VISITING SCIENTISTS, ENGINEERS AND EDUCATORS (VSEE) PROGRAM
COMPENSATION CERTIFICATION FORM

Because VSEE's are not eligible for federal benefits, please provide the information requested below regarding both the employee's salary and benefits information and indicate whether the institution will continue making contributions for the employee's benefits during the proposed leave of absence.

_____
EMPLOYER LOCATION

EMPLOYEE NAME _____ TITLE _____

DEPARTMENT _____

SALARY INFORMATION

The employee's salary: $ _____

Length of employee's appointment (please circle one): 9 / 10 / 11 / 12 months

Does the employee receive additional institutional income during the summers?

Yes _____ No _____

If yes, please provide amounts received for past two summers: $_____

$_____

Approved salary increase for the ensuing academic year: $_____
Effective date: _____

RETIREMENT INFORMATION

Institution's contribution to the individual's retirement fund: _____%

Does institution count summer income toward base for retirement?

Yes _____ No _____

Type of retirement plan (e.g. TIAA, State Retirement System, Other): _____

During the employee's proposed leave of absence, will the Institution continue to make the employer's contribution and accept reimbursement from NSF?

Yes _____ No _____

If no, can the employee buy-back into the retirement system when he/she returns to pay status?

Yes _____ No _____

FRINGE BENEFIT INFORMATION (NSF will deduct Social Security, Federal, and State taxes as required by law).

Institution's contribution to all other fringe benefits.

a) Health Benefits $_____
b) Life Insurance $_____
c) Other (Specify; e.g Long term disability) $_____

During the employee's proposed leave of absence, will the Institution continue to make the employer's contribution and accept reimbursement from NSF?

Yes _____ No _____

If no, can the employee continue coverage on the institution's plan if he/she makes direct payments to the home institution and/or carrier for the full cost of coverage?

Yes _____ No _____

Name, position title, and telephone number of your benefits program officer:

_____

The statements on this form, and any attachments to it, are true, complete and correct to the best of my knowledge and belief and are made in good faith. I understand that a knowing and willful false statement on this form can be punished by fine or imprisonment or both. (See section 1001 of title 18, United States Code)

_____
(Type Name, Position Title, and Telephone Number of Certifying Official)

_____
(Signature and Date)