

ESC USE ONLY

Substitute Aide

Date \_\_\_\_\_

Substitute Teacher

Name \_\_\_\_\_

Street Address \_\_\_\_\_

City, State, Zip Code \_\_\_\_\_

Phone No. \_\_\_\_\_

- Application received
- Employment Eligibility Verification Form received and verified (Verify with driver's license number and Social Security number)
- Copy of Social Security Card received
- Copy of Driver's License received
- New Hire Reporting Form received with employee information section filled in
- Statement Concerning Your Employment in a Job Not Covered By Social Security - received and signed
- Acceptable Use Policy - received and signed
- Fraud Form
- Tuberculosis High Risk Assessment form
- Copy of Teaching License Received
- Needs substitute license (Need to Apply online through ODE)
- BCI fingerprinting results received
- FBI fingerprinting results received



# Mercer County Educational Service Center

441 East Market Street  
Celina, Ohio 45822

Office: (419) 586-6628 Fax: (419) 586-3377

[www.mercercountyesc.org](http://www.mercercountyesc.org)

Shelly Vaughn  
Superintendent

Mary Brandon  
Treasurer

TO: Substitute Aide Applicants

In order for your name to be included on our substitute aide list, we will need the following information:

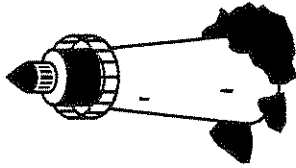
- your name, address, and phone number
- a copy of your Social Security card
- a copy of your driver's license

I have also enclosed the following forms:

1. Employment Eligibility Verification Form - Please fill out Section 1 (Employee Information and Verification) of this form and sign.
2. New Hire Reporting Form - Please fill out the employee information section. Do not fill in the date of hire.
3. Statement Concerning Your Employment in a Job Not Covered By Social Security - Please read, write in your name where it says "Employee Name", write in your Social Security number at "Employee ID #", sign at "Signature of Employee", and date.
4. Acceptable Use Policy - Please read and, on the back of the page, sign, print your name, and date.
5. Fraud-reporting Form - Please read, complete the form, and sign.
6. Tuberculosis High Risk Assessment Form - Please complete the form

Every substitute applicant is required to be fingerprinted (BCI and FBI). This can be done at our office when the above information is returned to us. Please bring with you your driver's license and \$60 cash or money order made out to the Mercer County Educational Service Center.

**In order to return your paper work, please call 419-586-6628 to make an appointment with Sue Cook**



**MERCER COUNTY EDUCATIONAL SERVICE CENTER**

Serving The School Districts of: Fort Recovery Local, Marion Local, Parkway Local,  
St. Henry Cons. Local, Celina City, Coldwater E.V.

441 East Market Street, Celina, OH 45822  
Phone: 419-586-6628 Fax: 419-586-3377

**SUBSTITUTE AIDE APPLICATION**

Please check the districts you would like to substitute in:

- |  |                                       |
|--|---------------------------------------|
| <input type="checkbox"/> Preschool     | <input type="checkbox"/> Coldwater    |
| <input type="checkbox"/> Celina        | <input type="checkbox"/> Marion Local |
| <input type="checkbox"/> Fort Recovery | <input type="checkbox"/> St. Henry    |
| <input type="checkbox"/> Parkway       |                                       |

First Name \_\_\_\_\_ M.I. \_\_\_\_\_ Last Name \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

High School Attended: \_\_\_\_\_ (Name) \_\_\_\_\_ (City) \_\_\_\_\_ (State)

College or University: \_\_\_\_\_

Undergraduate College \_\_\_\_\_ Degree \_\_\_\_\_ Year Granted \_\_\_\_\_

Please list below two references familiar with your work experience and personal character:

<u>Name</u>	<u>Address</u>	<u>Phone</u>
_____	_____	_____
_____	_____	_____

I certify that the information provided on this application is accurate and true to the best of my knowledge.

Applicant's Signature \_\_\_\_\_ Date \_\_\_\_\_

Applicants are considered for all positions without regard to sex, religion, color, age, national origin, size, handicap, race, ancestry, citizenship status, or status as a Vietnam era or special disabled veteran.

An Equal Opportunity Employer



# Employment Eligibility Verification

Department of Homeland Security  
U.S. Citizenship and Immigration Services

USCIS  
Form I-9  
OMB No. 1615-0047  
Expires 03/31/2016

**▶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.)

Last Name (Family Name)		First Name (Given Name)		Middle Initial	Other Names Used (if any)		
Address (Street Number and Name)			Apt. Number	City or Town		State	Zip Code
Date of Birth (mm/dd/yyyy)	U.S. Social Security Number		E-mail Address			Telephone Number	

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

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

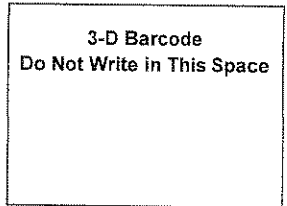
- A citizen of the United States
- A noncitizen national of the United States (See instructions)
- A lawful permanent resident (Alien Registration Number/USCIS Number): \_\_\_\_\_
- An alien authorized to work until (expiration date, if applicable mm/dd/yyyy) \_\_\_\_\_. Some aliens may write "NA" in his 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):		
Last Name (Family Name)		First Name (Given Name)		
Address (Street Number and Name)		City or Town	State	Zip Code



Employer Completes Next Page



## 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:

List A Identity and Employment Authorization	OR	List B Identity	AND	List C Employment Authorization
Document Title:		Document Title:		Document Title:
Issuing Authority:		Issuing Authority:		Issuing Authority:
Document Number:		Document Number:		Document Number:
Expiration Date (if any)(mm/dd/yyyy):		Expiration Date (if any)(mm/dd/yyyy):		Expiration Date (if any)(mm/dd/yyyy):
Document Title:				
Issuing Authority:				
Document Number:				
Expiration Date (if any)(mm/dd/yyyy):				
Document Title:				
Issuing Authority:				
Document Number:				
Expiration Date (if any)(mm/dd/yyyy):				

**3-D Barcode**  
Do Not Write in This Space

### Certification

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

The employee's first day of employment (mm/dd/yyyy): \_\_\_\_\_ (See instructions for exemptions.)

Signature of Employer or Authorized Representative		Date (mm/dd/yyyy)	Title of Employer or Authorized Representative Superintendent	
Last Name (Family Name) Vaughn	First Name (Given Name) Shelly	Employer's Business or Organization Name Mercer County Educational Service Ct		
Employer's Business or Organization Address (Street Number and Name) 441 E. Market St.		City or Town Celina	State OH	Zip Code 45822

### 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:
---	--------------------	--



---

## Statement Concerning Your Employment in a Job Not Covered by Social Security

---

Employee Name \_\_\_\_\_ Employee ID# \_\_\_\_\_  
Employer Name     Mercer County ESC     Employer ID#     34-1326142    

Your earnings from this job are not covered under Social Security. When you retire, or if you become disabled, you may receive a pension based on earnings from this job. If you do, and you are also entitled to a benefit from Social Security based on either your own work or the work of your husband or wife, or former husband or wife, your pension may affect the amount of the Social Security benefit you receive. Your Medicare benefits, however, will not be affected. Under the Social Security law, there are two ways your Social Security benefit amount may be affected.

### Windfall Elimination Provision

Under the Windfall Elimination Provision, your Social Security retirement or disability benefit is figured using a modified formula when you are also entitled to a pension from a job where you did not pay Social Security tax. As a result, you will receive a lower Social Security benefit than if you were not entitled to a pension from this job. For example, if you are age 62 in 2013, the maximum monthly reduction in your Social Security benefit as a result of this provision is \$395.50. This amount is updated annually. This provision reduces, but does not totally eliminate, your Social Security benefit. For additional information, please refer to Social Security Publication, "Windfall Elimination Provision."

### Government Pension Offset Provision

Under the Government Pension Offset Provision, any Social Security spouse or widow(er) benefit to which you become entitled will be offset if you also receive a Federal, State or local government pension based on work where you did not pay Social Security tax. The offset reduces the amount of your Social Security spouse or widow(er) benefit by two-thirds of the amount of your pension.

For example, if you get a monthly pension of \$600 based on earnings that are not covered under Social Security, two-thirds of that amount, \$400, is used to offset your Social Security spouse or widow(er) benefit. If you are eligible for a \$500 widow(er) benefit, you will receive \$100 per month from Social Security (\$500 - \$400=\$100). Even if your pension is high enough to totally offset your spouse or widow(er) Social Security benefit, you are still eligible for Medicare at age 65. For additional information, please refer to Social Security Publication, "Government Pension Offset."

### For More Information

Social Security publications and additional information, including information about exceptions to each provision, are available at [www.socialsecurity.gov](http://www.socialsecurity.gov). You may also call toll free 1-800-772-1213, or for the deaf or hard of hearing call the TTY number 1-800-325-0778, or contact your local Social Security office.

**I certify that I have received Form SSA-1945 that contains information about the possible effects of the Windfall Elimination Provision and the Government Pension Offset Provision on my potential future Social Security Benefits.**

Signature of Employee \_\_\_\_\_ Date \_\_\_\_\_



---

## Information about Social Security Form SSA-1945 Statement Concerning Your Employment in a Job Not Covered by Social Security

New legislation [Section 419(c) of Public Law 108-203, the Social Security Protection Act of 2004] requires State and local government employers to provide a statement to employees hired January 1, 2005 or later in a job not covered under Social Security. The statement explains how a pension from that job could affect future Social Security benefits to which they may become entitled.

Form SSA-1945, **Statement Concerning Your Employment in a Job Not Covered by Social Security**, is the document that employers should use to meet the requirements of the law. The SSA-1945 explains the potential effects of two provisions in the Social Security law for workers who also receive a pension based on their work in a job not covered by Social Security. The Windfall Elimination Provision can affect the amount of a worker's Social Security retirement or disability benefit. The Government Pension Offset Provision can affect a Social Security benefit received as a spouse, surviving spouse, or an ex-spouse.

Employers must:

- Give the statement to the employee prior to the start of employment;
- Get the employee's signature on the form; and
- Submit a copy of the signed form to the pension paying agency.

Social Security will not be setting any additional guidelines for the use of this form.

Copies of the SSA-1945 are available online at the Social Security website, [www.socialsecurity.gov/online/ssa-1945.pdf](http://www.socialsecurity.gov/online/ssa-1945.pdf). Paper copies can be requested by email at [ofsm.oswm.rqct.orders@ssa.gov](mailto:ofsm.oswm.rqct.orders@ssa.gov) or by fax at 410-965-2037. The request must include the name, complete address and telephone number of the employer. Forms will not be sent to a post office box. Also, if appropriate, include the name of the person to whom the forms are to be delivered. The forms are available in packages of 25. Please refer to Inventory Control Number (ICN) 276950 when ordering.

# NETWORK PRIVACY AND ACCEPTABLE USE POLICY FOR SUBSTITUTE TEACHERS/AIDES

It is the intention of the Mercer County Educational Service Center's Board of Education to protect the privacy of substitute teachers/aides who use the school computers, computer network, and electronic messaging systems to the maximum extent possible given the operational and security needs of the District. The purpose of this policy is to identify the limitations on this privacy and the general restrictions applying to the use of computers and electronic messaging systems of the District.

## Acceptable and Unacceptable Uses

The computers, computer network and messaging systems of the School District are intended for educational uses and work-related communications. Incidental use of the e-mail and voice mail systems by staff members for personal communications is permitted as long as such communications are limited in number, are initiated during non-work periods, and do not interfere with the primary intended uses of the system.

The following are uses which are unacceptable under any circumstances:

- the transmission of any language or images which are of a graphic sexual nature
- the transmission of jokes, pictures, or other materials which are obscene, lewd, vulgar, or disparaging of persons based on their race, color, sex, age, religion, national origin, or sexual orientation
- the transmission of messages or any other content which would be perceived by a reasonable person to be harassing or threatening
- uses that constitute defamation (libel or slander)
- uses that violate copyright laws
- uses that attempt to gain unauthorized access to another computer system or to impair the operation of another computer system (for example, the transmission of a computer virus or an excessively large e-mail attachment)
- any commercial or profit-making activities
- any fundraising activities, unless specifically authorized by an administrator

## Security and Integrity

Substitute teachers/aides shall not take any action which would compromise the security of any computer, network or messaging system. This would include the unauthorized release or sharing of passwords and the intentional disabling of any security features of the system.

(OVER)

Substitute teachers/aides shall not take any actions which may adversely affect the integrity, functionality, or reliability of any computer (for example, the installation of hardware or software not authorized by the System Administrator).

Substitute teachers/aides shall report to the System Administrator or a School District administrator any actions by students which would violate the security or integrity of any computer, network or messaging system whenever such actions become known to them in the normal course of their work duties. This shall not be construed as creating any liability for staff members for the computer-related misconduct of students.

### Right of Access

Although the Board of Education respects the natural desire of all persons for privacy in their personal communications, and will attempt to preserve this privacy whenever possible, the operational and security needs of the District's computer network and messaging systems require that full access be available at all times. The School District therefore reserves the right to access and inspect any computer, device, or electronic media within its systems and any data, information, or messages which may be contained therein. All such data, information, and messages are the property of the School District and substitute teachers/aides should have no expectation that any messages sent or received on the School District's systems will always remain private.

### AGREEMENT

I have read the "Network Privacy and Acceptable Use Policy for Substitute Teachers/Aides" relating to substitute teachers/aides use of the computers, computer networks, and electronic messaging systems of the School District.

I would like to be given access to the School District's computer network and any electronic messaging systems. I understand that such access is a privilege which may be withdrawn in the event of non-compliance with the above Policy.

I agree to comply with the "Network Privacy and Acceptable Use Policy for Substitute Teachers/Aides" and understand that access to the network and messaging systems is a privilege which may be withdrawn in the event of noncompliance with the above Policy.

\_\_\_\_\_  
Substitute Teacher/Aide Signature

PLEASE PRINT: \_\_\_\_\_

Date above signed: \_\_\_\_\_

ORC 117.103(B)(1)

The Auditor of the State of Ohio has established a reporting system whereby public employees can file complaints of fraud and misuse of public funds by public offices or officials. The system allows all Ohio citizens, including public employees, the opportunity to make anonymous complaints through a toll-free number, the Auditor of State's website or through United States mail. The contact information of the Auditor of State for fraud reporting is:

Telephone: 1-866-FRAUD OH (1-866-972-8364)  
Web: [www.ohioauditor.gov](http://www.ohioauditor.gov)  
U.S. Mail: Ohio Auditor of State's Office  
Special Investigations Unit  
88 East Broad Street  
P.O. Box 1140  
Columbus, Ohio 43215

Employees who file a complaint with the new fraud-reporting system receive some protections under Section 124.341 of the Revised Code. If a classified or unclassified employee becomes aware of a situation and reports it to the Auditor of State's fraud-reporting system, the employee is protected against certain retaliatory or disciplinary actions. If retaliatory or disciplinary action is taken against the employee, the employee has the right to appeal with the State Personnel Board of Review.

---

Acknowledgement of receipt of Auditor of State fraud-reporting system information

Pursuant to Ohio Revised Code 117.103(B)(1), a public office shall provide information about the Ohio fraud-reporting system and the means of reporting fraud to each new employee upon employment with the public office. Each new employee has thirty (30) days after beginning employment to confirm receipt of this information.

By signing below you are acknowledging Mercer County Educational Service Center provided you information about the fraud-reporting system as described in Section 117.103(A) of the Revised Code, and that you read and understand the information provided. You are also acknowledging you have received and read the information regarding Section 124.341 of the Revised Code and the protections you are provided as a classified or unclassified employee if you use the before-mentioned fraud-reporting system.

I have read the information provided by my employer regarding the fraud-reporting system operated by the Ohio Auditor of State's office. I further state that the undersigned signature acknowledges receipt of this information.

---

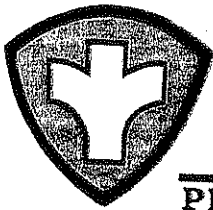
PRINT NAME, TITLE, AND DEPARTMENT

---

PLEASE SIGN NAME

---

DATE



# MERCER COUNTY CELINA CITY

*Health Department*



**PREVENT • PROMOTE • PROTECT**

Mercer County Health Department

## Tuberculosis High Risk Assessment Form

Name \_\_\_\_\_

Birthdate \_\_\_\_\_

Address \_\_\_\_\_

Age \_\_\_\_\_

Telephone \_\_\_\_\_

Race \_\_\_\_\_

Allergies \_\_\_\_\_

Place of Employment \_\_\_\_\_

### Please Circle Yes or No if any apply to you

Have you been in close contact with someone who has TB?

Yes No

Have you been in contact with someone with a positive skin test?

Yes No

Have you ever taken TB medication?

Yes No

Ever had a BCG vaccination

Yes No

Are you taking any Medications? \_\_\_\_\_

Yes No

### Please Circle Yes or No if any of these illnesses apply to you

Diabetes

Yes No

Cancer

Yes No

Hepatitis

Yes No

Permanent Kidney Damage

Yes No

Liver Disease

Yes No

Heavy use of Alcohol or Drugs

Yes No

Pregnant

Yes No

HIV infection

Yes No

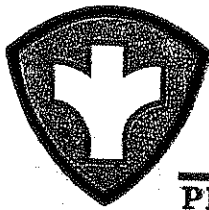
Surgical Removal of part of stomach or intestines

Yes No

220 W. LIVINGSTON ST. - B152. CELINA, OHIO 45822.

Work (419) 586-3251 ^ Fax (419) 586-2583 ^ Email: [healthdept@mccchd.org](mailto:healthdept@mccchd.org) ^ Website [www.mccchd.org](http://www.mccchd.org)

AN EQUAL OPPORTUNITY EMPLOYER



**MERCER COUNTY  
CELINA CITY**  
*Health Department*  
**PREVENT • PROMOTE • PROTECT**



Present Symptoms Please Circle Yes or No if any apply to you

Fatigue	Yes	No	Fever	Yes	No
Loss of Appetite	Yes	No	Cough	Yes	No
Weight Loss	Yes	No	Bloody Sputum	Yes	No
Chest Pain	Yes	No	Chills	Yes	No
Stomach upset	Yes	No	Shortness of Breath	Yes	No
Night sweats	Yes	No	Hoarseness	Yes	No

Notes:

---

---

---