



**UNIVERSITY OF WISCONSIN-MILWAUKEE
EMPLOYEE SELF-IDENTIFICATION FORM**

TO BE COMPLETED BY ALL NEW EMPLOYEES AND RETURNED TO YOUR PERSONNEL REPRESENTATIVE OR
TO HUMAN RESOURCES, ENGELMANN HALL, ROOM 125

Name: _____ SSN or EmplID: _____

Department: _____ Date: _____

The University of Wisconsin–Milwaukee (UWM) is an equal opportunity employer committed to the policies and principles of affirmative action. Although the completion of this form is voluntary, and refusal to complete it will not subject you to any adverse treatment, in order to respond to federal and state reporting requirements, it is important that the following information be gathered from all employees. The information provided will remain confidential and will not be used for any purpose inconsistent with the law.

Ethnicity, Race, and Gender

Are you Hispanic or Latino? (A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race.)

Yes No

What is your race? Please select all that apply.

American Indian or Alaska Native: A person having origins in any of the original peoples of North & South America, including Central America, who maintain tribal affiliation or community attachment.

Asian: A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, & Vietnam.

Black or African American: A person having origins in any of the black racial groups of Africa.

Native Hawaiian or other Pacific Islander: A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.

White: A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.

What is your gender?

Female Male



Veteran Status

UWM is a government contractor subject to the Vietnam Era Veterans' Readjustment Assistance Act of 1974, as amended, which requires government contractors to submit a report to the United States Department of Labor each year identifying the number of employees belonging to each specified "protected veteran" category. If you believe you belong to any of the categories of protected veterans as defined on the following page, please indicate by checking the appropriate box(es). I belong to the following classifications of protected veterans (Choose all that apply):

(1) **Disabled Veteran (Federal)**

Any person who was discharged or released from active duty because of a service-connected disability;
or

A veteran of the U.S. military, ground, naval, or air service who is entitled to compensation (or who but for the receipt of military retired pay would be entitled to compensation) under laws administered by the Secretary of Veterans Affairs.

(2) **Recently Separated Veteran (Federal)**

Any veteran during the three-year period beginning on the date of such veteran's discharge or release from active duty in the U.S. military, ground, naval, or air service.

(3) **Active Duty Wartime or Campaign Badge Veteran (Federal)**

A veteran who served on active duty in the U.S. military, ground, naval, or air service during a war, or in a campaign or expedition for which a campaign badge has been authorized under laws administered by the Department of Defense. For a complete list of campaigns, see <http://www.opm.gov/veterans/html/vgmedal2.asp>

(4) **Armed Forces Service Medal Veteran (Federal)**

A veteran who, while serving on active duty in the U.S. military, ground, naval, or air service, participated in a United States military operation for which an Armed Forces Service Medal was awarded pursuant to [Executive Order 12985](#).

(5) **Wartime Veteran (State)**

I had active service for **at least one day** during one of the wartime periods.

<http://dva.state.wi.us/Ben-wartimes.asp>

Percent disabled (if applicable): _____

(6) **Non-Wartime Veteran (State)**

A veteran who served on active duty for the full period of service obligation

Percent disabled (if applicable): _____

(7) **I am a protected veteran but choose not to self-identify the classifications to which I belong.**

(8) **I am NOT a protected Veteran**



Voluntary Self-Identification of Disability

From Form CC-305
OMB Control Number 1250-0005
Expires 01/31/2020

Why are you being asked to complete this form?

Because we do business with the government, we must reach out to, hire, and provide equal opportunity to qualified people with disabilities. To help us measure how well we are doing, we are asking you to tell us if you have a disability or if you ever had a disability. Completing this form is voluntary, but we hope that you will choose to fill it out. If you are applying for a job, any answer you give will be kept private and will not be used against you in any way.

If you already work for us, your answer will not be used against you in any way. Because a person may become disabled at any time, we are required to ask all of our employees to update their information every five years. You may voluntarily self-identify as having a disability on this form without fear of any punishment because you did not identify as having a disability earlier.

How do I know if I have a disability?

You are considered to have a disability if you have a physical or mental impairment or medical condition that substantially limits a major life activity, or if you have a history or record of such an impairment or medical condition.

Disabilities include, but are not limited to:

- Blindness
- Deafness
- Cancer
- Diabetes
- Epilepsy
- Autism
- Cerebral palsy
- HIV/AIDS
- Schizophrenia
- Muscular dystrophy
- Bipolar disorder
- Major depression
- Multiple sclerosis (MS)
- Missing limbs or partially missing limbs
- Post-traumatic stress disorder (PTSD)
- Obsessive compulsive disorder
- Impairments requiring the use of a wheelchair
- Intellectual disability (previously called mental retardation)

Please check one of the boxes below:

- YES, I HAVE A DISABILITY (or previously had a disability)
- NO, I DON'T HAVE A DISABILITY
- I DON'T WISH TO ANSWER

Your Name

Today's Date

ⁱSection 503 of the Rehabilitation Act of 1973, as amended. For more information about this form or the equal employment obligations of Federal contractors, visit the U.S. Department of Labor's Office of Federal Contract Compliance Programs (OFCCP) website at www.dol.gov/ofccp.

PUBLIC BURDEN STATEMENT: According to the Paperwork Reduction Act of 1995 no persons are required to respond to a collection of information unless such collection displays a valid OMB control number. This survey should take about 5 minutes to complete.

Print Form

Clear Form

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