THE UNIVERSITY OF TENNESSEE
HEALTH SCIENCE CENTER

PERSONAL DATA FORM

Effective Date _____ ☐ New ☐ Update

Form of Address: ☐ Mr. ☐ Mrs. ☐ Miss. ☐ Ms. ☐ Dr.

Last Name _____ Middle Name _____

First Name _____

Email Adress _____

Known as _____ Soc. Security # _____

Birth Date _____ (mm/dd/yyyy) Gender ☐ Male ☐ Female ☐ Nonbinary

Nationality _____ Marital Status ☐ Single ☐ Married

☐ Name Change Previous Name _____

PERMANENT RESIDENCE (IT0006-Subtype 1)

C/O _____

Street _____

County _____ City _____

State _____ Zip _____

Home Telephone _____ Cell Phone _____

Please include Area Code Please include Area Code

☐ Complete Information ☐ No Address ☐ No Phone/Address

☐ No Phone Number ☐ No Public Listing

OFFICE DETAILS (IT0006-Subtype 3)

Building Name _____ Building No. _____

Street Address _____ Room No. _____

County _____ City _____

State _____ Zip _____ Mail Stop _____

Telephone _____ Fax _____

Please include Area Code Please include Area Code

Would you like the following shared about your office information on the website and outlook?

_____

☐ Complete Information ☐ No Address ☐ No Phone/Address

☐ No Phone Number ☐ No Public Listing

EMERGENCY CONTACT (IT0006-Subtype 4)

Name _____

Address _____

City _____ State _____ Zip _____

Telephone _____ (Please include Area Code)

RESIDENCE STATUS (I-9) (IT0094)

☐ U.S. Citizen

☐ Permanent Resident

☐ Non-resident Alien

I-9 Date _____

IMMIGRATION STATUS (IT0048)

Supporting Documentation Required

Country of Citizenship _____

Visa Type _____

Visa Expires _____

Original Date of Arrival to United States _____

Employee Name _____

ADDITIONAL PERSONAL DATA (IT0077)

Ethnicity (Check one of these options) ☐ Hispanic/Latino ☐ Not Hispanic/Latino

Race Category (Check all that apply. NOTE: More than one box may be checked.)

☐ American Indian or Alaskan Native ☐ Asian ☐ Black or African American

☐ Native Hawaiian or Other Pacific Islander ☐ White

Veteran Status (Check all that apply. NOTE: If a Recently Separated Vet, the discharge date is required.)

☐ Special Disabled Veteran ☐ Vietnam Era Veteran ☐ Other Protected Veteran

☐ Recently Separated Vet ☐ Armed Forces Service Medal Veteran

☐ Disabled Veteran ☐ Non-veteran Discharge Date _____
(Required for Recently Separated Vet)

Currently receiving retirement benefits from the State of Tennessee or from a federal retirement plan?

☐ YES ☐ NO If yes, what agency? _____

Retired from UT? ☐ YES ☐ NO

If yes, list department, address, and date(s) of employment. _____

_____

Ever employed by UT, the State of Tennessee, or by a Federal Agency before? ☐ YES ☐ NO

If yes, complete below:

Agency or Department	Full-time Part-time	Address	Dates	Employed under a different name

EDUCATION (IT0022)

Educational Level _____ Field of Study _____

Name/Location of Institution. _____ State _____

Type of Degree or Certificate_____ Year Degree Granted _____

Employee Signature _____ Date _____

The University of Tennessee is an EEO/AA/Title VI/Title IX/Section 504/ADA/ADEA institution in the provision of its education and employment programs and services.

THE UNIVERSITY OF TENNESSEE HEALTH SCIENCE CENTER

THE UNIVERSITY *of* *TENNESSEE*
Health Science Center

Human Resources
910 Madison Ave, Suite WP012
Memphis, TN 38163
Tel: (901) 448-5600 Fax: (901) 448-5170

THE UNIVERSITY OF TENNESSEE
HEALTH SCIENCE CENTER
AUTHORIZATION OF DISCLOSURE

(This form allows authorization to verify your employment.)

PLEASE SIGN ONLY ONE

I, the undersigned, authorize the Office of Human Resources of the University of Tennessee to provide the following information to the persons or entities hereinafter mentioned: period of employment, positions held, and salary (if requested in writing).

I fully understand and agree that the above personnel information may be made available by the Office of Human Resources or other UT Departments to prospective employers, lending institutions, and other persons and entities seeking said personnel information for employment, credit and other business.

Date: _____ Signature: _____

Department: _____

****

I do NOT authorize the above disclosure:

Date: _____ Signature: _____

Department: _____

ATTENTION: The Law of the State of Tennessee makes the Personnel Records of UT public domain. This gives any citizen of the State of Tennessee the right to view your personnel file when they present proper ID showing they are a citizen.

Revised 7/2017

University of Tennessee Health Science Center

Confidentiality Agreement

Each faculty member, staff member, other employee, and student of the University of Tennessee Health Science Center who is afforded access to confidential, protected health information in medical or dental records, billing records, research records or in other forms which is considered individually identifiable, agrees to abide by the following terms:

1. Patient care information, whether written, oral, or in electronic computer system form is confidential and may be accessed only by employees or authorized contracted personnel who need that information to perform their job or contractual responsibilities. Only authorized personnel may release patient care information to individuals outside the health system.
2. I understand that this information belongs to the patient; I am only the caretaker. I must guard the documentation appropriately to prevent conversation being overheard by people without a right to know the information. This includes, but is not limited to the following:
    a. Keeping patient information secure, private, and out of public viewing
    b. Protecting computerized data by logging off when leaving a work station
    c. Keeping information secure by not discussing patient specific issues in public areas such as elevators or anywhere outside the workplace.
3. I agree that personnel may only access information necessary to perform their job responsibilities. I agree not to disclose, communicate, or use any patient information in any manner whatsoever other than within the course of my job responsibilities. Even within those responsibilities, I will limit the dissemination of information to those persons who have a need to know.
4. I agree to dispose of copies of reports and other confidential information by shredding them when the final reports have been proofread and signed. I also agree to safeguard tapes and other recording media on which confidential information has been recorded.
5. I understand that the confidentiality of information survives the termination of my relationship with the University of Tennessee.
6. I understand that if I do not keep this information confidential, or if I allow or participate in the inappropriate dissemination of (or access to) personal patient information, I will be subject to disciplinary action according to the University Code of Conduct and other University policies in addition to facing the possibility of litigation and monetary sanctions.
7. I understand that criminal offenses regarding disclosure of protected patient information will be reported to the proper authorities.
8. I agree to comply with all state and federal laws applicable to the use of confidential patient information including the Privacy Act of 1974, the Health Insurance Portability and Accountability Act of 1996 (HIPPA), the Patient Privacy Protection Act and the Tennessee Medical Record Act, the Health Information Technology for Economic and Clinical Health (HITECH) Act of 2009, and the Family Educational Rights and privacy Act (FERPA) of 1974.

My signature attests to the fact that I have read, understand and agree to abide by the terms of this statement and to the University of Tennessee's policies on confidentiality of patient care information as well as the policies on confidentiality of payroll, personnel, student, and financial records.

Printed Name_____

Signature_____

Department Name_____

Date_____

THE UNIVERSITY *of TENNESSEE*
Health Science Center

Human Resources
910 Madison Ave, Suite WP012
Memphis, TN 38163
Tel: (901) 448-5600 Fax: (901) 448-5170

Name: _____

Position Number: _____

Date: _____

Note: This page will not be copied for dissemination beyond the Office of Human Resources and/or other departments who may need this information for Affirmative Action or legal purposes. This invitation is being extended to you after a job offer.

INVITATION TO APPLICANTS FOR EMPLOYMENT TO IDENTIFY THEMSELVES DISABLED

THIS SECTION PERTAINS ONLY TO DISABLED PERSONS. A person with a disability refers to any person who has a physical or mental impairment that substantially limits one or more major life activities (performing manual task, learning, walking, seeing, hearing, speaking, etc.), has a record of such impairment, or is regarded as having such impairment.

The UT Health Science Center is a government contractor subject to Section 504 of the Rehabilitation Act of 1973, which require employers to take affirmative action to employ qualified disabled individuals. If you feel you meet the above definition of disabled, the UT Health Science Center invites you to inform us so that you may be given consideration under our affirmative action program.

Provision of this information is entirely voluntary, and choosing not to provide it will not to result in any adverse treatment. The information will be used only according to the regulation of the Act. The information is considered confidential, except that (1) supervisors may be informed regarding restrictions on the work or duties of disabled persons and any necessary accommodations and (2) first aid personnel may be informed, where appropriate, if the condition might require emergency treatment.

Please describe disability_____

Do you have any health problems or physical limitations which would affect your ability to perform the essential functions of the job for which you are applying? If yes,
explain_____

_____

_____

If so, what reasonable accommodations, if any, could the University take to enable you to perform?
_____

THE ABOVE INFORMATION IS VOLUNTARY AND WILL BE KEPT CONFIDENTIAL AND USED ONLY IN ACCORDANCE WITH THE ACTS AND THE REGULATIONS AT 41 CFR 60-250 AND 41 CFR 60-741. REFUSAL TO PROVIDE THIS INFORMATION WILL NOT SUBJECT YOU TO ANY ADVERSE TREATMENT.

Revised July 2, 2008