SULLIVAN COUNTY PERSONNEL DEPARTMENT APPLICATION FOR EXAMINATION OR EMPLOYMENT

Form SC-330 10/96

LAST NAME | FIRST NAME | M.I. | Social Security # (Required) | EXAM # (if applicable) | TITLE

Instructions are on the reverse side

Town Of Fallsburg Human Resource Department
19 Railroad Plaza, P.O. Box 2019
South Fallsburg, New York 12779-2019 Tel. (845) 434-8810 Ext 307

A) MAILING ADDRESS

Street, Apt., P.O. Box

City or Post Office State Zip Code

(_____) _____ (_____) _____
Home Phone Day Phone

B) LEGAL RESIDENCY

1) STATE of residency: _____
2) COUNTY of residency: _____
3) TOWN of residency: _____
4) VILLAGE residency: _____
5) SCHOOL DIST. NAME: _____

C)

1) What is your date of birth? Month: ____ Day: ____ Year: ____
2) Are you a United States Citizen? [ ]Yes [ ]No
3) Have you ever been convicted of a violation of the Selective Training and Service Acts of the United States? [ ]Yes [ ]No

Equal Employment Opportunity Policy: The Sullivan County government does not discriminate on the basis of age, race, religion, creed, color, national origin, gender, disability, marital status, sexual orientation, and/or veterans status.

D) INDICATE WITH A CHECK MARK (✓) ANY OF THE FOLLOWING STATEMENTS WHICH APPLY TO YOU. PROVIDE ADDITIONAL INFORMATION OR FORMS AS REQUESTED (All forms are available from the Personnel Department, unless otherwise noted) :

1) [ ] I am applying for additional credit as a non-disabled war veteran: Complete Form SC-311, *Application for Veterans Credits*
2) [ ] I am applying for additional credit as a disabled war veteran: Complete Form SC-311, *Application for Veterans Credits*, AND Form MSD-332-VC-3, *Authorization for Disability Record*
3) [ ] I am requesting an alternate test date because I observe the Sabbath on the regular test date, OR for some other reason. I understand that the Personnel Officer will determine whether a reason is deemed acceptable to grant an alternate test date: Complete a *Request for Alternate Test Date* form.
4) [ ] I am currently in default on a loan made or guaranteed by the New York State Higher Education Services Corporation.
5) [ ] Check if you have ever been convicted of any crime (felony or misdemeanor): Provide specifics on a separate piece of paper* *Applicants may attach a copy of either a Certificate of Relief from Disabilities form or a Certificate of Good Conduct form, issued by the State Parole Board.*
6) [ ] Check if you have ever resigned, been dismissed, or otherwise been terminated from a position in the public service upon written charges of incompetency or misconduct: Provide specifics on a separate piece of paper*
7) [ ] Check if you were ever discharged from any employment except for lack of work or funds, disability, or medical condition: Provide specifics on a separate piece of paper*

*Not an automatic bar to employment. Each case is considered and evaluated on individual merits in relation to the duties and responsibilities of the position for which you are applying.

E) FILING FEES for an exam can be collected when BOTH THE EXAM NUMBER AND DATE have been assigned. This information can be found in the announcement or notice of exam. Read carefully and check ONLY one:

1) [ ] No fee enclosed. The exam number and/or date have not yet been assigned. DO NOT MARK ANYTHING ELSE IN THIS SECTION. You will be notified when the exam is announced.
2) [ ] I have enclosed the fee. The amount of the fee is listed on page (2) of the exam announcement. The fee will NOT BE REFUNDED if your application is DISAPPROVED.
3) [ ] The exam number and date have been assigned, but I am requesting a waiver of the fee because (check ONLY one):
   - [ ] I am receiving public assistance as described in the Instructions for this section on page (4). I AM PROVIDING the Type of Assistance: _____ Providing Agency: _____ Case No.: _____
   - [ ] I am certified as eligible to receive assistance under the job training and partnership act. I AM PROVIDING a copy of appropriate documentation.
   - [ ] I am unemployed AND primarily responsible for the support of a household. I AM PROVIDING a copy of documentation of unemployment status AND I affirm that I am primarily responsible for the support of a household.

F) Affirmation: I affirm under penalties of perjury that all statements made on this application (including any attached papers) are true. I understand that all statements made by me in connection with this application are subject to investigation and verification. I understand that if I practice, or attempt to practice, any deception or fraud in my application, examination, or in securing eligibility for appointment, or if I make an intentional false statement of any material fact in this application, I may be disqualified from appointment and/or my appointment may be revoked.

X _____ _____ _____
Signature of Applicant Date Other name(s) you have been known by (Please print)

#

OFFICE USE ONLY (Do NOT write in this area)

1) FEE PAID	2) QUALIFICATION	3) ADM	4) ALT. ARRANGEMENTS	5) RESULTS	6) PERFORMANCE TESTS	7) CERTIFIC
[ ] Yes [ ] Wv	[ ] Q	[ ] Q	[ ] ACC [ ] ATD [ ] ATS [ ] AJT	[ ] Q Vet pts	[ ] TYP [ ] STN [ ] 911 [ ] PFA	[ ][ ][ ]Dt
R#	[ ] Cond		ACC	ND 2.5 5.0	TYP TIME	St
[ ] No	[ ] DQ	[ ] DQ	ATD TIME	D 5.0 10.0	STN TIME	Co
Exam notice sent [ ]	Application determination sent [ ] [ ] [ ] [ ]	Adm ltr sent [ ]	ATS	Keyed sent [ ][ ]	911 TIME	Tn
			AJT		PFA TIME	Vl
			ACC ATD ATS AJT		TYP STN 911 PFA	Sd
			[ ] [ ] [ ] [ ]		[ ] [ ] [ ] [ ] Q/DQ	
					[ ] [ ] [ ] [ ] Sent	[ ][ ][ ]Ky

NOTE: When filling out your application form, check to make sure that all appropriate questions have been answered. An incomplete application may result in its disapproval. **IF YOU ARE FILLING OUT MORE THAN ONE APPLICATION,** you may provide photocopies of pages (2) and (3) for the additional applications.

EDUCATION AND EXPERIENCE MUST BE FILLED IN COMPLETELY. A RESUME IS NOT SUFFICIENT

G) Have you graduated from high school**? [ ] Yes [ ] No If not, what grade did you complete? _____

If Yes, provide NAME and LOCATION OF High School: _____

H) Do you have a high school equivalency diploma**? [ ] Yes [ ] No If No, go on to Section I. If yes, provide:

Issuing Governmental Authority: _____ Number: _____ Date of issue: _____

**includes a diploma issued by an education department of any of the states of the United States (U.S.) OR a holder of a comparable diploma issued by any commonwealth, territory, or possession of the U.S. or by the Canal Zone OR a holder of a report from the U.S. Armed Forces, certifying the successful completion of the tests of general education development, high school level.

I)

	Name of School and City in which located	Dates of Attendance From: (Mo/Yr) To: (Mo/Yr)	Full or Part Time	No of Years Credited	Were you Graduated?	Type of Course or Major Subject	Number of College Credits Received	Degree Received	Date of Degree
College, University, Professional, Technical and Other Schools or Special Courses									

J) Do you have a valid New York State Driver's License? [ ] Yes [ ] No If No, go on to Section K.

If Yes, indicate: [ ] CDL-A [ ] CDL-B [ ] CDL-C [ ] NON-CDL-C [ ] D [ ] E Provide Driver's license #: _____

State all restrictions: _____

If you have a CDL, state all endorsements: _____

K) OTHER LICENSES

Complete this section if a license, certificate or other authorization to practice a trade or profession is listed as a requirement on the announcement for which you are applying.

Name of trade or profession	License Number	Granted by (Licensing Agency)	City or State of
Specialty	**Date License First Issued**	**Registered**	**From: Mo/Yr** **To: Mo/Yr**

INSTRUCTIONS FOR COMPLETING SECTION L: DESCRIPTION OF EXPERIENCE

On the following page describe in detail all experience relevant to the position being sought.

1) You are responsible for knowing the minimum qualifications for the examination or position for which you are applying.
2) In listing your experience, be more specific in describing that which relates to the position for which you are applying.
3) Begin with your most recent experience.
4) You are responsible for submitting an accurate, adequate and clear description of your experience. Omissions or vagueness will NOT be resolved in your favor.
5) Include MILITARY SERVICE experience when appropriate.
6) Relevant VOLUNTEER (unpaid) experience will be considered if verified and fully documented (unless otherwise stated on the exam announcement).
7) If your title or duties changed materially in the course of your service in any one organization, indicate such CHANGE clearly and as a SEPARATE ENTRY.
8) If more space is needed, attach 8-1/2" x 11" sheets of paper.
9) Describe the nature of the work personnally performed by you, with the estimate of percentage of time spent on each type of work.
10) State size and kind of working force, if any, supervised by you and the extent of such supervision.

L) EXPERIENCE

Dates of Employment (Mo/Yr) (Mo/Yr) From: / To: /	Firm Name	Address	City and State
Earnings $ (circle one) per Wk/Mo/Yr	Duties:		
Type of Business			
Your exact title			
Name of your Supervisor			
Supervisor's title			
No. of hours worked per week (exclusive of overtime)			

Dates of Employment (Mo/Yr) (Mo/Yr) From: / To: /	Firm Name	Address	City and State
Earnings $ (circle one) per Wk/Mo/Yr	Duties:		
Type of Business			
Your exact title			
Name of your Supervisor			
Supervisor's title			
No. of hours worked per week (exclusive of overtime)			

Dates of Employment (Mo/Yr) (Mo/Yr) From: / To: /	Firm Name	Address	City and State
Earnings $ (circle one) per Wk/Mo/Yr	Duties:		
Type of Business			
Your exact title			
Name of your Supervisor			
Supervisor's title			
No. of hours worked per week (exclusive of overtime)			

Dates of Employment (Mo/Yr) (Mo/Yr) From: / To: /	Firm Name	Address	City and State
Earnings $ (circle one) per Wk/Mo/Yr	Duties:		
Type of Business			
Your exact title			
Name of your Supervisor			
Supervisor's title			
No. of hours worked per week (exclusive of overtime)			

ALL STATEMENTS ARE SUBJECT TO VERIFICATION

Form **W-4**

Department of the Treasury
Internal Revenue Service

Employee's Withholding Certificate

Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay.
Give Form W-4 to your employer.
Your withholding is subject to review by the IRS.

OMB No. 1545-0074

2025

Step 1: Enter Personal Information

(a) First name and middle initial	Last name	(b) Social security number
Address		**Does your name match the name on your social security card?** If not, to ensure you get credit for your earnings, contact SSA at 800-772-1213 or go to *www.ssa.gov*.
City or town, state, and ZIP code		

(c) ☐ **Single** or **Married filing separately**
☐ **Married filing jointly** or **Qualifying surviving spouse**
☐ **Head of household** (Check only if you're unmarried and pay more than half the costs of keeping up a home for yourself and a qualifying individual.)

TIP: Consider using the estimator at *www.irs.gov/W4App* to determine the most accurate withholding for the rest of the year if: you are completing this form after the beginning of the year; expect to work only part of the year; or have changes during the year in your marital status, number of jobs for you (and/or your spouse if married filing jointly), dependents, other income (not from jobs), deductions, or credits. Have your most recent pay stub(s) from this year available when using the estimator. At the beginning of next year, use the estimator again to recheck your withholding.

Complete Steps 2–4 ONLY if they apply to you; otherwise, skip to Step 5. See page 2 for more information on each step, who can claim exemption from withholding, and when to use the estimator at *www.irs.gov/W4App*.

Step 2: Multiple Jobs or Spouse Works

Complete this step if you (1) hold more than one job at a time, or (2) are married filing jointly and your spouse also works. The correct amount of withholding depends on income earned from all of these jobs.

Do **only one** of the following.

(a) Use the estimator at *www.irs.gov/W4App* for the most accurate withholding for this step (and Steps 3–4). If you or your spouse have self-employment income, use this option; **or**

(b) Use the Multiple Jobs Worksheet on page 3 and enter the result in Step 4(c) below; **or**

(c) If there are only two jobs total, you may check this box. Do the same on Form W-4 for the other job. This option is generally more accurate than (b) if pay at the lower paying job is more than half of the pay at the higher paying job. Otherwise, (b) is more accurate . . . . . ☐

Complete Steps 3–4(b) on Form W-4 for only ONE of these jobs. Leave those steps blank for the other jobs. (Your withholding will be most accurate if you complete Steps 3–4(b) on the Form W-4 for the highest paying job.)

Step 3: Claim Dependent and Other Credits

If your total income will be $200,000 or less ($400,000 or less if married filing jointly):

Multiply the number of qualifying children under age 17 by $2,000 $ _____

Multiply the number of other dependents by $500 . . . . . $ _____

Add the amounts above for qualifying children and other dependents. You may add to this the amount of any other credits. Enter the total here . . . . . **3** $

Step 4 (optional): Other Adjustments

(a) Other income (not from jobs). If you want tax withheld for other income you expect this year that won't have withholding, enter the amount of other income here. This may include interest, dividends, and retirement income . . . . . **4(a)** $

(b) Deductions. If you expect to claim deductions other than the standard deduction and want to reduce your withholding, use the Deductions Worksheet on page 3 and enter the result here . . . . . **4(b)** $

(c) Extra withholding. Enter any additional tax you want withheld each **pay period** . . **4(c)** $

Step 5: Sign Here

Under penalties of perjury, I declare that this certificate, to the best of my knowledge and belief, is true, correct, and complete.

Employee's signature (This form is not valid unless you sign it.) _____ **Date** _____

Employers Only

Employer's name and address	First date of employment	Employer identification number (EIN)

NEW YORK STATE 2025

Department of Taxation and Finance

Employee's Withholding Allowance Certificate

New York State • New York City • Yonkers

IT-2104

First name and middle initial	Last name	Your Social Security number
Permanent home address *(number and street or rural route)*	Apartment number	Single or Head of household ☐ Married ☐
City, village, or post office	State / ZIP code	Married, but withhold at higher single rate ☐
		Note: If married but legally separated, mark an ***X*** in the *Single or Head of household* box.

Are you a resident of New York City (this includes the Bronx, Brooklyn, Manhattan, Queens, and Staten Island)? ..... Yes ☐ No ☐

Are you a resident of Yonkers? ..... Yes ☐ No ☐

Before making any entries, see the *Note* below, and if applicable, complete the worksheet in the instructions.

1	Total number of allowances you are claiming for New York State and Yonkers, if applicable *(from line 19, if using worksheet)*	**1**
2	Total number of allowances for New York City *(from line 31, if using worksheet)*	**2**

Use lines 3, 4, and 5 below to have additional withholding per pay period under special agreement with your employer.

3	New York State amount	**3**
4	New York City amount	**4**
5	Yonkers amount	**5**

I certify that I am entitled to the number of withholding allowances claimed on this certificate.

Penalty – A penalty of $500 may be imposed for any false statement you make that decreases the amount of money you have withheld from your wages. You may also be subject to criminal penalties.

Employee's signature	Date

Employee: Give this form to your employer and keep a copy for your records. Remember to review this form once a year and update it if needed.

Note: Single taxpayers with one job and zero dependents, enter ***1*** on lines 1 and 2 (if applicable). Married taxpayers with or without dependents, heads of household or taxpayers that expect to itemize deductions or claim tax credits, or both, complete the worksheet in the instructions. Visit *www.tax.ny.gov* (search: *IT-2104-I)* or scan the QR code below.

Employer: Keep this certificate with your records.

If any of the following apply, mark an ***X*** in each corresponding box, complete the additional information requested, and send an additional copy of this form to New York State. See ***Employer*** in the instructions. Visit *www.tax.ny.gov* (search: *IT-2104-I)* or scan the QR code below.

A Employee claimed more than 14 exemption allowances for New York State ..... A ☐

B Employee is a new hire or a rehire ... B ☐ First date employee performed services for pay *(mm-dd-yyyy) (see Box B instructions)*: ☐

You may report new hire information online instead of mailing the form to New York State. Visit *www.nynewhire.com*.

Note: Employers **must** report individuals under an **independent contractor arrangement** with contracts in excess of $2,500 using the online reporting website above, **not** Form IT-2104.

Are dependent health insurance benefits available for this employee? ..... Yes ☐ No ☐

If *Yes*, enter the date the employee qualifies *(mm-dd-yyyy)*: ☐

Employer's name and address *(Employer: complete this section only if you are sending a copy of this form to the New York State Tax Department.)*	Employer identification number

Scan here

https://www.tax.ny.gov/r/it2104i-2025

Scott DuBois, Town Comptroller
Vicki Korchanik, Principal Account Clerk
Jamie Decker, Billing Supervisor

Town of Fallsburg
P.O. Box 2019, 19 Railroad Plaza
South Fallsburg, New York 12779
(P) (845) 434-8810 ext 304 - 307
(F) (845) 434-8835

MEMORANDUM

TO: All Employees'

FROM: Vicki Korchanik, Principal Account Clerk

SUBJECT: Mandatory Direct Deposit Form

DATE: January 1, 2025

Before the Town can process your pay check, please be advised of and comply with the following:

- Complete the attached **MANDATORY DIRECT DEPOSIT FORM.**
- Enter the name of your bank, the routing number and account number.
- Check if this is a checking account or a savings account.
- Sign and date the form.

Return the above information to the Payroll Department.

Thanking you in advance for your assistance in this matter.

Cc: file

Encl.

Scott DuBois, Town Comptroller
Vicki Korchanik, Principal Account Clerk
Jamie Decker, Billing Supervisor

Town of Fallsburg
P.O. Box 2019, 19 Railroad Plaza
South Fallsburg, New York 12779
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MANDATORY DIRECT DEPOSIT FORM

NAME: _____

BANK NAME: _____

ROUTING NUMBER: _____

ACCOUNT NUMBER: _____

PLEASE CHECK ONE

CHECKING ACCOUNT _____ SAVINGS ACOUNT_____

SIGNATURE _____

DATE: _____

After receipt of this form, the process takes approximately two (2) payrolls to become effective.

PLEASE ATTACH A COPY OF THE VOIDED CHECK FROM YOUR ACCOUNT.

On payroll day, instead of a check you will receive direct deposit information showing you the same information as an original check. However, it will be non-negotiable because it is not a check and will say so. Your net check will be directly deposited into the account of your choice.

Employment Eligibility Verification

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

USCIS
Form I-9
OMB No. 1615-0047
Expires 08/31/2019

▶ **START HERE:** **Read instructions carefully before completing this form. The instructions must be available, either in paper or electronically, during completion of this form. Employers are liable for errors in the completion of this form.**

ANTI-DISCRIMINATION NOTICE: It is illegal to discriminate against work-authorized individuals. Employers **CANNOT** specify which document(s) an employee may present to establish employment authorization and identity. The refusal to hire or continue to employ 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 Last 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	Employee's E-mail Address	Employee's 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 boxes):

☐ 1. A citizen of the United States

☐ 2. A noncitizen national of the United States *(See instructions)*

☐ 3. A lawful permanent resident (Alien Registration Number/USCIS Number): _____

☐ 4. An alien authorized to work until (expiration date, if applicable, mm/dd/yyyy): _____
Some aliens may write "N/A" in the expiration date field. *(See instructions)*

Aliens authorized to work must provide only one of the following document numbers to complete Form I-9:
An Alien Registration Number/USCIS Number OR Form I-94 Admission Number OR Foreign Passport Number.

1. Alien Registration Number/USCIS Number: _____
OR
2. Form I-94 Admission Number: _____
OR
3. Foreign Passport Number: _____
Country of Issuance: _____

QR Code - Section 1
Do Not Write In This Space

Signature of Employee	Today's Date *(mm/dd/yyyy)*

Preparer and/or Translator Certification (check one):

☐ I did not use a preparer or translator. ☐ A preparer(s) and/or translator(s) assisted the employee in completing Section 1.
(Fields below must be completed and signed when preparers and/or translators assist an employee in completing Section 1.)

I attest, under penalty of perjury, that I have assisted in the completion of Section 1 of this form and that to the best of my knowledge the information is true and correct.

Signature of Preparer or Translator	Today's Date *(mm/dd/yyyy)*

Last Name *(Family Name)*	First Name *(Given Name)*

Address *(Street Number and Name)*	City or Town	State	ZIP Code

STOP *Employer Completes Next Page* STOP

Employment Eligibility Verification

Department of Homeland Security

U.S. Citizenship and Immigration Services

USCIS
Form I-9
OMB No. 1615-0047
Expires 08/31/2019

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 a combination of one document from List B and one document from List C as listed on the "Lists of Acceptable Documents.")

Employee Info from Section 1	Last Name *(Family Name)*	First Name *(Given Name)*	M.I.	Citizenship/Immigration Status

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)*				

Additional Information

QR Code - Sections 2 & 3
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	Today's Date *(mm/dd/yyyy)*	Title of Employer or Authorized Representative

Last Name of Employer or Authorized Representative	First Name of Employer or Authorized Representative	Employer's Business or Organization Name

Employer's Business or Organization Address (Street Number and Name)	City or Town	State	ZIP Code

Section 3. Reverification and Rehires *(To be completed and signed by employer or authorized representative.)*

A. New Name *(if applicable)*			B. Date of Rehire *(if applicable)*
Last Name *(Family Name)*	First Name *(Given Name)*	Middle Initial	Date *(mm/dd/yyyy)*

C. If the employee's previous grant of employment authorization has expired, provide the information for the document or receipt that establishes continuing 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	Today's Date *(mm/dd/yyyy)*	Name of Employer or Authorized Representative

LISTS OF ACCEPTABLE DOCUMENTS
All documents must be UNEXPIRED

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

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

Examples of many of these documents appear in Part 13 of the Handbook for Employers (M-274).

Refer to the instructions for more information about acceptable receipts.

Scott DuBois, Town Comptroller
Vicki Korchanik, Principal Account Clerk
Jamie Decker, Billing Supervisor

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MEMORANDUM

TO: All Employees

FROM: Vicki Korchanik, Principal Account Clerk

SUBJECT: Emergency Contact Information

DATE: January 1, 2025

Please provide the following Emergency Contact Information for your file.

Employee Name: _____

Department: _____

Emergency Contact Name: _____

Relationship: _____

Emergency Contact Number: _____

Secondary Emergency Contact Name: _____

Relationship: _____

Secondary Emergency Contact Number: _____

If any of these contacts change in the future, please submit an updated form for the file.

Town of Fallsburg
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(F) (845) 434-8835

I have read the following Policies enacted by The Town of Fallsburg:

- Computer, E-Mail and Internet Policy _____ (Initials)
- Cellular Phone and Telephone Policy _____ (Initials)
- Vehicle Policy _____ (Initials)
- Substance Abuse Policy _____ (Initials)
- Work Place Violence, Discrimination, Harrassment Policy _____ (Initials)
- Attendance Memo _____ (Initials)
- Smoking Memo _____ (Initials)
- Sexual Harrassment Prevention and Training _____ (Initials)

I understand the information and if I had any questions, I have addressed them with my direct supervisor.

I also understand that if there is any un-authorized or improper use the town computer, town email account, town internet, town cellular phone, town telephone and Town Vehicle, it could result in disciplinary action.

I have read, understand and agree to comply with the foregoing policies, rules and conditions. I am aware that violations of these guidelines may subject me to disciplinary action, including termination from employment, legal action and criminal liability. I further understand that I have a responsibility to maintain a positive representation of the Town of Fallsburg and govern myself accordingly. Furthermore, I understand that these policies can be amended at any time.
Dated:_____

EMPLOYEE	TOWN OF FALLSBURG
_____	_____
Signature	Signature of Representative
_____	_____
Print Name and Title	Print Name and Title

Town of Fallsburg Payroll Department

MEMORANDUM

TO: All Employees

FROM: Vicki Korchanik, Principal Account Clerk

SUBJECT: Retirement Notification

DATE: January 1, 2025

In accordance with the Retirement and Social Security law Section 45, the Town of Fallsburg is required to notify each employee in writing of his or her rights to membership in the New York State Employees' Retirement System.

To comply with the Law, the Town is asking that you please acknowledge that you have been given notice by signing and dating this memorandum below where indicated.

Please note that retirement contribution rates are based on gross salary with three percent (3%) being the minimum. The rate will be deducted from your bi-weekly gross salary.

****

I, _____HEREBY ACKNOWLEDGE
THAT I HAVE BEEN GIVEN WRITTEN NOTICE AS TO MY RIGHTS
TO MEMBERSHIP IN THE NEW YORK STATE EMPLOYEE'S RETIREMENT
SYSTEM.

Do you wish to join the NYS Retirement System? ____Yes or ____ No

Have you ever been a member of the Retirement System? _____ Yes or _____No

If yes, are you retired? _____ Yes or _____ No?

_____ _____
Employee Signature Date

Office of the New York State Comptroller
NYSLRS
New York State and Local Retirement System
110 State Street, Albany, New York 12244-0001
Fax Number: (518) 486-4382
For questions concerning Member Enrollment call: (518) 474-3081

Received Date

Employees' Retirement System Membership Registration
RS 5420
(Rev. 10/18)

Plan	Tier	Rate	Date of Membership (mm/dd/yyyy)

NYSLRS ID

Social Security Number *

Registration Number

Part 1: Employee – Read information provided on page 2. Complete part 1 and sign at the bottom of the form.

Employee's Last Name:	First Name:	Middle Initial:

Employee's Address:	Apt	City	State	Zip Code

Former Name: (if applicable)	Date of Birth (mm/dd/yyyy)	Gender
		☐ Male ☐ Female

Are you receiving or about to receive a pension from a New York State or New York City public retirement system? ☐ Yes ☐ No
If yes, please indicate name of system: _____

Are you inactive or withdrawn from a New York State or New York City public retirement system? ☐ Yes ☐ No
If yes, please indicate name of system: _____

(NYS Teachers', NYS Employees', NYS Police and Fire, NYC Police Pension Fund, NYC Fire Pension Fund, NYC Board of Education, NYC Teachers', NYC Employees')

Part 2: Employer – See page 2 for additional information and instructions regarding the completion of this form.

Employer's Name:	Employer's Telephone:
Town of Fallsburg	845-434-8810
Employer's Address:	**Employer's Fax Number:**
19 Railroad Plaza, South Fallsburg, NY 12779	845-434-8835

Job Code [1]	Employee Classification		
	☐ 12 Month ☐ 10 Month ☐ 12 M Provisional ☐ On Call ☐ Seasonal ☐ Substitute ☐ Per Diem	☐ Regular [2] ☐ Temporary	☐ Full Time ☐ Part Time

Hire Date [3a]			Date of Full-Time Permanent Appointment [3b]			Location Code	Standard Workday [4]	For State Agency Use Only – Agency Code
Month	Day	Year	Month	Day	Year	3 0 0 9 2		
						For a substitute, seasonal, on call or per diem employee, please check if he/she is working on the day the application is being submitted. ☐ Yes		

Frequency of Payment

☐ Weekly ☐ Bi-Weekly ☐ Semi - Monthly ☐ Monthly ☐ Quarterly ☐ Semi- Annually ☐ Annually ☐ Other- Please Specify_____

Projected Annualized Wage [5]

Tier 6 requires employers to determine the Annualized Wage for individuals who work part-time, seasonal, or on an hourly, daily, or unit of work basis. We ask that you use this calculation for all other tiers as well. See page 2 for examples.

Important: If your employment is on a part-time, temporary or provisional basis, or less than 12 months a year, membership is optional. If your membership is optional, you must sign and date below to affirm Retirement System Membership.
I acknowledge that my membership in the New York state and Local Retirement System is governed by provisions of Article 15 of the Retirement and Social Security Law and that I am entitled to all the benefits thereof. I understand that, as required by law, a deduction will be made from my salary or compensation for retirement contributions.

Employee's Signature:_____ **Date:** _____

Employee's Telephone Number:	Employee's Email Address:

For important information and instructions – See Back Page

Part 1 – Employee Instructions

Important: If your employment is on a part-time, temporary or provisional basis, or less than 12 months a year, membership is optional. If your membership is optional and you **do not wish** to join the Retirement System, do not complete this application.

Warning: If you are receiving or are about to receive a pension from another New York State or New York City public retirement system, contact us directly before enrolling in NYSLRS. Enrollment may result in suspension of your pension benefit. NYSLRS retirees should contact us directly before enrollment to discuss working after retirement and possible restoration of membership.

Membership Information:

- If you are currently an active or vested member of any other public retirement system in New York State, you should contact that system concerning the advantages of transferring your membership to this System. Failure to contact that system could cause loss of the privilege of transferring membership and may affect contribution cessation dates.
- **If you were previously a member of any public retirement system in New York State, and your membership was terminated or withdrawn, you may be eligible for a reinstatement of that membership. It is highly recommended that if you have a prior Tier 1 or 2 membership in any New York public retirement system that you complete the Tier Reinstatement application, RS5506 and attach it with your membership registration application.**
- You may also be eligible to receive credit for public service earned with a participating employer before your current date of membership. This additional service may impact your future benefits.
- You are covered by the Death Benefit allowed by law for your tier and plan status. If you have not already done so, complete an RS5127 Designation of Beneficiary with Contingent Beneficiaries form to designate beneficiary(ies) to receive an Ordinary Death Benefit. If there is no RS5127 Designation of Beneficiary with Contingent Beneficiaries on file with this System, your Ordinary Death Benefit will become payable to your estate.

Part 2 – Employer Instructions

Field Explanation and information:

(1) Employee Payroll Title – If the title is accountant, auditor, physician, attorney, engineer or architect, please submit documentation as indicated at www.osc.state.ny.us/retire.employers/classify_an_employee.php.

(2) Projected Annual Wage- Examples of Tier 6 annual wage for individuals paid at an Hourly, Daily or Unit of Work basis of compensation:

Hourly Employees 12 month Employee _____ X _____ X 260 = $_____ Hourly Rate / Standard Workday / Days Worked / Annual Wage 10 month Employee: $_____ X _____ X 180 = $_____ Hourly Rate / Standard Workday / Days Worked / Annual Wage	**Daily Employees** 12 month Employee: $_____ X _____ X 260 = $_____ Daily Rate / Standard Workday / Days Worked / Annual Wage 10 month Employee: $_____ X _____ X 180 = $_____ Daily Rate / Standard Workday / Days Worked / Annual Wage
Unit of Work Employees $_____ X _____ = _____ Unit Rate / # of Events** / Annual Wage **Estimated or Actual	**Unit of Work Employee Example: Paid $50 per Meeting** $ 50 X 12 Meetings = $ 600 Unit Rate / #of Events*** / Annual Wage ***An estimate of the number of events is acceptable

Note: Any questions regarding annual wage, please contact the Retirement System.

***Social Security Disclosure Requirement**

In accordance with the Federal Privacy Act of 1974, you are hereby advised that disclosure of your Social Security account number is mandatory pursuant to Sections 11, and 34 of the Retirement and Social Security Law. The number will be used in identifying retirement records and in the administration of the Retirement System.

Personal Privacy Protection Law

The Retirement System is required by law to maintain records to determine eligibility for and calculate benefits. Failure to provide information may interfere with the timely payment of benefits. The System may be required to provide certain information to participating employers. The official responsible for record maintenance is the Director of Member and Employer Services, NYS and Local Retirement System, Albany, NY 12244; call toll-free at 1-866-805-0990 or 518-474-7736 in the Albany Area.

Office of the New York State Comptroller

NYSLRS

New York State and Local Retirement System

110 State Street, Albany, New York 12244-0001

Please type or print clearly in blue or black ink

Received Date

Designation of Beneficiary with Contingent Beneficiaries

RS 5127
(Rev. 12/18)

NYSLRS ID

Social Security Number [last 4 digits] XXX-XX-

Retirement System [check one]

Employees' Retirement System (ERS) ☐

Police and Fire' Retirement System (PFRS) ☐

THIS FORM MUST BE SIGNED, NOTARIZED AND FILED WITH THE RETIREMENT SYSTEM PRIOR TO YOUR DEATH TO BE EFFECTIVE.

Member / Pensioner Information

Name:_____ Former Name: (if applicable)_____

Home Address: _____

City, State, Zip Code:_____

Phone Number:_____ Email Address:_____

Employed by:_____ Employer Address:_____

IMPORTANT INFORMATION REGARDING THIS FORM

- If you find this form is not suited to the type of designation you prefer please advise the Retirement System. In the meantime, for your protection and the protection of your beneficiary(ies), you should make an interim designation using this form. If you wish to designate more beneficiaries than this form allows or to designate a Trust, Guardian-ship or payment under the Uniform Transfers to Minors Act please contact the Retirement System for the appropriate form.
- Attachments to your beneficiary form are **unacceptable**.
- New beneficiary forms filed will supersede any previous designation. Therefore, if you want to **add** or **delete** a beneficiary, for example a new child, you must include on the new form all beneficiaries you wish to designate.
- The same person or persons cannot be designated as both primary and contingent beneficiaries. We can make payment to a contingent beneficiary(ies) only if all primary beneficiary(ies) die before you do.
- If you wish to have these benefits distributed through your estate, you should name "my estate" as beneficiary. Your estate can be named as either primary or contingent beneficiary. However, if you name your estate as primary beneficiary, you may not name any contingent beneficiary.
- This form is for designating beneficiaries to receive your ordinary death or post retirement death benefit. You may not designate beneficiaries to receive accidental death benefits. The beneficiaries entitled to receive accidental death benefits are mandated by statute.

Make sure that you:

- **Complete all required information.**
- **Sign and date the form.**
- **Have the form notarized, making sure the notary has entered his or her expiration date.**
- **Mail your completed form to:**

  New York State and Local Retirement System
  110 State Street
  Albany, NY 12244-0001

PERSONAL PRIVACY PROTECTION LAW

In accordance with the Personal Privacy Law you are hereby advised that pursuant to the Retirement and Social Security Law, the Retirement System is required to maintain records. The records are necessary to determine eligibility for and to calculate benefits. Failure to provide in-formation may result in the failure to pay benefits the way you prefer. The System may provide certain information to participating employers. The official responsible for maintaining these records is the Director of Member & Employer Services, New York State and Local Retirement Systems, Albany, NY 12244. For questions concerning this form, please call 1-866-805-0990 or 518-474-7736.

SOCIAL SECURITY DISCLOSURE REQUIREMENT

In accordance with the Federal Privacy Act of 1974, you are hereby advised that disclosure of the Social Security Account Number is mandatory pursuant to sections 11, 31, 34 and 334 of the Retirement and Social Security Law. The number will be used in identifying retirement records and in the administration of the Retirement System.

Please go to the reverse side of this form to designate beneficiaries, sign and date the form and have the form notarized.

IMPORTANT – You must complete other side

Do not alter this form or make stipulations. The use of correction fluid or other alterations on this form will render the designation invalid.

To the Comptroller of the State of New York:

Designation of Primary Beneficiary(ies). I hereby name the following beneficiary(ies) to receive any ordinary death or post retirement death benefit payable on my behalf. If I have named more than one beneficiary, it is my intention that those living at the time of my death should share equally any benefit payable. I reserve the right to change the designation at any time.

Name _____ ☐ Male ☐ Female
Address _____
_____
Relationship _____ Birth Date _____
Phone Number _____

Name _____ ☐ Male ☐ Female
Address _____
_____
Relationship _____ Birth Date _____
Phone Number _____

Name _____ ☐ Male ☐ Female
Address _____
_____
Relationship _____ Birth Date _____
Phone Number _____

Name _____ ☐ Male ☐ Female
Address _____
_____
Relationship _____ Birth Date _____
Phone Number _____

Designation of Contingent Beneficiary(ies). If all of the designated primary beneficiaries die before I do, any ordinary death or post retirement death benefit payable on my behalf shall be paid to the following. If I have named more than one beneficiary, it is my intention that those living at the time of my death should share equally any benefit payable. If I out-live these beneficiaries, any benefit payable should be paid to my estate or any other beneficiary I name thereafter. I reserve the right to change this designation at any time.

Name _____ ☐ Male ☐ Female
Address _____
_____
Relationship _____ Birth Date _____
Phone Number _____

Name _____ ☐ Male ☐ Female
Address _____
_____
Relationship _____ Birth Date _____
Phone Number _____

Name _____ ☐ Male ☐ Female
Address _____
_____
Relationship _____ Birth Date _____
Phone Number _____

Name _____ ☐ Male ☐ Female
Address _____
_____
Relationship _____ Birth Date _____
Phone Number _____

This form must be signed, dated and notarized in order to be valid.

I certify that the information on my application is true and complete to the best of my knowledge. I further certify that I am aware that any false statement I knowingly make or permit to be made on this or any record of the Retirement System constitutes a crime punishable by potential incarceration and other sanctions.

Member / Pensioner Signature _____ Date _____

ACKNOWLEDGEMENT TO BE COMPLETED BY A NOTARY PUBLIC

State of _____ County of _____ On the _____ day of _____ in the year _____ before me, the undersigned, personally appeared _____, personally known to me or proved to me on the basis of satisfactory evidence to be the individual(s) whose name(s) is (are) subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their capacity(ies), and that by his/her/their signature(s) on the instrument, the individual(s), or the person upon behalf of which the individual(s) acted, executed the instrument.

_____
NOTARY PUBLIC (Please sign and affix stamp)