



Cornell Cooperative Extension Schuyler County

# Hidden Valley 4-H Camp

Age 16/17 Counselors

Hiring PAPERWORK

ALL FORMS REQUIRED

Note:

You MUST complete all items highlighted in yellow and return all forms to the no later than Tuesday, May 1, 2018.

Failure to submit your paperwork on time will affect your hiring status.

Hidden Valley 4-H Camp

Attn: Jenn Sweet

323 Owego ST Unit #5

Montour Falls, NY 14865

607.535.7176 prompt 3

Faxes and email scans will not be accepted. ONLY paper format and please ensure proper postage.

# Form W-4 (2017)

**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 2017 expires February 15, 2018. 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 can't claim exemption from withholding if your total 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 don't apply to supplemental wages greater than \$1,000,000.

**Basic instructions.** If you aren't 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 2017. 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](http://www.irs.gov/w4).

## Personal Allowances Worksheet (Keep for your records.)

<b>A</b>	Enter "1" for yourself if no one else can claim you as a dependent . . . . .	<b>A</b>	
<b>B</b>	Enter "1" if: <span style="font-size: 2em;">}</span> <ul style="list-style-type: none"> <li>• You're single and have only one job; or</li> <li>• You're married, have only one job, and your spouse doesn't work; or</li> <li>• Your wages from a second job or your spouse's wages (or the total of both) are \$1,500 or less.</li> </ul>	<b>B</b>	
<b>C</b>	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.) . . . . .	<b>C</b>	
<b>D</b>	Enter number of dependents (other than your spouse or yourself) you will claim on your tax return . . . . .	<b>D</b>	
<b>E</b>	Enter "1" if you will file as head of household on your tax return (see conditions under Head of household above) . . . . .	<b>E</b>	
<b>F</b>	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.)	<b>F</b>	
<b>G</b>	<b>Child Tax Credit</b> (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.	<b>G</b>	
<b>H</b>	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.) ▶	<b>H</b>	

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 <b>W-4</b> Department of the Treasury Internal Revenue Service	<h2 style="margin: 0;">Employee's Withholding Allowance Certificate</h2> <p style="margin: 0;">▶ 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.</p>	OMB No. 1545-0074  <span style="font-size: 2em; font-weight: bold;">2017</span>
1 Your first name and middle initial <span style="float: right;">Last name</span>		2 Your social security number
Home address (number and street or rural route)		3 <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> 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. ▶ <input type="checkbox"/>
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 2017, 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 . . . . . ▶		
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)



Department of Taxation and Finance

# Employee's Withholding Allowance Certificate

New York State • New York City • Yonkers

# IT-2104

First name and middle initial		Last name		Your social security number	
Permanent home address (number and street or rural route)			Apartment number		Single or Head of household <input type="checkbox"/> Married <input type="checkbox"/>
City, village, or post office		State	ZIP code		Married, but withhold at higher single rate <input type="checkbox"/>
Note: If married but legally separated, mark an X in the Single or Head of household box.					
Are you a resident of New York City? ..... Yes <input type="checkbox"/> No <input type="checkbox"/>					
Are you a resident of Yonkers? ..... Yes <input type="checkbox"/> No <input type="checkbox"/>					
<b>Complete the worksheet on page 3 before making any entries.</b>					
1 Total number of allowances you are claiming for New York State and Yonkers, if applicable (from line 17) .....				1	
2 Total number of allowances for New York City (from line 28) .....				2	
Use lines 3, 4, and 5 below to have additional withholding per pay period under special agreement with your employer.					
3 New York State amount .....				3	
4 New York City amount .....				4	
5 Yonkers amount .....				5	

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

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

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

**Employer: Keep this certificate with your records.**

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

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

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

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

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

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

### Changes effective for 2017

Form IT-2104 has been revised for tax year 2017. The worksheet on page 3 and the charts beginning on page 4, used to compute withholding allowances or to enter an additional dollar amount on line(s) 3, 4, or 5, have been revised. If you previously filed a Form IT-2104 and used the worksheet or charts, you should complete a new 2017 Form IT-2104 and give it to your employer.

### Who should file this form

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

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

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

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



**Employment Eligibility Verification**  
**Department of Homeland Security**  
**U.S. Citizenship and Immigration Services**

**USCIS**  
**Form I-9**  
 OMB No. 1615-0047  
 Expires 08/31/2019

▶ **START HERE:** Read instructions carefully before completing this form. The instructions must be available, either in paper or electronically, during completion of this form. Employers are liable for errors in the completion of this form.

**ANTI-DISCRIMINATION NOTICE:** It is illegal to discriminate against work-authorized individuals. Employers **CANNOT** specify which document(s) an employee may present to establish employment authorization and identity. The refusal to hire or continue to employ an individual because the documentation presented has a future expiration date may also constitute illegal discrimination.

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

Last Name (Family Name)		First Name (Given Name)		Middle Initial	Other Last 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 [ ][ ] - [ ][ ] - [ ][ ][ ][ ]		Employee's E-mail Address		Employee's 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 boxes):

<input type="checkbox"/> 1. A citizen of the United States	
<input type="checkbox"/> 2. A noncitizen national of the United States (See instructions)	
<input type="checkbox"/> 3. A lawful permanent resident (Alien Registration Number/USCIS Number): _____	
<input type="checkbox"/> 4. An alien authorized to work until (expiration date, if applicable, mm/dd/yyyy): _____ Some aliens may write "N/A" in the expiration date field. (See instructions)	
<p><i>Aliens authorized to work must provide only one of the following document numbers to complete Form I-9: An Alien Registration Number/USCIS Number OR Form I-94 Admission Number OR Foreign Passport Number.</i></p> <p>1. Alien Registration Number/USCIS Number: _____  <b>OR</b>          2. Form I-94 Admission Number: _____  <b>OR</b>          3. Foreign Passport Number: _____          Country of Issuance: _____</p>	
<div style="border: 1px solid black; padding: 5px; width: fit-content; margin: 0 auto;">           QR Code - Section 1            Do Not Write in This Space         </div>	

Signature of Employee	Today's Date (mm/dd/yyyy)
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**Preparer and/or Translator**

I did not use a preparer or translator. (Fields below must be completed by the employee, Section 1.)

I attest, under penalty of perjury, that I have assisted in the completion of Section 1 of this form and that to the best of my knowledge the information is true and correct.

Signature of Preparer or Translator		Today's Date (mm/dd/yyyy)	
Last Name (Family Name)		First Name (Given Name)	
Address (Street Number and Name)		City or Town	State ZIP Code



**LISTS OF ACCEPTABLE DOCUMENTS**  
**All documents must be UNEXPIRED**

Attach a  
 Photocopy  
 of this

Employees may present one selection from List A  
 or a combination of one selection from List B and one selection from List C.

<p align="center"><b>LIST A</b></p> <p align="center"><b>Documents that Establish Both Identity and Employment Authorization</b></p>	<p align="center"><b>OR</b></p> <p align="center"><b>LIST B</b></p> <p align="center"><b>Documents that Establish Identity</b></p>	<p align="center"><b>AND</b></p> <p align="center"><b>LIST C</b></p> <p align="center"><b>Documents that Establish Employment Authorization</b></p>
<p>1. U.S. Passport or U.S. Passport Card</p>	<p>1. Driver's license or ID card issued by a State or outlying possession of the United States provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address</p>	<p>1. A Social Security Account Number card, unless the card includes one of the following restrictions:            (1) NOT VALID FOR EMPLOYMENT            (2) VALID FOR WORK ONLY WITH INS AUTHORIZATION            (3) VALID FOR WORK ONLY WITH DHS AUTHORIZATION</p>
<p>2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551)</p>	<p>2. ID card issued by federal, state or local government agencies or entities, provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address</p>	<p>2. Certification of Birth Abroad issued by the Department of State (Form FS-545)</p>
<p>3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa</p>	<p>3. School ID card with a photograph</p>	<p>3. Certification of Report of Birth issued by the Department of State (Form DS-1350)</p>
<p>4. Employment Authorization Document that contains a photograph (Form I-766)</p>	<p>4. Voter's registration card</p>	<p>4. Original or certified copy of birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal</p>
<p>5. For a nonimmigrant alien authorized to work for a specific employer because of his or her status:</p> <p>a. Foreign passport; and</p> <p>b. Form I-94 or Form I-94A that has the following:</p> <p>(1) The same name as the passport; and</p> <p>(2) An endorsement of the alien's nonimmigrant status as long as that period of endorsement has not yet expired and the proposed employment is not in conflict with any restrictions or limitations identified on the form.</p>	<p>5. U.S. Military card or draft record</p>	<p>5. Native American tribal document</p>
<p>6. Passport from the Federated States of Micronesia (FSM) or the Republic of the Marshall Islands (RMI) with Form I-94 or Form I-94A indicating nonimmigrant admission under the Compact of Free Association Between the United States and the FSM or RMI</p>	<p>6. Military dependent's ID card</p>	<p>6. U.S. Citizen ID Card (Form I-197)</p>
	<p>7. U.S. Coast Guard Merchant Mariner Card</p>	<p>7. Identification Card for Use of Resident Citizen in the United States (Form I-179)</p>
	<p>8. Native American tribal document</p>	<p>8. Employment authorization document issued by the Department of Homeland Security</p>
	<p>9. Driver's license issued by a Canadian government authority</p>	
	<p><b>For persons under age 18 who are unable to present a document listed above:</b></p>	
	<p>10. School record or report card</p>	
	<p>11. Clinic, doctor, or hospital record</p>	
	<p>12. Day-care or nursery school record</p>	

Examples of many of these documents appear in Part 8 of the Handbook for Employers (M-274).

Refer to the instructions for more information about acceptable receipts.



**PART I** Employee Information

I authorize Cornell University to deposit my pay to my checking or savings account(s) and, if there is any error, to make the necessary corrections to my account.

(Check one) Deposit Action: New:  Change:  Stop:

Full Name: \_\_\_\_\_

Employee ID Number: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Department/Unit: CCE Schuyler Hidden Valley Camp

Work Phone: (607) 535-7161

Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

**PART II** Employee Bank Information

Note: You may deposit at up to three banks. LAST BANK SPECIFIED WILL RECEIVE THE BALANCE OF YOUR PAY.  
Deposits to multiple accounts within a single bank must be arranged through your bank.

Bank 1 Name: \_\_\_\_\_

Address: \_\_\_\_\_

Routing Number: \_\_\_\_\_

Account Number: \_\_\_\_\_

Account Type: Checking:  Savings:

Amount to be Deposited: \$ \_\_\_\_\_ (put 100% or "ALL")

Bank 2 Name: \_\_\_\_\_

Address: \_\_\_\_\_

Routing Number: \_\_\_\_\_

Account Number: \_\_\_\_\_

Account Type: Checking:  Savings:

Amount to be Deposited: \$ \_\_\_\_\_

Bank 3 Name: \_\_\_\_\_

Address: \_\_\_\_\_

Routing Number: \_\_\_\_\_

Account Number: \_\_\_\_\_

Account Type: Checking:  Savings:

Amount to be Deposited: \$ \_\_\_\_\_

**PART III** Special Instructions

*You MUST attach a voided check!*

\* Return this form AND a VOIDED CHECK or DEPOSIT SLIP for each bank account, to the Payroll Office \*



## Health History Form for Camp Staff

*\*Because we want to support your ability to do your job well, please complete this form accurately and completely.*

Return Completed Form to

Hidden Valley 4-H Camp  
323 Owego St., Unit #5  
Montour Falls, NY 14865

Questions?  
Call 607-535-7161.

Name: \_\_\_\_\_  
First Name Middle Initial Last Name

Date of Birth: \_\_\_\_\_ Sex: \_\_\_\_\_  
Month Day Year

Permanent Address: \_\_\_\_\_

Preferred Phone #: (\_\_\_\_) \_\_\_\_\_ E-mail: \_\_\_\_\_

Country of Residence: \_\_\_\_\_

Your Contract Start Date: \_\_\_\_\_ End Date: \_\_\_\_\_

Your Job Title: \_\_\_\_\_

International Staff: rate your ability to speak English. 0 1 2 3 4 5  
None Good Excellent

- Return this form to our camp office at least four weeks before you arrive. People hired within four weeks of their start date should not send this form; bring it with you and give it to the Health Center staff at camp.
- Keep a copy of the completed form for your records; note changes that occur and inform the healthcare provider of these changes.
- Notify the camp director if you are exposed to a communicable disease within three weeks of beginning your job.
- The camp expects that you arrive in good health and capable of doing the job for which you were hired.
- Information on this form is available to Health Center staff and your work supervisor(s).

**Allergies:** Check those that apply to you.

\_\_\_\_\_ I have no known allergies.

\_\_\_\_\_ I have an allergy to this food: \_\_\_\_\_ This causes anaphylaxis?  Yes  No  
Describe what happens if you eat this food and how the reaction is managed:

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_ I am allergic to this medication/s: \_\_\_\_\_ This causes anaphylaxis?  Yes  No

\_\_\_\_\_ I am allergic to these substances: \_\_\_\_\_ This causes anaphylaxis?  Yes  No  
Describe what happens if you eat this food and how the reaction is managed:

\_\_\_\_\_  
\_\_\_\_\_

**Nutrition:** Our expectation is that staff set an example for campers by eating the provided menu. We can work effectively with some medically prescribed diets but cannot cater to individual food preferences. There are times when you might need to simply not eat a served item.

\_\_\_\_\_ I eat a regular, varied diet and am prepared to eat a variety of foods while at camp.

\_\_\_\_\_ I am a vegetarian of this type:  Semi-vegetarian (no pork or beef)  Vegan (no meats, eggs or dairy)

Pesco (no pork, beef or chicken)  Lacto-ovo (no beef, pork, chicken, seafood, or fish)

\_\_\_\_\_ I am lactose-intolerant. Be prepared to manage your intolerance using products such as Lactaid or food avoidance.

\_\_\_\_\_ I avoid \_\_\_\_\_ because of religious beliefs. [Insert this if appropriate: Camp kitchens are not kosher.]

\_\_\_\_\_ I respond with an anaphylactic reaction when I eat this food: \_\_\_\_\_

**Chronic Concerns:** Check all that pertain to you and provide information about supportive health care. \*Asthma or Diabetes? Complete additional form available [insert information here].

\_\_\_\_\_ I have no chronic health concerns.

\_\_\_\_\_ I have the following chronic health concern(s):  Asthma\*  Headaches/Migraines  Sleep problem  Diabetes\*

Difficult breathing  Dysmenorrhea  Fainting  Surgery history  Seizure disorder: \_\_\_\_\_

Back pain or injury  Knee or ankle weakness  Other: \_\_\_\_\_

Provide information about supportive healthcare needed for each checked item:

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**Immunization History:** Provide the month & year for immunizations. Asterisked (\*) immunizations must be current.

Immunization	Date — Month(s) & Year(s)	Immunization	Date — Month(s) & Year(s)
Tetanus Booster*	Current within 10 years:	Polio*	
Varicella* (Chicken Pox)		MMR (Mumps, Measles, Rubella)*	
Meningitis		Pneumococcal	
Pertussis Booster (Whooping Cough)	Recommended Update at 12 years:	DPT (diphtheria, tetanus, pertussis)*	
Hepatitis B		Hepatitis A	
Influenza			

**Medication:** Bring enough medication to last or bring your written prescription to order a refill. Prescription meds MUST be in pharmacy containers with appropriate labels; other remedies must be in original container. International Staff: translate information to English.

\_\_\_\_\_ I do not take medication on a routine basis.

\_\_\_\_\_ I take routine medication (include vitamins) as noted below.

Name of Medication	Reason for Taking It	Dose Given & When	Date Started?
		<input type="checkbox"/> Breakfast Dose: _____ <input type="checkbox"/> Evening Meal Dose: _____ <input type="checkbox"/> Bedtime Dose: _____ <input type="checkbox"/> Other: _____	
		<input type="checkbox"/> Breakfast Dose: _____ <input type="checkbox"/> Evening Meal Dose: _____ <input type="checkbox"/> Bedtime Dose: _____ <input type="checkbox"/> Other: _____	
		<input type="checkbox"/> Breakfast Dose: _____ <input type="checkbox"/> Evening Meal Dose: _____ <input type="checkbox"/> Bedtime Dose: _____ <input type="checkbox"/> Other: _____	



## General Physical History

1. Have you ever been hospitalized? ..... Yes No  
Have you ever had surgery? ..... Yes No
2. Have you ever passed out during or after exercise/physical exertion? ..... Yes No  
Have you ever been dizzy during or after exercise/physical exertion? ..... Yes No  
Have you ever had chest pain during or after exercise/physical exertion? ..... Yes No  
Do you tire more quickly than your friends during exercise/physical exertion? ..... Yes No  
Have you ever had high blood pressure? ..... Yes No  
Have you ever been told that you had a heart murmur? ..... Yes No  
Have you ever had racing of your heart or skipped heartbeats? ..... Yes No
3. Do you have skin problems (itching, rashes, acne)? ..... Yes No
4. Have you ever been knocked out, fainted, or become unconscious? ..... Yes No  
Have you ever had a seizure? ..... Yes No  
Have you ever had a stinger, burner, or pinched nerve? ..... Yes No
5. Have you ever had heat or muscle cramps? ..... Yes No  
Have you ever been dizzy or passed out in the heat? ..... Yes No
6. Have you ever sprained, strained, dislocated, fractured, broken, or had repeated swelling or other injuries to any of your body areas?  
..... Yes No  
If so, where?  Head  Shoulder  Thigh  Neck  Chest  Forearm  Shin/calf  
 Back  Wrist  Hand  Ankle  Elbow  Knee  Hip  Foot  
Can you lift and carry 30 pounds (14 kilograms) at least ten times without assistance or discomfort? ..... Yes No
7. Have you had chicken pox or are you immunized for chicken pox? ..... Yes No
8. Have you had mononucleosis in the past nine months? ..... Yes No
9. Do you have an uncorrected hearing problem? ..... Yes No  
Do you have an uncorrected vision (sight) problem? ..... Yes No  
Do you wear glasses or contacts or use protective eye wear? ..... Yes No
10. Do you smoke and/or use other tobacco products? ..... Yes No
11. Do you have any piercings? ..... Yes No  
If so, where?  Ears  Eyebrow  Nose  Tongue  Belly Button  Nipple  Other: \_\_\_\_\_
12. Do you have any problems with your teeth? ..... Yes No
13. Have you been in countries other than the United States in the past nine months? ..... Yes No  
If yes, list the countries and the length of time spent in them.  
Country: \_\_\_\_\_ Dates: \_\_\_\_\_  
Country: \_\_\_\_\_ Dates: \_\_\_\_\_  
Country: \_\_\_\_\_ Dates: \_\_\_\_\_
14. For women: Do you have a menstrual problem (pain, irregularity, etc.)? ..... Yes  
No

Explain and/or provide more detail about the General Physical Health questions to which you responded "yes."

Name of your physician: \_\_\_\_\_ Office Phone: (\_\_\_\_) \_\_\_\_\_

Name of your dentist/orthodontist: \_\_\_\_\_ Office Phone: (\_\_\_\_) \_\_\_\_\_

**Mental & Emotional Health Information**

- A. Have you been diagnosed with attention deficit disorder (ADD) or AD/HD. . . . . Yes No
- B. Do you have a psychiatric diagnosis such as depression, OCD, panic/anxiety, bipolar disorder that will impact your work? . . . Yes No
- C. Do you have an eating disorder that will impact your work? Type: \_\_\_\_\_ . . . . Yes No
- D. Do you have a learning disability that will impact your work? Type: \_\_\_\_\_ . . . . Yes No
- E. Do you have an emotional health concern that will impact your work? . . . . . Yes No
- F. During the past year, have you seen a professional about mental/emotional concerns that will impact your work?

If "yes" to any question in this section, attach a statement that:

- (a) Describes the concern and your management plan for addressing it while working at camp; and
- (b) Describes the support needed from your work supervisor to compliment your plan. Refer to the Essential Functions of your job, available [insert location], if there are questions.

**Paying for Health Care:**

- There is usually no charge for health care provided by the camp's Health Center staff.
- Staff are financially responsible for health care provided by out-of-camp providers.
- If you will be using personal insurance while working at camp, it is your responsibility to know how to access that insurance. Bring your insurance card and know how to use it. Consider obtaining pre-authorization if your insurance requires this.

**Emergency Contact:** Whom do you want us to contact in an emergency?

First Contact: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Relationship to You: \_\_\_\_\_

Alternate Contact: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Relationship to You: \_\_\_\_\_

**Authorization for Health Care:** Parental signature required for staff less than 18 years of age.

This health history is correct insofar as I know. I am capable of performing the essential functions of my job and participating in assigned work duties as noted on this form. I understand my health information will be used by the camp Health Center staff in providing care to me and may be reviewed by work supervisor.

Signature of Staff Person: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Parent (if needed): \_\_\_\_\_ Date: \_\_\_\_\_





NEW YORK STATE AND LOCAL RETIREMENT SYSTEM  
110 STATE STREET, MAIL DROP 6-5  
ALBANY NY 12244-0001

# Survivor's Benefit Program

## Non-Member Employee Designation of Beneficiary for Eligible Employees of a New York State Agency

RS 6357

(Rev. 3/03)

Please PRINT all entries and submit to your Personnel Office. DO NOT mail to the NYS and Local Retirement System.  
PLEASE SEE REVERSE SIDE FOR INSTRUCTIONS.

CHECK THE  
APPROPRIATE BOX:

- I have never been a member of any public retirement system.  
 I am or have been a member of this retirement system: \_\_\_\_\_

Name \_\_\_\_\_ Ret. Reg. Number \_\_\_\_\_  
Home Address \_\_\_\_\_ Social Security Number \_\_\_\_\_  
City, State \_\_\_\_\_ Zip Code \_\_\_\_\_ Former Name \_\_\_\_\_  
Date of Birth \_\_\_\_\_

To the Comptroller of the State of New York.  
Designation of Beneficiary(ies)

I hereby name the following beneficiary(ies) to receive any survivor's benefit payable on my behalf. I realize that, if a death benefit is payable for which the beneficiary(ies) are mandated by law, this designation will be superseded. If I have named more than one beneficiary, it is my intention that those living at the time of my death should share equally any benefit payable. I reserve the right to change the designation at any time.

1 Name \_\_\_\_\_  
Relationship \_\_\_\_\_ Birth Date \_\_\_\_\_  
Soc. Sec. No.\* \_\_\_\_\_ Sex \_\_\_\_\_  
Address (Street, City, State, Zip) \_\_\_\_\_

2 Name \_\_\_\_\_  
Relationship \_\_\_\_\_ Birth Date \_\_\_\_\_  
Soc. Sec. No.\* \_\_\_\_\_ Sex \_\_\_\_\_  
Address (Street, City, State, Zip) \_\_\_\_\_

3 Name \_\_\_\_\_  
Relationship \_\_\_\_\_ Birth Date \_\_\_\_\_  
Soc. Sec. No.\* \_\_\_\_\_ Sex \_\_\_\_\_  
Address (Street, City, State, Zip) \_\_\_\_\_

4 Name \_\_\_\_\_  
Relationship \_\_\_\_\_ Birth Date \_\_\_\_\_  
Soc. Sec. No.\* \_\_\_\_\_ Sex \_\_\_\_\_  
Address (Street, City, State, Zip) \_\_\_\_\_

**DESIGNATION OF CONTINGENT BENEFICIARY(IES)**

If all the above named beneficiaries die before I do, any amount payable on my behalf should be paid to the following. If I have named more than one beneficiary, it is my intention that those living at the time of my death should share any benefit equally. This designation revokes all previous designations I have made.

Name \_\_\_\_\_  
Relationship \_\_\_\_\_ Birth Date \_\_\_\_\_  
Soc. Sec. No.\* \_\_\_\_\_ Sex \_\_\_\_\_  
Address (Street, City, State, Zip) \_\_\_\_\_

Name \_\_\_\_\_  
Relationship \_\_\_\_\_ Birth Date \_\_\_\_\_  
Soc. Sec. No.\* \_\_\_\_\_ Sex \_\_\_\_\_  
Address (Street, City, State, Zip) \_\_\_\_\_

Member's Signature \_\_\_\_\_ Date \_\_\_\_\_

Employed By: Name of Agency \_\_\_\_\_ Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

**ACKNOWLEDGEMENT TO BE COMPLETED BY A NOTARY PUBLIC**

State of \_\_\_\_\_ County of \_\_\_\_\_

On the \_\_\_\_\_ day of \_\_\_\_\_ in the year \_\_\_\_\_ before me, the undersigned, personally appeared \_\_\_\_\_ personally known to me or proved to me on the basis of satisfactory evidence to be the individual(s) whose name(s) is (are) subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their capacity(ies), and that by his/her/their signature(s) on the instrument, the individual(s), or the person upon behalf of which the individual(s) acted, executed the instrument.

NOTARY PUBLIC (Please sign and affix stamp)

**PERSONAL FINANCY PROTECTION LAW**

In accordance with the Personal Financy Law you are hereby advised that pursuant to the Retirement and Social Security Law, the Retirement System is required to maintain records. The records are necessary to determine eligibility for and to calculate benefits. Failure to provide information may result in the failure to pay benefits. The System may provide certain information to participating employers. The official responsible for maintaining these records is the Director of Member Services, New York State and Local Retirement System, Albany, NY 12244-0001; toll-free at 1-800-805-0090 or 474-7731 in the Albany area.

**SOCIAL SECURITY NUMBER PROTECTION**

In accordance with the Federal Privacy Act of 1974, you are hereby advised that disclosure of the Social Security Account Number is mandatory pursuant to Sections 11, 34, 311 and 334 of the Retirement and Social Security Law. The number will be used in identifying retirement records and in the administration of the Retirement System.

**WAIVER OF MEMBERSHIP IN  
NEW YORK STATE EMPLOYEES' RETIREMENT SYSTEM  
CONTRACT COLLEGES AND EXTENSION ASSOCIATIONS  
CORNELL UNIVERSITY**

I hereby waive my right and privilege to participate as a member or otherwise in the New York State Employees' Retirement System. In exercising this waiver, I understand that:

1. As a part-time, temporary or seasonal employee on the payroll of the contract colleges at Cornell University, I am eligible to apply for membership in the New York State Employees' Retirement System.
2. As long as I continue as a part-time, temporary or seasonal employee, I will not be subject to the employee contribution obligation nor shall I be given retirement credit under said System.
3. I understand that my employment will be subject to Social Security taxes (FICA) and, as a result, I will receive Social Security credit relating to this employment.

In exercising this waiver, I hereby expressly release and relieve Cornell University from any and all liability or responsibility for providing retirement or beneficiary benefits for me or any other person in respect of my earnings to which I have hereby waived my rights.

Signature \_\_\_\_\_

Print Name \_\_\_\_\_

Social Security Number \_\_\_\_\_

Department CCE Schuyler County

Dated: \_\_\_\_\_



HIDDEN VALLEY 4-H CAMP  
323 Owego Street, Unit 5  
Montour Falls, NY 14865  
(607) 535-7161



## Personnel Policies Acknowledgement

- I acknowledge receipt of the Hidden Valley 4-H Camp Personnel Policies and understand that this document supersedes all prior documents and any other verbal or written agreements.
- I have read and understand the camp policies. I also understand and agree that my employment is at-will, which means I have the right to terminate my employment at any time and for any reason and the Camp has the same right.
- I shall endeavor to understand and faithfully interpret the camp philosophy, objectives, and goals in my relationship with campers and all staff.
- I shall conduct myself in an exemplary manner, recognizing that I am an adult role model for my campers. By my behavior, I will always try to demonstrate high moral values. I recognize that my conduct when I am away from the camp premises also reflects on the camp.
- I shall always seek to be truthful, honest, and fair in my communication and interaction with campers and all staff including directors.
- I accept the challenge of helping my campers increase their awareness of and responsibility to others and to the world of nature, helping them gain in self-confidence and self-concept, and of teaching them new skills.
- I shall refrain from abusive language and any form of corporal punishment or embarrassment in my dealing with campers and other staff.
- I shall be accepting of the diverse racial, national, religious, and cultural background of my campers, and not seek to impose my own particular views.

THE CAMP RESERVES THE RIGHT TO CANCEL THIS AGREEMENT WITHOUT NOTICE, IN FULL OR PART: (a) in the event of unsatisfactory service; (b) for personal conduct not in accordance with camp standards; (c) or should low camper attendance require a reduction in force for all or part of the camping season. If the agreement is cancelled for any reason the employee will be paid only for that portion of the season which he/she has served.

The staff member (and parent/guardian as required) indicates agreement with the above terms and the understanding outlined on the Personnel Policies document included by affixing their signature(s) below on this date.

\_\_\_\_\_  
Staff Member Signature Date \_\_\_\_\_

\_\_\_\_\_  
Staff Member's Parent/Guardian's Signature Date \_\_\_\_\_  
(if staff member is under 18 years of age)

\_\_\_\_\_  
Camp Director Signature Date \_\_\_\_\_

## CONFIDENTIALITY AGREEMENT EMPLOYEE

The undersigned Employee of Cornell Cooperative Extension ("Extension") has had and/or will have access to certain confidential information relating to clients or program participants or Extension as a result of his/her employment with Extension. The Employee acknowledges the confidential nature of the Confidential Information and agrees to keep same confidential as provided herein. As used herein, the term "Confidential Information" shall mean any and all financial information or other information about the client or program participant gained by the employee during his/her employment or designated as Confidential Information in a written directive given to the Employee or general written directives related to programming by Extension.

The Employee shall (1) treat the Confidential Information as confidential; (2) will not in any way disclose Confidential Information except as directed by Extension as part of the Employee's employment responsibilities or unless under legal compulsion to do so, to any person entity other than its representatives who require such information in connection with its business with Extension; and (3) will not use the Confidential Information for his/her own benefit or for purposes other than the furtherance of Extension and its business.

Upon request or direction by Extension or upon termination of employment with Extension, the employee will promptly deliver all Confidential Information in written or other media form (together with any and all copies or summaries the Employee may have created there from) to Extension.

The obligation of the Employee to maintain the confidentiality of the Confidential Information shall survive the termination of employment of the Employee regardless of the reason or reasons for termination of employment with Extension.

Executed this \_\_\_\_\_ day of \_\_\_\_\_, 2017

Cornell Cooperative Extension of Schuyler County

BY: \_\_\_\_\_

\_\_\_\_\_  
EMPLOYEE SIGNATURE

\_\_\_\_\_  
EMPLOYEE NAME

**Voluntary Disclosure Statement**  
**All Camp Staff FM 16**  
 Developed and approved by the  
*American Camping Association®*

Mail this form to the address below by \_\_\_\_\_ ( date)

Name \_\_\_\_\_ Birth date \_\_\_\_\_  
Last First Middle

Home address \_\_\_\_\_  
Street Address City State  
Zip

Social Security # \_\_\_\_\_ Other names by which known (e.g., maiden name) \_\_\_\_\_

Home phone \_\_\_\_\_ Business phone (if applicable) \_\_\_\_\_

School or College \_\_\_\_\_

Address \_\_\_\_\_  
Street Address City State  
Zip

Driver's License # \_\_\_\_\_ State \_\_\_\_\_ Expiration Date \_\_\_\_\_

1. Previous residence(s) for last 5 years (include college and home residences):

City \_\_\_\_\_ State \_\_\_\_\_ Years \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Years \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Years \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Years \_\_\_\_\_

(Continue on separate sheet if necessary.)

2. Have you ever been convicted of any crime relating in any manner to children and/or your conduct with them?  
 No  Yes  
 If yes, please explain: (Use a separate sheet if necessary.)

\_\_\_\_\_

\_\_\_\_\_

3. Have you ever been convicted of any crime including, but not limited to, those listed below and/or any crime similar in any manner to those listed below?  
 No  Yes

- Indecent assault and battery on a child under fourteen
- Indecent assault and battery on a mentally retarded person
- Indecent assault and battery on a person who has obtained the age of fourteen
- Rape
- Rape of a child under sixteen with force
- Assault with intent to commit rape
- Kidnapping of a child under sixteen with intent to commit rape
- Distribution and trafficking of narcotics or other controlled substances
- Intent to commit any of the above crimes



If yes, please explain: (Use a separate sheet if necessary.)

4. Have you ever been adjudged liable for civil penalties or damages involving sexual or physical abuse of children?  
 Yes                       No  
If yes, please explain: (Use a separate sheet if necessary.)

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5. Are you now or have you ever been subject to any court order involving sexual or physical abuse of a minor, including, but not limited to a domestic order or protection?  Yes  
 No  
If yes, please explain: (Use a separate sheet if necessary.)

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6. Have your parental rights ever been terminated for reasons involving sexual or physical abuse of children?  Yes  
 No  
If yes, please explain: (Use a separate sheet if necessary.)

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I understand that:

- a. The camp may deny employment to any person who answers any of questions numbered 2-5 above in the affirmative.
- b. In applying for a camp position the information which I have furnished on this form is subject to verification, which may include a criminal history check and request from any Central Registry of child abusers.
- c. The camp may terminate employment or volunteer service of any person:
  - 1) found to have a history of complaints of abuse or a minor and/or
  - 2) found to have resigned, been terminated or been asked to resign from a position whether paid or unpaid, due to complaint(s) of sexual abuse of a minor.
- d. This disclosure statement must be updated yearly.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Signature of Minor's Parent or Guardian \_\_\_\_\_ Date \_\_\_\_\_



HIDDEN VALLEY 4-H CAMP  
323 Owego St., Unit 5  
Montour Falls, NY 14865  
(607) 535-7161



### Junior Counselor waiver

It is irrevocable Camp policy that no Junior Counselor, under 18 years of age, is permitted to drive a car while employed by Hidden Valley 4-H Camp, including during days off. It is also irrevocable Camp policy that no Junior Counselor while employed by Hidden Valley 4-H Camp, including during days off, is permitted to ride as a passenger in a vehicle, unless such vehicle is owned or leased by Hidden Valley 4-H Camp and is being driven by an adult employee of Hidden Valley 4-H Camp for Camp purposes designated by a senior staff member of Camp, subject to the following exception. Notwithstanding the general prohibition, a Junior Counselor will not be deemed to have violated this policy if he or she is riding as a passenger in another person's vehicle with the express prior written consent of Junior Counselor's Parents/Guardians. This policy is not subject to change or exception.

Junior Counselor and Parent/Guardian acknowledge and agree to such policy and that any activity by Junior Counselor as a passenger except as expressly permitted above is in violation of Camp policy and was done without consent or knowledge of Hidden Valley 4-H Camp.

Parents/Guardians hereby \_\_\_\_\_ prohibit or \_\_\_\_\_ expressly permit (Check One) their child, the Junior Counselor, to be a passenger in any other person's vehicle with the full understanding that such trip is without any supervision by or responsibility of Hidden Valley 4-H Camp.

Parents/Guardian Initials:

\_\_\_\_\_

I have read the agreement above and fully understand its terms and accept its conditions. In the event that this Agreement is executed by one Parent/Guardian, I represent that I am also acting as the agent of the other Parent/Guardian with the authority to permit my child to work at Hidden Valley 4-H Camp and to execute this Agreement on his/her behalf. I recognize that the Camp relies upon the representation herein made in accepting the agreement.

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Camp Director/Manager Signature

\_\_\_\_\_  
Date

*Cornell Cooperative Extension offers equal program and employment opportunities.*