The Lovett School

General Application for Employment

Shaded areas for office use.

Name _____

Field (s) _____

_____
Date of Application

Last Name | First Name | Middle Initial

Present Street Address | City | State | ZIP Code

Home Phone *(Please include area codes)* | Business Phone | Cell Phone | E-mail Address

Position(s) Applying for:

1. _____ Rate of Pay Expected $ _____ per _____

2. _____ Rate of Pay Expected $ _____ per _____

Are you interested in ( ) full-time or ( ) part-time employment?

Specify days and hours if part-time: _____

Have you previously been employed by The Lovett School? ❑ Yes ❑ No If yes, when? _____

List any friends or relatives employed by The Lovett School: _____

Are there any special skills, qualifications, or other experiences you feel would especially qualify you for the position(s) for which you are applying?

If you are under 18 years of age, can you provide a work permit? ❑ Yes ❑ No

If hired, can you furnish proof of your authorization to work in the U.S.? ❑ Yes ❑ No
(Proof of U.S. citizenship and immigration status will be required upon employment.)

The Lovett School is an independent, coeducational, college preparatory day school, Kindergarten through Grade 12, which does not discriminate on the basis of race, color, gender, religion, sexual orientation, age, disability, and national or ethnic origin in the hiring of its employees.

Rec'd.: _____ Ent'd.: _____ Resp.: _____

Routing: _____

EDUCATION:
Secondary Schools and Colleges (List most recent first.) Degrees Dates

____

____

____

Have you ever been placed on disciplinary probation or suspension from a college or university? ❑ Yes ❑ No
If yes, please attach an explanation.

EMPLOYMENT HISTORY: (List most recent first.)

Dates		Name & Address of Current Employer	Salary		Supervisor's Name	Reason for Leaving
From	To		Start	Finish		
Description of your responsibilities:						

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From	To		Start	Finish		
Description of your responsibilities:						

List any job-related organizations in which you have participated in the last year. *(Omit those referring to age, race, national/ethnic origin, gender, or disability.)*: ____

____

____

Have you ever been convicted of a violation of a federal, state, county, or municipal law, regulation, or ordinance?
(Disregard events prior to your 18th birthday and minor traffic violations.) ❑ Yes ❑ No If yes, please attach an explanation.

PROFESSIONAL REFERENCES: (Include at least one former employer. Do not include personal friends, family, or neighbors.)

Name	Title	Employer
Address		Phone Number
Name	Title	Employer
Address		Phone Number
Name	Title	Employer
Address		Phone Number

I certify that the information provided on this application is true, correct, and complete to the best of my knowledge and belief and I agree that falsified information or significant omissions may disqualify me from consideration for further consideration for employment and may be considered justification for termination if discovered at a later date.

I authorize persons, schools, current and previous employers, and organizations named in this application to provide The Lovett School with any relevant information that may be required. I further release all parties providing information from any and all liability or claims for damages whatsoever that may result from this information's release, disclosure, maintenance, or use.

I understand that I may be asked to take a medical examination, which may include drug testing, either prior to commencement of employment or after I have become employed, as deemed necessary by The Lovett School.

This application has been read by me in its entirety. I understand that this application does not constitute an employment contract of any kind.

Signature of Applicant: _____ Date: _____

RETURN TO:
THE LOVETT SCHOOL
ATTN: Human Resources
4075 Paces Ferry Road, N.W.
Atlanta, Georgia 30327-3099
(404) 262-3032
www.lovett.org

DO NOT WRITE BELOW THIS LINE

INTERVIEW: ❑ Yes ❑ No Date: _____ Interviewed by: _____

Results of Interview: _____

_____

_____

_____

Employed: ❑ Yes ❑ No Date of Employment: _____

Starting Salary: _____

Job Title: _____

2013-2014 PART-TIME NEW HIRE DATA SHEET

_____ _____

First Name Middle Name Last Name Preferred Name

As printed on your Social Security Card

SS#: _____ Date of Birth: _____

Street Address: _____ Home Phone: _____

City:_____ ST:_____ Zip: _____ Personal E-mail: _____

Gender: **M** or **F** ***(circle one)*** Marital Status:_____

Ethnicity: □Caucasian □African-American □Native American □Asian
□ Middle Eastern □Hispanic □ Multi Racial □Pacific Islander □Other_____

ITEMS TO BE COMPLETED AND RETURNED TO HUMAN RESOURCES

1. □ Background Check Release Form **(Fill out both pages)**
2. □ Staff Application
3. □ Part-Time New Hire Data Sheet
4. □ W-4 Federal Tax Withholding Form
5. □ G-4 Georgia State Tax Withholding Form
6. □ I-9 Employment Eligibility Verification Form
7. □ I-9 Identification **(See pg. 9 of I-9 form for the "List of Acceptable Documents")**
8. □ Direct Deposit Authorization Form – attach voided check **(Deposit Slips not accepted)**
9. □ Workers' Compensation Memorandum
10. □ Emergency Contact Form
11. □ Acknowledgment of Handbook Receipt
12. □ Authorization for Payroll Deduction for the 403(b) Retirement Plan

Signature:_____ **Date**:_____

This notice must be posted in a conspicuous place readily accessible to the employee at all times.

OFFICIAL NOTICE

This business operates under the Georgia Workers' Compensation Law.

WORKERS MUST REPORT ALL ACCIDENTS IMMEDIATELY TO THE EMPLOYER BY ADVISING THE EMPLOYER PERSONALLY, AN AGENT, REPRESENTATIVE, BOSS, SUPERVISOR, OR FOREMAN.

If a worker is injured at work, the employer shall pay medical and rehabilitation expenses within the limits of the law. In some cases the employer will also pay a part of the worker's lost wages.

Work injuries and occupational diseases should be reported in writing whenever possible. The worker may lose the right to receive compensation if an accident is not reported within 30 days.

The employer will supply free of charge, upon request, a form for reporting accidents and will also furnish, free of charge, information about workers' compensation. The employer will also furnish to the employee, upon request, copies of board forms on file with the employer pertaining to an employee's claim.

A worker injured on the job must select a doctor from the list below. The minimum panel shall consist of at least six physicians, including an orthopedic surgeon with no more than two physicians from industrial clinics. Further, this panel shall include one minority physician, whenever feasible (see Rule 201 for definition of minority physician). The Board may grant exceptions to the required size of the panel where it is demonstrated that more than four physicians are not reasonably accessible. One change of doctor, from the list, may be made without permission. Further changes require the permission of the employer or the State Board of Workers' Compensation.

State Board of Workers' Compensation
270 Peachtree Street, N.W.
Atlanta, Georgia 30303-1299
404-656-3818 or 1-800-533-0682
http://www.ganet.org.sbwc/

PROVIDER LISTINGS

WORKERS' COMPENSATION ONLY

Clinic
Concentra Medical Centers
220 N Cobb Pkwy
Marietta, GA 30062
770-424-7125

Clinic
Choice Care Occupational Medicine
338 W Peachtree St.
Atlanta, GA 30308
404-564-2400

Orthopedic Surgeon
Ortho Atlanta
105 Collier Rd NW Ste 2000
Atlanta, GA 30309
(404) 352-1053

Orthopedic Surgeon
Dominion Orthopaedic Clinic L LC
Dr. Sutlive, MD
5555 Peachtree Dunwoody Rd NE
Atlanta, GA 30342
(770) 455-4009

Orthopedic Surgeon
Peachtree Orthopaedic Clinic
Michael Bernot, MD
1901 Phoenix BLVD. Ste 200
College Park, GA 30349
404-355-0743

Primary Care Physician
Camp Creek Primary Care PC
Walter Smith, JR, MD
3890 Redwine RD. SW
Atlanta, GA 30331
770-507-0112

Primary Care Physician
Lavista Family Medicine PC
Mikhail, Gorokhov, MD
2910 N Druid Hills Rd NE Ste A
Atlanta, GA 30329
404-320-6050

Primary Care Physician
Perimeter North Family Medicine
960 Johnson Ferry RD. Ste 300
Atlanta, GA 30342
404-255-7325

(Additional doctors may be added on a separate sheet)
The insurance company providing coverage for this business under the Workers Compensation Law is:
Key Risk P.O. Box 49129 Greensboro, NC 27419

Name: The Lovett School	Address: 4075 Paces Ferry Rd. NW Atlanta, GA 30327	Radius: 16.8 mile(s)	Generated: 7/12/2013

IF YOU HAVE QUESTIONS PLEASE CONTACT THE STATE BOARD OF WORKERS' COMPENSATION AT 404-656-3818 OR 1-800-533-0682 OR VISIT http://www.sbwc.georgia.gov
Willfully making a false statement for the purpose of obtaining or denying benefits is a crime subject to penalties of up to $10,000.00 per violation (O.C.G.A. §34-9-18 and §34-9-19).

GEORGIA STATE BOARD OF WORKERS' COMPENSATION

BILL OF RIGHTS FOR THE INJURED WORKER

As required by law, O.C.G.A. §34-9-81.1, this is a summary of your rights and responsibilities. The Workers' Compensation Law provides you, as a worker in the State of Georgia, with certain rights and responsibilities should you be injured on the job. The Workers' Compensation Law provides you coverage for a work-related injury even if an injury occurs on the first day on the job. In addition to rights, you also have certain responsibilities. Your rights and responsibilities are described below.

Employee's Rights

1. If you are injured on the job, you may receive medical rehabilitation and income benefits. These benefits are provided to help you return to work. Your dependents may also receive benefits if you die as a result of a job-related injury.
2. Your employer is required to post a list of at least six doctors or the name of the certified WC/MCO that provides medical care, unless the Board has granted an exception. You may choose a doctor from the list and make one change to another doctor on the list without the permission of your employer. However, in an emergency, you may get temporary medical care from any doctor until the emergency is over, then you must get treatment from a doctor on the posted list.
3. Your authorized doctor bills, hospital bills, rehabilitation in some cases, physical therapy, prescriptions, and necessary travel expenses will be paid if injury was caused by an accident on the job.
4. You are entitled to weekly income benefits if you have more than seven days of lost time due to an injury. Your first check should be mailed to you within 21 days after the first day you missed work. If you are out more than 21 consecutive days due to your injury, you will be paid for the first week.
5. Accidents are classified as being either catastrophic or non-catastrophic. Catastrophic injuries are those involving amputations, severe paralysis, severe head injuries, severe burns, blindness, or of a nature and severity that prevents the employee from being able to perform his or her prior work and any work available in substantial numbers within the national economy. In catastrophic cases, you are entitled to receive two-thirds of your average weekly wage but not more than $500 per week for a job-related injury for as long as you are unable to return to work. You also are entitled to receive medical and vocational rehabilitation benefits to help in recovering from your injury. If you need help in this area call the State Board of Workers' Compensation at (404) 656-3818.
6. In all other cases (non-catastrophic), you are entitled to receive two-thirds of your average weekly wage but not more than $500 per week for a job related injury. You will receive these weekly benefits as long as you are totally disabled, but no longer than 400 weeks. If you are not working and it is determined that you have been capable of performing work with restrictions for 52 consecutive weeks or 78 aggregate weeks, your weekly income benefits will be reduced to two-thirds of your average weekly wage but no more the $334 per week, not to exceed 350 weeks.
7. When you are able to return to work, but can only get a lower paying job as a result of your injury, you are entitled to a weekly benefit of not more than $334 per week for no longer than 350 weeks.
8. Your dependent(s), in the event you die as a result of an on-the-job accident, will receive burial expenses up to $7,500 and two-thirds of your average weekly wage, but not more than $500 per week. A widowed spouse with no children will be paid a maximum of $150,000. Benefits continue until he/she remarries or openly cohabits with a person of the opposite sex.
9. If you do not receive benefits when due, the insurance carrier/employer must pay a penalty, which will be added to your payments.

Employee's Responsibilities

1. You should follow written rules of safety and other reasonable policies and procedures of the employer.
2. You must report any accident immediately, but not later than 30 days after the accident, to your employer, your employer's representative, your foreman or immediate supervisor. Failure to do so may result in the loss of your benefits.
3. An employee has a continuing obligation to cooperate with medical providers in the course of their treatment for work related injuries. You must accept reasonable medical treatment and rehabilitation services when ordered by the State Board of Workers' Compensation or the Board may suspend your benefits.
4. No compensation shall be allowed for an injury or death due to the employee's willful misconduct.
5. You must notify the insurance carrier/employer of your address when you move to a new location. You should notify the insurance carrier/employer when you are able to return to full-time or part-time work and report the amount of your weekly earnings because you may be entitled to some income benefits even though you have returned to work.
6. A dependent spouse of a deceased employee shall notify the insurance carrier/employer upon change of address or remarriage.
7. You must attempt a job approved by the authorized treating physician even if the pay is lower than the job you had when your were injured. If you do not attempt the job, your benefits may be suspended.
8. If you believe you are due benefits and your insurance carrier/employer denies these benefits, you must file a claim within one year after the date of last authorized medical treatment or within two years of your last payment of weekly benefits or you will lose your right to these benefits.
9. If your dependent(s) do not receive allowable benefit payments, the dependent(s) must file a claim with the State Board of Workers' Compensation within one year after your death or lose the right to these benefits.
10. Any request for reimbursement to you for mileage or other expenses related to medical care must be submitted to the insurance carrier/employer within one year of the date the expense was incurred.
11. If an employee unjustifiably refuses to submit to a drug test following an on-the-job injury, there shall be a presumption that the accident and injury were caused by alcohol or drugs. If the presumption is not overcome by other evidence, any claim for workers' compensation benefits would be denied.
12. You shall be guilty of a misdemeanor and upon conviction shall be punished by a fine of not more than $10,000.00 or imprisonment, up to 12 months, or both, for making false or misleading statements when claiming benefits. Also, any false statements or false evidence given under oath during the course of any administrative or appellate division hearing is perjury.

The State Board of Workers' Compensation will provide you with information regarding how to file a claim and will answer any other questions regarding your rights under the law. If you are calling in the Atlanta area the telephone number is (404) 656-3818, outside the metro Atlanta area call 1-800-533-0682, or write the State Board of Workers' Compensation at: 270 Peachtree Street, N.W., Atlanta, Georgia 30303-1299 or visit our website: http://www.sbwc.georgia.gov. A lawyer is not needed to file a claim with the Board; however, if you think you need a lawyer and do not have your own personal lawyer, you may contact the Lawyer Referral Service at (404) 521-0777- or 1-800 237-2629.

IF YOU HAVE QUESTIONS PLEASE CONTACT THE STATE BOARD OF WORKERS' COMPENSATION AT 404-656-3818 OR 1-800-533-0682 OR VISIT http://www.sbwc.georgia.gov

Willfully making a false statement for the purpose of obtaining or denying benefits is a crime subject to penalties of up to $10,000.00 per violation (O.C.G.A. §34-9-18 and §34-9-19).

WORKER'S COMPENSATION MEMORANDUM

This is to certify that I have reviewed the official notice of the panel of physicians certified to treat worker's comp claims (see next page).

I understand that when I am involved in an on-the-job injury and emergency treatment is not necessary, I must accept the services of a physician from the panel. (If I desire to obtain medical services from a physician not listed on the panel, I may do so; however, I will be liable for those medical expenses.) The physician selected from the panel may arrange for appropriate consultation, referral, and other specialized medical services, as the nature of the injury requires. If I am dissatisfied with the physician selected, I may request a change in physicians by contacting the Business Office.

In the case of an emergency, I should be taken to the nearest emergency room. However, all follow-up care must, thereafter, be rendered by a physician from the panel, or a panel physician's referral.

I further understand that I must notify my supervisor and the Business Office as soon as the injury occurs, regardless of the extent of the injury. Delay in notification may result in denial of payment for medical services rendered.

Please sign below and return to Human Resources.

_____ _____

Signature of Employee Date

THE LOVETT SCHOOL
EMERGENCY CONTACT FORM

To have contact information available in case of an Emergency, please fill out the following form. This information will be kept confidentially in the Infirmary.

Employee Legal First Name (PLEASE PRINT) _____

Employee Legal Last Name (PLEASE PRINT) _____

List 2 people who could be contacted in the event of an emergency

1. Name_____ Relationship_____

Home Phone _____ Cell Phone_____

2. Name _____ Relationship_____

Home Phone_____ Cell Phone_____

NOTE: If you have medical information the Infirmary needs to know about that would be important to your treatment in case of an emergency, please visit the Infirmary and fill out an emergency card.

ACKNOWLEDGMENT OF EMPLOYEE HANDBOOK
2013-2014

By signing below, I acknowledge that I have received a copy of The Lovett School Employee Handbook and/or have located the electronic version of the handbook under the Human Resources section of the Lovett website. I am aware of the policies contained in this Employee Handbook, including the Equal Employment Opportunity and Harassment policies. I recognize that all members of the school's administration are dedicated to ensuring the school's policies and that the procedures and benefits are administered fairly and uniformly. I am aware that I have the opportunity to ask any questions about matters contained in the handbook.

The policies and procedures contained in this employee handbook are guidelines only. Lovett reserves absolute discretion to deviate from these policies and procedures as it deems appropriate and in the interest of Lovett.

Unless you have previously executed an employment contract, your employment with Lovett is an at-will employment under the laws of the State of Georgia. This means that your employment may be terminated at any time with or without notice from Lovett, and you may quit your employment with Lovett, at any time. Nothing in this handbook should be considered to alter the at-will nature of your employment with Lovett. No one except the headmaster is authorized to alter the at-will nature of the employment of any employee. Such alteration must be in writing and be signed by the headmaster.

***This page will be maintained in your personnel file and should be returned to Human Resources.**

_____
Print Name

_____
Signature of Employee

_____
Date Received