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 ________________________________
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.

<table>
<thead>
<tr>
<th>Last Name (Family Name)</th>
<th>First Name (Given Name)</th>
<th>Middle Initial (if any)</th>
<th>Other Last Names Used (if any)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address (Street Number and Name)</td>
<td>Apt. Number (if any)</td>
<td>City or Town</td>
<td>State ZIP Code</td>
</tr>
<tr>
<td>Date of Birth (mm/dd/yyyy)</td>
<td>U.S. Social Security Number</td>
<td>Employee's Email Address</td>
<td>Employee's Telephone Number</td>
</tr>
</tbody>
</table>

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.

Check one of the following boxes to attest to your citizenship or immigration status (See page 2 and 3 of the instructions):

- [ ] 1. A citizen of the United States
- [ ] 2. A noncitizen national of the United States (See Instructions.)
- [ ] 3. A lawful permanent resident (Enter USCIS or A-Number.)
- [ ] 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
- Form I-94 Admission Number
- 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.

<table>
<thead>
<tr>
<th>Document Title 1</th>
<th>Issuing Authority</th>
<th>Document Number (if any)</th>
<th>Expiration Date (if any)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Document Title 2 (if any)</td>
<td>Issuing Authority</td>
<td>Document Number (if any)</td>
<td>Expiration Date (if any)</td>
</tr>
<tr>
<td>Document Title 3 (if any)</td>
<td>Issuing Authority</td>
<td>Document Number (if any)</td>
<td>Expiration Date (if any)</td>
</tr>
</tbody>
</table>

Additional Information

Check here if you used an alternative procedure authorized by DHS to examine documents.

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.

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

Employer’s Business or Organization Address, City or Town, State, ZIP Code

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).

<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><strong>Documents that Establish Both Identity and Employment Authorization</strong></td>
<td><strong>Documents that Establish Identity</strong></td>
<td><strong>Documents that Establish Employment Authorization</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. U.S. Passport or U.S. Passport Card</td>
<td>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</td>
<td>1. A Social Security Account Number card, unless the card includes one of the following restrictions:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551)</td>
<td>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</td>
<td>(1) NOT VALID FOR EMPLOYMENT</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa</td>
<td>3. School ID card with a photograph</td>
<td>(2) VALID FOR WORK ONLY WITH INS AUTHORIZATION</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Employment Authorization Document that contains a photograph (Form I-766)</td>
<td>4. Voter’s registration card</td>
<td>(3) VALID FOR WORK ONLY WITH DHS AUTHORIZATION</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. For an individual temporarily authorized to work for a specific employer because of his or her status or parole:</td>
<td>5. U.S. Military card or draft record</td>
<td>2. Certification of report of birth issued by the Department of State (Forms DS-1350, FS-545, FS-240)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>a. Foreign passport; and</td>
<td>6. Military dependent’s ID card</td>
<td>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</td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. Form I-94 or Form I-94A that has the following:</td>
<td>7. U.S. Coast Guard Merchant Mariner Card</td>
<td>4. Native American tribal document</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(1) The same name as the passport; and</td>
<td>8. Native American tribal document</td>
<td>5. U.S. Citizen ID Card (Form I-197)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(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.</td>
<td>9. Driver’s license issued by a Canadian government authority</td>
<td>6. Identification Card for Use of Resident Citizen in the United States (Form I-179)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>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</td>
<td><strong>For persons under age 18 who are unable to present a document listed above:</strong></td>
<td>7. Employment authorization document issued by the Department of Homeland Security</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>10. School record or report card</td>
<td>For examples, see Section 7 and Section 13 of the M-274 on ustrs.gov/i-9-central.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>12. Day-care or nursery school record</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Acceptable Receipts

May be presented in lieu of a document listed above for a temporary period.

For receipt validity dates, see the M-274.

- Receipt for a replacement of a lost, stolen, or damaged List A document.
- Receipt for a replacement of a lost, stolen, or damaged List B document.
- Receipt for a replacement of a lost, stolen, or damaged List C document.

*Refer to the Employment Authorization Extensions page on I-9 Central for more information.
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 uniforms, equipment, and 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 equipment or 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
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: __________________________________________

Maiden Name: ___________ If married, spouse’s full 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 ☐

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 that 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 the 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 ______________________