
Printed name of Employee

Social Security Number

Position

LOYALTY OATH

(H.B. 918-1968 OK Leg.)

I do solemnly swear (or affirm) that I will support the Constitution and the Laws of the United States of America and the Constitution and the Laws of the State of Oklahoma, and that I will faithfully discharge, according to the best of my ability, the duties of my office or employment during such time as I am an employee of:

Broken Arrow Public Schools District I-3

Signature of Employee

Subscribed and sworn before me this _____ day of _____ 20 _____

State of Oklahoma, County of _____

Commission # _____ My commission expires _____

Notary Public _____



Employment Eligibility Verification

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

USCIS
Form I-9

OMB No.1615-0047
Expires 07/31/2026

START HERE: Employers must ensure the form instructions are available to employees when completing this form. Employers are liable for failing to comply with the requirements for completing this form. See below and the [Instructions](#).

ANTI-DISCRIMINATION NOTICE: All employees can choose which acceptable documentation to present for Form I-9. Employers cannot ask employees for documentation to verify information in **Section 1**, or specify which acceptable documentation employees must present for **Section 2** or Supplement B, Reverification and Rehire. Treating employees differently based on their citizenship, immigration status, or national origin may be illegal.

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 (if any)	Other Last Names Used (if any)	
Address (Street Number and Name)			Apt. Number (if any)	City or Town		State ZIP Code
Date of Birth (mm/dd/yyyy)	U.S. Social Security Number		Employee's Email Address			Employee's Telephone Number
<p>I am aware that federal law provides for imprisonment and/or fines for false statements, or the use of false documents, in connection with the completion of this form. I attest, under penalty of perjury, that this information, including my selection of the box attesting to my citizenship or immigration status, is true and correct.</p>	Check one of the following boxes to attest to your citizenship or immigration status (See page 2 and 3 of the instructions.):					
	<input type="checkbox"/> 1. A citizen of the United States					
	<input type="checkbox"/> 2. A noncitizen national of the United States (See Instructions.)					
	<input type="checkbox"/> 3. A lawful permanent resident (Enter USCIS or A-Number.)					
<input type="checkbox"/> 4. A noncitizen (other than Item Numbers 2. and 3. above) authorized to work until (exp. date, if any)						
If you check Item Number 4. , enter one of these:						
USCIS A-Number		OR	Form I-94 Admission Number		OR	Foreign Passport Number and Country of Issuance
Signature of Employee					Today's Date (mm/dd/yyyy)	

If a preparer and/or translator assisted you in completing Section 1, that person **MUST** complete the [Preparer and/or Translator Certification](#) on Page 3.

Section 2. Employer Review and Verification: Employers or their authorized representative must complete and sign **Section 2** within three business days after the employee's first day of employment, and must physically examine, or examine consistent with an alternative procedure authorized by the Secretary of DHS, documentation from List A OR a combination of documentation from List B and List C. Enter any additional documentation in the Additional Information box; see Instructions.

	List A	OR	List B	AND	List C
Document Title 1					
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					
Document Title 2 (if any)	Additional Information				
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					
Document Title 3 (if any)	<input type="checkbox"/> Check here if you used an alternative procedure authorized by DHS to examine documents.				
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					

Certification: I attest, under penalty of perjury, that (1) I have examined the documentation presented by the above-named employee, (2) the above-listed documentation appears 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.

First Day of Employment (mm/dd/yyyy):

Last Name, First Name and Title of Employer or Authorized Representative		Signature of Employer or Authorized Representative		Today's Date (mm/dd/yyyy)
Employer's Business or Organization Name Broken Arrow Public Schools		Employer's Business or Organization Address, City or Town, State, ZIP Code 701 S Main Street , Broken Arrow, OK 74012		

For reverification or rehire, complete [Supplement B, Reverification and Rehire](#) on Page 4.

LISTS OF ACCEPTABLE DOCUMENTS

All documents containing an expiration date must be unexpired.

* Documents extended by the issuing authority are considered unexpired.

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

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

LIST A Documents that Establish Both Identity and Employment Authorization	OR	LIST B Documents that Establish Identity	AND	LIST C Documents that Establish Employment Authorization
<ol style="list-style-type: none"> 1. U.S. Passport or U.S. Passport Card 2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551) 3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa 4. Employment Authorization Document that contains a photograph (Form I-766) 5. For an individual temporarily authorized to work for a specific employer because of his or her status or parole: <ol style="list-style-type: none"> a. Foreign passport; and b. Form I-94 or Form I-94A that has the following: <ol style="list-style-type: none"> (1) The same name as the passport; and (2) An endorsement of the individual's status or parole as long as that period of endorsement has not yet expired and the proposed employment is not in conflict with any restrictions or limitations identified on the form. 6. Passport from the Federated States of Micronesia (FSM) or the Republic of the Marshall Islands (RMI) with Form I-94 or Form I-94A indicating nonimmigrant admission under the Compact of Free Association Between the United States and the FSM or RMI 	OR	<ol style="list-style-type: none"> 1. Driver's license or ID card issued by a State or outlying possession of the United States provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address 2. ID card issued by federal, state or local government agencies or entities, provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address 3. School ID card with a photograph 4. Voter's registration card 5. U.S. Military card or draft record 6. Military dependent's ID card 7. U.S. Coast Guard Merchant Mariner Card 8. Native American tribal document 9. Driver's license issued by a Canadian government authority <li style="text-align: center;">For persons under age 18 who are unable to present a document listed above: 10. School record or report card 11. Clinic, doctor, or hospital record 12. Day-care or nursery school record 	AND	<ol style="list-style-type: none"> 1. A Social Security Account Number card, unless the card includes one of the following restrictions: <ol style="list-style-type: none"> (1) NOT VALID FOR EMPLOYMENT (2) VALID FOR WORK ONLY WITH INS AUTHORIZATION (3) VALID FOR WORK ONLY WITH DHS AUTHORIZATION 2. Certification of report of birth issued by the Department of State (Forms DS-1350, FS-545, FS-240) 3. Original or certified copy of birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal 4. Native American tribal document 5. U.S. Citizen ID Card (Form I-197) 6. Identification Card for Use of Resident Citizen in the United States (Form I-179) 7. Employment authorization document issued by the Department of Homeland Security For examples, see Section 7 and Section 13 of the M-274 on uscis.gov/i-9-central. The Form I-766, Employment Authorization Document, is a List A, Item Number 4, document, not a List C document.
<p>Acceptable Receipts</p> <p>May be presented in lieu of a document listed above for a temporary period.</p> <p>For receipt validity dates, see the M-274.</p>				
<ul style="list-style-type: none"> • Receipt for a replacement of a lost, stolen, or damaged List A document. • Form I-94 issued to a lawful permanent resident that contains an I-551 stamp and a photograph of the individual. • Form I-94 with "RE" notation or refugee stamp issued to a refugee. 	OR	<p>Receipt for a replacement of a lost, stolen, or damaged List B document.</p>	AND	<p>Receipt for a replacement of a lost, stolen, or damaged List C document.</p>

*Refer to the Employment Authorization Extensions page on [I-9 Central](#) for more information.

EMPLOYMENT STATUS AND EQUIPMENT AGREEMENT

CERTIFIED EMPLOYEES

Certified personnel (full-time and part-time) shall be employed, initially, in the Broken Arrow Public School District on a temporary contract. The temporary contract shall be in effect for the first two years of employment.

Insurance benefits become effective the first of the month following the employee's hire date.

Upon separation from employment I understand I must return any equipment or district property assigned to me or their cost will be deducted from my final check.

SUPPORT EMPLOYEES

Hourly support personnel (full-time and part-time) shall be employed, initially, in the Broken Arrow Public School District on a temporary employee status. The temporary employee status shall be in effect for the employee's entire first year of employment.

Insurance benefits become effective the first of the month following the employee's hire date.

I authorize the cost of my post-offer physical (if applicable) to be deducted from my final pay check if I resign my employment prior to completion of sixty calendar (60) days.

Upon separation from employment I understand I must return any uniforms, equipment, and district property assigned to me or their cost will be deducted from my final check.

STAFF DOCUMENTATION AGREEMENT

To locate the Broken Arrow Public Schools District Policy Guide: Go to www.baschools.org/BoardPolicies

To locate the Negotiated Agreement and Standards of Performance and Conduct for Teachers: Go to <https://www.baschools.org/vimages/shared/vnews/stories/5b7b2c4ff2277/NegotiationsAgreement-2023-24.pdf>

I acknowledge that I know where to locate Board Policies and the Negotiated Agreement. These documents describe important information about Broken Arrow Public Schools, and I understand that I should consult Human Resources if I have any questions. I understand and agree that I will read and comply with these policies and standards and any revisions and am bound by the provisions contained therein.

Since the information and policies described here are necessarily subject to change, I acknowledge that revisions to these documents may occur. I understand that Broken Arrow Public Schools may change, modify, suspend, interpret or cancel, in whole or part, any of the published or unpublished policies or practices, with or without notices, at its sole discretion, without giving cause or justification to any employee.

If you do not have access to the website, a paper copy of the above mentioned documents is available in the Human Resources Department. If you have any questions concerning a personnel matter, you may reach the Human Resources Department at 918-259-5704.

By signing below I acknowledge that I have been notified of where to find the above mentioned documents.

PRINTED EMPLOYEE NAME

EMPLOYEE SIGNATURE

DATE

Broken Arrow Public Schools
Professional Employment Application
ADDENDUM

In order to avoid the possibility of discrimination or bias in the employment process, certain types of information which once were routinely asked on job applications may no longer be included. However, once an applicant has been employed this information becomes pertinent and important to an employer for a variety of reasons, and the employer has the right to maintain these records in the employee's personnel file. Now that you have been employed by the Broken Arrow Public Schools, you are requested to complete these questions and return this form to the Human Resources Department immediately.

Full name as shown on your Social Security Card: _____
First Name Middle Name Last Name

Maiden Name _____ If married, spouse's full name: _____
First Name Middle Name Last Name

Marital Status: Married Single Divorced Widowed Gender: Male Female

By what other names, single or married, have you maintained in college or on employment records?

1. _____ 2. _____ 3. _____

Date of Birth _____ U.S. Citizen: YES NO
Month — Day — Year

Certain reports the District is required to report by law ask for a description of Staff by race.

Please indicate your ethnicity:

- Yes, Hispanic/Latino
 No, not Hispanic/Latino

Please indicate you race:

- American Indian/Alaskan Native Native Hawaiian or Pacific Islander
 Asian White Black or African American

Emergency contact information in the event of an emergency involving you during the work day/your shift:

Full name: _____ Relationship: _____

Street Address: _____

City, State, Zip Code: _____

Phone number including area code: (____) _____ (____) _____ (____) _____
Daytime Number Evening Number Cell Number

Your Signature _____ Date: _____

Authorization Release Form

Authorization for Use or Disclosure of Protected Personal/Health Information

1. I hereby authorize Broken Arrow Public Schools to disclose and/or discuss the information described in paragraphs 3a, 3b, and/or 3c, to the following individual(s):

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

2. Authorization for release of personal/health information covering the period of (check one)

a. from (date) _____ - to (date) _____ OR

b. all past, present and future periods.

3. I hereby authorize the release of personal/health information as follows (check one):

a. PERSONNEL FILE

- Complete Personnel File
 The following information only:

b. BENEFIT FILE

- Complete Benefit File
 The following information only:

c. MEDICAL FILE

- Complete Medical File
 The following information only:

4. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization.

5. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

Printed Name of Employee

Signature of Employee

Date

EMPLOYER'S WORKERS' COMPENSATION NOTICE TO EMPLOYEES

All employees of this employer who are entitled to benefits of the Administrative Workers' Compensation Act are hereby notified that this employer has complied with all rules of the Workers' Compensation Commission, and that this employer has secured payment of compensation for all employees and their dependents in accordance with the Act. All employees are further notified this employer will furnish first aid, medical, surgical, hospital, optometric, podiatric and nursing services, medicine, crutches and other apparatus as may be reasonably necessary in connection with the injury received by the employee, as well as payments of compensation to any injured employee or the employee's dependents as provided in the Act. This applies to care for all injuries and illnesses arising out of and in the course of employment.

WARNING: Any person who knowingly, and with intent to injure, defraud and deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony. (Title 36 S 3613.1 O.S.)

EMPLOYEE'S RESPONSIBILITIES IN CASE OF WORK-RELATED INJURY

Job safety is every employee's responsibility. All accidents or occurrences involving potential injury shall be reported to your supervisor immediately.

If accidentally injured or affected by cumulative trauma occupational disease arising out of and in the course of employment, however slight, you as the employee must notify your employer immediately. Notice shall be given to your immediate supervisor or administrator in charge of the location of operations where the injury occurred. Unless notice is given to the employer within thirty (30) days of injury, any claim for compensation may be forever barred. If accidentally injured or affected by an occupational disease or death, the employee may file a claim for compensation with the Worker's Compensation Commission. Your employer will furnish you with the appropriate forms to file any compensation claim. A claim for compensation for any accidental injury or death must be filed with the Commission within one (1) year of the date of injury; a death claim must be filed within two (2) years of the date of death; a claim for compensation for occupational disease or illness must be filed within two (2) years of the last injurious exposure; and a claim for compensation for cumulative trauma must be filed within one (1) year of the date of injury. A claim for additional compensation is barred unless filed within one (1) year of the last payment of disability compensation or two (2) years from the date of injury, whichever is longer.

An injured worker must report an incident to his/her immediate supervisor during the shift in which the injury occurs and should not leave the work site without reporting their injury. Prior to authorizing medical treatment, all forms must be submitted to the Workers' Comp Team within 24 hours of the incident/injury.

WORKERS' COMPENSATION FRAUD PENALTIES

Upon filing a notice of injury, permission is given to the administrator of the Workers' Compensation Commission, the Workers' Compensation Court of Existing Claims, the Insurance Commissioner, the Attorney General, a District Attorney or their designees to examine all records, including medical records, relating to the notice or any matter contained in or relating to the notice.

Each conviction for Workers' Compensation Fraud is punishable by seven (7) years in the State penitentiary and a Ten Thousand Dollar (\$10,000.00) fine. Workers' Compensation Fraud includes:

- Concealing information or providing false, incomplete or misleading statements in support of a worker's compensation claim.
- Assisting another in presenting a false claim.
- Seeking or accepting benefits while failing to immediately disclose any change in material fact, your physical condition, circumstance, employment status or income.

I hereby declare under penalty of perjury that I have examined this notice, and that I understand or have had explained to me all statements contained herein.

Print Name _____

Signature _____

Date _____