



UNIVERSITY AFFILIATE INFORMATION FORM (Non-Payroll Appointments Only)

(Please print legibly and provide all information requested)

Name: _____ Last First MI		
SSN: _____ - _____ - _____ Date of Birth ____/____/____ <input type="checkbox"/> Male <input type="checkbox"/> Female (SSN and Date of Birth are required for access to university services and will not be used for any other purpose)		
Permanent Street Address _____ City State Zip Code Home phone: (____) _____	Person to notify in emergency: Name _____ Phone _____ Address _____	
Have you previously worked for SSU? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what Department(s): _____ Dates: _____		
Will your duties as an unpaid affiliate include unsupervised access to minors? <input type="checkbox"/> Yes <input type="checkbox"/> No		
<p>I agree to familiarize myself with, and abide by, Savannah State University rules and policies regarding conduct, confidentiality, safety and welfare. I understand that I may be subject to the same pre-employment screening and criminal background checks as paid employees performing similar duties.</p> <p>I understand that the State of Georgia provides general liability coverage to university affiliates, but no other university or state-sponsored employee medical, retirement, workers compensation, or other insurance plans apply to this association.</p> <p>I understand that if I am issued a university access card it is the property of the university and is issued at the university's sole discretion. I will not represent myself as a university employee, and I understand that the university may revoke my access to its facilities and/or require that I return the card at any time for any reason.</p> <p>My signature below affirms that all information on this information form is accurate to the best of my knowledge and I agree to abide by the conditions outlined above.</p> <p>Signature: _____ Date: ____/____/____</p>		
Assignment Begin Date: _____ Assignment End Date: _____ (Note: University Affiliate assignments are effective for the current fiscal year only unless the assignment period is superseded by a written contract.)		
Department Name: _____		
Department Head/Chair Name: _____		
Department Head/Chair Signature: _____ Date: ____/____/____		
This form must be forwarded to Human Resources after completion. HR Review by: _____ BANNER #: _____ HRMS ID #: _____		