Scott & White Memorial - Temple
Hillcrest - Waco
Scott & White Hospital - Brenham
Children’s Hospital - Temple
Scott & White Hospital - Taylor
Wayne & Eileen Hard Regional Medical Center - Marble Falls
Scott & White - Round Rock
Mentorplex - Killeen
Scott & White Continuing Care Hospital - Temple
Santa Fe Hospital - Temple
Scott & White Hospital - College Station
Scott & White Hospital - Elaro

Physician New Hire Packet
Welcome to Scott & White!

New Hire Packet Details

Welcome!
The Scott & White Healthcare Team would like to extend a warm welcome to you!

The Human Resources Team is committed to providing world-class service, both to the patients we serve and to the staff members who are the heart and soul of Scott & White. Our goal is to make the new hire process as smooth as possible and if there is anything we may do to help you, please contact us.

The purpose of new staff orientation is to introduce you to our culture at Scott & White.

Again, welcome to Scott & White!

Packet Contents:

Information Sheets to Keep:
1. New Hire Packet Details
2. Physician Code of Conduct
3. New Hire Checklist
4. Staff Parking FAQ
5. Online Physician/Provider Profile
6. Scott & White Caduceus Society

Please print the pages of this packet listed below and return the completed forms to your Human Resources recruiter.

Forms to be turned in:
1. Health Assessment Form
2. Dietary Restrictions
3. Data Capture Form
4. IPR & Conflict of Interest Policies
5. Parking Permit
6. Form I-9
7. Form 8850 (if applicable)
8. Form 9061 (required with 8850 if applicable)

New Hire Orientation Details

Dress: Professional attire is expected. Scrubs & other department specific uniforms are acceptable for staff wearing these in their role at Scott & White. Blue jeans, shorts, tank tops, flip flops, capris and other casual dress items are not allowed.

Meals: A light, healthy breakfast item and lunch items are provided at all locations. It is a working lunch so please plan to remain on site. **Please let us know if you have special dietary needs at the time you turn in your new hire paperwork.

Full-time, Part-time and PRN staff are required to attend orientation prior to beginning in their job role.
# New Hire Documentation Details

<table>
<thead>
<tr>
<th>Item</th>
<th>Details/ Instructions</th>
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<tbody>
<tr>
<td>Proof of citizenship</td>
<td>▪ Please bring proof of citizenship or eligibility documents to work in the United States. We can make copies of these documents at the time of your orientation.</td>
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<tr>
<td></td>
<td>▪ <strong>Two forms of identification are required.</strong> (A list of acceptable documents is included in the I-9 section of this packet.)</td>
</tr>
<tr>
<td>Vehicle License Plate Numbers</td>
<td>License plate numbers for all vehicles are needed for Scott &amp; White parking permits</td>
</tr>
<tr>
<td>Life Insurance Beneficiary Information</td>
<td>The following information is required to designate an individual as a beneficiary for life insurance:</td>
</tr>
<tr>
<td></td>
<td>▪ Name</td>
</tr>
<tr>
<td></td>
<td>▪ Address</td>
</tr>
<tr>
<td></td>
<td>▪ Social Security Number</td>
</tr>
<tr>
<td>TB Skin Test</td>
<td><strong>A TB skin test is required of all Scott &amp; White staff.</strong> If you have been TB skin tested in the previous three months, please bring a copy of your test results on the first day of orientation. If you cannot take the TB skin test because of a prior positive result, you can sign the appropriate form at that time. Also, if you have results of a very recent chest x-ray as a result of a prior positive TB skin test, you should bring those with you at the time of orientation.</td>
</tr>
<tr>
<td>Suit Coat (for men)</td>
<td>Men are required to wear a suit coat for their formal portrait (and badge photo).</td>
</tr>
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</table>
Physician Code of Conduct

The Scott & White Physician Code of Conduct enables physicians and the healthcare team to provide the most personalized, comprehensive, and highest quality healthcare, enhanced by medical education and research.

Our ability to successfully fulfill our Mission is dependent in part on physician behavior. Each of us is a leader within our sphere of influence and how we treat our patients, colleagues, and staff will set the tone for how care is delivered. We can expect better from those around us only when we do better ourselves and lead by example.

We seek to create ideals that define the type of physician behavior that will enable Scott & White to fulfill its mission and attain its vision. We will eradicate disruptive behavior which is defined by the American Medical Association as a style of interaction with physician, hospital personnel, patients, family members, or others that interferes with patient care.

RELATIONSHIP TO PATIENTS
We will:
- Treat patients with respect and dignity.
- Learn about the person as well as the condition.
- Partner with our patients in medical decision making.
- Engage, listen, and clearly explain issues to our patients so that time spent with us exceeds their expectations.
- Strive to make each patient feel as though he or she is our only patient.
- Aim to have phone calls returned promptly.
- Strive to be timely and respect our patients’ time as much as our own.
- Apologize when behind schedule.
- Respect patient privacy.
- Earn patient’s loyalty through our behavior.

RELATIONSHIP TO PHYSICIANS
We will:
- Treat our colleagues and referring physicians with dignity and respect.
- Communicate effectively with each other to enhance continuity and quality of care.
- Look for the good in others and share these views with patients to improve perception and experience with Scott & White primary and specialty care physicians.
- Foster the spirit of teaching and learning from each other.
- Look for opportunities to help each other improve.
- Avoid criticizing another physician’s treatment or actions amongst staff or patients, and view differences as opportunities to improve.
- Encourage camaraderie and interaction amongst colleagues both in and out of the workplace.
- Value the uniqueness of others.
- Treat our colleagues in the way in which we want to be treated.
- Give a helping hand gladly should someone need it.
- Employ a team approach to patient care.
- Interact and communicate with physician colleagues in a respectful, cooperative way for the good of patient care.

RELATIONSHIP TO STAFF
We will:
- Treat staff with dignity and respect.
- Work to lead a team where our philosophy, integrity, commitment, compassion, and caring is evident to those around us.
- Strive to make others better by expecting more of ourselves.
- Influence and communicate with those around us in a positive and cooperative way.
- Thank and recognize those who allow us to do what we do.
- Look for opportunities to do things better.
- Invite the input of others and take an active ownership role to implement change.
- Respect the time of others.
- Educate rather than criticize.
- Work to be leaders who are respected because of our actions.
- Return pages in a timely fashion.
- Submit charges for services provided in a timely fashion.

PATIENT ENCOUNTERS/PROGRESS NOTES:
- A senior staff physician performs regular and timely assessments and daily documentation for hospital patients.
- When working in conjunction with training physicians (residents and/or fellows) the responsible physician documents review of the resident’s or fellow’s progress note entries, and indicates their daily communication and participation in the assessment of the patient and in the development of the patient’s management plan.
- When working in conjunction with residents and/or fellows there will be daily communication, regarding the patient’s clinical status, between attending physician and supervised residents/fellows.
- When there is a transfer of patient’s care to a new attending record, there will be communication of the hand off in regard to the current status of the patient.
- Document the change of the attending physician in the medical record/physician’s order.

Physician Signature______________________________          Date______________________
Name: __________________________
Start Date: __________________________

**Orientation Meals**
**Dietary Restrictions**

Please list any dietary restrictions we should be aware of:

______________________________________________________________________
MEDICAL HISTORY

In order to safely and accurately complete your post-offer drug screening, administer any necessary vaccinations or other testing, and carefully assess your ability to perform key job functions, please list any medications taken during the past 30 days that you believe may interfere with your ability to perform essential job functions or successfully complete the drug screening process (including any over-the-counter medications):

________________________________________________________________________________________

List any allergies or sensitivities you have, including food, medications, latex/powdered gloves or other: ____________________________________________________________

Do you have any of the following medical conditions that are relevant to the essential job functions of this position?

- [ ] Epilepsy or Convulsions
- [ ] Fainting/Dizzy Spells
- [ ] Impaired Hearing
- [ ] Abnormal Color Vision
- [ ] Asthma/Shortness of Breath
- [ ] Problems working in High Temperature Environments
- [ ] Hernia
- [ ] Chronic Headaches / Migraines
- [ ] Chronic Infection
- [ ] Back Pain or Spinal Disorders
- [ ] Back Surgery
- [ ] Bone or Joint Problems: surgeries or sports injuries
- [ ] High Blood Pressure or Other Cardiac Issues
- [ ] Chronic Skin Problems
- [ ] Diabetes
- [ ] Chronic Pain
- [ ] Vision Problems
- [ ] Other (please describe below)

Do you affirm that you will be able to perform the job duties of the position you are being evaluated for without need for restriction or accommodation?  **Yes**  **No** (please circle)

If needed, what restrictions do you feel you will need?
________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

FOR STAFF HEALTH USE ONLY

<table>
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JOB RISK LEVEL CATEGORIES

Category 1: Employees with job responsibilities that include tasks involving exposure to blood, body fluids, tissues, or other potentially infectious materials. (Examples: physicians, nurses, laboratory, dental, dialysis, and environmental services staff, etc.)

The risk level requires proof of vaccination and/or immunity for the following:

- Hepatitis B (Hep B)
- Measles, Mumps, and Rubella (MMR)
- Varicella (Chicken Pox)
- Tetanus, Diphtheria, Acellular Pertussis (Tdap)
- Influenza (Flu)
- Tuberculosis Assessment (TB Screening)

Category 2: Employees with job responsibilities that do not routinely include tasks that may involve exposure to blood, body fluids, tissues, or other potentially infectious materials, but that may require performing unplanned tasks involving exposure to these materials as a condition of employment. (Examples: Health Unit Coordinators, clinic desk, pharmacy staff, and facilities maintenance, etc.)

The risk level requires proof of vaccination and/or immunity for the following:

- Hepatitis B (Hep B)
- Measles, Mumps, and Rubella (MMR)
- Varicella (Chicken Pox)
- Tetanus, Diphtheria, Acellular Pertussis (Tdap)
- Influenza (Flu)
- Tuberculosis Assessment (TB Screening)

Category 3: Employees with job responsibilities that do not include tasks that may involve exposure to blood, body fluids, tissues, or other potentially infectious materials, and performing unplanned tasks involving these materials is not a condition of employment. (Examples: medical records, administrative/secretarial, and Information Systems staff, receptionists, PSS, etc.)

The risk level requires proof of vaccination and/or immunity for the following:

- Hepatitis B (Hep B)
- Measles, Mumps, and Rubella (MMR)
- Varicella (Chicken Pox)
- Tetanus, Diphtheria, Acellular Pertussis (Tdap)
- Meningitis
- Influenza (Flu)
- TB Skin/Blood Test (within the past year)

PLEASE BRING THE FOLLOWING IMMUNIZATION/VACCINE RECORDS WITH YOU TO YOUR SCHEDULED APPOINTMENT AT EMPLOYEE HEALTH

I have reviewed the above risk level categories and understand I must meet the above minimum requirements for the appropriate risk level associated with my position in order to be compliant with the Baylor Scott & White Pre-Employment Screening Policy and agree to obtain the necessary vaccination or complete the necessary blood test to meet the minimum requirements.

I also understand that Baylor Scott & White Employee health will provide any vaccinations and/or blood tests necessary for the minimum policy requirements at no cost if I’m unable to produce valid documentation for the appropriate risk level category that has been assigned to my job description.

By my signature I affirm that the above information is true and complete to the best of my knowledge. I acknowledge understanding that omission or misrepresentation of any of the facts stated on this form may be considered an act of dishonesty and grounds for dismissal from Baylor Scott & White.

___________________________________________________________________________________

Employee/Applicant Signature Date

CONFIDENTIAL MEDICAL INFORMATION – FILE IN EMPLOYEE/STAFF HEALTH SERVICES MEDICAL RECORD ONLY

STAFF HEALTH, Post Offer Health Assessment Program, Rev. 07/2016
CENTRAL TEXAS DRUG SCREENING CERTIFICATION AND WAIVER

I authorize the release of drug screening results to Baylor Scott & White and also authorize blood, urine or other specimens to be collected and analyzed to determine the presence of narcotics, marijuana, cocaine, and other recreational drugs or substances or their derivatives. I agree to provide the Baylor Scott & White Employee Health department or the MRO with evidence of a valid prescription upon request.

Any questions or concerns I had about this procedure have been fully answered and I voluntarily consent to this employment application and processing request. I further release Baylor Scott & White and its testing laboratory, their employees, agents, and contractors from all liability relating to this testing regimen and the decisions made pursuant thereto regarding my application for or determination of continuing employment.

If I am an applicant completing post-offer, pre-employment screening, in the event I should be employed by Baylor Scott & White, this authorization will be retained throughout my employment tenure.

______________________________  ________________________________
Signature/Date/Time              Social Security Number

______________________________  ________________________________
Print Applicant Name             Driver’s License Number and State
## Senior & Executive Staff Data Capture Form

| Name: __________________________________________ | Social Security Number: _____-____-____ |
| (Must use name as it appears on Social Security Card) |

| Sex: □ Male  □ Female |

| Texas Mailing Address: |
| City: | County: |
| State: | Zip Code: |

**Phone #: (___)_____-____-____**

**Mandatory for anyone involved with patient care**

| Date of Birth: _____ / _____ / ______ |
| Month | Day | Year |

**EEOC Race - Ethnicity Identification (Please check all that apply.)**

- □ Hispanic or Latino
- □ White
- □ Black or African American
- □ Native Hawaiian or Other Pacific Islander
- □ Asian
- □ American Indian or Alaska Native

*During new hire orientation you will be referred to our internal website to verify and complete some onboarding action items. These action items will include the voluntary self-identification of disability and veteran status information.*

| Official Signature: | Date: |

| Employment Status: □ Full-Time □ Part-Time □ PRN | Standard hours per week: ________ |
| Hire Date: _______________ Rehire Date: ____________ | Job Code: ________ |

| Supervisor Name: ___________________ Dept: _______________ | Cost Center/Dept ID: ________ |
| Credentials (MD, DO, etc): ___________ | Junior Staff? □ Yes □ No |
| Salary: ________________ |

| Location: _____________ | Home Room#: _____________ |
| Clinic Telephone #: ________________ |

---

*Please do not write below this line. S&W office use only.*
**Intellectual Property**

<table>
<thead>
<tr>
<th>Number:</th>
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<tbody>
<tr>
<td>Department:</td>
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</tr>
<tr>
<td>Facility(ies)/Region(s):</td>
<td>System</td>
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<tr>
<td>Approver:</td>
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<tr>
<td>Approval Date(s):</td>
<td>02/01/2011, 04/12/2013</td>
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<tr>
<td>Reviewed Date(s):</td>
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<td>Revised Date(s):</td>
<td>04/12/2013</td>
</tr>
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<td>Keywords:</td>
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</table>

**PURPOSE**

To provide guidance on Intellectual Property (IP).

**POLICY**

The “Mission” of Scott & White Healthcare (S&W) is to provide personalized, comprehensive, high quality healthcare, enhanced by medical education and research. The pursuit of this Mission may result in the creation or development of IP, whose further development and commercialization has the potential to result in improved healthcare and enhancement of medical research and education.

Other than the copyright in scholarly publications governed by the Scott & White Healthcare Honoraria guidelines, S&W, its successors and assigns own all Intellectual Property conceived, created, developed and/or reduced to practice in whole or in part by any Creator using S&W Resources and, in the case of an individual receiving any portion of their salary from S&W, all IP that relates to such individual’s responsibility to S&W, S&W’s businesses, and/or S&W’s anticipated research or development, regardless in each case of whether S&W Resources are used (“S&W-Associated IP”). In the case of an individual receiving any portion of their salary from S&W, S&W-Associated IP includes IP conceived, created, developed and/or reduced to practice in whole or in part during a time of the day when the individual was not engaged in employment activities (including free time and vacation time) if the IP was developed using S&W Resources or if the IP relates to the scope of the individual’s responsibility to S&W, S&W’s businesses, and/or S&W’s anticipated research or development.

**APPLICATION**

This document replaces the “Scott & White Healthcare Intellectual Property Policy” that was approved by the Board of Directors on February 1, 2011, for all purposes except for IP created prior to the Effective Date, which shall remain governed thereby.

**DEFINITIONS**

*When used in this document with initial capital letter(s), the following word(s)/phrase(s) have the meaning(s) set forth below unless a different meaning is required by context.*

“Chief Executive Officer (CEO)” – The Chief Executive Office of Scott & White Healthcare.
“Creator” – Any individual or entity associated with S&W including, without limitation, an employee, agent, independent contractor, postdoctoral fellow, resident, student, visiting scholar, visiting industry representative and volunteer.

“Effective Date” – April 12, 2013.

“Innovations and Ventures Advisory Committee” – A committee composed of members selected by the Scott & White Healthcare Intellectual Property Committee (SWIPC) from business, venture, and technology development executives and S&W staff and charged with providing advice on licensing and commercialization strategy and revenue distribution concerning selected S&W-Associated IP as deemed appropriate by the SWIPC. The SWIPC is not obligated to follow any advice or recommendations made by the Innovations and Ventures Advisory Committee.

“Institutional Property (IP)” – All creations of the mind that can be protected by legal process, statute or common law, including without limitation inventions whether or not patentable, the reduction to practice of these creations, and the tangible and intangible property rights in or to any of the foregoing, including without limitation patent rights, copyright, trademarks, trade secrets, tangible research property, prototypes, products and know-how.

“Institutional Property Advisory Committee” – A committee composed of S&W staff charged with assisting SWIPC’s implementation of this Policy including, without limitation, providing input on licensing and commercialization strategy and revenue distributions concerning S&W-Associated IP.

“Net Revenue” – Payments received by the SWIPC from:

- a licensee to whom the SWIPC granted a license under the S&W-Associated IP; and
- an assignee to whom the SWIPC assigned S&W-Associated IP;

in each case less all costs and expenses relating to such S&W-Associated IP including, without limitation, attorneys’ fees for IP and licensing, marketing, travel, or other costs and expenses of the SWIPC. If the SWIPC receives equity shares from the licensing or assignment of S&W-Associated IP, then the SWIPC may decide to hold these shares until liquidation, in which case the payments received from liquidating the shares would be considered payments under Net Revenue, or distribute the shares in accordance with the foregoing as if the shares were payments received under Net Revenue.

“Scott & White Healthcare (S&W)” – Scott & White Healthcare, its successors and assigns, and includes all affiliated entities within the organizational structure of Scott & White Healthcare or any other entity that by prior agreement has been granted use of or operates under a name related to or owned by Scott and White Memorial Hospital, Scott, Sherwood and Brindley Foundation, Scott & White Clinic, or Scott & White Health Plan.

“Scott & White Healthcare Intellectual Property Committee (SWIPC)” – The Committee charged with evaluating, protecting, managing and transferring for commercialization S&W’s IP, and authorized on behalf of S&W to implement and enforce this Policy.

“S&W Resources” – Funds, equipment, facilities, personnel, patients, support, resources, contracts and/or other tangible or intangible property of S&W.
PROCEDURE

Obligations of Creators
Creators must submit to the SWIPC a completed Intellectual Property Disclosure Form regarding all S&W-Associated IP in a timely manner following the first of conception, creation, development or reduction to practice. A copy of this Intellectual Property Disclosure Form is available at http://swinventions.sw.org, or can be requested by sending an email to the attention of the SWIPC staff at Inventions@sw.org. Submission must be timely to avoid loss of rights in S&W-Associated IP. Creators should consult with the SWIPC prior to public disclosure or offer for sale of any product or service related to S&W-Associated IP to confirm that these activities are in the best interest of S&W and not in violation of obligations, contractual or otherwise, related to the S&W-Associated IP.

Creators are obligated to memorialize the ownership of S&W-Associated IP, and upon request shall execute a confirmatory assignment to Scott & White Healthcare, its successors and assigns of all rights, titles, and interests in and to any S&W-Associated IP. Creators shall assist the SWIPC in the evaluation and otherwise cooperate as reasonably requested throughout the protection and commercialization process including, without limitation, executing documents and taking other actions requested to file, prosecute, register, maintain, enforce, transfer and defend S&W-Associated IP.

Rights, titles and interests in or to S&W-Associated IP shall not be assigned or transferred by any Creator unless pursuant to the express written permission of Scott & White Healthcare, its successors or assigns.

The obligations of Creators under this Policy continue even if a Creator ceases to be associated with S&W.

Obligations of SWIPC
The SWIPC shall evaluate the potential for protection and commercialization of S&W-Associated IP, and endeavor to provide a preliminary evaluation to the Creators listed on the Intellectual Property Disclosure Form within 90 days of disclosure. The SWIPC may determine whether to initiate or continue to pursue protection or commercialization for S&W-Associated IP or whether to await supplemental data regarding the S&W-Associated IP.

If the SWIPC declines to initiate or continue to pursue protection and commercialization for S&W-Associated IP solely due to lack of market potential, then the SWIPC shall notify the Creators listed on the Intellectual Property Disclosure Form. Although the S&W-Associated IP will continue to be owned by Scott & White Healthcare, its successors and assigns, such Creators may choose under a separate written agreement with the SWIPC to pursue protection and commercialization of such S&W-Associated IP using funding and resources other than S&W Resources. Unless otherwise agreed by the parties to the agreement in writing, the agreement will be subject to the following terms:

• An irrevocable grant-back license to S&W to practice and have practiced by other non-profits the S&W-Associated IP including, without limitation, for patient care;

• Reimbursement for all costs incurred by S&W relating to the protection and/or commercialization of the S&W-Associated IP;

• 10% of all consideration received by the Creator(s) or on behalf of the Creator(s) after the total consideration received by the Creator(s) or on behalf of the Creator(s) exceeds $10,000, where such consideration shall include, but not be limited to the following: profit from sales; royalties; up-front payments; marketing, distribution, franchise, option, license, or documentation fees; bonuses;
consultancy payments; milestone payments; distributorship fees or advances; and equity securities or other non-cash consideration; and

- Other terms and conditions customary in such agreements including, without limitation indemnification of S&W and maintenance of sufficient insurance as determined by S&W.

If the SWIPC decides to abandon S&W-Associated IP, then the SWIPC shall notify the Creators listed on the Intellectual Property Disclosure Form, and those Creators may request that such S&W-Associated IP be assigned to them under a separate written agreement to pursue protection and commercialize independently of S&W and S&W Resources. If the SWIPC is able to enter into such agreement, and agrees to enter into such agreement, which it has the right to withhold, then the assignment shall be subject to the same terms listed above.

Employees have the option of submitting a formal written request to the SWIPC for return of any rights to S&W-Associated IP at least one year following the submission of an Intellectual Property Disclosure Form. The SWIPC will consider the request, and will respond to the Creators within 60 days following receipt of the formal written request. The SWIPC is under no obligation to return any rights to S&W-Associated IP to the Creators as a result of receiving the formal written request.

If the SWIPC determines to initiate or continue to pursue protection or commercialization for S&W-Associated IP, it will endeavor to do so, and may optionally engage the services of third parties in pursuing protection or commercialization.

Nothing in the foregoing or any agreement resulting therefrom shall affect the obligations of Creators to comply with this Policy including, without limitation, to disclose and assign improvements on the S&W-Associated IP.

**Distribution of Revenue**

To encourage and reward creativity, the SWIPC shall distribute an amount of Net Revenues of S&W-Associated IP to the Creators for such S&W-Associated IP pursuant to one of the following distribution allocations:

- 50% to Creator(s) or Designee of the Creator(s)
- 50% to S&W Healthcare

Special facts concerning certain S&W-Associated IP may warrant a different distribution of royalties that is negotiated, but in no event will S&W receive less than 50% of Net Revenues. Alternative distribution of Net Revenue may be made upon recommendation to the CEO.

If the Intellectual Property Disclosure Form lists more than one Creator, then the Intellectual Property Disclosure Form shall also list the share of the Creators’ Net Revenue to be allocated to each Creator. If the shares are not listed on the Intellectual Property Disclosure Form, are ambiguous or are disputed, then the SWIPC shall convene a committee composed of the chair of the department(s) involved, a member of the Innovations and Ventures Advisory Committee, and a member of the Intellectual Property Advisory Committee for the purpose of determining the appropriate allocation. This committee’s decision is final. If the IP is technology for which a patent application is filed, then an individual who is listed as a Creator on the corresponding Invention Disclosure Form will not receive Net Revenue if they are subsequently determined to not be an inventor under U.S. patent law.
**Waivers**

Waivers of the provisions of this Policy may be granted by the CEO on a case-by-case basis following an assessment of various considerations including, without limitation, whether the waiver would be in the best interest of S&W, consistent with S&W’s obligations to sponsors, and whether the waiver would result in a conflict of interest.

Waivers of all or any part of Scott & White Healthcare’s ownership of S&W-Associated IP shall be effective only if stated expressly in a writing signed by an authorized representative of Scott & White Healthcare.

**Implementation and Revisions**

*Current Association with S&W*

If Employees or other individuals subject to this Policy believe they have IP or have created IP during the term of their employment that for any reason should not be subject to this Policy, then such individual must fully disclose to the SWIPC this IP along with the documentation necessary to support its exception under the Policy 90 days following the Effective Date. Thereafter, any IP not disclosed and excepted in writing from this Policy shall be S&W-Associated IP if it otherwise falls within the definition.

*New Association with S&W*

Employees or other individuals subject to this Policy beginning their association with S&W after the Effective Date of this Policy must fully disclose to the SWIPC any IP they have created that predates their association with S&W along with documentation necessary to support its exception under the Policy within three months of first association with S&W. Thereafter, any IP not disclosed and excepted in writing from this Policy shall be S&W-Associated IP if it otherwise falls within the definition.

*Subsequent Revisions*

Scott & White Healthcare may change this Policy at any time without notice.

**Applicable Law**

This Policy shall be administered in accordance with the laws of the state of Texas without regard to conflict-of-law principles, and applicable federal and international laws, regulations and court orders governing IP and assignments.

The SWIPC shall have authority and discretion to interpret and apply this Policy to ensure compliance with all applicable laws and regulations, other S&W policies, and S&W’s contractual obligations. The provisions of this Policy are severable, and if any provision of this Policy is determined to be invalid or unenforceable under any controlling body of law, such invalidity or non-enforceability shall not in any way affect the validity or enforceability in any jurisdiction where valid and enforceable or the validity or enforceability of the remaining provisions. The SWIPC may reform any invalid or unenforceable provisions to effectuate the intent of Scott & White Healthcare as evidenced on the Effective Date.

**RELATED DOCUMENTS**

**REFERENCE(S)**

The information contained herein should not be considered standards of professional practice or rules of conduct or for the benefit of any third party. This document is intended to provide guidance and allow for professional discretion and/or deviation when the individual healthcare provider or, if applicable, the “Approver” deems appropriate under the circumstances.
Intellectual Property Agreement for Personnel of Scott & White Healthcare

I understand that Intellectual Property of Scott & White Healthcare, which includes its affiliate entities within its organizational structure, is governed by its official policy entitled the Scott & White Healthcare Intellectual Property Policy, as may be amended from time to time by S&W (the “Policy”; published on InSite in the Policies/Procedures Home).

Pursuant to the Policy, and in consideration of my employment referenced below and/or other valuable consideration provided by S&W under its Policy, the receipt and sufficiency to which I agree, I hereby agree as follows:

1. Capitalized terms that are not defined in this agreement shall be given their meanings assigned in the Policy. I am employed by an entity of S&W and I agree to abide by the terms and conditions of the Policy. This is a valid and binding agreement between Scott & White Healthcare and me, that I have had the opportunity to have reviewed along with the current Policy by my counsel prior to signing, and is binding on my estate, heirs, successors and assigns.

2. I will disclose to S&W or its designee all S&W-Associated IP.

3. I will assign and hereby do assign to Scott & White Healthcare, its successors and assigns all rights, title, and interest in and to any such S&W-Associated IP, including without limitation, the right to sue for and retain damages for past, present and future infringement thereof and the right of priority, including without limitation to claim priority benefit of or to patent applications claiming S&W-Associated IP and request the Commissioner for Patents in the United States, and similar authorities outside the United States, to issue said patents to and in the name of Scott & White Healthcare, its successors or assigns.

4. I will execute anything lawfully requested by S&W to document this assignment and take further lawful actions requested of me to file, prosecute, register, maintain, enforce, transfer and defend S&W-Associated IP.

5. Unless approved by S&W, I have not and will not enter into any agreements with any third party regarding any such S&W-Associated IP.

6. The obligations in this agreement, as well as my other obligations under the Policy, commenced on the date of my hire by S&W and continue even if I cease to be associated with S&W. All records, notebooks and documentation, whether maintained in writing, electronic or other form, relating to S&W-Associated IP (as that term is defined in the Policy) shall at all times belong to and remain the sole property of Scott & White Healthcare, its successors and assigns.

7. This agreement is governed by the laws of the state of Texas without regard to any choice of law provisions.

8. I understand that Creator(s) of S&W-Associated IP shall share in the distribution of Net Revenue with S&W as described in the Policy.

Please note that it is required that your signature be witnessed at the time of signing.

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I. Purpose
The purpose of this Conflict of Interest Policy is to assure appropriate interactions between Scott & White Healthcare (S&W) and the biomedical industry regarding patient care, education and research, and corporate business practices. This Policy provides guidelines for responding to certain situations which, if mis-handled, could result in a conflict of interest.

This Policy is intended to supplement, and not replace, (1) the Conflict of Interest Policy set forth in the bylaws of Scott & White Healthcare and/or any affiliate of Scott & White Healthcare, (2) the Employee Handbook, (3) the Guiding Business Principles, and/or (4) any other S&W publication, policy, or procedure that provides general information or describes the manner in which employees should deal with specific situations. Due to the nature of S&W’s operations and variations necessary to accommodate individual situations, the guidelines set forth in this Policy may not apply to every employee or in every situation. S&W reserves the right to rescind, modify or deviate from these or other guidelines, policies, practices or procedures from time to time as it considers necessary, at its sole discretion, either in individual or organization-wide situations, with or without notice.

II. Scope
This Policy shall apply to all employees organization-wide, including but not limited to employees of (1) Scott & White Clinic, and (2) Scott and White Memorial Hospital and Scott, Sherwood and Brindley Foundation.

III. Guidelines

A. Gifts

(3) Personal Gifts: Personal gifts from industry to S&W employees are prohibited, including entertainment, recreation and non-approved travel.

(4) Donations of Equipment: Equipment may be donated to S&W through the Corporate Relations Division of the Development Office. The Development Office shall obtain the estimated value and source of such donation and report the information to the Conflict of Interest (COI) Committee. Distribution of the equipment will be determined by the Development Office (in consultation with Supply Chain Services), or by the Department Chair of the department for which the donation was intended, with no involvement by the donor industry. Distribution of such equipment may be audited by the COI Committee. The receipt, but not the amount, of each donation of equipment will be publicly available.

(5) Monetary Donations: Money may be donated to S&W through the Corporate Relations Division of the Development Office. The Development Office shall deposit the money into an appropriate educational or building account. The amount of each donation and the source of such donation shall be reported to the Conflict of Interest (COI) Committee. Distribution of the money will be determined by the Development Office, or by the Department Chair of the department for which the donation was intended, with no involvement by the donor industry. Distribution of such money may be audited by the COI Committee. The receipt, but not the amount, of each monetary donation will be publicly available.

B. Meals

(1) On-site: Funding from industry to provide meals to S&W employees, residents and/or medical students is prohibited.

(2) Off-site: Employees, faculty and/or trainees may participate in off-site industry-sponsored programs or meetings which include a meal, provided that the amount expended per person does not exceed $125.
C Prescription Drug Samples

(3) Hospitals: Prescription drug samples may not be delivered or received on any hospital-licensed property. In Temple, hospital-licensed property includes the entire facility comprising Scott and White Memorial Hospital (SWMH), the contiguous space comprising Scott & White Clinic on the Temple Main Campus, the Pavilion, and the Santa Fe Skilled Nursing Facility. Patients who receive services at these locations and who cannot afford their prescription medications may be directed to the Social Work Department. Social Work will determine whether the patient qualifies for medication assistance or reduced-cost drugs.

(4) MOBs and Outlying Clinics (including CDM and the Temple Pediatrics Clinic on the Temple Main Campus): Prescription drug samples may be delivered by the industry representative to a non-patient-care area in the facility where the samples will be disbursed. The non-patient care area must also be a location where industry representatives will not have access to residents or students. All sample deliveries will be signed for by the Medical Director of the facility, or his/her designee. All sample drug use will be carefully documented at the site of disbursement.

D Travel Paid for by Industry

Payment of travel expenses by industry requires preauthorization by the traveling individual’s chairman (or equivalent position). Industry-sponsored travel is acceptable for pre-approved faculty-industry interactions only, including product evaluations, site assessments, etc. Expense reports submitted by the traveler to the industry for reimbursement must be copied to the COI Committee. Payment for meals (not to exceed $125 per individual per meal) by industry during approved travel is permissible.

E External Remuneration

Provision of services outside of S&W that are the same or materially similar to the services provided by the individual to S&W (including product development) must be pre-approved by the individual’s chairman (or equivalent position). Any remuneration for such services will be reported by the individual to such person’s chairman (or equivalent position) and forwarded by chairman (or equivalent position) to the COI Committee. Such remuneration includes but is not limited to earnings, consulting fees, honoraria, licensing fees, royalties and medical service fees. The existence of these relationships (but not the compensation amount) will be publicly available. Such relationships and compensation amounts may be disclosed to outside authorities as legally required.

F Industry Representative Access

S&W prohibits industry representatives from having unregulated access to its employees and trainees. Any industry representative, including representatives providing technical expertise or inventory management services, must register through the appropriate S&W administrative process, respond to an invitation extended by SW staff, make an appointment to come to S&W, and then come at the appointed time.

G Academic Support, Industry-Sponsored Scholarships, and Other Educational Funds

Third party support of educational and research programs (including but not limited to employee scholarships, training funds, educational literature or materials, textbooks and educational CD-ROMs) is permissible if intended to facilitate training of employees, students and residents. Funds and/or materials should be received by the Corporate Relations Division of the Development Office and deposited by the Development Office into an appropriate account. The Development Office shall obtain the estimated value and source of such resources and report such information to the Conflict of Interest (COI) Committee. Distribution of these funds will be the responsibility of the Department Chair, with no involvement by the donor industry. Funds received from industry and the distribution of such funds by the Department Chair may be audited by the COI Committee. The receipt (but not the amount) of each academic donation will be publicly available. Donations, including the amounts, may be disclosed to outside authorities as legally required.
H Participation in Industry-Sponsored Programs

(1) Participation in industry-sponsored speakers' bureaus must be pre-approved by the Department Chair. Approval will be based, in part, on whether the speaker is presenting his/her own work or expertise. Serving as an agent for corporate marketing is strongly discouraged. Information regarding each event (name of sponsoring institution, topic(s) presented, date(s) and location) must be reviewed prior to approval being given. If participation is approved, such information will be forwarded to the COI Committee. Participants are required to fully disclose participation, including compensation received, in any such program. Compensation should be at no more than fair market value.

(2) “Ghost writing,” which involves the addition of a S&W employee’s name on a publication to which the individual did not contribute significantly, is prohibited.

(3) Accepting payment for attendance only at industry-sponsored meetings is prohibited.

(4) Accepting personal gifts from industry at industry-sponsored events is prohibited.

I Industry Marketing

It is permissible to distribute flyers and/or invitations to local industry-sponsored education events, so long as the product for which education is being provided is already being purchased by Scott & White.

J Process of Determining Whether Conflict of Interest Exists

An employee who wishes to receive guidance as to whether certain conduct or actions constitute a conflict of interest should do the following:

(1) Prior to engaging in the conduct, the employee should contact his/her chairman (or equivalent position) for approval. If the chairman (or equivalent position) cannot make a determination, or if the employee disagrees with the determination made by his/her chairman (or equivalent position) the employee may contact either the Corporate Compliance Officer (Frank Anderson, 724-4386) or the Assistant General Counsel (Kate Arthur, 724-5741). Mr. Anderson and Ms. Arthur will confer to determine whether the conduct, as described by the employee, constitutes a conflict of interest.

(2) Employees who disagree with the decision reached by Mr. Anderson and Ms. Arthur may appeal to the COI Committee. The individual employee will be given the opportunity to appear before the COI Committee and provide a verbal explanation of why the desired conduct does not constitute a conflict of interest. The COI Committee will then determine by majority vote whether to allow or disallow the conduct in question. The decision of the COI Committee is final and not subject to further appeal.

Failure to adhere to these guidelines, including pre-approval and disclosure of activities as described above, could result in administrative sanctions, including probation, suspension or termination of employment.

I have read and understood the Conflict of Interest policy described, and will comply with it to the best of my ability. I understand that failure to adhere to these guidelines, including pre-approval and disclosure of activities as described above, could result in administrative sanctions, including probation, suspension or termination of employment.

Name (printed): ____________________________________________

Signature: ________________________________________________

Date: ____________________________________________________
Frequently Asked Questions (FAQ) on Parking Information

Parking: Scott & White staff are required to park in designated Staff Parking Lots. Please do NOT park in patient parking areas. Staff who park in patient parking are subject to any of the following: parking tickets, a boot placed on your vehicle, towing of your vehicle, and counseling up to termination.

Off-Duty Staff going to any Scott & White facilities for personal or patient care needs must leave a written note with date, time, and summary of business on the dashboard of vehicle if they park in patient parking areas. Forms are available on InSite (at the Security Services page).

Staff Parking Locations: Temple Main: (see Temple main campus map)
Children’s Hospital: (see Children’s Hospital campus map)
Continuing Care Hospital: (see CCH campus map)
Round Rock: (see Round Rock campus map)
Santa Fe: (see Santa Fe campus map)
Scott & White Health Plan (see SWHP campus map)
West Campus: (see West campus map)
All other sites: Your supervisor will show you where to park for your building

Handicap Parking Staff: May park in handicap parking spaces with appropriate placard or license plate. Please park in the appropriate type space (no cars in van accessible spaces).

Vehicle Parking Exception: Staff with borrowed vehicles, rental vehicles, or new vehicles without plates must park in designated Staff Parking and leave a written note on the dashboard (name, date, time, work phone number). Forms are available on InSite (at the Security Services page)

Vehicle Registration: All staff working must register their vehicles for employee parking.

Vehicle Sticker Placement: Attach registration sticker to the outside of the lower left (driver’s side) rear window of your vehicle. Convertibles may attach the sticker to the lower right (passenger’s side) of the front window of the vehicle.
**CTX PARKING PERMIT**

**ALL STAFF ARE REQUIRED TO REGISTER THEIR VEHICLE**

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**CHECK ONE OF THE FOLLOWING:**

- ☐ STAFF MEMBER
- ☐ SENIOR STAFF
- ☐ CONTRACTOR
- ☐ ADMINISTRATION
- ☐ RESIDENT
- ☐ STUDENT
- ☐ OTHER ________________________________

**VEHICLE #1 INFORMATION**

- ☐ ADD TO RECORDS OR
- ☐ DELETE FROM RECORDS

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**VEHICLE #2 INFORMATION**

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**FOR OFFICE USE ONLY**

- PERMIT #1: 
- PERMIT #2: 
- CARD #: 

Attach permit to the outside of the lower left (driver’s side) rear window of your vehicle. Convertible may attach the permit to the lower right (passenger’s side) of the front window of the vehicle.
Online Physician/Provider Profile

The most popular pages on our website, sw.org, are the physician/provider directory profiles pages. Each day hundreds of patients search for a provider at Scott & White Healthcare. Not only does your profile information display on our website, it is also included on the S&W Mobile iPhone App. Physician Relations creates a printed version to distribute to physician offices, too. Most importantly, search engines like Google crawl our web pages daily so that your information shows up when a patient is searching for a doctor/provider.

To start the process- you will soon receive an email providing you with a temporary password to log in to your profile page. Once logged in, you will be able to make changes and updates to your profile so that we have your most current information. Some of your information may already be pre-populated by the Medical Credentialing office. You will even have an option to designate a proxy to update your profile in your absence. Please complete the online form in 5 business days. Any questions regarding updates or to request a temporary password to make changes on should be directed to Providerdirectory@swmail.sw.org. This email address is in Outlook as “Provider Directory”.

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**Andres E. Avots-Avalins, MD, PhD**

- Chairman, Scott & White Board of Directors
- Gastroenterology, Internal Medicine

**Board【1994】- Texas AM Health Science Center College of Medicine**

**Board【1993】- University of Texas Medical Branch at Galveston, TX, MD, 1993**

**Residency【1992】- University of Texas at Austin, TX, SA, 1992**

**Specialty【Radiology】- Communicate Pathology, University of Utah, Salt Lake City**

**Specialty【Radiology】- Internal Medicine Residency, University of Utah, Salt Lake City**

**Scott & White Appointment**

**July 17, 1992**

**Publications and Research**

- **Oncology**

**Professional Activities**


**Provider directory@swmail.sw.org**
# TMA/County Medical Society Membership Application

**For CMS use only:** Date Receiv’d. __________ Dat Comp. __________ IMIS# __________

**For TMA use only:** ME# __________ IMIS# __________ RC __________

Membership Type: [ ] Resident [ ] Active [ ] Military [ ] Associate

I will arrive in _________ County __________ on __________ Date

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**Biographical Data**

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[ ] Office Address (check if this is your preferred contact address)

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[ ] Home Address (check if this is your preferred contact address)

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Date of Birth __________

Texas Medical License# __________

UPIN# __________

SSN# __________

[ ] Yes [ ] No

If married, is spouse also a physician?

Marital Status

Spouse’s Name __________

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**Specialty Designation**

ECFMG #: __________

Specialty: Primary __________ Secondary __________

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**Board Certifications**

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**Previous Practice**

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**Hospital Affiliations**

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Have you ever had an application for membership in a medical society rejected? Yes ☐ No ☐
Have you ever been convicted of a crime, other than a non-felony motor vehicle violation? ☐ ☐
Has your medical license ever been revoked or suspended? ☐ ☐
Have you ever been subjected to disciplinary action by any of the following?
- Board of Medical Examiners ☐ ☐
- County/State Medical Society ☐ ☐
- Hospital Medical Staff ☐ ☐

Note: Completion of this section is required.

I hereby apply for membership in the ___________________ County Medical Society and Texas Medical Association and, if accepted, agree to abide by and be subject to terms and conditions of the Constitution and Bylaws of the Society and of the Texas Medical Association and the Principles of the Medical Ethics of the American Medical Association.

In consideration of the ___________________ County Medical Society processing my application for membership, I grant permission and consent for you to obtain from any appropriate source all relevant information concerning my credentials and qualifications.

I further authorize disclosure of information generally considered to be reliable which has a bearing on my professional competence, character, and ethical qualifications to all hospitals, medical discipline boards, and medical licensure boards which request such information.

I hereby release, and hold harmless from liability or loss, the ___________________ County Medical Society, the Texas Medical Association, and any other County Medical Society to which I transfer, their officers, agents, employees, and members for acts performed in good faith and without malice in connection with evaluating my application and my credentials and qualifications, and hereby release from any liability any and all individuals and organizations, who, in good faith and without malice, provide information to the above named organizations, or their authorized representatives, concerning my professional competence, ethical conduct, character and other qualifications for membership.

I understand that if my application for membership is denied by the Board of Censors, I have a right to appeal the denial to the County Medical Society pursuant to the Hearings Procedure Manual. I also understand that if my application for membership is denied, based on professional competence or conduct, the County Medical Society must report such a professional review action to the National Practitioner Data Bank through the Texas State Board of Medical Examiners within 15 days of the date that all due process rights have been exhausted.

I also agree that biographical information will be disseminated in accordance with the policy and procedures established by the TMA Council on Communication unless otherwise directed by me.

We, your Board of Censors, have had the above application under consideration, and: ☐ Approve ☐ Disapprove on ______ Date ______

Signature and Title

Signature and Title

Signature and Title

Signature and Title

Note: Membership becomes effective when application has been approved and dues have been paid to the Association.

Please submit payment with membership application.
Anti-Discrimination Notice. It is illegal to discriminate against any work-authorized individual in hiring, discharge, recruitment or referral for a fee, or in the employment eligibility verification (Form I-9 and E-Verify) process based on that individual’s citizenship status, immigration status or national origin. Employers CANNOT specify which document(s) they will accept from an employee. The refusal to hire an individual because the documentation presented has a future expiration date may also constitute illegal discrimination. For more information, call the Office of Special Counsel for Immigration-Related Unfair Employment Practices (OSC) at 1-800-255-7688 (employees), 1-800-255-8155 (employers), or 1-800-237-2515 (TDD), or visit www.justice.gov/crt/about/ose.

What Is the Purpose of This Form?

Employers must complete Form I-9 to document verification of the identity and employment authorization of each new employee (both citizen and noncitizen) hired after November 6, 1986, to work in the United States. In the Commonwealth of the Northern Mariana Islands (CNMI), employers must complete Form I-9 to document verification of the identity and employment authorization of each new employee (both citizen and noncitizen) hired after November 27, 2011. Employers should have used Form I-9 CNMI between November 28, 2009 and November 27, 2011.

General Instructions

Employers are responsible for completing and retaining Form I-9. For the purpose of completing this form, the term "employer" means all employers, including those recruiters and referrers for a fee who are agricultural associations, agricultural employers, or farm labor contractors.

Form I-9 is made up of three sections. Employers may be fined if the form is not complete. Employers are responsible for retaining completed forms. Do not mail completed forms to U.S. Citizenship and Immigration Services (USCIS) or Immigration and Customs Enforcement (ICE).

Section 1. Employee Information and Attestation

Newly hired employees must complete and sign Section 1 of Form I-9 no later than the first day of employment. Section 1 should never be completed before the employee has accepted a job offer.

Provide the following information to complete Section 1:

Name: Provide your full legal last name, first name, and middle initial. Your last name is your family name or surname. If you have two last names or a hyphenated last name, include both names in the last name field. Your first name is your given name. Your middle initial is the first letter of your second given name, or the first letter of your middle name, if any.

Other names used: Provide all other names used, if any (including maiden name). If you have had no other legal names, write "N/A."

Address: Provide the address where you currently live, including Street Number and Name, Apartment Number (if applicable), City, State, and Zip Code. Do not provide a post office box address (P.O. Box). Only border commuters from Canada or Mexico may use an international address in this field.

Date of Birth: Provide your date of birth in the mm/dd/yyyy format. For example, January 23, 1950, should be written as 01/23/1950.

U.S. Social Security Number: Provide your 9-digit Social Security number. Providing your Social Security number is voluntary. However, if your employer participates in E-Verify, you must provide your Social Security number.

E-mail Address and Telephone Number (Optional): You may provide your e-mail address and telephone number. Department of Homeland Security (DHS) may contact you if DHS learns of a potential mismatch between the information provided and the information in DHS or Social Security Administration (SSA) records. You may write "N/A" if you choose not to provide this information.
All employees must attest in Section 1, under penalty of perjury, to their citizenship or immigration status by checking one of the following four boxes provided on the form:

1. **A citizen of the United States**

2. **A noncitizen national of the United States:** Noncitizen nationals of the United States are persons born in American Samoa, certain former citizens of the former Trust Territory of the Pacific Islands, and certain children of noncitizen nationals born abroad.

3. **A lawful permanent resident:** A lawful permanent resident is any person who is not a U.S. citizen and who resides in the United States under legally recognized and lawfully recorded permanent residence as an immigrant. The term "lawful permanent resident" includes conditional residents. If you check this box, write either your Alien Registration Number (A-Number) or USCIS Number in the field next to your selection. At this time, the USCIS Number is the same as the A-Number without the "A" prefix.

4. **An alien authorized to work:** If you are not a citizen or national of the United States or a lawful permanent resident, but are authorized to work in the United States, check this box.

   If you check this box:
   
   a. Record the date that your employment authorization expires, if any. Aliens whose employment authorization does not expire, such as refugees, asylees, and certain citizens of the Federated States of Micronesia, the Republic of the Marshall Islands, or Palau, may write "N/A" on this line.

   b. Next, enter your Alien Registration Number (A-Number)/USCIS Number. At this time, the USCIS Number is the same as your A-Number without the "A" prefix. If you have not received an A-Number/USCIS Number, record your Admission Number. You can find your Admission Number on Form I-94, "Arrival-Departure Record," or as directed by USCIS or U.S. Customs and Border Protection (CBP).

      (1) If you obtained your admission number from CBP in connection with your arrival in the United States, then also record information about the foreign passport you used to enter the United States (number and country of issuance).

      (2) If you obtained your admission number from USCIS within the United States, or you entered the United States without a foreign passport, you must write "N/A" in the Foreign Passport Number and Country of Issuance fields.

Sign your name in the "Signature of Employee" block and record the date you completed and signed Section 1. By signing and dating this form, you attest that the citizenship or immigration status you selected is correct and that you are aware that you may be imprisoned and/or fined for making false statements or using false documentation when completing this form. To fully complete this form, you must present to your employer documentation that establishes your identity and employment authorization. Choose which documents to present from the Lists of Acceptable Documents, found on the last page of this form. You must present this documentation no later than the third day after beginning employment, although you may present the required documentation before this date.

**Preparer and/or Translator Certification**

The Preparer and/or Translator Certification must be completed if the employee requires assistance to complete Section 1 (e.g., the employee needs the instructions or responses translated, someone other than the employee fills out the information blocks, or someone with disabilities needs additional assistance). The employee must still sign Section 1.

**Minors and Certain Employees with Disabilities (Special Placement)**

Parents or legal guardians assisting minors (individuals under 18) and certain employees with disabilities should review the guidelines in the Handbook for Employers: Instructions for Completing Form I-9 (M-274) on www.uscis.gov/I-9Central before completing Section 1. These individuals have special procedures for establishing identity if they cannot present an identity document for Form I-9. The special procedures include (1) the parent or legal guardian filling out Section 1 and writing "minor under age 18" or "special placement," whichever applies, in the employee signature block; and (2) the employer writing "minor under age 18" or "special placement" under List B in Section 2.
Section 2. Employer or Authorized Representative Review and Verification

Before completing Section 2, employers must ensure that Section 1 is completed properly and on time. Employers may not ask an individual to complete Section 1 before he or she has accepted a job offer.

Employers or their authorized representative must complete Section 2 by examining evidence of identity and employment authorization within 3 business days of the employee’s first day of employment. For example, if an employee begins employment on Monday, the employer must complete Section 2 by Thursday of that week. However, if an employer hires an individual for less than 3 business days, Section 2 must be completed no later than the first day of employment. An employer may complete Form I-9 before the first day of employment if the employer has offered the individual a job and the individual has accepted.

Employers cannot specify which document(s) employees may present from the Lists of Acceptable Documents, found on the last page of Form I-9, to establish identity and employment authorization. Employees must present one selection from List A OR a combination of one selection from List B and one selection from List C. List A contains documents that show both identity and employment authorization. Some List A documents are combination documents. The employee must present combination documents together to be considered a List A document. For example, a foreign passport and a Form I-94 containing an endorsement of the alien’s nonimmigrant status must be presented together to be considered a List A document. List B contains documents that show identity only, and List C contains documents that show employment authorization only. If an employee presents a List A document, he or she should not present a List B and List C document, and vice versa. If an employer participates in E-Verify, the List B document must include a photograph.

In the field below the Section 2 introduction, employers must enter the last name, first name and middle initial, if any, that the employee entered in Section 1. This will help to identify the pages of the form should they get separated.

Employers or their authorized representative must:

1. Physically examine each original document the employee presents to determine if it reasonably appears to be genuine and to relate to the person presenting it. The person who examines the documents must be the same person who signs Section 2. The examiner of the documents and the employee must both be physically present during the examination of the employee’s documents.

2. Record the document title shown on the Lists of Acceptable Documents, issuing authority, document number and expiration date (if any) from the original document(s) the employee presents. You may write "N/A" in any unused fields.

   If the employee is a student or exchange visitor who presented a foreign passport with a Form I-94, the employer should also enter in Section 2:
   
   a. The student’s Form I-20 or DS-2019 number (Student and Exchange Visitor Information System-SEVIS Number); and the program end date from Form I-20 or DS-2019.

3. Under Certification, enter the employee’s first day of employment. Temporary staffing agencies may enter the first day the employee was placed in a job pool. Recruiters and recruiters for a fee do not enter the employee’s first day of employment.

4. Provide the name and title of the person completing Section 2 in the Signature of Employer or Authorized Representative field.

5. Sign and date the attestation on the date Section 2 is completed.

6. Record the employer’s business name and address.

7. Return the employee’s documentation.

Employers may, but are not required to, photocopy the document(s) presented. If photocopies are made, they should be made for ALL new hires or re-verifications. Photocopies must be retained and presented with Form I-9 in case of an inspection by DHS or other federal government agency. Employers must always complete Section 2 even if they photocopy an employee’s document(s). Making photocopies of an employee’s document(s) cannot take the place of completing Form I-9. Employers are still responsible for completing and retaining Form I-9.
Unexpired Documents

Generally, only unexpired, original documentation is acceptable. The only exception is that an employee may present a certified copy of a birth certificate. Additionally, in some instances, a document that appears to be expired may be acceptable if the expiration date shown on the face of the document has been extended, such as for individuals with temporary protected status. Refer to the Handbook for Employers: Instructions for Completing Form I-9 (M-274) or I-9 Central (www.uscis.gov/I-9Central) for examples.

Receipts

If an employee is unable to present a required document (or documents), the employee can present an acceptable receipt in lieu of a document from the Lists of Acceptable Documents on the last page of this form. Receipts showing that a person has applied for an initial grant of employment authorization, or for renewal of employment authorization, are not acceptable. Employers cannot accept receipts if employment will last less than 3 days. Receipts are acceptable when completing Form I-9 for a new hire or when reverification is required.

Employees must present receipts within 3 business days of their first day of employment, or in the case of reverification, by the date that reverification is required, and must present valid replacement documents within the time frames described below.

There are three types of acceptable receipts:

1. A receipt showing that the employee has applied to replace a document that was lost, stolen or damaged. The employee must present the actual document within 90 days from the date of hire.

2. The arrival portion of Form I-94/I-94A with a temporary I-551 stamp and a photograph of the individual. The employee must present the actual Permanent Resident Card (Form I-551) by the expiration date of the temporary I-551 stamp, or, if there is no expiration date, within 1 year from the date of issue.

3. The departure portion of Form I-94/I-94A with a refugee admission stamp. The employee must present an unexpired Employment Authorization Document (Form I-766) or a combination of a List B document and an unrestricted Social Security card within 90 days.

When the employee provides an acceptable receipt, the employer should:

1. Record the document title in Section 2 under the sections titled List A, List B, or List C, as applicable.

2. Write the word "receipt" and its document number in the "Document Number" field. Record the last day that the receipt is valid in the "Expiration Date" field.

By the end of the receipt validity period, the employer should:

1. Cross out the word "receipt" and any accompanying document number and expiration date.

2. Record the number and other required document information from the actual document presented.

3. Initial and date the change.

See the Handbook for Employers: Instructions for Completing Form I-9 (M-274) at www.uscis.gov/I-9Central for more information on receipts.

Section 3. Reverification and Rehires

Employers or their authorized representatives should complete Section 3 when reverifying that an employee is authorized to work. When rehiring an employee within 3 years of the date Form I-9 was originally completed, employers have the option to complete a new Form I-9 or complete Section 3. When completing Section 3 in either a reverification or rehire situation, if the employee’s name has changed, record the name change in Block A.

For employees who provide an employment authorization expiration date in Section 1, employers must reverify employment authorization on or before the date provided.
Some employees may write "N/A" in the space provided for the expiration date in Section 1 if they are aliens whose employment authorization does not expire (e.g., asylees, refugees, certain citizens of the Federated States of Micronesia, the Republic of the Marshall Islands, or Palau). Reverification does not apply for such employees unless they chose to present evidence of employment authorization in Section 2 that contains an expiration date and requires reverification, such as Form I-766, Employment Authorization Document.

Reverification applies if evidence of employment authorization (List A or List C document) presented in Section 2 expires. However, employers should not reverify:

1. U.S. citizens and noncitizen nationals; or
2. Lawful permanent residents who presented a Permanent Resident Card (Form I-551) for Section 2.

Reverification does not apply to List B documents.

If both Section 1 and Section 2 indicate expiration dates triggering the reverification requirement, the employer should reverify by the earlier date.

For reverification, an employee must present unexpired documentation from either List A or List C showing he or she is still authorized to work. Employers CANNOT require the employee to present a particular document from List A or List C. The employee may choose which document to present.

To complete Section 3, employers should follow these instructions:

1. Complete Block A if an employee's name has changed at the time you complete Section 3.
2. Complete Block B with the date of rehire if you rehire an employee within 3 years of the date this form was originally completed, and the employee is still authorized to be employed on the same basis as previously indicated on this form. Also complete the "Signature of Employer or Authorized Representative" block.

3. Complete Block C if:
   a. The employment authorization or employment authorization document of a current employee is about to expire and requires reverification; or
   b. You rehire an employee within 3 years of the date this form was originally completed and his or her employment authorization or employment authorization document has expired. (Complete Block B for this employee as well.)

   To complete Block C:
   a. Examine either a List A or List C document the employee presents that shows that the employee is currently authorized to work in the United States; and
   b. Record the document title, document number, and expiration date (if any).

4. After completing block A, B or C, complete the "Signature of Employer or Authorized Representative" block, including the date.

For reverification purposes, employers may either complete Section 3 of a new Form I-9 or Section 3 of the previously completed Form I-9. Any new pages of Form I-9 completed during reverification must be attached to the employee's original Form I-9. If you choose to complete Section 3 of a new Form I-9, you may attach just the page containing Section 3, with the employee's name entered at the top of the page, to the employee's original Form I-9. If there is a more current version of Form I-9 at the time of reverification, you must complete Section 3 of that version of the form.

What Is the Filing Fee?

There is no fee for completing Form I-9. This form is not filed with USCIS or any government agency. Form I-9 must be retained by the employer and made available for inspection by U.S. Government officials as specified in the "USCIS Privacy Act Statement" below.

USCIS Forms and Information

For more detailed information about completing Form I-9, employers and employees should refer to the Handbook for Employers: Instructions for Completing Form I-9 (M-274).
You can also obtain information about Form I-9 from the USCIS Web site at www.uscis.gov/I-9Central, by e-mailing USCIS at I-9Central@dhs.gov, or by calling 1-888-464-4218. For TDD (hearing impaired), call 1-877-875-6028.

To obtain USCIS forms or the Handbook for Employers, you can download them from the USCIS Web site at www.uscis.gov/forms. You may order USCIS forms by calling our toll-free number at 1-800-870-3676. You may also obtain forms and information by contacting the USCIS National Customer Service Center at 1-800-375-5283. For TDD (hearing impaired), call 1-800-767-1833.

Information about E-Verify, a free and voluntary program that allows participating employers to electronically verify the employment eligibility of their newly hired employees, can be obtained from the USCIS Web site at www.dhs.gov/E-Verify, by e-mailing USCIS at E-Verify@dhs.gov or by calling 1-888-464-4218. For TDD (hearing impaired), call 1-877-875-6028.

Employees with questions about Form I-9 and/or E-Verify can reach the USCIS employee hotline by calling 1-888-897-7781. For TDD (hearing impaired), call 1-877-875-6028.

**Photocopying and Retaining Form I-9**

A blank Form I-9 may be reproduced, provided all sides are copied. The instructions and Lists of Acceptable Documents must be available to all employees completing this form. Employers must retain each employee's completed Form I-9 for as long as the individual works for the employer. Employers are required to retain the pages of the form on which the employee and employer enter data. If copies of documentation presented by the employee are made, those copies must also be kept with the form. Once the individual's employment ends, the employer must retain this form for either 3 years after the date of hire or 1 year after the date employment ended, whichever is later.

Form I-9 may be signed and retained electronically, in compliance with Department of Homeland Security regulations at 8 CFR 274a.2.

**USCIS Privacy Act Statement**

**AUTHORITIES:** The authority for collecting this information is the Immigration Reform and Control Act of 1986, Public Law 99-603 (8 USC 1324a).

**PURPOSE:** This information is collected by employers to comply with the requirements of the Immigration Reform and Control Act of 1986. This law requires that employers verify the identity and employment authorization of individuals they hire for employment to preclude the unlawful hiring, or recruiting or referring for a fee, of aliens who are not authorized to work in the United States.

**DISCLOSURE:** Submission of the information required in this form is voluntary. However, failure of the employer to ensure proper completion of this form for each employee may result in the imposition of civil or criminal penalties. In addition, employing individuals knowing that they are unauthorized to work in the United States may subject the employer to civil and/or criminal penalties.

**ROUTINE USES:** This information will be used by employers as a record of their basis for determining eligibility of an employee to work in the United States. The employer will keep this form and make it available for inspection by authorized officials of the Department of Homeland Security, Department of Labor, and Office of Special Counsel for Immigration-Related Unfair Employment Practices.

**Paperwork Reduction Act**

An agency may not conduct or sponsor an information collection and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. The public reporting burden for this collection of information is estimated at 35 minutes per response, including the time for reviewing instructions and completing and retaining the form. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to: U.S. Citizenship and Immigration Services, Regulatory Coordination Division, Office of Policy and Strategy, 20 Massachusetts Avenue NW, Washington, DC 20529-2140; OMB No. 1615-0047. **Do not mail your completed Form I-9 to this address.**
START HERE. Read instructions carefully before completing this form. The instructions must be available during completion of this form.

ANTI-DISCRIMINATION NOTICE: It is illegal to discriminate against work-authorized individuals. Employers CANNOT specify which document(s) they will accept from an employee. The refusal to hire an individual because the documentation presented has a future expiration date may also constitute illegal discrimination.

Section 1. Employee Information and Attestation (Employees must complete and sign Section 1 of Form I-9 no later than the first day of employment, but not before accepting a job offer.)

<table>
<thead>
<tr>
<th>Last Name (Family Name)</th>
<th>First Name (Given Name)</th>
<th>Middle Initial</th>
<th>Other Names Used (if any)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Address (Street Number and Name)</th>
<th>Apt. Number</th>
<th>City or Town</th>
<th>State</th>
<th>Zip Code</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
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<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Date of Birth (mm/dd/yyyy)</th>
<th>U.S. Social Security Number</th>
<th>E-mail Address</th>
<th>Telephone Number</th>
</tr>
</thead>
<tbody>
<tr>
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</tr>
</tbody>
</table>

I am aware that federal law provides for imprisonment and/or fines for false statements or use of false documents in connection with the completion of this form.

I attest, under penalty of perjury, that I am (check one of the following):

- [ ] A citizen of the United States
- [ ] A noncitizen national of the United States (See instructions)
- [ ] A lawful permanent resident (Alien Registration Number/USCIS Number):

  

- [ ] An alien authorized to work until (expiration date, if applicable, mm/dd/yyyy)

  Some aliens may write "N/A" in this field. (See instructions)

  For aliens authorized to work, provide your Alien Registration Number/USCIS Number OR Form I-94 Admission Number:

  1. Alien Registration Number/USCIS Number: _______________________________

     OR

     2. Form I-94 Admission Number: _______________________________

     If you obtained your admission number from CBP in connection with your arrival in the United States, include the following:

     Foreign Passport Number: _______________________________

     Country of Issuance: _______________________________

     Some aliens may write "N/A" on the Foreign Passport Number and Country of Issuance fields. (See instructions)

Signature of Employee: _______________________________

Date (mm/dd/yyyy): _______________________________

Preparer and/or Translator Certification (To be completed and signed if Section 1 is prepared by a person other than the employee.)

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

Signature of Preparer or Translator: _______________________________

Date (mm/dd/yyyy): _______________________________

<table>
<thead>
<tr>
<th>Last Name (Family Name)</th>
<th>First Name (Given Name)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Address (Street Number and Name)</th>
<th>City or Town</th>
<th>State</th>
<th>Zip Code</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Section 2. Employer or Authorized Representative Review and Verification

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

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

<table>
<thead>
<tr>
<th>List A</th>
<th>OR</th>
<th>List B</th>
<th>AND</th>
<th>List C</th>
</tr>
</thead>
<tbody>
<tr>
<td>Document Title:</td>
<td>Document Title:</td>
<td>Document Title:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Issuing Authority:</td>
<td>Issuing Authority:</td>
<td>Issuing Authority:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Document Number:</td>
<td>Document Number:</td>
<td>Document Number:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Expiration Date (if any)(mm/dd/yyyy):</td>
<td>Expiration Date (if any)(mm/dd/yyyy):</td>
<td>Expiration Date (if any)(mm/dd/yyyy):</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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.)

<table>
<thead>
<tr>
<th>Signature of Employer or Authorized Representative</th>
<th>Date (mm/dd/yyyy)</th>
<th>Title of Employer or Authorized Representative</th>
</tr>
</thead>
<tbody>
<tr>
<td>Last Name (Family Name) First Name (Given Name)</td>
<td>Employer’s Business or Organization Name</td>
<td></td>
</tr>
<tr>
<td>Employer’s Business or Organization Address (Street Number and Name)</td>
<td>City or Town Temple</td>
<td></td>
</tr>
<tr>
<td>State TX</td>
<td>Zip Code 76508</td>
<td></td>
</tr>
</tbody>
</table>

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

A. New Name (if applicable) Last Name (Family Name) First Name (Given Name) Middle Initial

B. Date of Rehire (if applicable) (mm/dd/yyyy):

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

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

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

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

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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.

<table>
<thead>
<tr>
<th>LIST A</th>
<th>Documents that Establish Both Identity and Employment Authorization OR</th>
<th>LIST B</th>
<th>Documents that Establish Identity AND</th>
<th>LIST C</th>
<th>Documents that Establish Employment Authorization</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>U.S. Passport or U.S. Passport Card</td>
<td>1.</td>
<td>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</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td>Permanent Resident Card or Alien Registration Receipt Card (Form I-551)</td>
<td>2.</td>
<td>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</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td>Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa</td>
<td>3.</td>
<td>School ID card with a photograph</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td>Employment Authorization Document that contains a photograph (Form I-766)</td>
<td>4.</td>
<td>Voter’s registration card</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5.</td>
<td>For a nonimmigrant alien authorized to work for a specific employer because of his or her status:</td>
<td>5.</td>
<td>U.S. Military card or draft record</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>a. Foreign passport; and</td>
<td>6.</td>
<td>Military dependent’s ID card</td>
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<tr>
<td></td>
<td>(1) The same name as the passport and</td>
<td>7.</td>
<td>U.S. Coast Guard Merchant Mariner Card</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>(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.</td>
<td>8.</td>
<td>Native American tribal document</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>b. Form I-94 or Form I-94A that has the following:</td>
<td>9.</td>
<td>Driver’s license issued by a Canadian government authority</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>(1) The same name as the passport and</td>
<td></td>
<td>For persons under age 18 who are unable to present a document listed above:</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>(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.</td>
<td>10.</td>
<td>School record or report card</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6.</td>
<td>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</td>
<td>11.</td>
<td>Clinic, doctor, or hospital record</td>
<td></td>
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<td></td>
<td></td>
<td>12.</td>
<td>Day-care or nursery school record</td>
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</table>

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

Refer to Section 2 of the instructions, titled "Employer or Authorized Representative Review and Verification," for more information about acceptable receipts.
Pre-Screening Notice and Certification Request for the Work Opportunity Credit

Job applicant: Fill in the lines below and check any boxes that apply. Complete only this side.

Your name ___________________________ Social security number ▶

Street address where you live ____________________________________________

City or town, state, and ZIP code __________________________________________

County __________________________ Telephome number _____________________

If you are under age 40, enter your date of birth (month, day, year) ____________

1 □ Check here if you received a conditional certification from the state workforce agency (SWA) or a participating local agency for the work opportunity credit.

2 □ Check here if any of the following statements apply to you.
   • I am a member of a family that has received assistance from Temporary Assistance for Needy Families (TANF) for any 9 months during the past 18 months.
   • I am a veteran and a member of a family that received Supplemental Nutrition Assistance Program (SNAP) benefits (food stamps) for at least a 3-month period during the past 15 months.
   • I was referred here by a rehabilitation agency approved by the state, an employment network under the Ticket to Work program, or the Department of Veterans Affairs.
   • I am at least age 18 but not age 40 or older and I am a member of a family that:
      a. Received SNAP benefits (food stamps) for the past 6 months; or
      b. Received SNAP benefits (food stamps) for at least 3 of the past 5 months, but is no longer eligible to receive them.
   • During the past year, I was convicted of a felony or released from prison for a felony.
   • I received supplemental security income (SSI) benefits for any month ending during the past 60 days.
   • I am a veteran and I was unemployed for a period or periods totaling at least 4 weeks but less than 6 months during the past year.

3 □ Check here if you are a veteran and you were unemployed for a period or periods totaling at least 6 months during the past year.

4 □ Check here if you are a veteran entitled to compensation for a service-connected disability and you were discharged or released from active duty in the U.S. Armed Forces during the past year.

5 □ Check here if you are a veteran entitled to compensation for a service-connected disability and you were unemployed for a period or periods totaling at least 6 months during the past year.

6 □ Check here if you are a member of a family that:
   • Received TANF payments for at least the past 18 months; or
   • Received TANF payments for any 18 months beginning after August 5, 1997, and the earliest 18-month period beginning after August 5, 1997, ended during the past 2 years; or
   • Stopped being eligible for TANF payments during the past 2 years because federal or state law limited the maximum time those payments could be made.

7 □ Check here if you are in a period of unemployment that is at least 27 consecutive weeks and for all or part of that period you received unemployment compensation.

Signature—All Applicants Must Sign

Under penalties of perjury, I declare that I gave the above information to the employer on or before the day I was offered a job, and it is, to the best of my knowledge, true, correct, and complete.

Job applicant’s signature ▶ Date

For Privacy Act and Paperwork Reduction Act Notice, see page 2.

Cat. No. 22851L

Form 8850 (Rev. 3-2016)
### Individual Characteristics Form (ICF)

#### Work Opportunity Tax Credit

**APPLICANT INFORMATION**

<table>
<thead>
<tr>
<th>Control No. (For Agency use only)</th>
<th>Date Received (For Agency Use only)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**EMPLOYER INFORMATION**

<table>
<thead>
<tr>
<th>Employer Name</th>
<th>Employer Address and Telephone</th>
<th>Employer Federal ID Number (EIN)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**APPLICANT INFORMATION**

<table>
<thead>
<tr>
<th>Applicant Name (Last, First, MI)</th>
<th>Social Security Number</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

8. Have you worked for this employer before?  
   Yes____ No ______
   If YES, enter last date of employment:________

**APPLICANT CHARACTERISTICS FOR WOTC TARGET GROUP CERTIFICATION**

<table>
<thead>
<tr>
<th>Employment Start Date</th>
<th>Starting Wage</th>
<th>Position</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

12. Are you at least age 16, but under age 40?  
   Yes___ No ___
   If YES, enter your date of birth ________________

13. Are you a Veteran of the U.S. Armed Forces?  
   Yes ___ No ___
   If NO, go to Box 14.
   If YES, are you a member of a family that received Supplemental Nutrition Assistance Program (SNAP) benefits (Food Stamps) for at least 3 months during the 15 months before you were hired?  
     Yes___ No ___
     If YES, enter name of primary recipient __________________ and city and state where benefits were received__________________.
     OR, are you a veteran entitled to compensation for a service-connected disability?  
       Yes___ No ___
     If YES, were you discharged or released from active duty within a year before you were hired?  
       Yes___ No ___
     OR, were you unemployed for a combined period of at least 6 months (whether or not consecutive) during the year before you were hired?  
       Yes ___ No __

14. Are you a member of a family that received Supplemental Nutrition Assistance Program (SNAP) (formerly Food Stamps) benefits for the 6 months before you were hired?  
   Yes___ No ___
   OR, received SNAP benefits for at least a 3-month period within the last 5 months but you are no longer receiving them?  
     Yes___ No ___
   If YES to either question, enter name of primary recipient __________________ and city and state where benefits were received__________________.

15. Were you referred to an employer by a Vocational Rehabilitation Agency approved by a State?  
   Yes___ No ___
   OR, by an Employment Network under the Ticket to Work Program?  
     Yes___ No ___
   OR, by the Department of Veterans Affairs?  
     Yes___ No ___
16. Are you a member of a family that received TANF assistance for at least the last 18 months before you were hired?  Yes  No

OR, are you a member of a family that received TANF benefits for any 18 months beginning after August 5, 1997, and the earliest 18-month period beginning after August 5, 1997, ended within 2 years before you were hired?  Yes No

OR, did your family stop being eligible for TANF assistance within 2 years before you were hired because a Federal or state law limited the maximum time those payments could be made?  Yes No

If NO, are you a member of a family that received TANF assistance for any 9 months during the 18-month period before you were hired?  Yes No

If YES, to any question, enter name of primary recipient__________________________ and the city and state where benefits were received______________________________.

17. Were you convicted of a felony or released from prison after a felony conviction during the year before you were hired?  Yes  No

If YES, enter date of conviction_________________________ and date of release__________________.

Was this a Federal ______ or a State conviction ________? (Check one)

18. Do you live in a Rural Renewal County or Empowerment Zone?  Yes  No

19. Do you live in an Empowerment Zone and are at least age 16, but not yet 18, on your hiring date?  Yes  No

20. Did you receive Supplemental Security Income (SSI) benefits for any month ending within 60 days before you were hired?  Yes  No

21. Are you a veteran unemployed for a combined period of at least 6 months (whether or not consecutive) during the year before you were hired?  Yes  No

22. Are you a veteran unemployed for a combined period of at least 4 weeks but less than 6 months (whether or not consecutive) during the year before you were hired?  Yes  No

23. Sources used to document eligibility: (Employers/Consultants: List all documentation provided or forthcoming. SWAs: List all documentation used in determining target group eligibility and enter your initials and date when the determination was made.)

I certify that this information is true and correct to the best of my knowledge. I understand that the information above may be subject to verification.

24(a). Signature: (See instructions in Box 24(b) for who signs this signature block)  

24. (b) Signatory Options: Indicate with a ✓ mark who signed this form:

- Employer,  Consultant,  SWA,
- Participating Agency,  Applicant,  or
- Parent/Guardian (if applicant is a minor)

25. Date:
INSTRUCTIONS FOR COMPLETING THE INDIVIDUAL CHARACTERISTICS FORM (ICF), ETA 9061. This form is used together with IRS Form 8850 to help state workforce agencies (SWAs) determine eligibility for the Work Opportunity Tax Credit (WOTC) Program. The form may be completed on behalf of the applicant, by 1) the employer or employer representative, the SWA, a participating agency, or 2) the applicant directly (if a minor, the parent or guardian must sign the form) and signed (Box 24a.) by the individual completing the form. This form is required to be used, without modification, by all employers (or their representatives) seeking WOTC certification. Every verification request must include an IRS Form 8850 and an ETA Form 9061 or 9002, if a Conditional Certification was issued to the individual certifying the new hire as "eligible" under the requested target group.

Boxes 1 and 2. SWA. For agency use only.

Boxes 3-5. Employer Information. Enter the name, address including ZIP code, telephone number, and employer Federal ID number (EIN) of the employer requesting the certification for the WOTC. Do not enter information pertaining to the employer’s representative, if any.

Boxes 6-11. Applicant Information. Enter the applicant’s name and social security number as they appear on the applicant’s social security card. In Box 8, indicate whether the applicant previously worked for the employer, and if Yes, enter the last date or approximate last date of employment. This information will help the “48-hour” reviewer to, early in the verification process, eliminate requests for former employees and to issue denials to these type of requests, or certifications in the case of “qualifying rehires” during valid “breaks in employment” (see pages III-12 and III-13, Nov. 2002, Third Ed., ETA Handbook 408) during the first year of employment.

Boxes 12-22. Applicant Characteristics. Read questions carefully, answer each question, and provide additional information where requested.

On January 2, 2013, President Obama signed into law the American Taxpayer Relief Act of 2012 retroactively authorizing the Empowerment Zones (EZs) and WOTC non-veteran groups from December 31, 2011 through December 31, 2013. This Act also authorized continuation of the VOW Act of 2011 expanded veterans and provisions through December 31, 2013. Form updates. “Empowerment Zones” was added to Box 18 to capture data for Designated Community Residents who must reside in a Rural Renewal County or EZ to be determined eligible for WOTC certification. A new Box 19 was added to this form to capture information on the Summer Youth group activated when the EZs were reauthorized. Members of the Summer Youth group must reside in an EZ to be determined eligible for WOTC certification. Boxes 19-21 were renumbered and are now Boxes 20-22. Box 22 below became Box 23, Sources to Document Eligibility.

Box 23 Sources to Document Eligibility. The applicant or employer is requested to provide documentary evidence to substantiate the YES answers in Boxes 12 through 22. List or describe the documentary evidence that is attached to the ICF or that will be provided to the SWA. Indicate in parentheses next to each document listed whether it is attached (A) or forthcoming (F). Some examples of acceptable documentary evidence are provided below. A letter from the agency that administers a relevant program may be furnished specifically addressing the question to which the applicant answered YES. For example, if an applicant answers YES to either question in Box 14 and enters the name of the primary recipient and the city and state in which the benefits were received, the applicant could provide a letter from the appropriate SNAP (formerly Food Stamp) agency stating to whom SNAP benefits were paid, the months for which they were paid, and the names of the individuals included on the grant for each month. SWAs will use this box to document the sources used when verifying target group eligibility, followed by their initials and the date the determination was completed.

Examples of Documentary Evidence and Collateral Contacts. Employers/Consultants: You may check with your SWA to find out what other sources you can use to prove target group eligibility. (You are encouraged to provide copies of documentation or names of collateral contacts for each question for which you answered YES.)

QUESTION 12
- Birth Certificate
- Driver’s License
- School I.D. Card
- Work Permit
- Federal/State/Local Gov’t I.D.
- Copy of Hospital Record of Birth

QUESTION 13
- DD-214 or Discharge Papers
- Reserve Unit Contacts or Letters of Separation
- Letter issued only by the Department of Veterans Affairs (VA) on VA Letterhead or bearing the Agency Stamp, with signature, certifying Veteran status or that the Veteran has a service-connected disability.

QUESTIONS 14 & 16
- TANF/SNAP (Food Stamp) Benefit History
- Signed statement from Authorized Individual with a specific description of the months benefits that were received
- Case number identifier

QUESTION 15
- Vocational Rehabilitation Agency Contact
- Veterans Administration for Disabled Veterans

- Signed Letter of Separation or related document from authorized Individual on DVA letterhead or agency stamp with specific description of months benefits were received.
- For SWAs: To determine Ticket Holder (TH) eligibility, Fax page 1 of Form 8850 to MAXIMUS at: 703-983-1051 to verify if applicant: 1) is a TH, and 2) has an Individual Work Plan from an Employment Network.

QUESTION 17
- Parole Officer’s Name or Statement
- Correction Institution Records
- Court Records Extracts

QUESTIONS 18 & 19
- To determine if a Designated Community Resident (DCR) lives in a Rural Renewal County, visit the site: www.usps.com Click on Find Zip Code; Enter & Submit Address/Zip Code; Click on Mailing Industry Information; Download and Print the Information, then compare the county of the address to the list in the Instructions to IRS Form 8850.
- To determine if the DCR or a Summer Youth lives in an Empowerment Zone, check the Instructions to IRS Form 8850, or visit the U.S. Department of Housing and Urban Development’s “locator” at: http://egis.hud.gov/ezrolocator/.
QUESTION 20

- SSI Record or Authorization
- SSI Contact
- Evidence of SSI Benefits

QUESTIONS 21 & 22

- Unemployment Insurance (UI) Claims Records
- UI Wage Records

Box 24(a). Signature. The person who completes the form signs the signature block.

Box 24(b). Signatory Options. Qualified individuals/entities which can sign the form instead of the applicant: (a) Employer, (b) Consultant, (c) SWA staff, (d) Participating Agency staff, (e) Applicant, or (f) Parent or guardian (If applicant is a minor, the parent or guardian must sign).

Box 25. Date. Enter the month, day and year when the form was completed.

Persons are not required to respond to this collection of information unless it displays a currently valid OMB Control Number. Respondent’s obligation to reply to these questions is required to obtain and retain benefits per law 104-188. Public reporting burden for this collection of information is estimated to average 20 minutes per response including the time for reading instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing burden to the U.S. Department of Labor, Employment and Training Administration, Division of National Programs, Tools, and Technical Assistance, 200 Constitution Ave., NW, Room C-4510, Washington, D.C. 20210 (Paperwork Reduction Project Control No. 1205-0371).

(Cut along dotted line and keep in your files)

TO: THE JOB APPLICANT OR EMPLOYEE,

Privacy Act Statement: The Internal Revenue Code of 1986, Section 51, as amended and its enacting legislation, P.L. 104-188, specify that the State Workforce Agencies are the "designated" agencies responsible for administering the WOTC certification procedures of this program. The information you have provided completing this form will be disclosed by your employer to the State Workforce Agency. Provision of this information is voluntary. However, the information is required for your employer to receive the federal tax credit. IF THE INFORMATION YOU PROVIDE IS ABOUT A MEMBER OF YOUR FAMILY, YOU SHOULD PROVIDE HIM/HER A COPY OF THIS NOTICE.

1. Where a Federal/State/Local Gov’t., School I.D. Card, or Work Permit does not contain age or birth date, another valid document must be obtained to verify an individual’s age.

2. ESPL No. 05-98, dated 3/18/98, officially rescinded the authority to use Form I-9 as proof of age and residence. Therefore, the I-9 is not a valid piece of documentary evidence since May 1998.
Physician’s Signature Card

NAME: ____________________________________________
(Please Print)

DEA NUMBER: ____________________________________

Specialty: ________________________________________

________________________________________
Signature as used on prescriptions

Scott & White Physician’s Signature Card
(Return to Outpatient Pharmacy)
Dear Scott & White Prescriber:

Each year, Texas law requires physician prescribing authorization documents to be renewed. In this mailing you will find documents requiring your attention that, when signed, should help reduce phone calls to your office and better serve your patients.

The attachments are:

(1) a document granting Scott & White pharmacies authorization to refill a prescription one additional time while waiting for refill authorization;
(2) a document granting the Scott & White pharmacies authorization to dispense a quantity different than the quantity prescribed (typically either a 34-day or 90-day supply based on health plan benefit coverage); and
(3) a document explaining and authorizing therapeutic interchange (when applicable) by the Scott & White pharmacies.
One-Time Refill

Texas Pharmacy law grants only a 72-hour supply of medication while waiting for prescription refill authorization. Because the Scott & White Pharmacies and physician offices periodically experience an increased volume of refill requests, the Scott & White Pharmacies are asking that physicians consider granting a one-time refill for prescriptions included in the categories listed below while waiting for authorization. This will provide patients with their medications and diabetic supplies in a timely manner and hopefully reduce the expected increase in pharmacy calls to physicians for authorization.

- Cardiovascular agents (antianginals, antiarrythmics, antihypertensives, cardiac glycosides, cholesterol lowering agents). Anticoagulant agents are excluded.
- Anticonvulsants
- Antidepressants
- Antidiabetic supplies and agents
- Antiparkinsonian agents
- Antiasthmatic agents
- Estrogen replacement agents
- Progesterone replacement agents
- Ophthalmic agents - Anti-glaucoma agents
- Contraceptives
- Potassium supplements
- Thyroid replacement agents (natural, synthetic)

Signing and dating this form will allow the SWHP Pharmacy to provide one refill for these medications, if requested by the patient, through December 31, 2014. This document will be renewed yearly in accordance with Texas Pharmacy law.

__________________________  __________________________  __________________
Physician Signature          Physician Printed Name         Date

Please send this completed form to S&W Prescription Services by fax to (254) 298-6133. If you have any questions, please contact your Scott & White Health Plan Pharmacy.

Thank you.
Quantity Increase

The Scott & White Pharmacies and physician offices periodically experience an increased volume of requests for maintenance supplies due to changes in prescription benefit coverage. In addition, state pharmacy laws require physician notification to change the quantity dispensed if different from the quantity written on the prescription.

The Health Plan Pharmacies are asking that physicians consider granting the pharmacies authority to increase or decrease a patient’s prescription quantity if certain criteria, as listed below, are met and the prescription is included in the “maintenance medication” categories listed below. This will provide patients with their medications in a timely manner and hopefully reduce the expected increase in pharmacy calls to physicians for authorization.

Required Criteria:
1. There are no changes in the directions or dosage strength of the drug
2. The increase would not exceed the quantity originally prescribed by the physician (original plus refills)
3. The patient desires a 34-day or 90-day supply, and the request complies with the member’s contract

Maintenance Medication Category:
- Cardiovascular agents (antianginals, antiarrythmics, antihypertensives, cardiac glycosides, cholesterol-lowering agents, diuretics)
- Anticonvulsants
- Antidiabetic agents and Supplies
- Antiparkinsonian agents
- Antiasthmatic agents
- Estrogen and Progestin replacement agents
- Potassium supplements
- Thyroid replacement agents (natural, synthetic)
- Selective Serotonin Reuptake Inhibitors
- Tricyclic Antidepressants
- Bupropion, Bupropion SR, Bupropion XL
- Venlafaxine, Venlafaxine ER
- Antigout Agents
- Antiglaucoma Agents
- Agents for Treatment of Urinary Incontinence
- Agents for Treatment of Osteoporosis
- Testosterone Cypionate
- Lithium carbonate, Lithium carbonate ER
- Lithium citrate

Signing and dating this form will allow the SWHP Pharmacy to provide increased prescription quantity to a 34-day or 90-day supply for these maintenance medications, if requested by the patient, through December 31, 2014. This document will be renewed yearly in accordance to Texas Pharmacy law.

__________________________  _______________________  __________
Physician Signature          Physician Printed Name          Date

Please send this completed form to S&W Prescription Services by fax to (254) 298-6133. If you have any questions, please contact your Scott & White Health Plan Pharmacy.
Thank you.
2014 PHYSICIAN AUTHORIZATION FOR THERAPEUTIC INTERCHANGE

As a physician who treats members of the Scott and White Health Plan (SWHP), I am familiar with the methods by which the SWHP determines pharmaceutical equivalency.

In those instances where benefit language encourages use of a therapeutically equivalent medication, I hereby authorize the SWHP Pharmacies and the SWHP Provider Pharmacies to substitute and dispense to the plan members the SWHP-approved pharmaceutically equivalent product.

For purposes of this order, I understand “approved pharmaceutically equivalent products” to include:

Specific drugs that have been declared as “clinically equivalent” by the SWHP P&T Committee and thus qualify for “therapeutic substitution”. The drugs eligible for therapeutic interchange are noted in the table below. Note: this provision refers to the approved SWHP formulary conversion programs for specific drugs and classes of drugs.

<table>
<thead>
<tr>
<th>Therapeutic Interchange Description</th>
<th>Effective Date</th>
<th>Status of Conversion (Active/Inactive)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Felodipine converted to equivalent amlodipine dose</td>
<td>8/25/08</td>
<td>Active</td>
</tr>
<tr>
<td>Felodipine 2.5 mg orally once daily</td>
<td>Amlodipine 2.5 mg orally once daily</td>
<td></td>
</tr>
<tr>
<td>Felodipine 5 mg orally once daily</td>
<td>Amlodipine 5 mg orally once daily</td>
<td></td>
</tr>
<tr>
<td>Felodipine 10 mg orally once daily</td>
<td>Amlodipine 10 mg orally once daily</td>
<td></td>
</tr>
<tr>
<td>Betaseron converted to equivalent Extavia dose</td>
<td>10/24/11</td>
<td>Active</td>
</tr>
<tr>
<td>Betaseron 0.0625 mg - 0.25 mg SQ QOD</td>
<td>Extavia 0.0625 mg - 0.25 mg SQ QOD</td>
<td></td>
</tr>
<tr>
<td>Low-Dose Crestor® &amp; Vytorin® converted to equivalent atorvastatin dose</td>
<td>3/25/13</td>
<td>Active</td>
</tr>
<tr>
<td>Crestor 5mg once daily</td>
<td>Vtorin 10/10mg once daily</td>
<td>atorvastatin 20mg orally once daily</td>
</tr>
<tr>
<td>Crestor 10mg once daily</td>
<td>Vtorin 10/20mg once daily</td>
<td>atorvastatin 40mg orally once daily</td>
</tr>
<tr>
<td>Crestor 20mg once daily</td>
<td>Vtorin 10/40mg once daily</td>
<td>atorvastatin 80mg orally once daily</td>
</tr>
</tbody>
</table>

Below are listed those medications I choose to exclude from this authorization when written or ordered by brand name accompanied by the following two notations on the face of the prescription: “dispense as written” and “brand medically necessary” (per state law, these must be handwritten by the prescriber). I understand that this list can be amended by addition or deletion upon notice from me, and that, in any case, this authorization can be overridden by the notation of both “dispense as written” and “brand medically necessary” on the face of the prescription.

[ ] (Additional Items May Be Added on Back of This Page)

___________________________
Signature

Printed Name

DEA Number

DPS Number

NPI Number

Date

THIS LETTER SUPERSEDES ALL OTHER NOTICES, PERMITS, OR AUTHORIZATIONS
Please send this completed form to S&W Prescription Services by fax to (254) 298-6133. If you have any questions, please contact your Scott & White Health Plan Pharmacy.
The Scott & White Caduceus Society is a leadership association of Scott & White physicians, senior staff and emeritus physicians with continuing commitment to the ideals of our founders and a common interest on perpetuating Scott & White’s mission to provide the most personalized, comprehensive, highest quality healthcare enhanced by the medical education and research.

A Shared Vision
Members of the Scott & White Caduceus Society have chosen a personal way to help extend the tradition of excellence and the pioneering spirit of the Scott & White model of medical practice, education and research. Through participation, members acknowledge the value of their contributions to the vision and success of Scott & White.

Objectives
- To provide widespread understanding of Scott & White’s purposes, accomplishments and needs.
- To pledge ourselves and our resources in support of Scott & White’s educational and scientific programs.
- To develop the Society as a symbol of sustained leadership, fellowship and support for Scott & White today and into the future.

Membership
An invitation to join this prestigious society is extended to all Scott & White physicians, senior staff and emeritus physicians. Members indicate their intent to do one of the following:
- Make an outright gift or pledge of $10,000 or more.
- Make an initial gift of $1,000 or more and contribute at this level annually until gifts total 10,000; thereafter, make annual gifts in accordance with individual financial capability.
- Make an initial gift of $500 and contribute annually at this level until reaching age 40; thereafter, make annual gifts of $1,000 until reaching $10,000.
- Provide $25,000 or more through a planned gift. Members of Scott & White’s Office of Development will be pleased to discuss the variety of planned giving options available.

Note: Gifts may be designed for the general support of medical education and research at Scott & White or for a specific purpose consistent with the objectives of Scott & White. Gifts are deductible to the full extent provided by existing laws.

A Foundation of Teamwork
In 1897, Arthur Carroll Scott, Sr., M.D. and Raleigh R. White, Jr., M.D. embodied the ideal of devoted teamwork. In those early years, they became co-adventurers on the frontiers of medicine. They extended membership in their medical practice to skilled physicians from diverse specialties, laying the foundation for the Scott & White of today.

Those who studied and worked with Doctors Scott and White were taught the skills and ideals of medicine. To those who later came to Scott & White for training, the founders provided a standard of excellence along with a model of compassion and human understanding.
A Model of Excellence
Scott & White physicians, senior staff and emeritus physicians have become a significant part of the institution’s heritage and continue to have a deep and abiding commitment to strengthening and perpetuating the dynamic environment of medicine created by the founders.

In response to this desire and commitment, and with an understanding of Scott & White’s potential and growth, Scott & White Memorial Hospital and the Scott, Sherwood and Brindley Foundation established the Scott & White Caduceus Society in 1999, providing opportunity for meaningful participation in Scott & White’s future.

The Society derives its name from the caduceus of Greek mythology. The single staff entwined by two serpents is the wand of Apollo, given to Hermes. It has become a symbol of the medical profession and is also a central element of the Scott & White logo.

Today, the Scott & White Caduceus Society continues in the finest spirit of teamwork, supporting future leadership in medical practice, research and education.

Benefits and Recognition
The benefits of membership in the Scott & White Caduceus Society include the satisfaction of perpetuating the ideals and aspirations of Doctors Scott and White and personally contributing to the progress and accomplishments of this great institution.

Annual meetings of the Society are to be held each May including a dinner and business meeting. New members are to be recognized at this event and presented at Scott & White Caduceus Society lapel pin.

Caduceus Society members will be recognized by giving level on the Donor Wall located in the Hall of Honor on the Temple Campus.

Giving Levels
- Associate $500 . . . . $9,999
- Bronze $10,000 . . . $24,999
- Silver $25,000 . . . $49,999
- Gold $50,000 . . . $99,999
- Platinum $100,000 and up

Members will also be listed in various Scott & White publications and may receive plaques for specific designated gifts as an expression of Scott & White’s gratitude for their leadership and support.

For further information please contact
Amy Perkins in the Development Office
254-724-2768 or 800-293-4483

Yes, I am interested in joining the following way:
Membership Invitation

You are invited to membership in the Scott & White Caduceus Society, an association of Scott & White physicians, senior staff and emeritus physicians committed to the ideals of Doctors Arthur Carroll Scott, Sr. and Raleigh R. White, Jr. The Society is committed to perpetuating the excellence of medical practice, education and research at Scott & White. Please join your colleagues in this important endeavor.

Name ____________________________  
Spouse Name ____________________________  
SSN*  
Department ____________________________  
Home Address ____________________________  
City ____________________________  
State ____________________________ Zip  
Home Phone ____________________________  
Work Phone ____________________________  
Email ____________________________  

*For payroll deduction only  

☐ Make an initial gift of $1,000 or more and contribute at this level annually until gifts total $10,000; thereafter, make annual gifts in accordance with individual financial capabilities.  

☐ Make an initial gift of $500 and contribute annually at this level until reaching age 40; thereafter, make annual gifts of $1,000 until reaching $10,000.  

☐ Provide $25,000 or more through a planned gift. Members of Scott & White’s Office of Development will be pleased to discuss the variety of planned giving options available.  

☐ I wish my gifts to be used for the general support of medical education and research.  

☐ I wish my gifts to be used for ____________________________  

Payment Options:  

☐ Check payable to Scott & White is enclosed in the amount of__________________________  

☐ Please deduct a total of __________ through payroll deduction over the course of _______ months.  

☐ Please bill my credit card in the amount of________.  

☐ Visa  
☐ MC  
☐ Am Ex  
☐ Discover  

Card #  
Name on Card  
Expiration Date  
Signature  

For more information call the Office of Development at 254-724-2768 or 800-293-4483 or visit development.sw.org.  

☐ Make an outright gift or pledge of $10,000 or more.