NEW MEXICO TECH
SCIENCE • ENGINEERING • RESEARCH UNIVERSITY

PERSONAL INFORMATION

Name _____ Social Security Number_____

Mailing Address _____

Phone Number (____) _____ Birth Date_____

Marital Status_____ Spouse Name _____

Ethnicity: Non Minority (1)☐ Black (2)☐ Hispanic (3)☐ American Indian (4)☐ Asian (5) ☐

Are you a Citizen? Yes ☐ No ☐ If No, Visa Type _____

Education	Date Completed	Major	School
High School Diploma Yes ☐ No ☐	_____	_____	_____
College 1 2 3 4 5 6	_____	_____	_____
Bachelor's Degree	_____	_____	_____
Master's Degree	_____	_____	_____
Doctorate Degree	_____	_____	_____
Vocational School	_____	_____	_____
State of Training School	_____		

Are you currently a student? Yes ☐ No ☐ Name of School _____
How many hours are you enrolled for? _____
Will you be a student next semester? Yes ☐ No ☐ Name of School _____

Are you currently employed with another NM school system? Yes ☐ No ☐
Name of School _____

Emergency Notification
Name_____ Phone Number_____ Relationship_____

Are/or have you been a Vendor with NM Tech? Yes ☐ No ☐
If yes, provide Vendor Name _____

The Following Information Is Voluntary:
Are you a Veteran? Yes ☐ No ☐ If yes, give dates of services _____
Are you a Disabled Veteran? Yes ☐ No ☐ If yes, give details _____

Do you have a physical or mental impairment which substantially limits one or more major life activities or do you have a record of such impairment or are you regarded as having such impairment?
Yes ☐ No ☐ please give details _____

EMPLOYEE SIGNATURE _____ DATE _____

NEW MEXICO TECH
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E-VERIFY PARTICIPATION BY NEW MEXICO TECH

Federal law requires all employers to verify the identity and employment eligibility of all persons, newly hired and presently employed under a Federal Contract and subcontract, using the E-Verify Internet Based System.

E-Verify is an Internet-based system operated by the Department of Homeland Security (DHS) in partnership with the Social Security Administration (SSA) that allows participating employers, of which New Mexico Institute of Mining and Technology has chosen to participate, to electronically verify the employment eligibility of their newly hired employees. U.S. Citizenship and Immigration Services (USCIS administers the program.

The program provides participating employers an automated Internet-based resource to verify the employment eligibility of newly hired employees. Participating employers run authorization checks on all newly hired employees, including U.S. citizens and non-U.S citizens, against SSA and DHS databases (about 449 million, and 60 million records respectively). Through this process, E-Verify assists employers in maintaining a legal workforce and protects jobs for authorized U.S. workers.

New Mexico Tech will provide the Social Security Administration (SSA) and the Department of Homeland Security (DHS), with information from each new employee's Form I-9 to confirm work authorization.

IMPORTANT: If the Government cannot confirm that you are authorized to work, this employer is required to provide you written instructions and an opportunity to contact SSA and/or DHS before taking adverse action against you, including terminating your employment.

Employers may not use E-Verify to pre-screen job applicants, and may not limit or influence the choice of documents presented for use on the Form I-9.

If you believe that your employer has violated its responsibilities under this program or has discriminated against you during the verification process based upon your national origin or citizenship status, please call the Office of Special Counsel for Immigration Related Unfair Employment Practices at 1-800-255-7688 (TDD: 1-800-237-2515).

I have read the above policy and have been given the opportunity to ask questions concerning this policy.

EMPLOYEE SIGNATURE_____ DATE_____

NEW MEXICO TECH
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HARASSMENT

It is the policy of New Mexico Tech that all employees be able to enjoy a work environment that is free of discrimination and harassment. Harassment of any kind creates an intimidating, hostile and offensive work environment that destroys working relationships and productivity. Harassment refers to behavior that is personally offensive, impairs morale, or interferes with the ability of employees to perform well. Any harassment of an employee or employees by any other employee or employees cannot be tolerated. This policy refers to but is not limited to harassment due to age, race, color, national origin, ancestry, religion, sex, physical or mental disability, medical condition, or veteran status. Harassment includes unsolicited or pictures degrading either to gender or to racial, religious, or ethnic groups. Sexual Harassment includes sexual advances, request for sexual favors, and other conduct that is sexual and offensive. Employees who engage in any of these activities are subject to a disciplinary action that could result in the termination of employment.

Individuals who believe that they have been subjected to harassment should make it clear that such behavior is offensive to them and should not continue. If the offensive behavior does continue, it should be brought to the attention of the employee's supervisor, Director of Affirmative Action and Compliance, the Director of Human Resources or another appropriate manager. Any manager or supervisor made aware of such a harassment incident must promptly inform the Affirmative Action and Compliance Office and the Human Resources Office of such incidents. The Affirmative Action Office will investigate all harassment complaints.

Managers and supervisors are expected to halt any harassment of which they become aware by restating the policy and, when necessary, by more direct disciplinary action.

The above policy has been explained to me, and I have had the opportunity to ask questions about the policy.

EMPLOYEE SIGNATURE _____ DATE _____

Employment Eligibility Verification

Department of Homeland Security

U.S. Citizenship and Immigration Services

USCIS Form I-9

OMB No.1615-0047

Expires 07/31/2026

START HERE: Employers must ensure the form instructions are available to employees when completing this form. Employers are liable for failing to comply with the requirements for completing this form. See below and the Instructions.

ANTI-DISCRIMINATION NOTICE: All employees can choose which acceptable documentation to present for Form I-9. Employers cannot ask employees for documentation to verify information in **Section 1**, or specify which acceptable documentation employees must present for **Section 2** or Supplement B, Reverification and Rehire. Treating employees differently based on their citizenship, immigration status, or national origin may be illegal.

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 (if any)	Other Last Names Used (if any)

Address (Street Number and Name)	Apt. Number (if any)	City or Town	State	ZIP Code

Date of Birth (mm/dd/yyyy)	U.S. Social Security Number	Employee's Email Address	Employee's Telephone Number

I am aware that federal law provides for imprisonment and/or fines for false statements, or the use of false documents, in connection with the completion of this form. I attest, under penalty of perjury, that this information, including my selection of the box attesting to my citizenship or immigration status, is true and correct.

Check one of the following boxes to attest to your citizenship or immigration status (See page 2 and 3 of the instructions.):

- ☐ 1. A citizen of the United States
- ☐ 2. A noncitizen national of the United States (See Instructions.)
- ☐ 3. A lawful permanent resident (Enter USCIS or A-Number.)
- ☐ 4. A noncitizen (other than **Item Numbers 2.** and **3.** above) authorized to work until (exp. date, if any)

If you check **Item Number 4.**, enter one of these:

USCIS A-Number	OR	Form I-94 Admission Number	OR	Foreign Passport Number and Country of Issuance

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

If a preparer and/or translator assisted you in completing Section 1, that person MUST complete the Preparer and/or Translator Certification on Page 3.

Section 2. Employer Review and Verification: Employers or their authorized representative must complete and sign Section 2 within three business days after the employee's first day of employment, and must physically examine, or examine consistent with an alternative procedure authorized by the Secretary of DHS, documentation from List A OR a combination of documentation from List B and List C. Enter any additional documentation in the Additional Information box; see Instructions.

	List A	OR	List B	AND	List C
Document Title 1					
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					
Document Title 2 (if any)					
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					
Document Title 3 (if any)					
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					

Additional Information

☐ Check here if you used an alternative procedure authorized by DHS to examine documents.

Certification: I attest, under penalty of perjury, that (1) I have examined the documentation presented by the above-named employee, (2) the above-listed documentation appears 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.

First Day of Employment (mm/dd/yyyy):

Last Name, First Name and Title of Employer or Authorized Representative	Signature of Employer or Authorized Representative	Today's Date (mm/dd/yyyy)

Employer's Business or Organization Name	Employer's Business or Organization Address, City or Town, State, ZIP Code

For reverification or rehire, complete Supplement B, Reverification and Rehire on Page 4.

LISTS OF ACCEPTABLE DOCUMENTS

All documents containing an expiration date must be unexpired.
* Documents extended by the issuing authority are considered unexpired.
Employees may present one selection from List A or a
combination of one selection from List B and one selection from List C.
Examples of many of these documents appear in the Handbook for Employers (M-274).

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 an individual temporarily authorized to work for a specific employer because of his or her status or parole: **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 individual's status or parole 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 For examples, see **Section 7** and **Section 13** of the M-274 on **uscis.gov/i-9-central**. The Form I-766, Employment Authorization Document, is a List A, **Item Number 4.** document, not a List C document.
		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:		
		10. School record or report card		
		11. Clinic, doctor, or hospital record		
		12. Day-care or nursery school record		
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				

Acceptable Receipts

May be presented in lieu of a document listed above for a temporary period.
For receipt validity dates, see the M-274.

• Receipt for a replacement of a lost, stolen, or damaged List A document. • Form I-94 issued to a lawful permanent resident that contains an I-551 stamp and a photograph of the individual. • Form I-94 with "RE" notation or refugee stamp issued to a refugee.	**OR**	Receipt for a replacement of a lost, stolen, or damaged List B document.	Receipt for a replacement of a lost, stolen, or damaged List C document.

*Refer to the Employment Authorization Extensions page on **I-9 Central** for more information.

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INTERNET, E-MAIL AND OTHER ON-LINE SERVICES

Electronic mail (e-mail) is an office communications tool for preparing, sending, and retrieving electronic messages on personal computers. On-line services such as the internet are communications tools for sending and retrieving information and messages on personal computers. These systems are provided for business purposes; use for personal purposes is a privilege and is permissible only within reasonable limits. Use of these systems for conducting a business, exchange of or viewing pornographic materials, or for activities contrary to law or New Mexico Tech policies is prohibited.

All e-mail and internet records are considered to be Institute records and should be transmitted only to individuals who have a business need to receive them. Additionally, as Institute records, e-mail and internet records are subject to disclosure to law enforcement or government officials or to other third parties through subpoena or other process. Employees should always ensure that Institute information contained in e-mail and internet messages by employees may not necessarily reflect the views of New Mexico Tech's officers or directors. Abuse of the e-mail or internet systems, through excessive personal use, or use in violation of Law or New Mexico Tech policies will result in disciplinary action and/or loss of access to New Mexico Tech's computer systems.

While New Mexico Tech does not intend to regularly review employees' e-mail and internet records, employees have no right or exception of privacy in e-mail or internet. New Mexico Tech owns the computer and software making up the e-mail and internet systems and permits employees to use them in the performance of their duties for the Institute. E-mail messages and internet records are to be treated like shared paper files, with the expectation that anything in them is available for review by authorized representatives of the Institute. Employee e-mail messages and internet records may be disclosed to law enforcement or government officials or to other third parties, without notification to or permission from the employee sending or receiving the messages and records.

Employees should also be aware that log-on and other passwords may not be shared with any third party, nor may they be shared with another employee, unless such password(s) is requested by an authorized officer of the Institute.

The Above policy has been explained to me and I have had the opportunity to ask questions about the policy.

EMPLOYEE SIGNATURE_____ DATE_____

NEW MEXICO NEW HIRE REPORTING FORM
Federal Employer Identification Number: 85-6000411

EMPLOYEE INFORMATION

Name: _____

SSN: _____

Date of Birth_____

Address: _____

City/State/Zip Code_____

Date of Hire_____

IMPORTANT HEALTH, DENTAL AND VISION INSURANCE INFORMATION

Regular, regular limited term, and full time temporary employees are eligible to participate in the New Mexico Tech health, dental, and vision plans. New Mexico Tech pays the larger portion of the premiums and the employee pays a portion – those amounts are explained in the NMPSIA information packet. In order to obtain coverage, the employee must select the plan(s) most beneficial for him/her and must complete the enrollment form in the packet as soon as possible but not later than 31 days after starting work.

Deductions for premiums will be made as soon after the employee enrolls as possible. NMPSIA health insurance requires that premiums be paid in advance of the start of coverage. In some cases, depending on the employee start date, double deductions must be made for one pay period in order to have health coverage at the start of the following month.

Example #1: A new employee begins working on March 15th and completes the NMPSIA enrollment that week. A double deduction will be made for health insurance at the next pay period in order to begin coverage on April 1st.

Example #2: A new employee begins working on March 15th and completes the NMPSIA enrollment towards the end of the month. Deductions for health insurance will be made in April at both pay periods but coverage will not begin until May 1st.

Please keep these examples in mind when deciding when to enroll in the health, dental and vision plans. Likewise, if you terminate employment at New Mexico Tech, your health, dental, and vision insurance will terminate at the end of the month in which you terminate regardless of the effective date.

EMPLOYEE SIGNATURE_____ DATE_____

For Employer Use: PAYROLL DEDUCTIONS	MEDICAL	DENTAL	VISION	DISABILITY	ADDITIONAL LIFE	Former Employer (if covered under NMPSIA)	Basic Life Eff. Date (mm/dd/yyyy)	Other Cvg Eff. Date (mm/dd/yyyy)
	$	$	$	$	$			

New Mexico Public Schools Insurance Authority

EMPLOYEE ENROLLMENT / CHANGE FORM

This form is Effective 1/1/2025.

Eligibility Administrative Office (505) 988-4974 (800) 233-3164 FAX (505) 988-8943

District/Entity Name	District/Entity #
New Mexico Tech	108

RESET FORM

1

Social Security Number	Name (Last, First, Middle)	Date of Birth

Mailing Address	City	State	Zip Code	Home Phone Number

Marital Status	Gender	E-Mail Address Mandatory (Do not block emails from **no-reply@easipta.com**)	Work Phone Number	Cell Phone Number
☐ S ☐ M	☐ F ☐ M			

REASON FOR CHANGE (Answer questions below):

What event took place?

What date did event take place?

☐ New Hire (enrolling within 31 days of hire) ☐ Evidence of Insurability

☐ Qualifying Event (enrolling within 31 days of event)

2 ENROLLMENT

What is your current enrollment status? ☐ Employee Only ☐ 2-Party (Employee + Spouse or Child) ☐ Family (Employee + 2 or more)

What enrollment status are you requesting? ☐ Employee Only ☐ 2-Party (Employee + Spouse or Child) ☐ Family (Employee + 2 or more)

Check One : ☐ **ADD COVERAGE / DEPENDENTS** ☐ **CANCEL COVERAGE / DEPENDENTS**

BASIC LIFE: The Standard **$50,000** ☐ **Decline Free Basic Life**

MEDICAL:

☐ **Blue Cross Blue Shield of NM**
- ☐ High Option (*Default*)
- ☐ Low Option
- ☐ EPO Option

☐ **Presbyterian (*Default*)**
- ☐ High Option (*Default*)
- ☐ Low Option

☐ Decline Medical

Reason: _____

Eligible for Medicaid? ☐ Yes ☐ No

DENTAL: ☐ **Blue Cross Blue Shield of NM Dental (Default)** ☐ High Option ☐ Low Option ☐ **United Concordia** ☐ High Option ☐ Low Option ☐ **Delta Dental** ☐ High Option ☐ Low Option ☐ Decline Dental

☐ **VISION**: **Davis Vision** (2 year enrollment required) ☐ Decline Vision

☐ **LONG TERM DISABILITY**: **The Standard 90 Day BWP** (New Hire, Qualifying Event, or Evidence of Insurability) ☐ Decline Long Term Disability

☐ **ADDITIONAL LIFE**: **The Standard** (New Hire, Qualifying Event, or Evidence of Insurability) **Select:** ☐ 1X Employee Base Annual Salary ☐ Spouse Life ☐ Child Life ☐ Decline Employee Additional Life ☐ Decline Dependent Life ☐ Decline Child Life

3 DEPENDENT INFORMATION

List all dependents you wish to enroll. Provide requested information for additional dependents on separate form.
Indicate an A (add), D (drop), C (continue coverage), or N/A (not applicable) for all names listed below.

Med	Dntl	Visn	Add'l Life	Dependent's Name (Last, First, Middle)	Social Security Number **(REQUIRED)**	Date of Birth (mm/dd/yyyy) **(REQUIRED)**	Gender **(REQUIRED)**	Dependent's Relationship to You **(REQUIRED)**	Proof of Marriage, Birth, Loss of Coverage, or Court Order Attached **(REQUIRED)**
							☐ F ☐ M		☐ Yes ☐ No
							☐ F ☐ M		☐ Yes ☐ No
							☐ F ☐ M		☐ Yes ☐ No
							☐ F ☐ M		☐ Yes ☐ No

4 EMPLOYEE AUTHORIZATION STATEMENT

I hereby authorize my school district/employer to deduct from my earnings until further written notice, amounts equal to the contribution required of me toward the plan(s) herein enrolled. I hereby apply to the Authority for the coverage offered to myself and dependents shown above. I understand that services will be available subject to the exclusions, limitations and the conditions described in the Master Group Insurance Policies. I authorize any hospital, physician, or other health care provider to furnish (when applicable) to the Insurance Carrier such medical information as it may require for myself and my dependents. I authorize the Insurance Carrier to coordinate benefits and/or reimbursements with other health plans or insurance companies. Under penalties of perjury and insurance fraud, I declare that I have examined this application and supporting documentation, and to the best of my knowledge and belief, they are true, correct, and complete. **Read reverse side before signing.**

RETURN THIS FORM TO YOUR EMPLOYER BENEFITS OFFICE NO LATER THAN 31 DAYS FROM YOUR EVENT

EMPLOYEE SIGNATURE _____ DATE _____

5 EMPLOYER CERTIFICATION

ALL INFORMATION IN THIS SECTION IS REQUIRED TO DETERMINE ELIGIBILITY. PLEASE COMPLETE THIS SECTION THOROUGHLY. FORM MUST BE SIGNED BY EMPLOYER.

I attest that to the best of my knowledge that this applicant is an employee of my district/entity (or meets the one-bus owner definition) and works the minimum number of hours per week required for NMPSIA benefits.

Date of Hire	Base Annual Salary	# of hours worked weekly	Job Title	☐ Check ***only*** if Variable Hour Employee	Date Variable Hour Employee became eligible for **medical only** coverage	Date Received in Your Office
	$					

EMPLOYER BENEFITS SPECIALIST SIGNATURE: **DATE:**

New Mexico Public Schools Insurance Authority

Eligibility Administrative Office: Erisa Administrative Services, Inc. • Phone: (800) 233-3164 or (505) 988-4974 • Fax: (505) 988-8943

SCHEDULE A – BENEFICIARY ASSIGNMENT NM TECH

Employee Social Security Number	Employee Name	School District/Employer New Mexico Tech - 108
Mailing Address:		Date of Birth (in mm/dd/yyyy format)

Primary Beneficiary:

(For multiple beneficiaries, distribution must equal 100% for each life benefit)

Beneficiary Name	Date of Birth (in mm/dd/yyyy format)	Relationship to the Employee	Address	Basic Life Percent	Additional Life Percent

(For multiple beneficiaries, distribution must equal 100% for each life benefit)

Secondary Beneficiary (in the event the primary beneficiary is not living at the time of the insured's death):

Beneficiary Name	Date of Birth (in mm/dd/yyyy format)	Relationship to the Employee	Address	Basic Life Percent	Additional Life Percent

STATEMENT OF MARITAL STATUS (check one)

☐ I AM NOT MARRIED. I understand that if I marry, it will affect my right to dispose of community property, and that I should then review my beneficiary designation.

☐ I AM MARRIED. My spouse is the Primary Beneficiary and/or is designated to receive 50% or more of my benefit.

☐ I AM MARRIED. My spouse is not the Primary Beneficiary and/or is designated to receive less than 50% of my benefit.

EMPLOYEE SIGNATURE _____ **DATE:** _____

Witnessed by Employer: _____ **DATE:** _____

IMPORTANT NOTE: Community Property Laws are applicable to employees living in New Mexico, Arizona, Texas, California, Idaho, Nevada, Washington, or Wisconsin; therefore, a spouse has property interest in insurance provided to the employee through his/her employment.

RETURN TO YOUR EMPLOYER'S BENEFIT OFFICE

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OFFICIAL TRANSCRIPTS

Faculty and professional staff are required to request official transcripts to be sent to the Human Resources Department for the employee's personnel file. Transcripts of all post secondary, graduate and post graduate coursework may be requested for the file. Highest degree earned transcripts are mandatory as well as transcripts used to qualify for employment positions, if different than highest degree earned transcripts. Transcripts should be requested by the employee during the first month of employment and should be sent directly to the Human Resources Department. If the official transcripts were sent to the Human Resources Department as part of the application process, these will suffice. Signature below acknowledges compliance with this policy

EMPLOYEE SIGNATURE _____ DATE _____

Employee Data Form

Must be completed by the
Employee and Certified by the Employer

Employer must provide a copy to NMERB
Fax to (855)214-0835 or (505)827-8010

Name:		SSN:	☐ M ☐ F
DOB:	Phone:	Email:	

By supplying NMERB with your Email you are agreeing to receive emails from NMERB. Your Email will not be shared or sold.

Mailing address:

City:	State:	Zip:

Active Member:

☐ **New Hire:** I have never been employed by a public school, charter school, university, or college, or other NMERB affiliated employer in New Mexico.

☐ **Re-Hire:** I am not currently employed by a public school, charter school, university, or college, or other NMERB affiliated employer in New Mexico, however I have contributed to NMERB in the past.

☐ **Multiple NMERB Employers:** I am currently employed by another NMERB Employer.

Check one only for other NMERB Employer:

☐ Part Time
☐ Full Time
☐ ARP (College or University)

Name of other NMERB Employer:

NMERB Retiree:

☐ I am retired through the New Mexico Educational Retirement Board.

***Check one*:**

☐ I am approved under the RTW Program 36 Months with a 90-day layout. Effective 05/18/2022.

☐ I am approved under the RTW Program 12-month layout.

☐ I am approved RTW Program Less Than $15,000 with a 90-day layout.

☐ I am approved RTW Program .25FTE or less (FTE is combined with multiple employers)

All NMERB Retirees

☐ I have provided a copy of my approved Return-to-Work documentation to my employer.

NMPERA Retiree:

☐ I am retired from the New Mexico Public Employees Retirement Association. I will provide documentation of this to the employer.

(If you are retired from a PERA system from a state other than New Mexico, you are identified as an Active Member in the NMERB system)

Name Change: Previous Name:_____
Last First Initial

*Upon receipt of your first paystub from your employer, verify that your SSN is correct on the paystub and that the NMERB contributions were deducted by your employer.

Employee Signature:_____ **Date:**_____

EMPLOYER CERTIFICATION

This is to certify that the above person is employed in the Position of: _____

Start Date:_____ District/University: New Mexico Tech

Obtained Proof from the NMERB Retiree of their Approved RTW status: ☐

Revised 08/2023 **Authorized Signature:**_____ **Date:**_____

Pre-Retirement Beneficiary Designation Form

Member to mail completed form to address below

MEMBER INFORMATION

☐ New designation ☐ Change designation

Name (First, Middle, Last) | Last 4 digits of SSN XXX–XX– | Gender ☐ M ☐ F

Mailing address

City | State | Zip

Date of birth (mm/dd/yyyy) | Phone | Employer

Marital status (Required – check ☒ one)

☐ Never married ☐ Married _____ (mm/dd/yyyy) ☐ Married, previously divorced ☐ Divorced ☐ Widowed

I am approved for NMERB disability retirement: ☐ No ☐ Yes

BENEFICIARY DESIGNATION

1. I am married and designating someone other than my spouse as a Beneficiary ☐ No ☐ Yes, see **Spousal Consent**
2. I elect to provide my designated beneficiary(ies) listed below (check ☒ only one coverage option):

☐ **Option B Coverage**: My beneficiary will have the option to select a lifetime benefit or a one-time lump sum payment upon my death. *You can only name one beneficiary (a living person or Special Needs Trust), not an organization.*

Name (First, Middle, Last) | SSN/EIN/TIN | Gender ☐ M ☐ F

Mailing address | City | State | Zip

Date of birth (mm/dd/yyyy) | Phone | Relationship to you: Choose One

☐ **No Option B Coverage**: My beneficiary(ies) will receive a one-time lump sum payment upon my death. I reject Option B coverage, as described in 22-11-29(J).

Name (First, Middle, Last) | SSN/EIN/TIN | Gender ☐ M ☐ F

Mailing address | City | State | Zip

Date of birth (mm/dd/yyyy) | Phone | Relationship to you: Choose One | % allocation

List additional beneficiaries on page 2.

MEMBER AUTHORIZATION

I hereby authorize the NMERB to change my address as indicated above and hereby declare that all of the information provided on this page is true and complete to the best of my knowledge.

X _____ _____

Member's signature | Date (mm/dd/yyyy)

New Mexico Educational Retirement Board (NMERB)
P.O. Box 26129, Santa Fe, New Mexico 87502-0129
Phone: (505) 585-3510 or toll-free 1 (800) 663-1919

Rev 06/23

Pre-Retirement Beneficiary Designation Form

Member to mail completed form to address below

☐ **No Option B Coverage** (continued from page 1)

Name (First, Middle, Last) | SSN/EIN/TIN | Gender ☐ M ☐ F

Mailing address | City | State | Zip

Date of birth (mm/dd/yyyy) | Phone | Relationship to you: Choose One | % allocation

Name (First, Middle, Last) | SSN/EIN/TIN | Gender ☐ M ☐ F

Mailing address | City | State | Zip

Date of birth (mm/dd/yyyy) | Phone | Relationship to you: Choose One | % allocation

Name (First, Middle, Last) | SSN/EIN/TIN | Gender ☐ M ☐ F

Mailing address | City | State | Zip

Date of birth (mm/dd/yyyy) | Phone | Relationship to you: Choose One | % allocation

SPOUSAL CONSENT TO WAIVE ENTITLEMENT

I hereby certify that I am the spouse of the above-named Member and have read this Beneficiary Designation form as completed and signed by my spouse. I hereby freely consent to the beneficiary designation made herein. I understand beneficiary payment, if any, will be made to such beneficiary or beneficiaries named on this form.

X _____ _____

Spouse's signature | Date (mm/dd/yyyy)

Witnessed in the presence of a Notary Public

State of _____ County of _____

Notary Stamp

Subscribed and sworn to before me by _____ on the ___ day of _____, 20___.

X _____ _____

Notary public signature | My commission expires (mm/dd/yyyy)

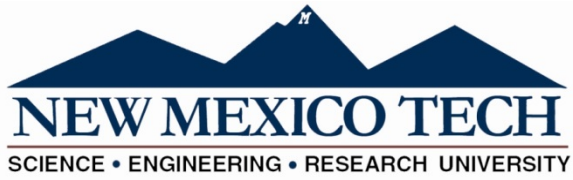
MEMBER AUTHORIZATION

I hereby declare that all of the information provided on this page is true and complete to the best of my knowledge.

X _____ _____

Member's signature | Date (mm/dd/yyyy)

New Mexico Educational Retirement Board (NMERB)
P.O. Box 26129, Santa Fe, New Mexico 87502-0129
Phone: (505) 585-3510 or toll-free 1 (800) 663-1919



PROPERTY CLEARANCE AGREEMENT

I, _____, understand and agree that in the event I resign my position, or my employment at New Mexico Tech is terminated, that my final pay check will be released to me only upon completion of the property clearance form.

EMPLOYEE SIGNATURE _____ DATE _____

NEW MEXICO TECH
SCIENCE • ENGINEERING • RESEARCH UNIVERSITY

ACKNOWLEDGEMENT

With my signature below, I acknowledge that I received a copy of the New Health Insurance Marketplace Coverage Options and your Health Coverage Options.

I understand it is my responsibility to read this information. If I do not understand this information, it is my responsibility to contact the Human Resources Office at 575-835-5206 to obtain assistance.

EMPLOYEE SIGNATURE_____ DATE_____

NEW MEXICO TECH
SCIENCE • ENGINEERING • RESEARCH UNIVERSITY

ACKNOWLEDGEMENT

With my signature below, I acknowledge that I received a copy of the New Mexico Tech's Drug Policy. I also received a list of controlled substances, including how these substances are administered and the effects of these substances. In addition, I received a description of the Federal penalties and sanctions for illegal possession of controlled substance and a list of Federal penalties for trafficking of controlled substances.

I understand it is my responsibility to read this information. If I do not understand this information, it is my responsibility to contact the Human Resources Office at 575-835-5206 to obtain assistance.

EMPLOYEE SIGNATURE_____ DATE_____

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)

Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 12-31-2026)

PART A: General Information

Even if you are offered health coverage through your employment, you may have other coverage options through the Health Insurance Marketplace ("Marketplace"). To assist you as you evaluate options for you and your family, this notice provides some basic information about the Health Insurance Marketplace and health coverage offered through your employment.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options in your geographic area.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium and other out-of-pocket costs, but only if your employer does not offer coverage, or offers coverage that is not considered affordable for you and doesn't meet certain minimum value standards (discussed below). The savings that you're eligible for depends on your household income. You may also be eligible for a tax credit that lowers your costs.

Does Employment-Based Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that is considered affordable for you and meets certain minimum value standards, you will not be eligible for a tax credit, or advance payment of the tax credit, for your Marketplace coverage and may wish to enroll in your employment-based health plan. However, you may be eligible for a tax credit, and advance payments of the credit that lowers your monthly premium, or a reduction in certain cost-sharing, if your employer does not offer coverage to you at all or does not offer coverage that is considered affordable for you or meet minimum value standards. If your share of the premium cost of all plans offered to you through your employment is more than 9.12%[1] of your annual household income, or if the coverage through your employment does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit, and advance payment of the credit, if you do not enroll in the employment-based health coverage. For family members of the employee, coverage is considered affordable if the employee's cost of premiums for the lowest-cost plan that would cover all family members does not exceed 9.12% of the employee's household income.[1,2]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered through your employment, then you may lose access to whatever the employer contributes to the employment-based coverage. Also, this employer contribution -as well as your employee contribution to employment-based coverage- is generally excluded from income for federal and state income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis. In addition, note that if the health coverage offered through your employment does not meet the affordability or minimum value standards, but you accept that coverage anyway, you will not be eligible for a tax credit. You should consider all of these factors in determining whether to purchase a health plan through the Marketplace.

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[1] Indexed annually; see https://www.irs.gov/pub/irs-drop/rp-22-34.pdf for 2023.

[2] An employer-sponsored or other employment-based health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs. For purposes of eligibility for the premium tax credit, to meet the "minimum value standard," the health plan must also provide substantial coverage of both inpatient hospital services and physician services.

When Can I Enroll in Health Insurance Coverage through the Marketplace?

You can enroll in a Marketplace health insurance plan during the annual Marketplace Open Enrollment Period. Open Enrollment varies by state but generally starts November 1 and continues through at least December 15.

Outside the annual Open Enrollment Period, you can sign up for health insurance if you qualify for a Special Enrollment Period. In general, you qualify for a Special Enrollment Period if you've had certain qualifying life events, such as getting married, having a baby, adopting a child, or losing eligibility for other health coverage. Depending on your Special Enrollment Period type, you may have 60 days before or 60 days following the qualifying life event to enroll in a Marketplace plan.

There is also a Marketplace Special Enrollment Period for individuals and their families who lose eligibility for Medicaid or Children's Health Insurance Program (CHIP) coverage on or after March 31, 2023, through July 31, 2024. Since the onset of the nationwide COVID-19 public health emergency, state Medicaid and CHIP agencies generally have not terminated the enrollment of any Medicaid or CHIP beneficiary who was enrolled on or after March 18, 2020, through March 31, 2023. As state Medicaid and CHIP agencies resume regular eligibility and enrollment practices, many individuals may no longer be eligible for Medicaid or CHIP coverage starting as early as March 31, 2023. The U.S. Department of Health and Human Services **is offering a temporary Marketplace Special Enrollment period to allow these individuals to enroll in Marketplace coverage.**

Marketplace-eligible individuals who live in states served by HealthCare.gov and either- submit a new application or update an existing application on HealthCare.gov between March 31, 2023 and July 31, 2024, and attest to a termination date of Medicaid or CHIP coverage within the same time period, are eligible for a 60-day Special Enrollment Period. **That means that if you lose Medicaid or CHIP coverage between March 31, 2023, and July 31, 2024, you may be able to enroll in Marketplace coverage within 60 days of when you lost Medicaid or CHIP coverage.** In addition, if you or your family members are enrolled in Medicaid or CHIP coverage, it is important to make sure that your contact information is up to date to make sure you get any information about changes to your eligibility. To learn more, visit HealthCare.gov or call the Marketplace Call Center at 1-800-318-2596. TTY users can call 1-855-889-4325.

What about Alternatives to Marketplace Health Insurance Coverage?

If you or your family are eligible for coverage in an employment-based health plan (such as an employer-sponsored health plan), you or your family may also be eligible for a Special Enrollment Period to enroll in that health plan in certain circumstances, including if you or your dependents were enrolled in Medicaid or CHIP coverage and lost that coverage. Generally, you have 60 days after the loss of Medicaid or CHIP coverage to enroll in an employment-based health plan, but if you and your family lost eligibility for Medicaid or CHIP coverage between March 31, 2023 and July 10, 2023, you can request this special enrollment in the employment-based health plan through September 8, 2023. Confirm the deadline with your employer or your employment-based health plan.

Alternatively, you can enroll in Medicaid or CHIP coverage at any time by filling out an application through the Marketplace or applying directly through your state Medicaid agency. Visit https://www.healthcare.gov/medicaid-chip/getting-medicaid-chip/ for more details.

How Can I Get More Information?

For more information about your coverage offered through your employment, please check your health plan's summary plan description or contact

_____

_____.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit **HealthCare.gov** for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer name	4. Employer Identification Number (EIN)
New Mexico Institute of Mining & Technology	85-6000-411
5. Employer address	6. Employer phone number
801 Leroy Place-HR	(575)835-5643

7. City	8. State	9. ZIP code
Socorro	NM	87801

10. Who can we contact about employee health coverage at this job?	
Angie Gonzales	
11. Phone number (if different from above)	12. Email address angie.gonzales@nmt.edu

Here is some basic information about health coverage offered by this employer:

- As your employer, we offer a health plan to:
  - ☐ All employees. Eligible employees are:
  - ☒ Some employees. Eligible employees are:

    Full-Time Employees who regularly work 20 or more hours per week; or
    Temporary Employees who regularly work 40 or more hour per week.

- With respect to dependents:
  - ☐ We do offer coverage. Eligible dependents are:
  - ☐ We do not offer coverage.

☒ If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, **HealthCare.gov** will guide you through the process. Here's the employer information you'll enter when you visit **HealthCare.gov** to find out if you can get a tax credit to lower your monthly premiums.

The information below corresponds to the Marketplace Employer Coverage Tool. Completing this section is optional for employers, but will help ensure employees understand their coverage choices.

13. **Is the employee currently eligible for coverage offered by this employer, or will the employee be eligible in the next 3 months?**

☐ **Yes** (Continue)
13a. If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage? _____ (mm/dd/yyyy) (Continue)
☐ **No** (STOP and return this form to employee)

14. Does the employer offer a health plan that meets the minimum value standard*?
☐ Yes (Go to question 15) ☐ No (STOP and return form to employee)

15. For the lowest-cost plan that meets the minimum value standard* **offered only to the employee** (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/ she received the maximum discount for any tobacco cessation programs, and didn't receive any other discounts based on wellness programs.
a. How much would the employee have to pay in premiums for this plan? $_____
b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

If the plan year will end soon and you know that the health plans offered will change, go to question 16. If you don't know, STOP and return form to employee.

16. What change will the employer make for the new plan year?_____
☐ Employer won't offer health coverage
☐ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)
a. How much would the employee have to pay in premiums for this plan? $_____
b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

• An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)

5/1/2025

New Employee Required Sexual Misconduct & Awareness Training

New Tech Employee,

Federal law requires all new employees working at institutions of higher education to receive Title IX awareness training, as well as information about resources and individuals' rights. Training also covers how to report violations of New Mexico Tech's Sexual Misconduct Policy, Title IX sexual discrimination and sex-based harassment (e.g. sexual assault, relationship violence and stalking) offenses. New employees should receive this training within the first 30 days of their hire date.

This Online Sexual Misconduct & Title IX Training Module includes a video of approximately 45-minute and a brief quiz. Please work with your supervisor to find a convenient time during your workday complete the online training module option. Supervisors and unit Vice Presidents will be informed and asked to take action for non-compliance.

This training can be obtained by clicking on this Online Sexual Misconduct & Title IX Training Module hypertext link, snap a shot of the QR Code to the right or typing https://www.brainshark.com/trainedsolutions/nmtemployeev2tix into a Web browser.

In order to help make your experience simpler:

- We recommend completing this online training on a school computer or personal computer with a **strong internet connection**. We do not recommend viewing the training on a mobile device or using a cellular data plan to view the training. Because the video and audio are quite large, a strong internet connection is crucial to viewing and hearing the entire training.
- To view the training, please ensure that your browser has the **latest Flash enabled**, the pop-up blocker is turned off, and that cookies are enabled.
- Please be aware that there is a **video requirements in addition to the final quiz** in order to receive your Certificate of Completion. **You must review at least 80% of the video and receive a 70% or greater on the quiz to successfully complete the training.** To check your progress on the video, you can view the Completion Indicator on the left sidebar next to the Chapter Indicator. at the top of your training view page. The red eye dot will turn green when the minimum criteria is satisfied. You can go back into the video and retake the quiz as often as needed so you can meet the training requirements. Please contact the Title IX Coordinator (see contact information below if you need assistance or any accommodations.

Approximately 10-20 minutes after completing this online module a Certificate of Completion will be sent to your email within, **but be aware it may be caught in Spam**.

Here is a link access to a Spanish version (https://www.brainshark.com/trainedsolutions/nmtemployeesspanish) of the online training that has Spanish notes.

Please show your supervisor the Certificate of Completion (e.g. photo, hard copy) for confirmation. You should also maintain a copy of the certificate for your record.

Tech's Title IX Office will receive reports each week regarding the online module activity and completion. Records will be maintained in the Title IX office. Please email or call my office if you have any difficulties or questions:

Peter Phaiah, Ph.D.
Title IX Coordinator
Fidel Student Center, Rm. 288
575-835-5953 (Off.) 575-322-0001 (Cell.)
titleixcoordator@nmt.edu

All of these instructions and other resources are also contained within the module for our employees' convenience. Additional information and related resources can be found on the NMT Title IX Office Website.

It's on all of us to prevent sexual misconduct and sex discrimination (i.e., prohibited conduct) and eliminate any hostile environments!

Thank you,

Peter

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Drug Abuse Policy

The Drug Free Workplace Act of 1988 requires that all institutions receiving federal contracts of $ 25,000 or more, and all institutions receiving federal grants, provide their employees with a drug free workplace. Department of Defense regulations require that contractors establish procedures to ensure a drug free work force. The regents and the administration of New Mexico Tech support these requirements. They accept the challenge to maintain for all students and employees a safe and healthy environment. They intend to adhere to both the spirit and letter of the regulations by implementing and enforcing this drug policy. The regents and administration of New Mexico Tech are committed to protecting the rights of all students and employees. In keeping with the mission of New Mexico Tech, emphasis is given to education as a primary vehicle for reducing to zero the use of illegal drugs and the abuse of other drugs. Further, the regents and administration support and encourage research aimed at understanding drug effects and drug abuse and at developing effective treatment methods. All employees must comply with this drug policy and respects the rights of their fellow employees.

Rules Regarding Drugs

The New Mexico Tech Drug Policy prohibits the following:

1. Manufacture, distribution, dispensation, possessions, sale, purchase, or use of illegal drugs on Tech premises or business, or in Tech vehicles, or during work hours.
2. Storing and illegal drug in locker, desk, vehicle, or other repository on Tech premises.
3. Being under the influence of an illegal drug on Tech premises or business, or in Tech vehicles, or during work hours. Being "under the influence" of an illegal drug is defined as testing positive at a specific mg/kg level.
4. Switching or adulterating and urine or blood sample submitted for testing.
5. Refusal to consent to testing when required by this policy.
6. Failure on the part of an employee to report to the employee's supervisor warnings by a physician that certain job should not be attempted while taking a prescribed drug.
7. failure on the part of an employee to notify the Human Resources Office within 5 days of a conviction under and criminal drug for a violation occurring on Tech premises.

Compliance

All employees must comply with this drug policy.

Employee Drug Abuse Awareness Program

An educational program is being developed. This program will make I possible to inform students, employees, and their families about 1) the effects of illegal drug abuse, 2) the provisions of this drug policy, 3) signs and symptoms of drug abuse, and 4) the availability of treatment for those who seek it. Materials concerning drug abuse and drug effects will be available to all employees and their

families. Education about the effects of drugs and drug abuse will be accomplished in many ways. Among these are:

1. Materials on drug abuse will be included in academic coerces where appropriate.
2. Specials courses and seminars will be given and employees will be allowed time off to attend these offerings.
3. An employee assistance program (EAP) (see "Employee Assistance" on following page) will be able to answer questions about drug abuse and about this policy. The EAP will also be able to refer employees and students to other resources for assistance.
4. The library will make available books, journals, magazines, and cassettes, videotapes, and special publications giving information on drug abuse, treatment and rehabilitation programs, employees' right to a drug free workplace, and laws regarding drug use and abuse. The library will also make this policy available.
5. The Human Resources Office will distribute widely and make available, at several locations, lists of all illegal drugs.
6. Supervisory instruction will be provided on how to recognize when drugs may be contributing to a decline in performance or erratic employee behavior on the job.

Employee Assistance

The New Mexico Tech Employee Assistance Program's aim is to help employees who seeking help with drug related problems or have been referred by their supervisors because of declining performance or erratic on-the-job behavior. This program will help employees and students find treatment or counseling whenever it is feasible to do so. Referral to or consultation with the employee Assistance Program is never mandatory nor a continued employment. The employee has primary responsibility for voluntary seeking assistance when it is needed.

The Employee Benefit Plan provides some coverage for treatment or drug problems. Also, a variety of leave forms, paid and unpaid, may be available for employees receiving treatment for drug problems.

Employees who have drug problems are urged to seek help. They can contact the Employee Assistance Program without the permission or he knowledge of their supervisors. Assistance will be provided on a confidential basis. The continued to work at Tech of employees who seek such assistance will NOT be jeopardized because they seek help.

Employees who pursue treatment voluntarily or as a result for referral by the Employee Assistance Program and who continue to work at Tech must meet all established standards of conduct and job performance and comply with this drug policy.

Drug Testing

The Department of Defense requires contractors to perform unannounced random drug test for employees in sensitive positions on DOD contacts. This will be carried out in the following way. At least once a year, a day will be selected at random by the president of New Mexico Tech. Confidential Arrangements will be made with them firm carrying out the testing. On that day, all employees in sensitive positions will be considered eligible for testing. A random sample consisting of 10 to 50 percent of those eligible will be tested. The actual sample percent size and the method of random selection will be determined each year by the president of New Mexico Tech. Offers of employment and promotions and transfers to sensitive positions are conditional on testing drug free.

Employees must sign a consent form provided by the Human Resources Officer prior to the administration of any drug test authorizing the testing. Refusal to sign this consent for could result in disciplinary action, including termination of employment.

Testing will be conducted in strict accordance with the Mandatory Guidelines for Federal Drug Testing Programs issued by the Department of Health and Human Services. Sample collection will be conducted at a designated facility selected by Human Resources. Employees who are tested will be given the opportunity to submit any information that may have an effect, such as a false positive, on their teat results. Competent medical personal will evaluate this information. If it is determined that the employee's justification for a positive test result is sufficient that test will be declared void. Employees who test positive for illegal drugs may request a second test to be made of that specimen, and will be given the opportunity to explain the test results. A positive test is defined as a specimen that tests positive on the initial immunoassay and is confirmed positive by using gas chromatography/mass spectrometry techniques.

In addition to performing the random drug testing described above, all New Mexico Tech Hoist Operators will receive a mandatory unannounced annual drug test. This test will be administered under the same standards described above.

Sanctions for Violating the Drug Policy

Any employee working in a sensitive position who is found in violation of the policy will not be permitted to remain working in a sensitive position. The EMRTC Security Officer will notify the Department of Defense of violations by the employees working in sensitive positions.

Any employee who knowingly violates or refuses to comply with the policy may be subject t immediate and serve disciplinary action that may include, but is not limited, termination. This determination is made solely by the president of New Mexico Tech or his designated officer. All of the protection accorded by New Mexico Tech's grievance policies and other human resources policies are available to persons so disciplined.

Acknowledgement of Receipt of Policy

All employees of New Mexico Tech will sign a statement acknowledging that they have received a copy of the Policy and have read and understood the policy. Employees are expected to comply with the provisions of this policy.

Definitions

Definition of an **Employee**:

An employee is defined as any person on the payroll of New Mexico Tech.

Definition of **Illegal Drugs**:

As used in this policy, "Illegal drug" means any controlled substance included in Schedules I through V of Section 202 of the Controlled Substance Act, 21 U.S.C. Section 812, as amended, updated or republished, heretofore or hereafter, and further defined in 21 C.F.R. Section 1308 (1987), as amended, update or republished, heretofore or hereafter, except a controlled substance included in Schedules II through V and used by the employee whose conduct is in a question pursuant to a valid prescription for medical purposes filled in the United States.

Employees in Sensitive Positions:

"Employee in a Sensitive Position" means employee who has been granted security clearance for Department of Defense contract work and whose work currently allows or requires access to classified information, an employee who is certified to operate dump, stake and tractor trucks, backhoes, fork lifts, and front loaders, bulldozers, scrapers, graders and cranes, an employee who has responsibility for or access to Institute funds or an employee who works as a campus police officer or security officer.

Controlled Substances—Uses and Effects

U.S. Department of Justice,
Drug Enforcement Administration

	Class*	Trade or Other Names	Medical Uses	Dependence (Physical/Psycho.)	
NARCOTICS					
Opium	II III V	Dovers powder, Paregoric,	Analgesic, antidiarrheal	High	High
Morphine	II III	Morphine, MS-Contin, Roxanol, Roxanol-SR	Analgesic, antitussive	High	High
Codeine	II III V	Tylenol w/Codeine, Empirin w/Codeine, Robitussan A-C, Fiorinal w/Codeine	Analgesic, antitussive	Mod.	Mod.
Heroin	I	Diacetylmorphine, Horse, Smack	None	High	High
Hydro-morphone	II	Dilaudid	Analgesic	High	High
Meperidine (Pethidine)	II	Demerol, Mepergan	Analgesic	High	High
Methadone	II	Dolophine, Methadone, Methadose	Analgesic	High	High-low
Other narcotics	I II III IV V	Numorphan, Percodan, Percocet, Tylox, Tussionex, Fentanyl, Darvon, Lomotil, Talwin	Analgesic, antidiarrheal, antitussive	High-low	High-low
DEPRESSANTS					
Chloral Hydrate	IV	Noctec	Hypnotic	Mod.	Mod.
Barbiturates	II III IV	Amytal, Butisol, Fiorinal, Lotusate, Nembutal, Seconal, Tuinal, Phenobarbital	Anasthetic, anticonvulsant, sedative, hypnotic, veterinary euthanasia agent	High-mod.	High-mod.
Benzodiazepines	IV	Ativan, Dalmane, Diazepam, Librium, Xanax, Serax, Valium, Tranxexe, Verstran, Versed, Halcion, Paxipam, Restoril	Antianxiety, anticonvulsant, sedative, hypnotic	Low	Low
Methaqualone	I	Quaalude	Sedative, hypnotic	High	High
Glutethimide	III	Doriden	Sedative, hypnotic	High	Mod.
Other depressants	III IV	Equanil, Miltown, Noludar, Placidyl, Valmid	Antianxiety, sedative, hypnotic	Mod.	Mod.
STIMULANTS					
Cocaine	II	Coke, Flake, Snow, Crack	Local anesthetic	Possible	High
Amphetamines	II	Biphetamine, Delcobese, Desoxyn, Dexedrine, Obetrol	Attention deficit disorders, narcolepsy, weight control	Possible	High
Phenmetrazine	II	Preludin	Weight control	Possible	High
Methylphenidate	II	Ritalin	Attention deficit disorders, narcolepsy	Possible	Mod.
Other stimulants	III IV	Adipex, Cylert, Didrex, Ionamin, Melfiat, Plegine, Sanorex, Tenuate, Tepanil, Prelu-2	Weight control	Possible	High
HALLUCINOGENS					
LSD	I	Acid, Microdot	None	None	Unknown
Mescaline, Peyote	I	Mexc, Buttons, Cactus	None	None	Unknown
Amphetamine variants	I	2.5-DMA, PMA, STP, MDA, MDMA, TMA, DOM, DOB	None	Unknown	Unknown
Phencyclidine	II	PCP, Angel Dust, Hog	None	Unknown	High
Phencyclidine analogues	I	PCE, PCPy, TCP	None	Unknown	High
Other hallucinogens	I	Bufotenine, Iogaine, DMT, DET, Psilocybin, Psitocyn	None	None	Unknown
CANNABIS					
Marijuana	I	Pot, Acapulco Gold, Grass, Reefer, Sinsemilla, Thai Sticks	None	Unknown	Mod.
Tetrahydro-cannabinol	I II	THC, Marinol	Cancer chemotherapy, antinauseant	Unknown	Mod.
Hashish	I	Hash	None	Unknown	Mod.
Hashish oil	I	Hash Oil	None	Unknown	Mod.

Tolerance	Duration Hours	Usual Method of Administration	Possible Effects	Effects of Overdose	Withdrawal Syndrome
NARCOTICS					
Yes	3–6	Oral, smoked	Euphoria, drowsiness, respiratory depression, constricted pupils, nausea	Slow and shallow breathing, clammy skin, convulsions, coma, possible death	Watery eyes, runny nose, yawning, loss of appetite, irritability tremors, panic, cramps, nausea chills, sweating
Yes	3–6	Oral, smoked, injected			
Yes	3–6	Oral, injected			
Yes	3–6	Injected, sniffed, smoked			
Yes	3–6	Oral, injected			
Yes	3–6	Oral, injected			
Yes	12–24	Oral, injected			
Yes	Varies	Oral, injected			
DEPRESSANTS					
Yes	5–8	Oral	Slurred speech, disorientation, drunken behavior without odor of alcohol	Shallow respiration, clammy skin, dilated pupils, weak and rapid pulse, coma, possible death	Anxiety, insomnia, tremors, delirium, convulsions, possible death
Yes	1–16	Oral			
Yes	4–8	Oral			
Yes	4–8	Oral			
Yes	4–8	Oral			
Yes	4–8	Oral			
STIMULANTS					
Yes	1–2	Sniffed, smoked, injected	Increased alertness, excitation, euphoria, increased pulse rate & blood pressure, insomnia, loss of appetite	Agitation, increase in body temp., hallucinations, convulsions, possible death	Apathy, long periods of sleep, irritability, depression, disorientation
Yes	2–4	Oral, injected			
Yes	2–4	Oral, injected			
Yes	2–4	Oral, injected			
Yes	2–4	Oral, injected			
HALLUCINOGENS					
Yes	8–12	Oral	Illusions and hallucinations, poor perception of time and distance	Longer and intense "trip" episodes, psychosis, possible death	Withdrawal syndrome not reported
Yes	8–12	Oral			
Yes	Varies	Oral, injected			
Yes	Days	Smoked, oral, injected			
Yes	Days	Smoked, oral, injected			
Possible	Varies	Smoked, oral, injected			
CANNABIS					
Yes	2–4	Smoked, oral	Euphoria, relaxed inhibitions, increased appetite, disorientated behavior	Fatigue, paranoia, possible psychosis	Insomnia, hyperactivity and decreased appetite
Yes	2–4	Smoked, oral			
Yes	2–4	Smoked, oral			
Yes	2–4	Smoked, oral			