



# MILITARY AFFILIATE INFORMATION FORM

(Please print legibly and provide all information requested)

Name: _____		
Last	First	MI
SSN: _____ - _____ - _____      Date of Birth ____/____/____ <input type="checkbox"/> Male <input type="checkbox"/> Female		
<small>(SSN and Date of Birth are required for access to university services and will not be used for any other purpose)</small>		
Permanent Street Address _____ _____ City _____ State _____ Zip Code _____ Home phone: ( ____ ) _____		Person to notify in emergency: Name _____ Phone _____ Address _____
Have you ever worked in a paid position for SSU? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If yes, what Department(s): _____      Dates: _____		
Will your duties as a military affiliate include unsupervised access to minors? <input type="checkbox"/> Yes <input type="checkbox"/> No		
<p>I attest that I am working as an affiliate to Savannah State University in my capacity as an active duty member or a contract employee of the United States Armed Forces.</p> <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 SSU employees performing similar duties.</p> <p>I understand that the State of Georgia provides general liability coverage to military affiliates, but no other university or state-sponsored employee medical, retirement, workers compensation, or other insurance plans apply to this association. I understand that SSU and I both have the right to end the affiliate relationship at any time, for any reason, without advance notice.</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>		
Signature: _____		Date: ____/____/____
Assignment Begin Date: _____      Assignment End Date: _____		
<small>(Note: All affiliate assignments are effective for the current fiscal year only, and may be terminated at any time.)</small>		
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 #: _____		