

**MEDICAL COLLEGE OF GEORGIA**  
 EMPLOYEE/INDEPENDENT CONTRACTOR CLASSIFICATION CHECKLIST FOR  
 PROFESSIONAL SERVICE CONTRACT PAYMENTS  
 (ATTACHMENT A)



The information provided below will assist the Medical College of Georgia in determining whether the Provider performing the services will be classified, for federal, state and FICA tax purposes as an employee of the Medical College of Georgia or as an independent contractor. Complete Section I, Section II, Section II and Section IV (if necessary) as part of the attached Service Contract.

**Provider Information**

I. \_\_\_\_\_  
 Provider's Name Federal ID # or Social Security #  
 \_\_\_\_\_  
 Provider's Address City, State & Zip Phone Number  
 Is the Provider a USA citizen?  Yes  No  
 If No:  Resident Alien  Nonresident Alien  
 If Nonresident Alien: Country of Residence \_\_\_\_\_  
 Form 8233 Attached?  Yes  No

**Multiple Relationships with the University System of Georgia**

		YES	NO
II. A.	Is the Provider currently employed by the University System of Georgia?	<input type="checkbox"/>	<input type="checkbox"/>
B.	During the past 12 months prior to this contract, did the provider have a University System of Georgia position (including temporary) that performed the same or similar services?	<input type="checkbox"/>	<input type="checkbox"/>
C.	Is the Provider receiving Retirement Benefits from past employment with the University System of Georgia?	<input type="checkbox"/>	<input type="checkbox"/>
D.	Is it currently expected that the University System of Georgia will hire the Provider as an employee immediately following the termination of the Service Contract?	<input type="checkbox"/>	<input type="checkbox"/>
E.	Is any member of the Provider's immediate family (i.e. spouse, child or dependent) employed by the University System of Georgia?	<input type="checkbox"/>	<input type="checkbox"/>

If the answer is "No" to all questions, proceed to the questions in Section III.  
 If the answer is "Yes" to any of the 5 questions, the Provider should be classified as an employee and processed through Human Resources.

**Classification Guidelines**

		YES	NO
III. A.	Does the Provider provide the same or similar services to other entities or to the general public as part of a trade or business?	<input type="checkbox"/>	<input type="checkbox"/>
	If the answer is "Yes", continue answering the questions below. If the answer is "No", the Provider should be classified as an employee and processed through Human Resources.		
B.	Will the department provide the Provider with specific instructions regarding performance of the required work rather than rely on the Provider's expertise?	<input type="checkbox"/>	<input type="checkbox"/>
C.	Will the department set the number of hours and/or days of the week that the Provider is required to work, as opposed to allowing the Provider to set their own work schedule?	<input type="checkbox"/>	<input type="checkbox"/>
D.	Will the Medical College of Georgia conduct any training for the Provider in order for the Provider to perform the contracted task?	<input type="checkbox"/>	<input type="checkbox"/>
E.	Will the Provider be performing more than one task or project than what is outlined in the attached contract?	<input type="checkbox"/>	<input type="checkbox"/>
F.	Will the Provider be working on Medical College of Georgia premises and will the Medical College of Georgia provide use of equipment, supplies, utilities or space to perform the contracted task?	<input type="checkbox"/>	<input type="checkbox"/>

If the answer is "Yes" to any of questions B-F, the Provider must provide detailed clarification and attach to this form. Depending on the requested service, a determination will be made by Purchasing as to whether the Provider will be classified as an independent contractor or an employee.

**Provider's Signature**

IV. By signing below, I certify that the information and answers, to the best of my knowledge, are accurate and complete. I understand that the information will be used to determine whether the services requested will be processed under a contractual agreement or will be processed through Human Resources as an employee/employer agreement.

\_\_\_\_\_  
 Provider's Name (please print) Provider's Signature Date

\_\_\_\_\_  
 Taxpayer Identification Number (Federal Employer or Social Security #)