SEASONAL NEW HIRE/REHIRE CHECKLIST
City of Ocean City

Thank you for your interest in working for the City of Ocean City.
No one may start work without completing and returning this page along with the required documents listed below. This includes the New Hire/Rehire form, W-4 Form, Form I-9 and the Physical Verification Form, completed and signed by the examining physician.

I, _____ have received the following:
(PRINT FULL NAME)

1. You must complete the following forms before you can begin work:

- ❒ This Form (Seasonal New Hire/Rehire Checklist)
- ❒ New Hire/Rehire Form – Employee Section
- ❒ W-4 Employee's Withholding Allowance Certificate
- ❒ Employee's Certificate of Non-Residence in New Jersey (If you live in PA)
- ❒ Form I-9, Employment Eligibility Verification
- ❒ Authorization for Direct Deposit Form (optional)
- ❒ Conscientious Employee Protection Act – "Whistle Blower Act"
- ❒ Nepotism Disclosure Form

2. Fingerprint and Background Check

- ❒ Fingerprint and Background Check Consent Form (18 years and older only)
- ❒ IdentiGO New Jersey Universal Fingerprint Form

3. Employee Physical – Must be returned to your supervisor before you can begin work:

- ❒ List of City Physicians – Read this to find a doctor and schedule an appointment
- ❒ Seasonal Physical Form – Complete top section and give to the doctor
- ❒ Seasonal Physical Verification Form – Complete Name and Department, take to your physical
  When completed by doctor, return to your supervisor before you can begin work

4. Working Papers:

If you are less than 18 years old, you must obtain working papers from your school (if it is in New Jersey). If your school is not in New Jersey, you must obtain working papers from Ocean City High School.

5. Read and retain for your records:

- ❒ Seasonal Payroll Schedule
- ❒ iPay Instructions – View Pay Stubs and W-2 online
- ❒ Right-to-Know Pamphlet
- ❒ Labor Laws for Young Workers (if you are under the age of 18 years old)
- ❒ Right to be Free of Gender Inequity – must sign "Acknowledgement of Receipt"

Signature _____ Date _____

City of Ocean City 2015

EMPLOYEE SECTION

New Hire/Rehire Form

NAME (Last, First M.I.)

Social Security Number

Permanent Address (For W-2 Tax Form Mailing)		Summer Address (If Different)	
Street		Street	
Street 2		Street 2	
City		City	
State	Zip	State	Zip
Phone	Cell	Local	
Birth Date	Gender	Marital Status	
EMAIL			

DRIVERS LICENSE

State	DL Number	Type

Emergency Contact Information

Contact Name	Relationship	
Home Phone	Cell/Work	Print Form

Do Not Type Below This Line - For Hiring Department Use Only

Information below is subject to change by Payroll and Human Resources

NAME (Last, First Middle)		Action (New or Rehire)	
Department		Division	
Civil Service Title		Working Title	

- ☐ Seasonal
- ☐ Temporary
- ☐ Civil Service

- ○ Full Time — Hrs
- ○ Part Time — Hrs

- ○ Overtime Eligible
- ○ Exempt from OT

Civil Service Status

- ☐ Permanent
- ☐ Provisional
- ☐ Unclassified
- ☐ Temporary
- ☐ Elected

Bargaining Unit	
Requested Start Date	
Starting Salary/Rate	○ Hourly ○ Annually

Departmental Approval - Signature

Date

Payroll/HR Use

Form W-4 (2019)

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

Purpose. Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay. Consider completing a new Form W-4 each year and when your personal or financial situation changes.

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

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

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

General Instructions

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

You can also use the calculator at ***www.irs.gov/W4App*** to determine your tax withholding more accurately. Consider using this calculator if you have a more complicated tax situation, such as if you have a working spouse, more than one job, or a large amount of nonwage income not subject to withholding outside of your job. After your Form W-4 takes effect, you can also use this calculator to see how the amount of tax you're having withheld compares to your projected total tax for 2019. If you use the calculator, you don't need to complete any of the worksheets for Form W-4.

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

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

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

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

Specific Instructions

Personal Allowances Worksheet

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

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

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

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

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

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

Employee's Withholding Allowance Certificate

▶ Whether you're entitled to claim a certain number of allowances or exemption from withholding is subject to review by the IRS. Your employer may be required to send a copy of this form to the IRS.

OMB No. 1545-0074

2019

1 Your first name and middle initial	Last name	2 Your social security number
Home address (number and street or rural route)	3 ☐ Single ☐ Married ☐ Married, but withhold at higher Single rate. Note: If married filing separately, check "Married, but withhold at higher Single rate."	
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 800-772-1213 for a replacement card. ▶ ☐	

5	Total number of allowances you're claiming (from the applicable worksheet on the following pages)	5
6	Additional amount, if any, you want withheld from each paycheck	6 $
7	I claim exemption from withholding for 2019, and I certify that I meet **both** of the following conditions for exemption. • Last year I had a right to a refund of **all** federal income tax withheld because I had **no** tax liability, **and** • This year I expect a refund of **all** federal income tax withheld because I expect to have **no** tax liability. If you meet both conditions, write "Exempt" here . . . . . ▶	7

Under penalties of perjury, I declare that I have examined this certificate and, to the best of my knowledge and belief, it is true, correct, and complete.

Employee's signature
(This form is not valid unless you sign it.) ▶ Date ▶

8 Employer's name and address (**Employer:** Complete boxes 8 and 10 if sending to IRS and complete boxes 8, 9, and 10 if sending to State Directory of New Hires.)	9 First date of employment	10 Employer identification number (EIN)

AUTHORIZATION FOR DIRECT DEPOSIT

NAME: _____

SOCIAL SECURITY # _____ DEPT NAME _____

	BANK NAME 1	BANK NAME 2
NAME:		
ADDRESS:		
CITY/STATE:		
ZIP:		

	BANK ROUTING #	ACCOUNT NUMBER	CHECKING/SAVINGS (CHECK ONE)		AMOUNT - "ALL" OR $
1)					
2)					
3)					

NOTE: **YOU MUST SUBMIT A COPY OF EITHER A VOID CHECK OR DEPOSIT SLIP WITH THIS FORM TO VERIFY THE ACCOUNT NUMBER AND BANK**

COMMENTS: _____

_____

AUTHORIZATION STATEMENT:

BASED UPON THE ABOVE INFORMATION, DIRECT DEPOSIT INTO MY ACCOUNT IS AUTHORIZED.

_____ _____

EMPLOYEE SIGNATURE DATE

NJ-165
12-09, R-5

For Pennsylvania Residents Only

STATE OF NEW JERSEY
Department of the Treasury
Division of Taxation
PO Box 269
Trenton, NJ 08695-0269

EMPLOYEE'S CERTIFICATE OF NONRESIDENCE IN NEW JERSEY

Please Print or Type

First Name | MI | Last Name | Social Security No.

Street Address

City | State | Zip Code

PENNSYLVANIA RESIDENTS

I hereby declare, under penalties of perjury, that I am a resident of the State of Pennsylvania and that, pursuant to a reciprocal agreement existing between that State and the State of New Jersey, I claim exemption from withholding of New Jersey Gross Income Tax on compensation paid to me in the State of New Jersey and authorize my employer to withhold Pennsylvania Personal Income Taxes on my behalf.

Note: If you change your residence from Pennsylvania to any other state, *you must notify* your employer within 10 days.

(Date) (Signature)

MILITARY SPOUSES

Under the Servicemember Civil Relief Act (SCRA), as amended by the Military Spouses Residency Relief Act, you may be exempt from New Jersey income tax on your wages if (i) your spouse is a member of the armed forces present in New Jersey in compliance with military orders; (ii) you are present in New Jersey solely to be with your spouse; and (iii) you maintain your domicile in another state. If you claim exemption under the SCRA, attach a copy of your spousal military identification card to Form NJ-165.

I certify that I am not subject to New Jersey withholding. I meet the conditions set forth under the Servicemember Civil Relief Act, as amended by the Military Spouses Residency Relief Act.

(Date) (Signature)

NEW JERSEY EMPLOYER:

You are required to have a copy of this form on file for each employee receiving compensation paid in New Jersey and who is a resident of Pennsylvania and claims exemption from withholding of New Jersey Gross Income Tax under the reciprocal agreement entered into between New Jersey and Pennsylvania or who claims exemption from withholding of New Jersey Gross Income Tax under the Servicemember Civil Relief Act, as amended by the Military Spouses Residence Relief Act. **Do not forward this Form to the Division of Taxation.**

MAY BE REPRODUCED

DO NOT FORWARD THIS FORM TO THE DIVISION OF TAXATION

City of Ocean City
Part Time/Temp Seasonal
2019 Payroll Schedule

PPT/SEASONAL

PAY PERIOD - THUR - WED

PAPERWORK DUE DATE	PAY #	PAY DATE	Period Start	Period End
12/27/2018	1	1/11/2019	1/3/2019	1/16/2019
1/10/2019	2	1/25/2019	1/17/2019	1/30/2019
1/24/2019	3	2/8/2019	1/31/2019	2/13/2019
2/7/2019	4	2/22/2019	2/14/2019	2/27/2019
2/21/2019	5	3/8/2019	2/28/2019	3/13/2019
3/7/2019	6	3/22/2019	3/14/2019	3/27/2019
3/21/2019	7	4/5/2019	3/28/2019	4/10/2019
4/4/2019	8	4/19/2019	4/11/2019	4/24/2019
4/18/2019	9	5/3/2019	4/25/2019	5/8/2019
5/2/2019	10	5/17/2019	5/9/2019	5/22/2019
5/16/2019	11	5/31/2019	5/23/2019	6/5/2019
5/30/2019	12	6/14/2019	6/6/2019	6/19/2019
6/13/2019	13	6/28/2019	6/20/2019	7/3/2019
6/27/2019	14	7/12/2019	7/4/2019	7/17/2019
7/11/2019	15	7/26/2019	7/18/2019	7/31/2019
7/25/2019	16	8/9/2019	8/1/2019	8/14/2019
8/8/2019	17	8/23/2019	8/15/2019	8/28/2019
8/22/2019	18	9/6/2019	8/29/2019	9/11/2019
9/5/2019	19	9/20/2019	9/12/2019	9/25/2019
9/19/2019	20	10/4/2019	9/26/2019	10/9/2019
10/3/2019	21	10/18/2019	10/10/2019	10/23/2019
10/17/2019	22	11/1/2019	10/24/2019	11/6/2019
10/31/2019	23	11/15/2019	11/7/2019	11/20/2019
11/14/2019	24	11/29/2019	11/21/2019	12/4/2019
11/28/2019	25	12/13/2019	12/5/2019	12/18/2019
12/12/2019	26	12/27/2019	12/19/2019	1/1/2020

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 *(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):

☐ 1. A citizen of the United States

☐ 2. A noncitizen national of the United States *(See instructions)*

☐ 3. A lawful permanent resident (Alien Registration Number/USCIS Number): _____

☐ 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)*

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.

1. Alien Registration Number/USCIS Number: _____
OR
2. Form I-94 Admission Number: _____
OR
3. Foreign Passport Number: _____
Country of Issuance: _____

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 08/31/2019

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

Additional Information

QR Code - Sections 2 & 3
Do Not Write In This Space

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

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

Signature of Employer or Authorized Representative	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

CITY OF OCEAN CITY

AMERICA'S GREATEST FAMILY RESORT

DIVISION OF HUMAN RESOURCES

January 2, 2019

Dear City Team Member:

RE: Conscientious Employee Protection Act - "Whistleblower Act"
Employer retaliatory action; protected employee actions; employee responsibilities

1. New Jersey law prohibits an employer from taking any retaliatory action against an employee because the employee does any of the following:

   a. Discloses, or threatens to disclose, to a supervisor or to a public body an activity, policy or practice of the employer or another employer, with whom there is a business relationship, that the employee reasonably believes is in violation of a law, or a rule or regulation issued under the law, or, in the case of an employee who is a licensed or certified health care professional; reasonably believes constitutes improper quality of patient care;

   b. Provides information to, or testifies before, any public body conducting an investigation, hearing or inquiry into any violation of law, or a rule or regulation issued under the law by the employer or another employer, with whom there is a business relationship, or, in the case of an employee who is a licensed or certified health care professional, provides information to, or testifies before, any public body conducting an investigation, hearing or inquiry into quality of patient care; or

   c. Provides information involving deception of or misrepresentation to any shareholder, investor, client, patient, customer, employee, former employee, retiree or pensioner of the employer or any governmental entity.

   d. Provides information regarding any perceived criminal or fraudulent activity, policy or practice of deception or misrepresentation which the employee reasonably believes may defraud any shareholder, investor, client, patient, customer, employee, former employee, retiree or pensioner of the employer or any governmental entity.

   e. Objects to, or refuses to participate in, any activity, policy or practice which the employee reasonably believes:
      (1) is in violation of a law, or a rule or regulation issued under the law or, if the employee is a licensed or certified health care professional, constitutes improper quality of patient care;
      (2) is fraudulent or criminal; or
      (3) is incompatible with a clear mandate of public policy concerning the public health, safety or welfare or protection of the environment. N.J.S.A. 34: 19-3.

2. The protection against retaliation, when a disclosure is made to a public body, does not apply unless the employee has brought the activity, policy or practice to the attention of a supervisor of the employee by written notice and given the employer a reasonable opportunity to connect the activity, policy or practice. However, disclosure is not required where the employee reasonably believes that the activity, policy or practice is known to one or more supervisors of the employer or where the employee fears physical harm as a result of the disclosure, provided that the situation is an emergency in nature.

CONTACT INFORMATION

Your employer has designated the following contact person to receive written notifications, pursuant to paragraph 2 above (N.J.S.A. 34: 19-4):

Name: Elizabeth Woods, Esq., Director of Human Resources Phone: 609-525-9364
Address: 861 Asbury Avenue, Room 304, Ocean City, NJ 08226

Sincerely,

George Savastano
Business Administrator

I acknowledge receipt of a copy of this letter.

Your name (Print)

Signature Date

The original signed copy of this letter must be filed in your personnel folder.

Read, Print and Sign Page 3

Go to Page 3 to Print Form

2.28 NEPOTISM

Purpose: To establish the City policy for employment of immediate relatives in order to ensure both the reality and the appearance of fairness in the best interest of the City.

Policy: Unless otherwise prohibited by the Local Government Ethics Law, the NJ Department of Personnel Rules and Regulations, or the City of Ocean City Local Ordinances, immediate relatives will not be employed in regular full-time, regular part-time or seasonal positions where:

1. One relative would have the authority to supervise, appoint, remove, discipline or evaluate the performance of the other.
2. One relative would be responsible for auditing the work of the other or would have indirect influence over the other.
3. Other circumstances exist which would place the relatives in a situation of actual or reasonably-foreseeable conflict between the City's interest and their own.

Procedure:

1. In order to avoid potential improprieties, the City will avoid hiring family members of Department Heads and Middle Managers for permanent positions. Situations where family members supervise other family members are **not permitted.**

2. Family members include spouse, domestic partner, child, parent, sibling, brother-in-law, sister-in-law, son-in-law, daughter-in-law, mother-in-law, father-in-law, aunt, uncle, niece, nephew, step-parent and step-child, or any person related by blood or marriage residing in an employee's household.

3. Employees who marry, commence living together, or become related may continue in their employment if such continued employment does not result in the creation of a prohibited relationship. Where continued employment results in the creation of a prohibited relationship, the City will explore potential accommodations, including the reassignment of one or both employees to available positions for which the employees are qualified. If the employees are represented by a bargaining unit, the union representative(s) will be consulted in the process.

   If the City determines that an acceptable accommodation cannot be made, the City will notify the employees that one of the employees must separate their employment with the City within six months. In the event that the employees do not agree as to which one shall resign, the City will terminate the employee with the least seniority.

Nothing in this policy will be construed to abrogate the terms of any collectively negotiated agreement, including but not limited to the just cause provisions, grievance provisions and all procedural due process rights arising under such agreements to the fullest extent negotiable.

4. Prior to employment or appointment, all persons shall submit an official disclosure statement listing any relationships that they may have to City employees and elected or appointed City officials. The disclosure statement shall be maintained with the application in the official Personnel file.

5. **This revised policy is effective November 1, 2008. All employees hired prior to that date are considered grandfathered, including Seasonal employees.**

CITY OF OCEAN CITY

NEPOTISM DISCLOSURE FORM

Name _____ **Title** _____

Department/Division _____

Effective November 1, 2008, the City of Ocean City's revised Nepotism Policy 2.28 stipulates that immediate relatives will not be employed in regular full-time, regular part-time or seasonal positions where:

1. One relative would have the authority to supervise, appoint, remove, discipline or evaluate the performance of the other.
2. One relative would be responsible for auditing the work of the other or would have indirect influence over the other.
3. Other circumstances exist which would place the relatives in a situation of actual or reasonably-foreseeable conflict between the City's interests and their own.

Family members include spouse, domestic partner, child, parent, sibling, brother/sister-in-law, son/daughter-in-law, mother/father-in-law, aunt, uncle, niece, nephew, step-parent, step-child, or any person related by blood or marriage residing in an employee's household. **Employees hired prior to November 1, 2008, are grandfathered, including seasonal employees.**

CERTIFICATION

This certification must be signed by all employees:

I certify that I have read and understand the Nepotism Policy 2.28. I also certify that I am not entering a position, or I'm not currently in a position where I am related to any immediate family member (described above) employed by the City that falls under any of the situations described above.

Employee Signature: _____

Date: _____

Note: If this status changes, you must complete a new form which is available from your Manager or the Personnel Office.

This completed form will be filed in your Personnel File

NOTE: For 18 years of age and up ONLY

City of Ocean City

Fingerprint and Criminal History Check Consent Form For Employees, Job Applicants, Interns and Volunteers For The City of Ocean City

In accordance with Section 10-3 of the Revised General Ordinances of the City of Ocean City and NJSA 15A:3A-1 *et seq.*, I understand, as a condition of employment or my volunteer service for the City, that the City of Ocean City requires criminal history checks on all individuals who are employed by or are volunteering for the City.

By signing this form, I agree to be fingerprinted and consent to a criminal history check as a condition of employment or volunteer service. I also represent, attest and certify that I have never been convicted of any of the following crimes or disorderly persons offenses as defined by New Jersey law or the law of any other state, or that the guilty disposition of any of the crimes and/or offenses has been amended to a status of not guilty, or that any previous charges, as listed below, have been expunged:

2C:11 HOMICIDE – all offenses
2C:12 ASSAULT, ENDANGERING, THREATS – all offenses
2C:13 KIDNAPPING – all offenses
2C:14 SEXUAL OFFENSES – all offenses
2C:15 ROBBERY – all offenses
2C:20 THEFT – all offenses
2C:24 OFFENSES AGAINST THE FAMILY, CHILDREN AND INCOMPETENTS – all offenses
2C:35 CONTROLLED DANGEROUS SUBSTANCES – all offenses **except** paragraph (4) of subsection a. of NJS.2C:35-10

_____
Name (please print)

_____ _____
Signature Date

IdentoGO
By MorphoTrust USA

New Jersey Universal Fingerprint Form

www.bioapplicant.com/nj

(1) Originating Agency Number (ORI #)	(2) Category	(3) Statute Number
NJ920610Z	YSO	15A:3A-1

(4) Reason for Fingerprinting	(5) Document Type	(6) Payment Information
YOUTH SERVING ORGANIZATION EMPLOYEE	B1	$55.45

(7) Contributor's Case # (Unique Identifier)	(8) Miscellaneous

(9) First Name	(10) MI	(11) Last Name

(12) Daytime Phone Number	(13) Social Security Number (Optional)	(14) Date of Birth	(15) Height	(16) Weight
( ) -				

(17) Maiden or Alias Last Name	(18) Place of Birth (US State if US Citizen; Country for all others)	(19) Country of Citizenship

(20) Home Address

Address City State Zip

(21) Gender (Select one)	(22) Hair Color	(23) Eye Color	(24) Race (Select One)
[ ] Female [ ] Male [ ] Both			[A] Asian/ Pacific Islander (includes Asian Indian) [B] Black [I] American Indian / Alaska Native [W] White (Includes Hispanic/ Spanish Origin) [U] Unknown

(25) Occupation / Position (with respect to Requirement)	(26) Employer / Organization Name (with respect to Requirement) Employer Address City State Zip

Identification Requirement *- Acceptable Identification must be presented at the time of printing.* Identification presented MUST be one (1) document that is current (not expired). A combination of documents will not be accepted. The single document must include the following criteria: Photo, Name, Address (home/employer), Date of Birth. Acceptable ID must be issued by a Federal, State, County or Municipal entity for identification purposes. Examples of acceptable ID are: 1) Valid U.S. State Photo Driver's License/ Non Driver's License, 2) U.S. Passport, 3) USCIS Permanent Resident ID Card (issued after 5/10/2010), and 4) USCIS Employment Authorization Card (issued after 10/31/2010).

Please READ This Form Carefully:

Follow all of the instructions provided by your agency/employer to complete the fingerprint process. You must have this form (Blocks 1 through 26) completed prior to scheduling your fingerprint appointment via the website or call center. ***PLEASE PRINT LEGIBLY.*** *It is* ***required*** *that you* ***present*** *this completed Universal Fingerprint Form, IDG_NJAPP_020115_V2, at your scheduled appointment.*

Appointment Scheduling:

Scheduling is available anytime at www.bioapplicant.com/nj. Appointments may also be scheduled through our Call Center. English and Spanish speaking agents are available at **1-877-503-5981**, Monday through Friday, 8:00AM to 5:00PM EST and Saturday, 8:00AM to 12 Noon EST.

Payment:

When an applicant is responsible for payment, payment is required at the time of scheduling. The following forms of payment are accepted: Visa, MasterCard, prepaid debit cards, or electronic debit (ACH) from a checking account. Accounts will be debited immediately.

Cancel/ Reschedule:

Appointments may be canceled or rescheduled via the website or the call center before the deadline of 5PM EST the business day prior to the scheduled appointment (Saturday Noon for Monday appointments). An appointment fee of $10.00 plus tax ($10.70) will be incurred by applicants who do not cancel/reschedule their appointment prior to the deadline. MorphoTrust will refund the remainder of the fee paid (state/federal search fees) to the original payment method.

Unable to be Fingerprinted:

An applicant is considered "Unable to be Fingerprinted" for any of the following reasons: Failure to appear for scheduled appointment, inability to present proper identification, inability to present this completed Universal Fingerprint Form IDG_NJAPP_020115_V2, or the information on this form does not exactly match the information provided during the scheduling process. Applicants unable to be fingerprinted will incur a $10.00 plus tax ($10.70) appointment fee. MorphoTrust will refund the remainder of the fee paid (state/federal search fees) to the original payment method.

PCN and Receipts:

Upon the completion of fingerprinting you will be assigned a PCN number. The PCN will be recorded on this form and on your receipt. MorphoTrust will not provide *duplicate receipts, PCN Numbers or any appointment/printing information after the time of printing.*

Applicant ID Number:	Payment Authorization:	PCN:
Scheduled Day & Date:	Scheduled Time:	Scheduled Site:
Agency Information:		

You **MUST** retain a copy of this form and the receipt of printing for your personal records.

APPLICANTS MUST NOT ALTER, SHARE, OR REUSE THIS FORM

Full and Part Time Employees
City of Ocean City
PHYSICAL VERIFICATION FORM

This form must be returned to Human Resources before reporting for the first day of work.

Patient's Last Name (Please Print) _____ Patient's First Name _____

Job Title _____ Department / Division / Office _____

Type of Physical Required: ____ Comprehensive (Police, Fire)

____ Basic Administrative (All other titles)

THIS SECTION TO BE COMPLETED BY PHYSICIAN

PLEASE CHECK ONE:

( ) ABLE TO PERFORM JOB DUTIES

( ) UNABLE TO PERFORM JOB DUTIES

( ) ABLE TO PERFORM JOB DUTIES WITH ACCOMMODATIONS

Please specify restriction(s)/accommodation(s)

_____

_____

_____

Physician Stamp

Or

Physician Name (Please Print) _____

Physician Address _____

Physician Telephone # _____

Physician Signature _____

City Physicians

Ocean City Family Practice Dr. Gary Raab	500 Sixth Street, OCNJ	399-1862
AtlantiCare Family Medicine Dr. Chew, Dr. Paulvin	201 West Ave, OCNJ	391-7500
Dr. Chandrakant Udani	5548 Asbury Ave, OCNJ	399-1519

CITY OF OCEAN CITY

SEASONAL PHYSICAL

The objective of this evaluation is only to determine if the individual is capable of performing the essential function of the position offered.

TO BE COMPLETED BY APPLICANT:

NAME _____ POSITION _____

SSN: ___-___-___ Date of Birth: ___/___/___ Telephone ( ) ___-___

ADDRESS _____

Medical History – Have you ever had or have you now any of the following?
(For each "Yes" checked, please register remarks on reverse side.)

Yes	No	Condition	Yes	No	Condition	Yes	No	Condition	Yes	No	Condition
		a. Frequent severe headaches			h. High or low blood pressure			o. Excessive drinking habit			v. Record of traffic convictions
		b. Dizziness or fainting spells			i. Stomach trouble			p. Attempted suicide			w. Record of other conditions
		c. Unconscious for any reason			j. Kidney stone or blood in urine			q. Motion sickness requiring drugs			x. Neck injury
		d. Eye trouble except glasses			k. Sugar or albumin in urine			r. Military medical discharge			y. Workmns injury
		e. Hay fever			l. Epilepsy or fits			s. Medical rejection from or for military service			z. Back injury
		f. Asthma			m. Nervous trouble of any sort			t. Rejection for life insurance			aa. Skull injury
		g. Heart trouble			n. Any drug or narcotic habit			u. Admission to hospital			bb. Other illnesses

MEDICAL TREATMENT WITHIN PAST 5 YEARS

DATE	NAME AND ADDRESS OF PHYSICIAN CONSULTED	REASON

LIST NAME AND ADDRESS OF YOUR PRESENT FAMILY DOCTOR WHO LAST GAVE YOU A PHYSICAL EXAMINATION

APPLICANT'S DECLARATION

I hereby certify that all statements and answers provided by me in this examination form are complete and true to the best of my knowledge. I further certify that all prior medical problems have been listed and explained to the City or the examining physician. I understand that giving in complete or false information is grounds for dismissal and forfeiture of related benefits. I also understand that any offer of employment is subject to satisfactorily completing a physical examination.

Signature of Applicant (in ink) _____ Date _____

TO BE COMPLETED BY EXAMINING PHYSICIAN:

Check each item in appropriate column (Enter NE if not evaluated.)	Normal	Abnormal	Check each item in appropriate column (Enter NE if not evaluated.)	Normal	Abnormal
Skin			Heart		
Eyes			Lungs		
Ears			Abdomen		
Nose			Neurological		
Throat			Orthopedic Defects		
Teeth			Extremities		

Physical examination
Height_____ Weight_____ BP_____ Pulse_____ Hernia_____

Notes:

Date of examination	Medically ☐ Passed ☐ Not Passed	Physician's Signature

EMPLOYEE – TAKE THIS FORM TO PHYSICIAN
(PHYSICIAN RETAINS COMPLETED FORM)

City of Ocean City
Part Time/Temp Seasonal
2016 Payroll Schedule

PAY #	PAY DATE	Period Start	Period End
1	1/1/2016	12/10/2015	12/23/2015
2	1/15/2016	12/24/2015	1/6/2016
3	1/29/2016	1/7/2016	1/20/2016
4	2/12/2016	1/21/2016	2/3/2016
5	2/26/2016	2/4/2016	2/17/2016
6	3/11/2016	2/18/2016	3/2/2016
7	3/25/2016	3/3/2016	3/16/2016
8	4/8/2016	3/17/2016	3/30/2016
9	4/22/2016	3/31/2016	4/13/2016
10	5/6/2016	4/14/2016	4/27/2016
11	5/20/2016	4/28/2016	5/11/2016
12	6/3/2016	5/12/2016	5/25/2016
13	6/17/2016	5/26/2016	6/8/2016
14	7/1/2016	6/9/2016	6/22/2016
15	7/15/2016	6/23/2016	7/6/2016
16	7/29/2016	7/7/2016	7/20/2016
17	8/12/2016	7/21/2016	8/3/2016
18	8/26/2016	8/4/2016	8/17/2016
19	9/9/2016	8/18/2016	8/31/2016
20	9/23/2016	9/1/2016	9/14/2016
21	10/7/2016	9/15/2016	9/28/2016
22	10/21/2016	9/29/2016	10/12/2016
23	11/4/2016	10/13/2016	10/26/2016
24	11/18/2016	10/27/2016	11/9/2016
25	12/2/2016	11/10/2016	11/23/2016
26	12/16/2016	11/24/2016	12/7/2016
27	12/30/2016	12/8/2016	12/21/2016

ADP iPayStatements

We are pleased to announce ADP iPayStatements, a new benefit for all employees. Through ADP, our payroll provider, we are able to offer you access to your earnings statements (pay stubs) and W-2 forms 24 hours per day, 7 days a week.

In addition, you can choose to go paperless and never have to receive a paper copy of your pay voucher again.

How to Register on ADP iPayStatements

1. Go to https://ipay.adp.com
2. Click on "Register Now"
3. Enter the Self Service Registration Pass Code which is: **Cityofoc-1234** (not case sensitive)
4. Follow the instructions

You will be prompted to complete a registration process during which you must answer a few security questions and select a password. **You will be assigned a system generated User ID.** Your password must contain between 8 and 20 characters and at least one alpha and one numeric character. The security questions will be used to verify your identity if you ever forget your user ID or password. Passwords can also be reset by contacting Diane Wood in the Human Resources department at 525-9365.

Upon completing the registration process, you may access your W-2's (2011, 2012 & 2013) and pay statements (3 years).

The following three agencies work together to implement the **Worker and Community Right to Know (RTK)** Act:

New Jersey Department of Health and Senior Services
***Right to Know** Program*
PO Box 368
Trenton, NJ 08625-0368
(609) 984-2202
http://www.nj.gov/health/eoh/rtkweb/index.shtml

Enforces all provisions of the **RTK** Act in public workplaces and **RTK** labeling in private workplaces. The Program prepares Hazardous Substance Fact Sheets, the **RTK** brochure, and other materials to increase awareness of hazardous chemicals and help employers comply with the **RTK** Act. Printed materials are available upon request. Many are translated into Spanish.

New Jersey Department of Environmental Protection
*Office of Pollution Prevention and **Right to Know***
PO Box 405
Trenton, NJ 08625-0405
(609) 292-6714
www.nj.gov/dep/opppc/crtk/

Enforces the community provisions of the **RTK** Act in the private sector (except for labeling). The Department is also responsible for implementing Title III (Emergency Planning and **Community Right to Know**) of the federal Superfund Amendments and Reauthorization Act (SARA), which establishes requirements for industry regarding emergency planning and reporting of hazardous chemicals.

New Jersey Department of Labor and
Workforce Development
Office of Public Employees Occupational Safety and Health
PO Box 386
Trenton, NJ 08625-0386
(609) 292-7036
http://lwd.state.nj.us/lsse/employer/Public_Employees_OSH.html

Collects **RTK** fees from private employers and investigates complaints by public employees who suspect they are being discriminated against for exercising their rights under the **RTK** Act.

How to obtain information locally

You can obtain copies of the ***Right to Know Survey***, ***Community Right to Know Survey***, and Hazardous Substance Fact Sheets from your designated ***Right to Know*** county agency listed below:

Atlantic	(609) 645-5971	Ext. 4295
Bergen	(201) 634-2785	
Burlington	(609) 265-5521	Ext. 5521
Camden	(856) 374-6046	
Cape May	(609) 463-6413	
Cumberland	(856) 327-7602	Ext. 1129
Essex	(973) 497-9401	
Gloucester	(856) 218-4103	
Hudson	(201) 223-1133	
Hunterdon	(908) 788-1110	
Mercer	(609) 278-7165	
Middlesex	(732) 745-8480	
Monmouth	(732) 431-7456	
Morris	(973) 631-5484	
Ocean	(732) 341-9700	Ext. 7477
Passaic	(973) 225-3651	
Salem	(856) 935-7510	
Somerset	(908) 231-7506	
Sussex	(973) 579-0370	
Union	(908) 654-9730	
Warren	(908) 475-7960	

YOU HAVE A
RIGHT TO KNOW
ABOUT HAZARDOUS SUBSTANCES IN YOUR WORKPLACE AND COMMUNITY. USE IT.

5/10

J0254

YOU HAVE THE RIGHT TO KNOW

ABOUT HAZARDOUS SUBSTANCES IN YOUR WORKPLACE AND COMMUNITY

Chris Christie, Governor
Kim Guadagno, Lt. Governor

Poonam Alaigh, MD, MSHCPM, FACP
Commissioner

Public Health Services
Division of Epidemiology, Environmental and Occupational Health
Consumer, Environmental and Occupational Health Service
Right to Know Program

Right to be Free of Gender Inequity or Bias in Pay, Compensation, Benefits or Other Terms and Conditions of Employment

New Jersey and federal laws prohibit employers from discriminating against an individual with respect to his/her pay, compensation, benefits, or terms, conditions or privileges of employment because of the individual's sex.

FEDERAL LAW

Title VII of the Civil Rights Act of 1964 prohibits employment discrimination based on, among other things, an individual's sex. Title VII claims must be filed with the United States Equal Employment Opportunity Commission (EEOC) before they can be brought in court. Remedies under Title VII may include an order restraining unlawful discrimination, back pay, and compensatory and punitive damages.

The Equal Pay Act of 1963 (EPA) prohibits discrimination in compensation based on sex. EPA claims can be filed either with the EEOC or directly with the court. Remedies under the EPA may include the amount of the salary or wages due from the employer, plus an additional equal amount as liquidated damages.

Please be mindful that in order for a disparity in compensation based on sex to be actionable under the EPA, it must be for equal work on jobs the performance of which requires equal skill, effort, and responsibility, and which are performed under similar working conditions.

There are strict time limits for filing charges of employment discrimination. For further information, contact the EEOC at 800-669-4000 or at www.eeoc.gov.

NEW JERSEY LAW

The New Jersey Law Against Discrimination (LAD) prohibits employment discrimination based on, among other things, an individual's sex. LAD claims can be filed with the New Jersey Division on Civil Rights (NJDCR) or directly in court. Remedies under the LAD may include an order restraining unlawful discrimination, back pay, and compensatory and punitive damages.

Another State law, N.J.S.A. 34:11-56.1 et seq., prohibits discrimination in the rate or method of payment of wages to an employee because of his or her sex. Claims under this wage discrimination law may be filed with the New Jersey Department of Labor and Workforce Development (NJDLWD) or directly in court. Remedies under this law may include the full amount of the salary or wages owed, plus an additional equal amount as liquidated damages.

Please be mindful that under the State wage discrimination law a differential in pay between employees based on a reasonable factor or factors other than sex shall not constitute discrimination.

There are strict time limits for filing charges of employment discrimination. For more information regarding LAD claims, contact the NJDCR at 609-292-4605 or at www.njcivilrights.gov. For information concerning N.J.S.A. 34:11-56.1 et seq., contact the Division of Wage and Hour Compliance within the NJDLWD at 609-292-2305 or at http://lwd.state.nj.us.

This notice must be conspicuously displayed.

NEW JERSEY DEPARTMENT OF LWD
LABOR AND WORKFORCE DEVELOPMENT
nj.gov/labor

Acknowledgment of Receipt of Gender Equity Notification

I received a copy of the gender equity notification on the date listed below.
I have read it and I understand it.

_____ _____

Name (signature) Name (print)

_____

Date

NEW JERSEY DEPARTMENT OF
LWD
LABOR AND WORKFORCE DEVELOPMENT
nj.gov/labor