Montefiore

NEW HIRE FORMS

Management and Non-Union

ASSOCIATE AGREEMENT FORM

Patient Information Confidentiality Agreement:

I recognize that in the course of performing services at Montefiore. I may gain access to patient information which is required by law and by Montefiore's Administrative Policy Procedure - JH10.1 to be kept confidential and which may be disclosed only under limited conditions. I agree that:

I will keep confidential all patient information to which I gain access whether in the direct provision of care or otherwise. I will access and use patient information only on a need to know basis. I will disclose patient information only to the extent authorized and necessary to provide patient care. I will not discuss patient information in public places or outside of work. I understand that it is my obligation and responsibility to ensure the confidentiality of all patient information. Improper disclosure or misuse of patient information whether intentional or due to neglect on my part, is a breach of Montefiore's policy which will result in disciplinary action and could result in dismissal.

Computer Access Agreement:

During the course of my work at Montefiore, I may be assigned a computer identification number and instructed to develop a personal password. In order to maintain confidentiality of patient information stored in Montefiore computer systems, I agree that:

I will keep my computer identification number and passwords confidential and will not share them with anyone for any reason. I will not leave a computer terminal unattended without first logging off. I will contact security administration (718 920-4554) immediately if I have reason to believe that my computer identification number or password have been revealed. I will report immediately to security administration (718 920-4554) any suspected unauthorized access to patient information. I understand that it is my obligation and responsibility to protect my computer identification number and password from improper use, and not to do so is a breach of Montefiore's policy which will result in disciplinary action and could result in dismissal.

Working Shift Agreement:

I understand and agree that, in the position for which I am hired or assigned, it may be necessary to change my working hours to meet operational needs of the Medical Center.

Print Name: ______________________________

Signature: ______________________________ Date: ____________________________

Montefiore Health System
Conflict of Interest Disclosure Survey

Please describe any relationship that you or your immediate family members currently have; have had within the past twelve months; or anticipate having within the next twelve months, with any medical services company, supplier or manufacturer, or any other vendor or entity [collectively, Business (es)] potentially having a business relationship with Montefiore Health System and/or its affiliates and subsidiaries ("Montefiore").

Approved clinical trials need not be listed unless other factors below are present. Also, leadership positions or other work done with not-for-profit professional or charitable organizations not affiliated with pharmaceutical or device manufacturers need not be disclosed. If you are unsure whether a relationship should be disclosed you are encouraged to contact Lynn Stansel, Vice President & Counsel, Compliance at (718) 920-8239 or email us at conflicts@montefiore.org.

Name: ____________________________________ **Department:** ___________________________
(Print)

Title: _____________________________________ **Phone:** ________________________________

Primary Montefiore Health System Site: ____

Relationships to be listed include, but are not limited to, the following:

A. Professional Services

1. As set forth in the applicable Montefiore COI Policy, do you or a family member have a relationship with or interest in a Business (es)? If yes, please specify the name of the business and compensation over the past year.

☐ Yes ☐ No

____

____

2. Have you or a family member served as a consultant or independent contractor to a Business? If yes, please specify the relationship and compensation over the past year.

☐ Yes ☐ No

____

____

3. Have you or a family member held a title or position, such as medical director, board member, officer, director or principal to a Business over the past year? If yes, please explain.

☐ Yes ☐ No

____

____

4. Have you or a family member received payment for speaking engagements from a Business including participation on any Speaker Bureau? If yes, please list the name of the company and the total amount compensated over the past year.

☐ Yes ☐ No

____

____

B. Ownership Interests

5. Do you or a family member have or potentially have an ownership interest, such as holding shares of stock, stock options or future interests, partnership or membership interests, or other securities that could any way present or create an appearance of a potential conflict of interest ? If yes, please explain.

☐ Yes ☐ No

____

____

6. Do you or a family member have or potentially have any intellectual property interests, such as patents or royalties, related to work done for or with a Business?

☐ Yes ☐ No

____

____

C. Other Compensation

7. Have you or a family member received anything else of value, such as paid trips, gifts over $100, salary, referral fees, or honoraria from a Business? If yes, please list occurrences, amounts received and Business name.

☐ Yes ☐ No

____

____

D. Other

8. Please explain any other relationship not described above that you or your immediate family members have; have had within the past twelve months; or anticipate having within the next twelve months, with a Business. (Please refer to Conflict of Interest policy) for guidance, as necessary.

☐ Yes ☐ No

____

____

Montefiore Health System

Conflict of Interest Disclosure Survey Attestation

I attest that the information provided by me is true, accurate and complete to the best of my knowledge as of the date of submission. I agree to amend and resubmit this survey in the future as required to ensure that it remains accurate at all times.

______________________________ _________________________

Signature **Date**

MONTEFIORE DIRECT DEPOSIT - APPLICATION /CHANGE FORM

EMPLOYEE NAME **Last** **First** **Mi.**	**Daytime Telephone No.**

EMPLOYEE NUMBER: ______________________________________

6-digit number (EZ Time ID#). This number can be found on the back of your Montefiore ID or pay stub.

A) NEW ENROLLMENT:

PERSON (S) NAMED ON THE ACCOUNT (print exactly as it appears on your check)

ACCOUNT TYPE SAVINGS OR CHECKING (Circle only One)

***ABA NUMBER** ________________________ **ACCOUNT NUMBER** __________________________________

***Please confirm with your financial institutions that the ABA No. and account type is correct for Direct Deposit. Please attach a voided personal check or a copy of a personal check.**

COPY OF SAMPLE CHECK ATTACHED

EMPLOYEE AUTHORIZATION:

By signing below, I hereby authorize my employer, Montefiore to deposit my net pay directly into my checking or savings account each payday. If any monies to which I am not entitled are deposited into my account for any reason, including as the result of Montefiore's error I authorize Montefiore to direct the bank to return such funds directly to Montefiore in the full amount of the improper payment. This authorization allows Montefiore to direct my bank to return the funds at the time the overpayment is discovered, regardless of when the funds were improperly deposited into my account. I agree that this authorization will remain in effect until I provide my employer with written cancellation to terminate this service. I understand that 4 weeks must be allowed for implementation and any changes in direct deposit.

SIGNATURE______________________________________ DATE ________________________

B) CHANGE OF ENROLLMENT:

PERSON (S) NAME ON THE ACCOUNT____
ABA NUMBER ____
ACCOUNT NUMBER____
________ACCOUNT TYPE SAVINGS OR CHECKING
Circle only One

***Please confirm with your financial institution that the ABA No. and account type is correct for direct deposit.**
Please attach a voided personal check or a copy.

SIGNATURE_______________________________________ DATE____________________________________

C) CANCELLATION AUTHORIZATION:

I HEREBY AUTHORIZE MONTEFIORE MEDICAL CENTER TO CANCEL MY DIRECT DEPOSIT AUTHORIZATION AGREEMENT.

SIGNATURE____DATE: __________________________

Please fax completed form to (914) 378-6485 attn. Gale Kraft.

EMERGENCY CONTACT INFORMATION

Associate's Name: ______________________________

Associate's DOB::_________________________________

In case of an emergency please notify:

First Name: _____________________ Last Name: _______________________

Street: _________________________ City/State/Zip: ____________________

Telephone#1:____________________ Telephone #2:_____________________

Email: _________________________ Relationship: ______________________

First Name: _____________________ Last Name: _______________________

Street: _________________________ City/State/Zip: ____________________

Telephone#1:____________________ Telephone #2:_____________________

Email: _________________________ Relationship: ______________________

First Name: _____________________ Last Name: _______________________

Street: _________________________ City/State/Zip: ____________________

Telephone#1:____________________ Telephone #2:_____________________

Email: _________________________ Relationship: ______________________

Rev3/9/11/lr

ETHNICITY/RACE AND SEX SELF-IDENTIFICATION FORM
COMPLETING THIS FORM IS VOLUNTARY AND IS NOT
A REQUIREMENT FOR EMPLOYMENT

We believe that all persons are entitled to equal employment opportunities and we do not discriminate against our employees, applicants, or job seekers because of their race, color, sex, religion, national origin, disability, veteran status, age, or any other protected group status as defined by law.

We are subject to certain governmental recordkeeping and reporting requirements relating to the administration of civil rights and affirmative action laws and regulations. In order to comply with these laws, we invite you to voluntarily self-identify your ethnicity or race and gender. Submission of this information is voluntary and refusal to provide it will not influence our screening or hiring decisions and will not subject you to discharge, disciplinary or other adverse treatment. The information obtained will be kept confidential and separate from your application and/or personnel records and will only be used in accordance with the provisions of applicable laws, executive orders, and regulations.

Please complete the attached self-identification form, which includes the option to choose not to self-identify, and return it to us as soon as possible.

YOUR NAME:____________________________________DATE OF BIRTH: ________________________

SS#:____ POSITION:_______________________________

YOUR RACE/ETHNICITY:
1. __ White/Non- Minority (Not Hispanic or Latino)
2. __ Black or African American (Not Hispanic or Latino)
3. __ Asian (Not Hispanic or Latino)
4. __ Native Hawaiian or Other Pacific Islander (Not Hispanic or Latino)
5. __ American Indian or Alaska Native (Not Hispanic or Latino)
6. __ Two or More Races (Not Hispanic or Latino)
7. __ Choose Not to Self-Identify Race
8. __ Hispanic or Latino

YOUR SEX:
1. __ Female
2. __ Male
3. __ I Choose Not to Self-Identify Sex

ETHNICITY/RACE DEFINITIONS:
Hispanic or Latino: A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin regardless of race

White (Not Hispanic or Latino): A person having origins in any of the original peoples of Europe, the Middle East, or North Africa

Black or African American (Not Hispanic or Latino): A person having origins in any of the black racial groups of Africa

Asian (Not Hispanic or Latino): A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian Subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam

Native Hawaiian or Other Pacific Islander (Not Hispanic or Latino): A person having origins in any of the peoples of Hawaii, Guam, Samoa, or other Pacific Islands

American Indian or Alaska Native (Not Hispanic or Latino): A person having origins in any of the original peoples of North and South America (including Central America) and who maintain tribal affiliation or community attachment

Two or More Races (Not Hispanic or Latino): Persons who identify with two or more race categories named above

EMPLOYEE VOLUNTARY SELF-IDENTIFICATION FORM FOR VETERANS AND INDIVIDUALS WITH DISABILITIES

Pursuant to the Department of Labor's regulations, we are required to invite employees to self-identify with any of the veteran categories described below, or as an individual with a disability. This form is voluntary, and your decision to complete it will not in any way affect your employment.

Name:_______________________________________ SSN or EE#_________________________

Job title:______________________________________ Today's Date:_______________________

Date of Hire:__________________________________

Veteran Categories (you may check more than one box, if applicable)

☐ Disabled Veteran
☐ Armed Forces Service Medal Veteran
☐ Recently Separated Veteran: My discharge date was: _________________________
☐ Other Protected Veteran
☐ Decline to answer
☐ None of the above

Definitions:

Disabled Veteran	This term means (A) a veteran of the U.S. military, ground, naval or air service who is entitled to compensation (or who but for the receipt of military retired pay would be entitled to compensation) under the laws administered by the Secretary of Veterans Affairs, or (B) a person who was discharged or released from active duty because of a service-connected disability.
Armed Forces Service Medal Veteran	This term means any veteran who, while serving on active duty in the U.S. military, ground, naval, or air service, participated in a United States military operation for which an Armed Forces service medal was awarded pursuant to Executive Order No. 12985.
Recently Separated Veteran	This term means any veteran during the **three-year period** beginning on the date of such veteran's discharge or release from active duty in the U.S. military, ground, naval, or air service.
Other Protected Veteran	This term means a veteran who served on active duty in the U.S. military, ground, naval, or air service during a war or in a campaign or expedition for which a campaign badge has been authorized, under the laws administered by the Department of Defense.

Individual with a Disability

☐ Individual with a disability (Please use a separate sheet of paper to describe any requested reasonable accommodation)
☐ Not an individual with a disability
☐ Decline to answer

I, ____ acknowledge that I have read the following policies and procedures:

- Family, Medical, and Military Leaves of Absence
- Service Excellence
- Non-Discrimination and Anti-Harassment Policy
- Conflict of Interest Policy
- Social Media Policy
- Code of Conduct
- Pregnancy and Employment Rights
- Summary of Federal and State False Claims Laws
- ESTA (Earned Sick Time Act)

Signature: ____ Date: ____________________

Welcome to Montefiore Medical Center (MMC). We hope that you find your career at MMC stimulating, rewarding, and providing you with opportunities to expand your knowledge. Our mission is to heal, to teach, to discover and to advance the health of the communities we serve. To achieve our mission, the working community at MMC must be committed to achieving the highest standards of excellence and professionalism. It is the expectation that all Associates may work in an environment that embodies the Medical Center values of humanity, innovation, teamwork, diversity and equity.

The Human Resources (HR) Policies and Procedures are central to promoting and maintaining a positive work environment for all Associates and make clear and transparent expectations for conduct in the workplace. Below you will find a general summary of behavior that is prohibited under the rules and regulations set forth in the HR policy manual. While this summary provides a broad initial education on the MMC HR Policies and Procedures, Associates are expected to be familiar with the full HR policy manual. These documents can be found on the Human Resources section of the MMC intranet. Associates who do not have access to a computer should alert their Supervisor who will arrange for access to a computer terminal.

Associates (including but not limited to employed physicians, attending physicians, house staff, students, vendors, independent contractors, agency workers and volunteers) are expected to refrain from behaviors such as those noted below:

Inappropriate Conduct	***Relevant policies include, but are not limited to, the following***
1. Any form of patient abuse, mistreatment or neglect.	VII-1: Medical Center Rules and Regulations; VII-20: Maintaining a Nonviolent Workplace at Montefiore Medical Center
2. Inappropriate behavior toward or discourteous treatment of patients, colleagues, visitors, volunteers or any other person.	VI-3: Management of Disruptive Conduct; VI:5: Conflict Resolution; VI-6: Non-Discrimination and Anti-Harassment; VI-8: Non-Discrimination Against and Accommodation of Individuals with Disabilities; VII-1: Medical Center Rules and Regulations; VII-20: Maintaining a Nonviolent Workplace at MMC
3. Violation of the rules of common decency and morality including the use of profanity and/or offensive language or gestures.	See 2 Above
4. Fighting or engaging in horseplay. Offensive physical contact such as physically shoving, pushing, grabbing, holding, punching, kicking, slapping, spitting or other offensive conduct.	See 2 Above

5. Engaging in behavior or using language that reflects a discriminatory perception based on gender, sexual orientation, marital status, race, color, age, religion, national origin or disability in violation of applicable State and Federal laws.	VI-6: Non-Discrimination and Anti-Harassment; VI-8: Non-Discrimination Against and Accommodation of Individuals with Disabilities
6. Using e-mail, voice mail, fax or the internet to harass or discriminate on the basis of gender, sexual orientation, marital status, race, color, age, religion, national origin or disability in violation of applicable State and Federal laws.	VII-19: Use of Computer and Other Electronic Equipment; VII-18: Social Media Policy; VII-20: Maintaining a Nonviolent Workplace at MMC
7. Displaying or disseminating any material that is offensive and that could give rise to or form the basis for a sexual harassment complaint, an allegation of hostile work environment or a discrimination claim.	VI-6: Non-Discrimination and Anti-Harassment; VI-8: Non-Discrimination Against and Accommodation of Individuals with Disabilities; VII-18: Social Media Policy; VII-20: Maintaining a Nonviolent Workplace at MMC
8. Unauthorized photography or video/audio recording on Medical Center premises.	VII-15: Use of Cell Phones and Handheld Electronic Devices; VII-17: Taping/Eavesdropping on Conversations
9. Failure to keep Medical Center and/or patient information confidential including, but not limited to, accessing Medical Center and/or patient records without a business need.	I-6: Confidentiality of Associate's Personnel Information; I-7: Associate Personnel File; VII-1: Medical Center Rules and Regulations
10. Failure to withdraw from or report outside activities or interests that conflict with, detract from, or adversely affect the interest or reputation of the Medical Center.	VII-1: Medical Center Rules and Regulations
11. Any form of sexual misconduct or harassment.	VI-6: Non-Discrimination and Anti-Harassment
12. Engaging in criminal activity.	VII-1: Medical Center Rules and Regulations; VII-8: Drug and Alcohol Policy
13. Engaging in fraudulent behavior.	VII-1: Medical Center Rules and Regulations; VII-19: Use of Computer and Other Electronic Equipment
14. Accepting gratuities.	VII-2: Gratuities
15. Participating in or promoting any form of gambling.	VII-1: Medical Center Rules and Regulations
16. Unlawful possession, use, manufacture, distribution or dispensing of illegal drugs, controlled substances or alcoholic beverages while on Medical Center property or reporting to work under the influence of same.	VII-8: Drug and Alcohol Policy; VII-14: Omnibus Transportation Employee Testing Act
17. Possession of a firearm, weapon or dangerous instrument while on Medical Center property or engaged in Medical Center business.	VII-1: Medical Center Rules and Regulations
18. Theft, failing to preserve the assets of the Medical Center or misappropriation of funds.	VII-3: Property Pass; VII-13: Motor Vehicle Operator

	Policy; VII-14: Omnibus Transportation Employee Testing Act
19. Destruction, negligence, misuse, removal, defacement, misplacement of property or equipment belonging to the Medical Center or belonging to a patient, visitor or Associate.	VII-3: Property Pass; VII-13: Motor Vehicle Operator Policy; VII-14: Omnibus Transportation Employee Testing Act
20. Dishonesty, including falsification of records, reports, documents or time/attendance records.	III-14: Control of Excessive Absenteeism and Lateness; IV-4: Tracking and Reporting Time Worked During Non-Working Hours and Procedures for Reporting Payroll Errors; IV-5: Overtime; IV-6: Time Reporting Lateness, Absence, Missed Punches
21. Failure to record work time accurately.	See 20 Above
22. Excessive absenteeism and/or lateness.	See 20 Above
23. Failure to report to work on time and as scheduled.	See 20 Above
24. Failure to comply with Medical Center timekeeping procedures.	See 20 Above
25. Working unauthorized overtime.	See 20 Above
26. Unauthorized absence from work or leaving assigned work area without authorization.	See 20 Above
27. Smoking in Medical Center facilities or vehicles.	VII-7: Tobacco Free Environment
28. Interference with the work of other Associates.	VI-3: Management of Disruptive Conduct
29. Professional incompetence or failure to maintain a required license.	II-20: Licensure, Registration and Certification for Health Care Providers
30. Unsatisfactory performance of work assignments, negligence or carelessness in performing work assignments.	VII-1: Medical Center Rules and Regulations
31. Entering or remaining on Medical Center property outside of scheduled work hours or being in a restricted area without authorization.	VII-1: Medical Center Rules and Regulations
32. Sleeping, loitering, loafing, reading, watching television, using cell phones, performing personal work or engaging in other activities not pertaining to an Associate's job during work time.	VII-12: Sleeping Policy; VII-15: Use of Cell Phones and Handheld Electronic Devices
33. Failure to report an accident or injury.	V-12: Occupational Health Services; VII-13: Motor Vehicle Policy;
34. Violation of common safety practices; willful or continued disregard for safety rules or procedures.	VII-11: Unescorted Access to Radioactive Materials;
35. Failure to wear a Medical Center identification badge, with photo showing, at all times while on duty.	VII-1: Medical Center Rules and Regulations
36. Disregard of personal appearance, uniform, dress or personal hygiene.	VII-1: Medical Center Rules and Regulations
37. Failure to wear a prescribed uniform or failure to dress in appropriate business attire in areas where	VII-1: Medical Center Rules and Regulations

uniforms are not required.	
38. Insubordination by either refusing to follow a reasonable order or by engaging in rude or disrespectful behavior toward any Supervisor.	VI-3: Management of Disruptive Conduct
39. Refusal to report for a Fitness for Duty evaluation or follow through with testing and evaluation process.	V-12: Occupational Health Services
40. Unauthorized posting or removal of official business notices.	VII-1: Medical Center Rules and Regulations
41. Removing Medical Center records from the premises without authorization.	VII-1: Medical Center Rules and Regulations
42. Any other behavior contrary to federal, state or local laws and regulations such as, but not limited to, those pertaining to the Health Insurance Portability and Accountability Act (HIPAA), Anti-Retaliation/Whistle Blower Protection and Anti-Discrimination.	

Violations of any of the above listed rules and regulations will result in progressive discipline. Disciplinary action may begin at any level of progressive discipline, depending on an evaluation of the seriousness of the offense, and may entail counseling, a verbal warning, a written warning, suspension or termination of employment in accordance with Human Resources Policy and Procedure VI-2: Disciplinary Action.

I have received the summary of Montefiore Medical Center's Human Resources Policies and Procedures. I know where to locate a full set of Human Resources Policies and Procedures and understand that I am responsible for being familiar with and adhering to these policies and procedures.

______________________________ ______________________________ ___/___/_____

Print Name Signature Date

All Medical Center Human Resources policies and practices are guidelines and may be changed, modified or discontinued at any time by the Medical Center's Senior Vice President of Human Resources, or designee, with or without notice. Exceptions do not invalidate the basic policy.

NEW HIRE FORMS CHECK LIST

Please review the list below to ensure you have all the required documents to complete the New Hire process. Complete the checklist as you complete the forms.

NEW HIRE PAPERWORK

- ☐ Associate Agreement Form
- ☐ 1199 Dues Deduction Authorization (If Applicable)
- ☐ Conflict of Interest Survey
- ☐ Emergency Contact Form
- ☐ Direct Deposit Form (optional)(attach voided check)
- ☐ Ethnicity/Race and Sex Self-Identification Form
- ☐ Veterans and Disability Form
- ☐ Tax Forms
  - o W4
  - o IT-2104 (NYS/NYC)
  - o IT-2104.1 (Yonkers Non-Residency Certificate)
- ☐ Acknowledgement Form
- ☐ New Hire Packet Policy Summary for New Hires

ADDITIONAL DOCUMENTS NEEDED

- ☐ Original Social Security Card (Payroll Purposes)
- ☐ Identifications (Refer to list provided at www.newi9.com for proper forms to present)
- ☐ Licenses/Certificates (If Applicable)
- ☐ OSHA Certificates (If Applicable)
- ☐ New Associate Pre-Employment Procedures Form signed by Occupational Health Services. This form must be returned upon completion of your OHS appointments when the form is signed and you are medically cleared.