, including, without limitation, doing any of the following:
(1) Removing or suspending the employee from employment; (2) Withholding from the employee salary increases or employee benefits to which the employee is otherwise entitled; (3) Transferring or reassigning the employee;
(4) Denying the employee promotion that otherwise would have been received; (5) Reducing the employee in pay or position.
(C) An employee in the classified or unclassified civil service shall make a reasonable effort to determine the accuracy of any information reported under division (A) of this section. The employee is subject to disciplinary action, including suspension or removal, as determined by the employee's appointing authority, for purposely, knowingly, or recklessly reporting false information under division (A) of this section.
(D) If an appointing authority takes any disciplinary or retaliatory action against a classified or unclassified employee as a result of the employee's having filed a report or complaint under division (A) of this section, the employee's sole and exclusive remedy, notwithstanding any other provision of law, is to file an appeal with the state personnel board of review within thirty days after receiving actual notice of the appointing authority's action. If the employee files such an appeal, the board shall immediately notify the employee's appointing authority and shall hear the appeal. The board may affirm or disaffirm the action of the appointing authority or may issue any other order as is appropriate. The order of the board is appealable in accordance with Chapter 119. of the Revised Code.
(E) As used in this section: (1) "Purposely," "knowingly," and "recklessly" have the same meanings as in section 2901.22 of the Revised Code. (2) "Appropriate ethics commission" has the same meaning as in section 102.01 of the Revised Code. (3) "Inspector general" means the inspector general appointed under section 121.48 of the Revised Code.
Amended by 130th General Assembly File No. 25, HB 59, §101.01, eff. 9/29/2013. Amended by 129th General Assembly File No.73,HB 66, §1, eff. 5/4/2012. Effective Date: 10-31-1990; 07-01-2007; 2007 HB166 02-14-2008

Memorandum

TO: All Staff Members

FROM: Todd Cramer TC

DATE: September 14, 2015

SUBJECT: Hepatitis B Inoculations

Any staff member, who has not completed the series of Hepatitis B inoculations and is interested, can receive the vaccine (at no cost to you) by going to the location listed below.

ProMedica St. Luke's Hospital Occupational Health Services
Fallen Timbers Medical Center
5757 Monclova Road, Suite 17
Maumee, OH 43537
419-891-8003
Monday - Friday, 7:30 am – 4:30 pm

This is a walk-in service. **You will be required to show your Maumee City Schools identification card.**

Attached is an informational sheet regarding the Hepatitis B vaccine (series of three shots). If you have any further questions regarding the series of Hepatitis B inoculations, please contact the location listed above.

*Also attached is a form sheet (Form 8453.01 F4 Vaccination Request; Form 8453.01 F1 Waiver of Vaccination for Hepatitis B). Please sign the appropriate form (Request or Waiver) and return the signed sheet to my office. This form will become part of your confidential file. **Beginning this year, once you waive the inoculation, you will no longer receive the notification and duplicate paperwork.***

Thank you.

Attachments: Hepatitis B Vaccine Informational Sheet
Form 8453.01 F4 Vaccination Request
Form 8453.01 F1 Waiver of Vaccination for Hepatitis B

cc: Jane Fender, School Nurse

MAUMEE CITY SCHOOL DISTRICT

WAIVER OF VACCINATION FOR HEPATITIS B

I understand that due to my occupational exposure to blood or other potentially infectious materials I may be at risk of acquiring hepatitis B virus (HBV) infection. I have been given the opportunity to be vaccinated with hepatitis B vaccine, at no charge to myself. However, I decline hepatitis B vaccination at this time. I understand that by declining this vaccine, I continue to be at risk of acquiring hepatitis B, a serious disease. If in the future I continue to have occupational exposure to blood or other potentially infectious materials and I want to be vaccinated with hepatitis B vaccine, I can receive the vaccination series at no charge to me.

Printed Employee Name

Signature of Employee _____ Date

Signature of Witness _____ Date

1/30/15

MAUMEE CITY SCHOOL DISTRICT

VACCINATION **REQUEST**

I wish to be inoculated with the Hepatitis B vaccine as provided for by the School District. I have been adequately informed about the availability, need for, and nature of the Hepatitis B vaccination as well as of the consequences of not being immunized.

Signature of Staff Member _____ Date

VACCINE INFORMATION STATEMENT

Hepatitis B Vaccine

What You Need to Know

Many Vaccine Information Statements are available in Spanish and other languages. See www.immunize.org/vis

Hojas de información sobre vacunas están disponibles en español y en muchos otros idiomas. Visite www.immunize.org/vis

1 What is hepatitis B?

Hepatitis B is a serious infection that affects the liver. It is caused by the hepatitis B virus.

- In 2009, about 38,000 people became infected with hepatitis B.
- Each year about 2,000 to 4,000 people die in the United States from cirrhosis or liver cancer caused by hepatitis B.

Hepatitis B can cause:

Acute (short-term) illness. This can lead to:

- loss of appetite
- diarrhea and vomiting
- tiredness
- jaundice (yellow skin or eyes)
- pain in muscles, joints, and stomach

Acute illness, with symptoms, is more common among adults. Children who become infected usually do not have symptoms.

Chronic (long-term) infection. Some people go on to develop chronic hepatitis B infection. Most of them do not have symptoms, but the infection is still very serious, and can lead to:

- liver damage (cirrhosis)
- liver cancer
- death

Chronic infection is more common among infants and children than among adults. People who are chronically infected can spread hepatitis B virus to others, even if they don't look or feel sick. Up to 1.4 million people in the United States may have chronic hepatitis B infection.

Hepatitis B virus is easily spread through contact with the blood or other body fluids of an infected person. People can also be infected from contact with a contaminated object, where the virus can live for up to 7 days.

- A baby whose mother is infected can be infected at birth;
- Children, adolescents, and adults can become infected by:
  - contact with blood and body fluids through breaks in the skin such as bites, cuts, or sores;
  - contact with objects that have blood or body fluids on them such as toothbrushes, razors, or monitoring and treatment devices for diabetes;
  - having unprotected sex with an infected person;
  - sharing needles when injecting drugs;
  - being stuck with a used needle.

2 Hepatitis B vaccine: Why get vaccinated?

Hepatitis B vaccine can prevent hepatitis B, and the serious consequences of hepatitis B infection, including liver cancer and cirrhosis.

Hepatitis B vaccine may be given by itself or in the same shot with other vaccines.

Routine hepatitis B vaccination was recommended for some U.S. adults and children beginning in 1982, and for all children in 1991. Since 1990, new hepatitis B infections among children and adolescents have dropped by more than 95%—and by 75% in other age groups.

Vaccination gives long-term protection from hepatitis B infection, possibly lifelong.

3 Who should get hepatitis B vaccine and when?

Children and adolescents

- Babies normally get 3 doses of hepatitis B vaccine:

1st Dose:	Birth
2nd Dose:	1-2 months of age
3rd Dose:	6-18 months of age

  Some babies might get 4 doses, for example, if a combination vaccine containing hepatitis B is used. (This is a single shot containing several vaccines.) The extra dose is not harmful.

- Anyone through 18 years of age who didn't get the vaccine when they were younger should also be vaccinated.

Adults

- All unvaccinated adults at risk for hepatitis B infection should be vaccinated. This includes:
  - sex partners of people infected with hepatitis B,
  - men who have sex with men,
  - people who inject street drugs,
  - people with more than one sex partner,
  - people with chronic liver or kidney disease,
  - people under 60 years of age with diabetes,
  - people with jobs that expose them to human blood or other body fluids,

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

- household contacts of people infected with hepatitis B,
- residents and staff in institutions for the developmentally disabled,
- kidney dialysis patients,
- people who travel to countries where hepatitis B is common,
- people with HIV infection.

- Other people may be encouraged by their doctor to get hepatitis B vaccine; for example, adults 60 and older with diabetes. Anyone else who wants to be protected from hepatitis B infection may get the vaccine.
- Pregnant women who are at risk for one of the reasons stated above should be vaccinated. Other pregnant women who want protection may be vaccinated.

Adults getting hepatitis B vaccine should get 3 doses—with the second dose given 4 weeks after the first and the third dose 5 months after the second. Your doctor can tell you about other dosing schedules that might be used in certain circumstances.

4 Who should not get hepatitis B vaccine?

- Anyone with a life-threatening allergy to yeast, or to any other component of the vaccine, should not get hepatitis B vaccine. Tell your doctor if you have any severe allergies.
- Anyone who has had a life-threatening allergic reaction to a previous dose of hepatitis B vaccine should not get another dose.
- Anyone who is moderately or severely ill when a dose of vaccine is scheduled should probably wait until they recover before getting the vaccine.

Your doctor can give you more information about these precautions.

Note: You might be asked to wait 28 days before donating blood after getting hepatitis B vaccine. This is because the screening test could mistake vaccine in the bloodstream (which is not infectious) for hepatitis B infection.

5 What are the risks from hepatitis B vaccine?

Hepatitis B is a very safe vaccine. Most people do not have any problems with it.

The vaccine contains non-infectious material, and cannot cause hepatitis B infection.

Some mild problems have been reported:

- Soreness where the shot was given (up to about 1 person in 4).
- Temperature of 99.9°F or higher (up to about 1 person in 15).

Severe problems are extremely rare. Severe allergic reactions are believed to occur about once in 1.1 million doses.

A vaccine, like any medicine, could cause a serious reaction. But the risk of a vaccine causing serious harm, or death, is extremely small. More than 100 million people in the United States have been vaccinated with hepatitis B vaccine.

6 What if there is a serious reaction?

What should I look for?

- Look for anything that concerns you, such as signs of a severe allergic reaction, very high fever, or behavior changes.

  Signs of a severe allergic reaction can include hives, swelling of the face and throat, difficulty breathing, a fast heartbeat, dizziness, and weakness. These would start a few minutes to a few hours after the vaccination.

What should I do?

- If you think it is a severe allergic reaction or other emergency that can't wait, call 9-1-1 or get the person to the nearest hospital. Otherwise, call your doctor.
- Afterward, the reaction should be reported to the Vaccine Adverse Event Reporting System (VAERS). Your doctor might file this report, or you can do it yourself through the VAERS web site at **www.vaers.hhs.gov**, or by calling **1-800-822-7967**.

VAERS is only for reporting reactions. They do not give medical advice.

7 The National Vaccine Injury Compensation Program

The National Vaccine Injury Compensation Program (VICP) is a federal program that was created to compensate people who may have been injured by certain vaccines.

Persons who believe they may have been injured by a vaccine can learn about the program and about filing a claim by calling **1-800-338-2382** or visiting the VICP website at **www.hrsa.gov/vaccinecompensation**.

8 How can I learn more?

- Ask your doctor.
- Call your local or state health department.
- Contact the Centers for Disease Control and Prevention (CDC):
  - Call **1-800-232-4636** (**1-800-CDC-INFO**) or
  - Visit CDC's website at **www.cdc.gov/vaccines**

Vaccine Information Statement (Interim)

Hepatitis B Vaccine

2/2/2012

Office Use Only

42 U.S.C. § 300aa-26

MAUMEE CITY SCHOOL DISTRICT

716 Askin St
Maumee, Ohio 43537-3602
419-893-3200
Fax 419-891-5387
www.maumee.k12.oh.us

Federal and State Criminal Background Check

Governor Ted Strickland signed House Bill 190 into law on November 14, 2007. The law requires all new and current employees to undergo a Bureau of Criminal Investigation (BCII) and Federal Bureau of Criminal Investigation (FBI) background check once every five years. Schools are prohibited from hiring or continuing to employ a school employee who has been convicted or pled guilty to certain serious crimes.

The Maumee Board of Education has the equipment to conduct background checks for our volunteers and current or prospective employees only. Information regarding fingerprinting is listed below.

Location:	Maumee City Schools Administration Office 716 Askin St Maumee OH 43537
Hours:	Monday-Friday 8 a.m. – 3 p.m. Or call 419-893-3200 to make an appointment
Cost:	BCII $22.00 & FBI $24.00 Cash, credit card (Visa or MC), or check payable to: Maumee City Schools Volunteers – no charge

You will be required to provide your social security number and present your driver's license or state ID.

Your fingerprints will be electronically transmitted to the Ohio Bureau of Criminal Identification and Investigation (BCII) and a report will be sent back to Maumee City Schools.

NOTE: If you are applying for a teaching license, substitute license, pupil activity permit, or an educational aide permit, please be sure to tell the fingerprinting person that your results should be transmitted to the Ohio Department of Education.