



PENN HILLS SCHOOL DISTRICT

ADMINISTRATIVE OFFICES

260 Aster Street

Pittsburgh, Pennsylvania 15235

412-793-7000 – Telephone

412-793-1787 – Fax

www.phsd.k12.pa.us

PENN HILLS SCHOOL DISTRICT

Clearance Information Sheet

Welcome and thank you for your interest in employment with the Penn Hills School District!

Prior to you starting employment with the District, you must complete and submit the following clearances:

1. **ACT 114- FBI Clearance-** *Please submit your UE ID Number after your prints are scanned.*
<https://www.identogo.com/locations> to find a location near you from the UEP registration. This acronym 'UEP' represents the Universal Enrollment Platform and is the innovative solution provided by Idemia (MorphoTrust LLC) to simply and reduce cost.

Register with Identogo.com through the above site. Make sure you register for the **Department of Education** FBI clearance. The Service Code you will use is **1KG6XN**. Take your receipt and a valid photo id to the fingerprinting site. (Call the site first to be sure they are still open.) Once you have registered and had your prints scanned, please submit your registration id number (UE ID number) to the HR department..

2. **ACT 34- Pennsylvania Criminal History Check-** *Please use the website for this clearance not the printed form.*
<https://epatch.state.pa.us/Home.jsp>
Go to "New Record" and follow the instructions through to the Certification Page. Once the Search Results Table appears, click on the Control Number. (*Hint: Write down the Control Number for future reference.*) The Record Check Details page is opened. Click on the **Certification Page** to access your official Clearance. The Record Check Details page is only a receipt and not acceptable as a 'clearance'. Print 2 Certification Pages, 1 for you and one for your Personnel File.

3. **ACT 151 -Pennsylvania Child Abuse Clearance-** *Please use the website for this clearance not the printed form.*

NOTE: Effective December 31, 2014 an electronic form will be available to apply for your Child Abuse clearance online at <https://www.compass.state.pa.us/CWIS>

4. **Completion of Act 126 Mandated Reporter Training Part 1.** Please provide a copy of the certificate documented you have completed the training OR if you have not completed the training, go to www.reportabusepa.pitt.edu. This is a free online course offered through the Pennsylvania Child Welfare Resource Center. Upon completion, a copy of certificate must be submitted to the HR department.
5. **Completion of Act 126 Mandated Reporter Training Part 2.** Please provide a copy of the certificate documented you have completed the training OR if you have not completed the training, information will be provided to you through Safe Schools. This is a free online course offered through Penn Hills School District. Upon completion, a copy of certificate must be submitted to the HR department.



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

USCIS
Form I-9
 OMB No. 1615-0047
 Expires 10/31/2022

▶ **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 *(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 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 <i>(See Instructions)</i> | |
| <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. <i>(See Instructions)</i> | |
| <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: _____ OR 2. Form I-94 Admission Number: _____ OR 3. Foreign Passport Number: _____ Country of Issuance: _____</p> | |
| QR Code - Section 1 Do Not Write in This Space | |

| | |
|-----------------------|---------------------------|
| Signature of Employee | Today's Date (mm/dd/yyyy) |
|-----------------------|---------------------------|

Preparer and/or Translator Certification (check one):
 I did not use a preparer or translator. A preparer(s) and/or translator(s) assisted the employee in completing Section 1.
(Fields below must be completed and signed when preparers and/or translators assist an employee in completing 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 |

STOP *Employer Completes Next Page* STOP



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

USCIS
Form I-9
 OMB No. 1615-0047
 Expires 10/31/2022

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 a combination of one document from List B and one document from List C as listed on the "Lists of Acceptable Documents.")

| | | | | |
|-------------------------------------|-------------------------|-------------------------|------|--------------------------------|
| Employee Info from Section 1 | Last Name (Family Name) | First Name (Given Name) | M.I. | Citizenship/Immigration Status |
|-------------------------------------|-------------------------|-------------------------|------|--------------------------------|

| 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 | | <div style="border: 1px solid black; padding: 5px;"> Additional Information </div> | | <div style="border: 1px solid black; padding: 5px; text-align: center;"> QR Code - Sections 2 & 3 Do Not Write in This Space </div> |
| Issuing Authority | | | | |
| Document Number | | | | |
| Expiration Date (if any) (mm/dd/yyyy) | | | | |
| Document Title | | | | |
| Issuing Authority | | | | |
| Document Number | | | | |
| Expiration Date (if any) (mm/dd/yyyy) | | | | |

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 | Today's Date (mm/dd/yyyy) | Title of Employer or Authorized Representative | | |
| Last Name of Employer or Authorized Representative | First Name of Employer or Authorized Representative | Employer's Business or Organization Name | | |
| Employer's Business or Organization Address (Street Number and Name) | | City or Town | State | ZIP Code |

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

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

C. If the employee's previous grant of employment authorization has expired, provide the information for the document or receipt that establishes continuing 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 | Today's Date (mm/dd/yyyy) | Name of Employer or Authorized Representative |
|--|---------------------------|---|

LISTS OF ACCEPTABLE DOCUMENTS

All documents must be UNEXPIRED

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

| LIST A Documents that Establish Both Identity and Employment Authorization | OR | LIST B Documents that Establish Identity | AND | LIST C Documents that Establish Employment Authorization |
|--|----|---|-----|---|
| <ol style="list-style-type: none"> 1. U.S. Passport or U.S. Passport Card 2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551) 3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa 4. Employment Authorization Document that contains a photograph (Form I-766) 5. For a nonimmigrant alien authorized to work for a specific employer because of his or her status: <ol style="list-style-type: none"> a. Foreign passport; and b. Form I-94 or Form I-94A that has the following: <ol style="list-style-type: none"> (1) The same name as the passport; and (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. 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 | OR | <ol style="list-style-type: none"> 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 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 3. School ID card with a photograph 4. Voter's registration card 5. U.S. Military card or draft record 6. Military dependent's ID card 7. U.S. Coast Guard Merchant Mariner Card 8. Native American tribal document 9. Driver's license issued by a Canadian government authority <li style="text-align: center;">For persons under age 18 who are unable to present a document listed above: 10. School record or report card 11. Clinic, doctor, or hospital record 12. Day-care or nursery school record | AND | <ol style="list-style-type: none"> 1. A Social Security Account Number card, unless the card includes one of the following restrictions: <ol style="list-style-type: none"> (1) NOT VALID FOR EMPLOYMENT (2) VALID FOR WORK ONLY WITH INS AUTHORIZATION (3) VALID FOR WORK ONLY WITH DHS AUTHORIZATION 2. Certification of report of birth issued by the Department of State (Forms DS-1350, FS-545, FS-240) 3. Original or certified copy of birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal 4. Native American tribal document 5. U.S. Citizen ID Card (Form I-197) 6. Identification Card for Use of Resident Citizen in the United States (Form I-179) 7. Employment authorization document issued by the Department of Homeland Security |

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

Refer to the instructions for more information about acceptable receipts.

**SCHOOL PERSONNEL HEALTH RECORD
(FOR USE AFTER OFFER OF EMPLOYMENT HAS BEEN MADE)**

I. INFORMATION

School Position Offered _____

| | | | | |
|-----------|-------|----|-----|---------------|
| Last Name | First | MI | Sex | Date of Birth |
|-----------|-------|----|-----|---------------|

| | | |
|------------|------------|------------|
| Home Phone | Cell Phone | Work Phone |
|------------|------------|------------|

| | | | |
|-------------------------|------|-------|-----|
| Mailing Address: Street | City | State | Zip |
|-------------------------|------|-------|-----|

Emergency Contact

Name: _____ Relationship: _____

Address: _____

Telephone number: _____
 (Home) _____ (Work) _____ (Cell) _____

II. IMMUNIZATION HISTORY (Recommended, but not mandated by law)

| VACCINE <small>(Check appropriate box)</small> | Enter Month, Day, and Year Each Immunization DOSE Was Given | | | | |
|--|--|---|--|---|---|
| | 1 | 2 | 3 | 4 | 5 |
| Diphtheria, Tetanus with Pertussis <input type="checkbox"/> Td <input type="checkbox"/> TdaP | | | | | |
| Hepatitis B | | | | | |
| Measles-Mumps-Rubella (MMR) | | | Rubella Serology/Date/Titer Mumps disease diagnosed by a physician: Date Measles Serology/Date/Titer | | |
| Varicella <input type="checkbox"/> Vaccine <input type="checkbox"/> Disease <input type="checkbox"/> Serology Date: Neg/Pos | | | | | |
| Influenza | | | | | |

III. TUBERCULOSIS SKIN TEST RESULTS (Testing required per Regulations of the Department of Health)

| DATE GIVEN | SITE: LA / RA | GIVEN BY: | ANTIGEN NAME | MANUFACTURER / LOT # / EXP DATE | SIGNATURE |
|------------|------------------|-----------|-------------------|------------------------------------|-----------|
| | | | | | |
| DATE READ | RESULTS in MM | | READ BY SIGNATURE | | |
| | | | | | |

OR

IGRA TEST RESULTS

| DATE COLLECTED | TEST NAME (QFT-GIT, T-SPOT, etc) | POSITIVE | NEGATIVE | INDETERMINATE | QUANTITATIVE RESULT |
|----------------|----------------------------------|----------|----------|---------------|---------------------|
| | | | | | |

DATE TEST COMPLETED _____

SIGNATURE _____

Previously known/new positive reactors: _____

Chest X-ray:
(Attach a copy of the report.)

Date:

Results:

Other:

Date:

Results:

(Attach a copy of the report.)

Preventive Anti-Tuberculosis Chemotherapy ordered: No Yes Date: _____

IF SIGNIFICANT REACTION WAS REPORTED, THE PRIMARY CARE PROVIDER REPORT MUST STATE THAT THE APPLICANT IS CURRENTLY FREE FROM TUBERCULOSIS DISEASE.

IV. MEDICAL CONDITIONS (✓)

| | Yes | No | If Yes, Explain: |
|---------------------------------|--------------------------|--------------------------|------------------|
| Allergies | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Asthma | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Cardiac | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Chemical Dependency | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Drugs | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Alcohol | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Diabetes Mellitus | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Gastrointestinal Disorder | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Hearing Disorder | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Hypertension | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Neuromuscular Disorder | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Orthopedic Condition | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Respiratory Illness | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Seizure Disorder | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Skin Disorder | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Vision Disorder | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Other (Specify) | <input type="checkbox"/> | <input type="checkbox"/> | _____ |

V. PHYSICAL EXAMINATION (✓)

| | NORMAL | ABNORMAL | NOT EXAMINED | COMMENTS |
|-------------------------------|--------|----------|--------------|----------|
| Height (inches) | | | | |
| Weight (pounds) | | | | |
| Pulse | | | | |
| Blood Pressure | | | | |
| Hair/Scalp | | | | |
| Skin | | | | |
| Eyes – Visual Acuity: RL | | | | |
| Eyes – Color Vision | | | | |
| Ears – Hearing (dB) RL | | | | |
| Nose and Throat | | | | |
| Teeth and Gingiva | | | | |
| Lymph Glands | | | | |
| Heart – Murmur, etc... | | | | |
| Lungs – Adventitious Findings | | | | |

| | | | | |
|----------------------|--|--|--|--|
| Abdomen | | | | |
| Genitourinary | | | | |
| Neuromuscular System | | | | |
| Extremities | | | | |

Are there any special medical problems or chronic diseases which require restriction of activity, medication which might affect his/her work role? If so, specify

Are there any special equipment or accommodations needed to enable this person to perform their duties? If so, specify

 Physician Name (Print) Signature of Examiner Date

 Physician Address

The statements and answers as recorded above are full, complete and true to the best of my knowledge and belief. I understand that any false or misleading statements may cause termination of my employment.

I authorize the physician or other person to disclose any knowledge or information pertaining to my health to the employing authority for whom this examination is performed.

 Signature of Employee Date

COMMONWEALTH OF PENNSYLVANIA
SEXUAL MISCONDUCT/ABUSE DISCLOSURE RELEASE
(Pursuant to Act 168 of 2014)

Instructions

This standardized form has been developed by the Pennsylvania Department of Education, pursuant to Act 168 of 2014, to be used by school entities and independent contractors of school entities and by applicants who would be employed by or in a school entity in a position involving direct contact with children to satisfy the Act's requirement of providing information related to abuse or sexual misconduct. As required by Act 168, in addition to fulfilling the requirements under section 111 of the School Code and the Child Protective Services Law ("CPSL"), an applicant who would be employed by or in a school entity in a position having direct contact with children, must provide the information requested in SECTION 1 of this form and complete a written authorization that consents to and authorizes the disclosure by the applicant's current and former employers of the information requested in SECTION 2 of this form. The applicant shall complete one form for the applicant's current employer(s) and one for each of the applicant's former employers that were school entities or where the applicant was employed in a position having direct contact with children (therefore, the applicant may have to complete more than one form). Upon completion by the applicant, the hiring school entity or independent contractor shall submit the form to the applicant's current and former employers to complete SECTION 2. **A school entity or independent contractor may not hire an applicant who does not provide the required information for a position involving direct contact with children.**

Relevant Definitions:

Direct Contact with Children is defined as: "the possibility of care, supervision, guidance or control of children or routine interaction with children."

Sexual Misconduct is defined as: "any act, including, but not limited to, any verbal, nonverbal, written or electronic communication or physical activity, directed toward or with a child or a student regardless of the age of the child or student that is designated to establish a romantic or sexual relationship with the child or student. Such acts include, but are not limited to: (1) sexual or romantic invitation; (2) dating or soliciting dates; (3) engaging in sexualized or romantic dialogue; (4) making sexually suggestive comments; (5) self-disclosure or physical exposure of a sexual, romantic or erotic nature; or (6) any sexual, indecent, romantic or erotic contact with the child or student."

Abuse is defined as "conduct that falls under the purview and reporting requirements of the CPSL, 23 Pa.C.S. Ch. 63, is directed toward or against a child or a student, regardless of the age of the child or student."

Please Note

A prospective employer that receives any requested information regarding an applicant may use the information for the purpose of evaluating the applicant's fitness to be hired or for continued employment and shall report the information as appropriate to the Department of Education, a state licensing agency, law enforcement agency, child protective services agency, another school entity or to a prospective employer.

If the prospective employer decides to further consider an applicant after receiving an affirmative response to any of the questions listed in SECTIONS 1 and 2 of this form, the prospective employer shall request that former employers responding affirmatively to the questions provide additional information about the matters disclosed and include any related records. The **Commonwealth of Pennsylvania Sexual Misconduct/Abuse Disclosure Information Request** can be used to request this follow-up information. Former employers shall provide the additional information and records within 60 calendar days of the prospective employer's request.

The completed form and any information or records received shall not be considered public records for the purposes of the Act of February 14, 2008 (P.L. 6, No. 3) known as the "Right to Know Law."

The Department of Education shall have jurisdiction to determine willful violations of Act 168 and may, following a hearing, assess a civil penalty not to exceed \$10,000. School entities shall be barred from entering into a contract with an independent contractor who is found to have willfully violated the provisions of Act 168.

**COMMONWEALTH OF PENNSYLVANIA
SEXUAL MISCONDUCT/ABUSE DISCLOSURE RELEASE
(under Act 168 of 2014)**

(Hiring school entity or independent contractor submits this form to ALL current employer(s) and to former employer(s) that were school entities and/or where the applicant had direct contact with children)

| | | |
|-----|-------------------------------------|---|
| To: | Name of Current or Former Employer: | <input type="checkbox"/> No applicable employment |
| | Street Address: | |
| | City, State, Zip: | |
| | Telephone Number: | Fax Number: Email: |
| | Contact Person: | Title: |

The named applicant is under consideration for a position with our entity. The Pennsylvania General Assembly has determined that additional safeguards are necessary in the hiring of school employees to ensure the safety of the Commonwealth's students. The individual whose name appears below has reported previous employment with your entity. We request you provide the information requested in SECTION 2 of this form within **20 calendar days** as required by Act 168 of 2014.

SECTION 1: APPLICANT CERTIFICATION AND RELEASE (TO BE COMPLETED BY THE APPLICANT EVEN IF THE APPLICANT HAS NO CURRENT OR PRIOR EMPLOYMENT TO DISCLOSE)

| | |
|---|-----------------------|
| Applicant's Name (First, Middle, Last): | |
| Any former names by which the Applicant has been identified: | |
| DOB: | |
| Last 4 digits of Applicant's Social Security Number: | PPID (if applicable): |
| Approximate dates of employment with the entity listed above: | |
| Position(s) held with the entity: | |

Pursuant to Act 168, an employer, school entity, administrator, and/or independent contractor that provides information or records about a current or former employee or applicant shall be immune from criminal liability under the CPSL, the Educator Discipline Act, and from civil liability for the disclosure of the information, unless the information or records provided were knowingly false. Such immunity shall be in addition to and not in limitation of any other immunity provided by law or any absolute or conditional privileges applicable to such disclosure by the virtue of the circumstances of the applicant's consent thereto. Under Act 168, the willful failure to respond to or provide the information and records as requested may result in civil penalties and/or professional discipline, where applicable.

Have you (Applicant) ever:

- Yes No Been the subject of an abuse or sexual misconduct investigation by any employer, state licensing agency, law enforcement agency or child protective services agency (unless the investigation resulted in a finding that the allegations were false)?
- Yes No Been disciplined, discharged, non-renewed, asked to resign from employment, resigned from or otherwise separated from employment while allegations of abuse or sexual misconduct were pending or under investigation or due to adjudication or findings of abuse or sexual misconduct?
- Yes No Had a license, professional license or certificate suspended, surrendered or revoked while allegations of abuse or sexual misconduct were pending or under investigation or due to an adjudication or findings of abuse or sexual misconduct?

By signing this form, I certify under penalty of law that the statements made in this form are correct, complete, and true to the best of my knowledge. I understand that false statements herein, including, without limitation, any willful failure to disclose the information required, shall subject me to criminal prosecution under 18 Pa.C.S. § 4904 (relating to unsworn falsification to authorities) and to discipline up to, and including, termination or denial of employment, and may subject me to civil penalties and disciplinary action under the Educator Discipline Act. I also hereby authorize the above-named employer to release to the entity listed on page 3, the information requested in SECTION 2 of this form and any related records. I hereby release, waive, and discharge the above-named employer from any and all liability of any kind that may arise from such disclosure or release of records. I understand that third party vendors may be used to process this Act 168 pre-employment history review.

Signature of Applicant

Date

SECTION 2: CURRENT/FORMER EMPLOYER VERIFICATION (TO BE COMPLETED BY THE APPLICANT'S CURRENT EMPLOYER(S) AND ALL FORMER EMPLOYERS THAT WERE SCHOOL ENTITIES AND/OR WHERE THE APPLICANT HAD DIRECT CONTACT WITH CHILDREN)

Dates of employment of Applicant: _____

Contact telephone #: _____

To the best of your knowledge, has Applicant ever:

- Yes No Been the subject of an abuse or sexual misconduct investigation by any employer, state licensing agency, law enforcement agency or child protective services agency (unless the investigation resulted in a finding that the allegations were false)?
- Yes No Been disciplined, discharged, non-renewed, asked to resign from employment, resigned from or otherwise separated from employment while allegations of abuse or sexual misconduct were pending or under investigation or due to adjudication or findings of abuse or sexual misconduct?
- Yes No Had a license, professional license or certificate suspended, surrendered or revoked while allegations of abuse or sexual misconduct were pending or under investigation or due to an adjudication or findings of abuse or sexual misconduct?
- No records or other evidence currently exists regarding the above questions. I have no knowledge of information pertaining to the applicant that would disqualify the applicant from employment.

Former Employer Representative Signature and Title

Date

Return all completed information to:

| | | | |
|---|--------------|-----------------------------------|---|
| School Entity/Independent Contractor: Penn Hills School District | | | |
| Address: 260 Aster St. | | Phone: 412-793-7000 ext. 1260 | |
| City: Pittsburgh | State: PA | Zip: 15235 | Fax: 412-712-1009 Email: rkolla@phsd.k12.pa.us |
| Contact Person: Robert Kollar | | Title: Dir. of Human Resources | |

Date Form Received: _____

Received by: _____

PENN HILLS SCHOOL DISTRICT

ADMINISTRATIVE OFFICES

260 Aster Street

Pittsburgh, Pennsylvania 15235

412-793-7000 – Telephone

412-793-1787 – Fax

www.phsd.k12.pa.us



TO: All PHSD Employees, Substitutes and Contracted Individuals

FROM: Director of Human Resources

SUBJECT: Arrest/Conviction Report and Certification Form: Background Checks for School Employees

(under Act 24 of 2011 and Act 82 of 2012)

Act 82 of 2012 contains amendments to the Pennsylvania Public School Code and to the previous Act 24 of 2011 law that are designed to enhance the safety of school children. Among the changes is a requirement that **all current** school employees certify whether or not they have been previously arrested or convicted of a Section 111 (e) and Section 111 (f.1) offense. A complete list of all Section 111 (e) and Section 111 (f.1) offenses are on the enclosed revised PDE Form-6004.

Under Act 82, all current school employees are required to complete, sign and return the enclosed revised PDE Form-6004 to the Human Resources Department if they have an arrest and/or conviction of any offense listed under the Section 111 (e) and Section 111 (f.1) and they did not report said offense previously.

Additionally, within 72 hours, school employees must report any arrest and/or convictions of an offense listed in Section 111 (e) and Section 111 (f.1). PDE Form-6004 shall be used to report these arrests or convictions and the forms should be submitted to the Human Resources Department. The law provides that willful failure to timely report any such arrest or conviction can result in termination of your employment.

The law requires that if Human Resources has a reasonable belief that an employee was arrested or convicted under a Section 111 (e) and Section 111 (f.1) offense and the employee has not notified the Human Resources Department of such arrest and/or conviction, Human Resources will require the school employee to submit a current Section 111 background check. Under these circumstances, the background check shall be at the expense of the employee entity.

Finally, under Section 2070.9 (a) of the Professional Educator Discipline Act, the Chief School Administrator or Director of Human Resources is required to report to the Professional Standards and Practices Commission (PSPC) all instances of employees reporting an arrest or conviction noted on revised PDE Form-6004.

The form should be sent to Penn Hills School District, 260 Aster Street, Pittsburgh, PA 15235, Attention: Human Resources. Please note that your signature on the form certifies under penalty of law that the

statements you make on the form are true, correct and complete. Any false statements shall be subject to criminal prosecution under 18 Pa.C.S Section 4904.

Penn Hills School District appreciates your cooperation in complying with Act 82 by your submission of a completed PDE Form-6004 as part of your employment requirements.

The following is a summary of offenses and their effect on school employment:

| OFFENSE | EFFECT ON EMPLOYMENT |
|---|---|
| Sect 111(e) Crimes | Permanent Ban from School Employment |
| Felony of First, Second or Third Degree not listed in Sect 111(e) | 10 Year Ban from School Employment after expiration of sentence |
| First Degree Misdemeanor | 5 Year Ban from School Employment after expiration of sentence |
| Second Offense of DUI graded as First Degree Misdemeanor | 3 Year Ban from School Employment after expiration of sentence |

ARREST/CONVICTION REPORT AND CERTIFICATION FORM
(under Act 24 of 2011 and Act 82 of 2012)

Section 1. Personal Information

Full Legal Name: _____

Date of Birth: ____/____/____

Other names by which you have been identified: _____

Section 2. Arrest or Conviction

By checking this box, I state that I have NOT been arrested for or convicted of any Reportable Offense.

By checking this box, I report that I have been arrested for or convicted of an offense or offenses enumerated under 24 P.S. §§1-111(e) or (f.1) ("Reportable Offense(s)"). See Page 3 of this Form for a list of Reportable Offenses.

Details of Arrests or Convictions

For each arrest for or conviction of any Reportable Offense, specify in the space below (or on additional attachments if necessary) the offense for which you have been arrested or convicted, the date and location of arrest and/or conviction, docket number, and the applicable court.

Section 3. Child Abuse

By checking this box, I state that I have NOT been named as a perpetrator of a founded report of child abuse within the past five (5) years as defined by the Child Protective Services Law.

By checking this box, I report that I have been named as a perpetrator of a founded report of child abuse within the past five (5) years as defined by the Child Protective Services Law.

Section 4. Certification

By signing this form, I certify under penalty of law that the statements made in this form are true, correct and complete. I understand that false statements herein, including, without limitation, any failure to accurately report any arrest or conviction for a Reportable Offense, shall subject me to criminal prosecution under 18 Pa.C.S. §4904, relating to unsworn falsification to authorities.

Signature

Date

INSTRUCTIONS

Pursuant to 24 P.S. §1-111(c.4) and (j), the Pennsylvania Department of Education developed this standardized form (PDE-6004) to be used by current and prospective employees of public and private schools, intermediate units, and area vocational-technical schools.

As required by subsection (c.4) and (j)(2) of 24 P.S. §1-111, this form shall be completed and submitted by all current and prospective employees of said institutions to provide written reporting of any arrest or conviction for an offense enumerated under 24 P.S. §§1-111(e) and (f.1) and to provide notification of having been named as a perpetrator of a founded report of child abuse within the past five (5) years as defined by the Child Protective Services Law.

As required by subsection (j)(4) of 24 P.S. §1-111, this form also shall be utilized by current and prospective employees to provide written notice within seventy-two (72) hours after a subsequent arrest or conviction for an offense enumerated under 24 P.S. §§1-111(e) or (f.1).

In accordance with 24 P.S. §1-111, employees completing this form are required to submit the form to the administrator or other person responsible for employment decisions in a school entity. Please contact a supervisor or the school entity administration office with any questions regarding the PDE 6004, including to whom the form should be sent.

PROVIDE ALL INFORMATION REQUIRED BY THIS FORM LEGIBLY IN INK.

LIST OF REPORTABLE OFFENSES

- **A reportable offense enumerated under 24 P.S. §1-111(e) consists of any of the following:**

(1) An offense under one or more of the following provisions of Title 18 of the Pennsylvania Consolidated Statutes:

- Chapter 25 (relating to criminal homicide)
- Section 2702 (relating to aggravated assault)
- Section 2709.1 (relating to stalking)
- Section 2901 (relating to kidnapping)
- Section 2902 (relating to unlawful restraint)
- Section 2910 (relating to luring a child into a motor vehicle or structure)
- Section 3121 (relating to rape)
- Section 3122.1 (relating to statutory sexual assault)
- Section 3123 (relating to involuntary deviate sexual intercourse)
- Section 3124.1 (relating to sexual assault)
- Section 3124.2 (relating to institutional sexual assault)
- Section 3125 (relating to aggravated indecent assault)
- Section 3126 (relating to indecent assault)
- Section 3127 (relating to indecent exposure)
- Section 3129 (relating to sexual intercourse with animal)
- Section 4302 (relating to incest)
- Section 4303 (relating to concealing death of child)
- Section 4304 (relating to endangering welfare of children)
- Section 4305 (relating to dealing in infant children)
- A felony offense under section 5902(b) (relating to prostitution and related offenses)
- Section 5903(c) or (d) (relating to obscene and other sexual materials and performances)
- Section 6301(a)(1) (relating to corruption of minors)
- Section 6312 (relating to sexual abuse of children)
- Section 6318 (relating to unlawful contact with minor)
- Section 6319 (relating to solicitation of minors to traffic drugs)
- Section 6320 (relating to sexual exploitation of children)

(2) An offense designated as a felony under the act of April 14, 1972 (P.L. 233, No. 64), known as "The Controlled Substance, Drug, Device and Cosmetic Act."

(3) An offense SIMILAR IN NATURE to those crimes listed above in clauses (1) and (2) under the laws or former laws of:

- the United States; or
- one of its territories or possessions; or
- another state; or
- the District of Columbia; or
- the Commonwealth of Puerto Rico; or
- a foreign nation; or
- under a former law of this Commonwealth.

- **A reportable offense enumerated under 24 P.S. §1-111(f.1) consists of any of the following:**

(1) An offense graded as a felony offense of the first, second or third degree, other than one of the offenses enumerated under 24 P.S. §1-111(e), if less than (10) ten years has elapsed from the date of expiration of the sentence for the offense.

(2) An offense graded as a misdemeanor of the first degree, other than one of the offenses enumerated under 24 P.S. §1-111(e), if less than (5) five years has elapsed from the date of expiration of the sentence for the offense.

(3) An offense under *75 Pa.C.S. § 3802(a), (b), (c) or (d)* (relating to driving under influence of alcohol or controlled substance) graded as a misdemeanor of the first degree under *75 Pa.C.S. § 3803* (relating to grading), if the person has been previously convicted of such an offense and less than (3) three years has elapsed from the date of expiration of the sentence for the most recent offense.



CONFIDENTIALITY STATEMENT

I, _____,

agree that any and all information gained by me as a result of any connection while working at Penn Hills School District shall be confidential as provided by law. I further agree that I shall not divulge any such confidential information to any person except as may be authorized by the Penn Hills School District or by law.

X _____
Signature

Date

X _____
Witness Signature

Date

Penn Hills School District

Your Workers' Compensation Insurance Carrier is:
Excalibur Insurance Management Services LLC
707 Grant Street Gulf Tower Suite 2100 Pittsburgh, PA 15219
Phone: 412-697-1380

NOTICE TO EMPLOYEES IN CASE OF WORK-RELATED INJURIES

1. If you suffer a work-related injury, your employer or its insurance company must pay for reasonable surgical and medical services and supplies, orthopedic appliances and prosthesis, including training in their use.
2. In order to insure that your medical treatment will be paid for by your employer or the insurance company, you must select from one of the following health care providers. You must continue to visit one of the providers listed below, if you need treatment, for ninety (90) days from the date of your first visit.
3. If one of the providers below refers you to another licensed specialist, your employer or their insurer will pay the bill for these services.
4. After this ninety- (90) day period, if you still need treatment and your employer has provided a list as set forth below, you may choose to go to another health care provider for treatment. You should notify your employer of this action within five days of your visit to said provider.
5. If a physician on the list prescribes invasive surgery, you may obtain a second opinion from any physician of your choice. If the second opinion is different than the listed physician's opinion, you may determine which course of treatment to follow; however, the second opinion must contain a specific and detailed treatment plan. If you choose the second opinion, the procedures in that opinion must be performed by one of the physicians on the list for the first ninety- (90) days. Therefore, in this situation, the employee may be required to treat with an employer-designated provider for up to 180 days.
6. If you are faced with a medical emergency, you may secure assistance from a hospital, physician, or health care provider of your choice for your work related injury. However, when the emergency is resolved, you must seek treatment from a provider listed below.

| <u>Name</u> | <u>Address</u> | <u>Phone</u> | <u>Area of Specialty</u> |
|--|--|--------------|--------------------------------------|
| *Forbes Hospital | 2570 Haymaker Road Monroeville, PA 15146 | 412-858-2323 | Emergency Medicine |
| Concentra Medical Centers (Multiple Locations) | 15 Freeport Road, Suite 100 Pittsburgh, PA 15215 | 412-784-1678 | Occupational Medicine |
| MedExpress (Multiple Locations) | 3433 William Penn Highway Penn Center East Pittsburgh, PA 15235 | 412-825-3627 | Urgent Care/Occupational Medicine |
| Orthopaedic Specialists - UPMC (Multiple Locations) | 4803 Northern Pike Monroeville, PA 15146 | 877-471-0935 | Orthopedics |
| Orthopedic Associates of Pittsburgh (Multiple Locations) | 2550 Mossdale Blvd., Suite 405 Monroeville, PA 15146 | 412-373-1600 | Orthopedics |
| Catalane/Willis Surgical Association (Multiple Locations) | 4318 Northern Pike, Suite 101 Monroeville, PA 15146 | 412-771-2266 | General Surgery |
| Allegheny Health Network Department of Neurosurgery (Multiple Locations) | 2580 Haymaker Road Forbes Professional Building 2, Suite 106 Monroeville, PA 15146 | 412-858-7766 | Neurosurgery |
| East Suburban Ophthalmic Associates | 2571 Mossdale Blvd Monroeville, PA 15146 | 412-856-8811 | Ophthalmology |

* Follow-up at a panel Occupational Medicine provider for continuing treatment.

CONVENIENT NETWORK LOCATIONS LISTED BELOW

| | | | |
|--------------------------|---|----------------|------------------|
| Premier Comp PT Network | Call Toll Free for Closest Location | 1-888-594-4001 | Physical Therapy |
| Premier Comp MRI Network | Call Toll Free for Closest Location | 1-888-594-4001 | MRIs |
| Alius Health, LLC | Prescription Card Accepted at All Pharmacies | 1-844-661-4463 | Pharmacy RX |

Panel Date: 9/15/2020

I have read all of the above regarding treatment for my Workers' Compensation injury.

Employee Signature

Date

Penn Hills School District

Your Workers' Compensation Insurance Carrier is:
Excalibur Insurance Management Services LLC
707 Grant Street Gulf Tower Suite 2100 Pittsburgh, PA 15219
Phone: 412-697-1380

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3. If one of the providers below refers you to another licensed specialist, your employer or their insurer will pay the bill for these services.
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| Orthopedic Associates of Pittsburgh (Multiple Locations) | 2550 Mosside Blvd., Suite 405 Monroeville, PA 15146 | 412-373-1600 | Orthopedics |
| Catalano/Willis Surgical Association (Multiple Locations) | 4318 Northern Pike, Suite 101 Monroeville, PA 15146 | 412-771-2268 | General Surgery |
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| Allus Health, LLC | Prescription Card Accepted at All Pharmacies | 1-844-661-4463 | Pharmacy RX |

Panel Date: 9/15/2020

KEEP FOR YOUR RECORDS

The Pennsylvania Workers' Compensation Act requires that employees be given written notice of their rights and duties under Sec. 306 (f.1)(1)(i) of the Act if a list of designated health care providers is established by the employer. The text of this section is provided on the next page.

If you are viewing this electronically, your electronic signature will be your acknowledgement that you have been provided with your rights and duties; otherwise, you must acknowledge this with your signature and return it to your employer. You may keep a copy for your records.

Rights and Duties

As an employee of the commonwealth working at a location where a list of designated health care providers has been established and posted, you have the right to seek emergency medical treatment from any provider; for post-emergency and other injuries, you must obtain treatment for work-related injuries and illnesses from a designated health care provider for 90 days. The penalty for not using a designated health care provider is that the commonwealth is not liable for the medical bills incurred. Specific rights and duties are:

- The duty to obtain treatment for work-related injuries and illnesses from one or more of the designated health care providers for 90 days from the date of the first visit to a designated provider.
- The right to seek emergency medical treatment from any provider, but subsequent non-emergency treatment shall be by a designated provider for the remainder of the 90-day period.
- The right to have all reasonable medical supplies and treatment related to the injury paid for by your employer as long as treatment is obtained from a designated provider during the 90-day period.
- The right, during this 90-day period, to switch from one designated health care provider to another designated provider.
- The right to seek treatment from a provider if you are referred to that provider by a designated provider.
- The right to an additional opinion from a provider of your choice when invasive surgery is prescribed by the designated provider.
- The right to seek treatment or medical consultation from a non designated provider during the 90-day period, but the services shall be **at your expense** for the applicable 90 days.
- The right to seek treatment from any health care provider after the 90-day period has ended.
- The duty to **notify your employer of treatment by a non designated provider (after the 90 day period) within 5 days of the first visit to that provider.** The employer may not be required to pay for treatment rendered by a non designated provider prior to receiving this notification.

I acknowledge that I have been informed of my rights and duties under Sec. 306 (f.1)(1)(i) and that I understand them to the extent they are explained above.

Employee's Printed Name

Employee's Signature

Date

**If you have any questions, ask your human resources office or
call the Bureau of Workers' Compensation at 800.482.2383**

Text of Section 306 (f.1)(1)(i): The employer shall provide payment in accordance with this section for reasonable surgical and medical services, services rendered by physicians or other health care providers, including an additional opinion when invasive surgery may be necessary, medicines and supplies, as and when needed. Provided an employer establishes a list of at least six designated health care providers, no more than four of whom may be a coordinated care organization and no fewer than three of whom shall be physicians, the employee shall be required to visit one of the physicians or other health care providers so designated and shall continue to visit the same or another designated physician or health care provider for a period of ninety (90) days from the date of the first visit: provided, however, that the employer shall not include on the list a physician or other health care provider who is employed, owned or controlled by the employer or the employer's insurer unless employment, ownership or control is disclosed on the list. Should invasive surgery for an employee be prescribed by a physician or other health care provider so designated by the employer, the employee shall be permitted to receive an additional opinion from any health care provider of the employee's own choice. If the additional opinion differs from the opinion provided by the physician or health care provider so designated by the employer, the employee shall determine which course of treatment to follow: provided, that the second opinion provides a specific and detailed course of treatment. If the employee chooses to follow the procedures designated in the second opinion, such procedures shall be performed by one of the physicians or other health care providers so designated by the employer for a period of ninety (90) days from the date of the visit to the physician or other health care provider of the employee's own choice. Should the employee not comply with the foregoing, the employer will be relieved from liability for the payment for the services rendered during such applicable period. It shall be the duty of the employer to provide a clearly written notification of the employee's rights and duties under this section to the employee. The employer shall further ensure that the employee has been informed and that he understands these rights and duties. This duty shall be evidenced only by the employee's written acknowledgment of having been informed and having understood his rights and duties. Any failure of the employer to provide and evidence such notification shall relieve the employee from any notification duty owed, notwithstanding any provision of this act to the contrary, and the employer shall remain liable for all rendered treatment. Subsequent treatment may be provided by any health care provider of the employee's own choice. Any employee who, next following termination of the applicable period, is provided treatment from a nondesignated health care provider shall notify the employer within five (5) days of the first visit to said health care provider. Failure to so notify the employer will relieve the employer from liability for the payment for the services rendered prior to appropriate notice if such services are determined pursuant to paragraph (6) to have been unreasonable or unnecessary.