



### **FULL-TIME NEW HIRE PAPERWORK CHECKLIST**

- Application for Employment
- Delgado Comprehensive Safety Program Requirements
- Delgado Employee Safety Rules and Responsibilities
- Emergency Contact Information
- Federal Race/Ethnicity Disclosure Form
- Required Disclosures for Transferring/Rehired State Employees
- Self-Identification for Individuals with Disabilities
- Louisiana Workers' Compensation Second Injury Board Post-Hire/Conditional Job Offer Knowledge Questionnaire
- I-9 (with original I-9 documents)
- W-4
- L-4
- LCTCS Direct Deposit Form (voided check attached)
- LCTCS Recoupment Statement of Understanding Form
- Public Records Request Authorization Form
- Delgado Confidentiality Agreement
- Acknowledgement of Training and Policies

The above information was presented to me and I had the opportunity to ask questions. I understand that it is my responsibility to review this information and ensure that I abide by the provisions contained therein.

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Employee Signature

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Printed Name

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Date

# Delgado Application for Employment

***Online Application for Employment -  
“Careers @ Delgado”(Preferred):***

<https://www.dcc.edu/administration/offices/human-resources/careers/default.aspx>

***“Fillable” Application for Employment -  
Paper Form (Accepted Only for Adjunct Faculty):***

<http://docushare3.dcc.edu/docushare/dsweb/Get/Document-6753>



**Comprehensive Safety Program Requirements for All Employees**

Legislation establishing the Office of Risk Management (ORM) and the Loss Prevention (LP) Unit (R.S. 39:1543) calls for a comprehensive loss prevention program [“plan”] for implementation by all state agencies. These rules require Delgado Community College to implement an operational loss prevention plan to protect employees from injury. All state agencies and facilities shall be audited every 3 years by the Loss Prevention Unit concerning implementation of their loss prevention plan. During the non-audit years a compliance review shall be conducted by a Loss Prevention Officer.

Delgado is committed to providing a safe environment for students, employees, visitors, and persons using College facilities. A comprehensive safety program has been established to address the various threats to the safety of the College’s constituents. The College works in cooperation with appropriate federal, state and external agencies – in particular the State of Louisiana Office of Risk Management, which is responsible for coordination, implementation, and maintenance of safety and loss prevention programs within all State agencies. Furthermore, Delgado strives for adherence to and compliance with all safety-related laws and regulations.

As an employee of Delgado:

- You are required ***to complete several safety training modules within the first 30 days of hire and others at prescribed intervals of the first year of employment.***
- Because of the College’s current agency classification and ORM requirements, you are ***required to continue to complete monthly and annual safety training modules for the duration of your employment*** with the College.
- You will be presented with ***all training in an electronic format via email.***
- ***Failure to complete the designated training*** within the allotted timeframe ***may result in disciplinary action by the College.***

The College is committed to maintaining a safe working environment and complying with ORM standards and regulations. ***By signing below you are acknowledging that you have received and understand Delgado Community College’s Safety Program requirements.***

_____	_____	_____
Print Name	Department/Unit	Campus/Site
_____	_____	_____
Signature	Title	Date



## Employee Safety Rules and Responsibilities

All Delgado employees must take an active role to ensure their safety as well as the safety of others around them. The following is a list of key employee safety responsibilities and rules that must be used as a guide as employees move about throughout the workplace.

1. Immediately report any recognized potentially unsafe conditions, accidents/incidents, and property damages to your supervisor.
  - a. Accidents/Incidents are to be reported immediately to Campus Police as per the College's [Accident/Incident Reporting Route](#). First aid should be administered by trained professionals only.
  - b. Non-emergency unsafe conditions are to be entered into the [Delgado Maintenance Work Order System](#).
  - c. Emergency unsafe conditions and property damage must be *immediately* reported to the Delgado Safety and Risk Manager.
2. Follow all safety procedures defined by your job. Please consult your supervisor if in doubt about these safety procedures or if any impairment, permanent or temporary, that may reduce your ability to perform your duties.
3. Use personal protective equipment to protect yourself from equipment or dangerous tasks. Do not operate moving machinery with loose clothing, jewelry, or anything that can be snagged. Do not remove any safety guards from equipment without permission from manufacturer.
4. Do not operate machinery if you have not been trained and/or authorized to do so. This includes but is not limited to forklifts, golf carts, and state vehicles.
5. Maintain a neat environment. Store tools and equipment in a designated place as to not block walkways or create an unsafe condition. Place trash in its proper receptacle. Inspect tools and equipment before each use to ensure they are safe. Unsafe tools and equipment must be reported and replaced immediately.
6. Chemicals must be handled and stored as per its safety data sheet. Hazardous waste removal orders must be sent to the Delgado Safety and Risk Manager.
7. Theft or abuse of College property will not be tolerated.
8. Narcotics, illegal drugs, or unauthorized medically prescribed drugs shall not be used on campus. Employees taking medications containing narcotics must inform Human Resources before starting work so that a determination can be made if they must be allowed to work.
9. Smoking and vaping are not permitted on any Delgado property.
10. Fighting, horseplay, and practical jokes will not be tolerated in the workplace or classroom.
11. Except for police officers, weapons or firearms of any type will not be allowed on any Delgado facility.
12. Report any smoke, fire, or unusual odors to your supervisor immediately.
13. Always get a good night's rest. It is important that employees come to work rested and ready for work.
14. Maintain a good safety attitude. This is critical to the overall safety culture at Delgado Community College.
15. Be alert at all times and pay attention to what is going on at all times. Do not become complacent.
16. Do not hurry or take shortcuts. Employees are six times more likely to experience an accident or injury as a result of unsafe behaviors, such as taking shortcuts.
17. Follow all college Safety Policies and Rules. These are developed to protect the safety of each employee. Failure to follow safety rules may put an employee's safety at risk and other employees as well.

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Employee's Name (Print)

Signature

Date

Updated 1/2023



## EMERGENCY CONTACT INFORMATION (Please Print)

### EMPLOYEE INFORMATION

Employee's Name: \_\_\_\_\_

Banner I.D. Number: \_\_\_\_\_

Division: \_\_\_\_\_

Department: \_\_\_\_\_

### EMERGENCY CONTACT INFORMATION

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Relation to employee: \_\_\_\_\_

Daytime Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

Other Phone: \_\_\_\_\_

### PHYSICIAN CONTACT INFORMATION

Name: \_\_\_\_\_

Office Phone Number: \_\_\_\_\_

Emergency Phone Number: \_\_\_\_\_

### ADDITIONAL COMMENTS OR INSTRUCTIONS

(Notes on allergies, medical condition(s), additional contact information, etc.)

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Signed by: \_\_\_\_\_  
(Employee)

Date: \_\_\_\_\_

# Delgado Community College

## Federal Ethnicity & Race Reporting Form

**Employees:** All Delgado Community College employees are asked to self-identify their ethnicity and race in order for the College to comply with federal law, including Equal Employment Opportunity and Department of Education reporting requirements. No negative or otherwise adverse action will be taken whether you provide the information or not. Participation in the survey is voluntary. However, your cooperation and participation will allow the College to report the most accurate data for mandatory reporting purposes.

**This form will be kept in a confidential file separate from your application for employment.**

If you have any questions, you may contact the Human Resources Department.

**Data Collected is Confidential**

**Specific Instructions:** The two questions below are designed to identify your ethnicity and race. **Regardless of your answer to question 1, go to question 2.**

- 1. 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
- 2. Please select the racial category or categories with which you most closely identify. Check as many as apply.**
  - American Indian or Alaskan Native:** A person having origins in any of the original peoples of North and South America of North and South America (including Central America), and who maintains a tribal affiliation or community attachment.)
  - Asian:** A person having origins in any 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 and Vietnam.
  - Black or African-American:** A person with 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 people of Europe, Middle East or North Africa.

**PLEASE PRINT & SIGN YOUR NAME BELOW TO INDICATE THAT YOU HAVE READ AND REVIEWED THIS FORM.**

Print Name:

Signature:

Date:



**REQUIRED DISCLOSURES FOR TRANSFERRING OR REHIRED STATE EMPLOYEES**

**SECTION 1: EMPLOYMENT AT ANOTHER LOUISIANA STATE AGENCY**

Do you currently hold a position at any other Louisiana state agency?  YES  NO

*If Yes, please provide the names of any such agencies, the positions held, and the dates employed:*

Have you ever previously held a position at this or any other Louisiana state agency?  YES  NO

*If Yes, please provide the names of any such agencies, the positions held, and the dates employed:*

**SECTION 2: MEMBERSHIP IN A STATE RETIREMENT SYSTEM**

Have you ever paid into any Louisiana state retirement system?  YES  NO

*If Yes, please select which system:*

- Teachers Retirement System of Louisiana (TRSL)
- TRSL Optional Retirement Plan (ORP) *[please specify which one]:*
  - VALIC       VOYA (ING)       TIAA-CREF       Other: \_\_\_\_\_
- Louisiana State Employees Retirement System (LASERS)
- Other Louisiana State Retirement System: \_\_\_\_\_

**SECTION 3: RETIREMENT OR WITHDRAWAL FROM A STATE RETIREMENT SYSTEM**

Are you currently drawing a retirement from any Louisiana state retirement system?  YES  NO

*If Yes, please indicate which system: \_\_\_\_\_*

*Date of Retirement: \_\_\_\_\_*

Have you ever requested a refund from any Louisiana state retirement system?  YES  NO

*If Yes, please indicate which system: \_\_\_\_\_*

*Date of Withdrawal: \_\_\_\_\_*

**Please be advised that all employees are required to disclose their current status with any Louisiana state retirement system. Additionally, it is the employee’s responsibility to monitor his/her earnings limit as required by his/her particular retirement plan. Questions regarding any limitations to earnings should be directed to the Benefits Manager in the Office of Human Resources, and/or directly to the Retirement System.**

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date Form 2200/004 (12/14)

Office of the State Americans with Disabilities Act Coordinator (OSADAC)  
**VOLUNTARY SELF-IDENTIFICATION OF DISABILITY FORM**

Employee Name: \_\_\_\_\_ Personnel #: \_\_\_\_\_

**Why are you being asked to complete this form?**

As an executive branch state agency, the Louisiana Community and Technical College System (LCTCS) is required by La. R.S. 46:2597 to establish annual strategies and goals related to employment of individuals with disabilities. In order to effectively measure and report our progress to this end, La. R.S. 46:2597 requires us to ask employees if they have a disability or have ever had a disability. Because a person may become disabled at any time, we ask all of our employees to update their information at least every five (5) years.

Identifying yourself as an individual with a disability is **voluntary**, and we hope that you will choose to do so (if applicable). Your answer will be maintained confidentially and will not be seen by hiring officials or anyone else involved in making personnel decisions. Completing the form will not negatively impact you in any way. For more information about this form or the Americans with Disabilities Act, visit the Office of the State Americans with Disabilities Act (ADA) Coordinator's website at <https://www.doa.la.gov/office-of-state-ada-coordinator/>.

**How do you know if you have a disability?**

You are considered to have a disability if you have a physical or mental impairment that substantially limits a major life activity, or if you have a history or record of such an impairment. Disabilities include, but are not limited, to:

- Autism
- Autoimmune disorder, for example, lupus, fibromyalgia, rheumatoid arthritis, or HIV/AIDS
- Blind or low vision
- Cancer
- Cardiovascular or heart disease
- Celiac disease
- Cerebral palsy
- Deaf or hard of hearing
- Depression or anxiety
- Diabetes
- Epilepsy
- Gastrointestinal disorders, for example, Crohn's disease, or irritable bowel syndrome
- Intellectual disability
- Missing limbs or partially missing limbs
- Nervous system condition, for example, migraine headaches, Parkinson's disease or Multiple Sclerosis (MS)
- Psychiatric condition, for example, bipolar disorder, schizophrenia, Post Traumatic Stress Disorder (PTSD) or major depression

**Please check ONE of the boxes below:**

**YES**, I have a disability

**NO**, I do not have a disability

I do not wish to answer

You are encouraged to carefully review our agency's policy specific to the Americans with Disabilities Act and/or Disability Rights, and to request workplace accommodations as may be needed for your disability.

Employee Signature: \_\_\_\_\_

Date: \_\_\_\_\_



**LOUISIANA WORKERS' COMPENSATION SECOND INJURY BOARD  
POST-HIRE/CONDITIONAL JOB OFFER KNOWLEDGE QUESTIONNAIRE**

**EMPLOYEE:** The intent of this questionnaire is to provide your employer with knowledge about any pre-existing medical condition or disability which may entitle your employer to reimbursement from the Louisiana Workers' Compensation Second Injury Board in the event you suffer an on-the-job injury.<sup>1</sup> This reimbursement in no way affects the benefits owed to you by your employer or its insurance company under the Louisiana Workers' Compensation Act. La. R.S. 23:1021-1361. However, your failure to answer truthfully and/or correctly to any of the question on this questionnaire may result in a forfeiture of your workers' compensation benefits.

In order for your employer to be considered for reimbursement from the Second Injury Board, it has to show that it knowingly hired or retained you with a pre-existing medical condition or disability. To establish its knowledge, your employer is requesting that this questionnaire be completed.

**INSTRUCTIONS:** Please answer ALL questions completely. If a response requires an explanation, please provide a brief description on the Explanation Page. If you have any questions or need help in answering the questions on this form, please ask for assistance from the Employer Representative signing this form.

**NOTE:** Since this questionnaire contains medical information, you can request that the form be kept CONFIDENTIAL and not made part of your personnel file. Please let your employer know that you want the completed questionnaire placed in a sealed folder for confidentiality purposes.

**EMPLOYEE WARNING**

**FAILURE TO ANSWER TRUTHFULLY AND/OR CORRECTLY TO ANY OF THE QUESTIONS ON THIS FORM MAY RESULT IN A FORFEITURE OF YOUR WORKERS' COMPENSATION BENEFITS UNDER La. R.S. 23:1208.1.**

Employee Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Employer Representative Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Employer Name: \_\_\_\_\_

Employee Name: \_\_\_\_\_

Date of Birth (mm/dd/yyyy): \_\_\_\_\_ Male:                  Female:

Soc. Sec. # (last 4 digits only): \_\_\_\_\_

Home Address: \_\_\_\_\_

Telephone Number: ( \_\_\_\_ ) \_\_\_\_\_

<sup>1</sup> Under La. R.S. 23:1371(A), the purpose of the Second Injury Board is to encourage the employment, re-employment, or retention of employees who have a permanent partial disability.

**Disease and Other Medical Conditions you currently have or have ever had.**

For all conditions that you check yes, write a brief explanation on the Explanation Page.

[Please check the appropriate box next to each. Every illness/injury requires a Yes (Y) or No (N) answer.]

Y N	Y N	Y N	Y N
<input type="checkbox"/> <input type="checkbox"/> Diabetes	<input type="checkbox"/> <input type="checkbox"/> Cerebral Palsy	<input type="checkbox"/> <input type="checkbox"/> Arthritis	<input type="checkbox"/> <input type="checkbox"/> Heart Disease/Heart Attack
<input type="checkbox"/> <input type="checkbox"/> Silicosis	<input type="checkbox"/> <input type="checkbox"/> Tuberculosis	<input type="checkbox"/> <input type="checkbox"/> Parkinson's	<input type="checkbox"/> <input type="checkbox"/> Congestive Heart Failure
<input type="checkbox"/> <input type="checkbox"/> Varicose Veins	<input type="checkbox"/> <input type="checkbox"/> Multiple Sclerosis	<input type="checkbox"/> <input type="checkbox"/> Brain Damage	<input type="checkbox"/> <input type="checkbox"/> Vision Loss, one or both eyes
<input type="checkbox"/> <input type="checkbox"/> Asbestosis	<input type="checkbox"/> <input type="checkbox"/> Post Traumatic Stress	<input type="checkbox"/> <input type="checkbox"/> Asthma	<input type="checkbox"/> <input type="checkbox"/> Disability from Polio
<input type="checkbox"/> <input type="checkbox"/> Hyperinsulinism	<input type="checkbox"/> <input type="checkbox"/> Osteomyelitis	<input type="checkbox"/> <input type="checkbox"/> Dementia	<input type="checkbox"/> <input type="checkbox"/> Psychoneurotic Disability
<input type="checkbox"/> <input type="checkbox"/> Alzheimer's	<input type="checkbox"/> <input type="checkbox"/> Nervous Disorder	<input type="checkbox"/> <input type="checkbox"/> Thrombophlebitis	<input type="checkbox"/> <input type="checkbox"/> Ruptured or Herniated Disc
<input type="checkbox"/> <input type="checkbox"/> Emphysema	<input type="checkbox"/> <input type="checkbox"/> Muscular Dystrophy	<input type="checkbox"/> <input type="checkbox"/> Arteriosclerosis	<input type="checkbox"/> <input type="checkbox"/> Ankylosis or Joint Stiffening
<input type="checkbox"/> <input type="checkbox"/> Hearing Loss	<input type="checkbox"/> <input type="checkbox"/> Migraine Headaches	<input type="checkbox"/> <input type="checkbox"/> Hodgkin's	<input type="checkbox"/> <input type="checkbox"/> High/Low Blood Pressure
<input type="checkbox"/> <input type="checkbox"/> COPD	<input type="checkbox"/> <input type="checkbox"/> Mental Retardation	<input type="checkbox"/> <input type="checkbox"/> Cancer	<input type="checkbox"/> <input type="checkbox"/> Carpal Tunnel Syndrome
<input type="checkbox"/> <input type="checkbox"/> Hypertension	<input type="checkbox"/> <input type="checkbox"/> Kidney Disorder	<input type="checkbox"/> <input type="checkbox"/> Double Vision	<input type="checkbox"/> <input type="checkbox"/> Compressed Air Sequelae
<input type="checkbox"/> <input type="checkbox"/> Head Injury	<input type="checkbox"/> <input type="checkbox"/> Loss of Use of Limb	<input type="checkbox"/> <input type="checkbox"/> Mental Disorders	<input type="checkbox"/> <input type="checkbox"/> Disease of the Lung
<input type="checkbox"/> <input type="checkbox"/> Epilepsy	<input type="checkbox"/> <input type="checkbox"/> Seizure Disorder	<input type="checkbox"/> <input type="checkbox"/> Hemophilia	<input type="checkbox"/> <input type="checkbox"/> Coronary Artery Disease
<input type="checkbox"/> <input type="checkbox"/> Stroke	<input type="checkbox"/> <input type="checkbox"/> Sickle Cell Disease	<input type="checkbox"/> <input type="checkbox"/> Bleeding Disorder	<input type="checkbox"/> <input type="checkbox"/> Heavy Metal Poisoning

**Surgical Treatment** [Please check the appropriate box. Each illness/injury requires a Yes (Y) or No (N) answer.] For each Yes (Y) answer, please complete the information corresponding to the surgery on the right. Additional information can be provided on the Explanation Page, if necessary.

**Y N**

- Spinal Disc Surgery                      Year (approximate if unsure) \_\_\_\_\_
- Spinal Fusion Surgery                      Year (approximate if unsure) \_\_\_\_\_
- Amputated Foot                      Left      Right      Year (approx. if unsure) \_\_\_\_\_
- Amputated Leg                      Left      Right      Year (approx. if unsure) \_\_\_\_\_
- Amputated Arm                      Left      Right      Year (approx. if unsure) \_\_\_\_\_
- Amputated Hand                      Left      Right      Year (approx. if unsure) \_\_\_\_\_
- Knee Replacement                      Left      Right      Year (approx. if unsure) \_\_\_\_\_
- Hip Replacement                      Left      Right      Year (approx. if unsure) \_\_\_\_\_
- Other Joint Replacement                      Joint \_\_\_\_\_ Year \_\_\_\_\_
- Other Surgical Procedure                      Procedure \_\_\_\_\_ Year \_\_\_\_\_
- Other Surgical Procedure                      Procedure \_\_\_\_\_ Year \_\_\_\_\_
- Other Surgical Procedure                      Procedure \_\_\_\_\_ Year \_\_\_\_\_
- Other Surgical Procedure                      Procedure \_\_\_\_\_ Year \_\_\_\_\_

Employee Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Employer Representative: \_\_\_\_\_ Date: \_\_\_\_\_

**EXPLANATION PAGE**

Please use the space below to explain the illnesses and/or conditions that you checked a Yes (Y) or any other medical conditions that may not be listed on this form. Ask your employer for additional copies of this page if needed.

CONDITION: \_\_\_\_\_ Year Diagnosed (approx): \_\_\_\_\_

Are you still treating for this condition? Yes No

Are you taking medication for this condition? Yes No

Do you have any permanent restrictions for this condition? Yes No

Brief Explanation: \_\_\_\_\_

CONDITION: \_\_\_\_\_ Year Diagnosed (approx): \_\_\_\_\_

Are you still treating for this condition? Yes No

Are you taking medication for this condition? Yes No

Do you have any permanent restrictions for this condition? Yes No

Brief Explanation: \_\_\_\_\_

CONDITION: \_\_\_\_\_ Year Diagnosed (approx): \_\_\_\_\_

Are you still treating for this condition? Yes No

Are you taking medication for this condition? Yes No

Do you have any permanent restrictions for this condition? Yes No

Brief Explanation: \_\_\_\_\_

CONDITION: \_\_\_\_\_ Year Diagnosed (approx): \_\_\_\_\_

Are you still treating for this condition? Yes No

Are you taking medication for this condition? Yes No

Do you have any permanent restrictions for this condition? Yes No

Brief Explanation: \_\_\_\_\_

Employee Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Employer Representative: \_\_\_\_\_ Date: \_\_\_\_\_

Please answer the following questions.

1. Has any doctor ever restricted your activities? Yes No

If "Yes," please list the restrictions: \_\_\_\_\_

Were the restrictions: Permanent Temporary

Are your activities currently restricted? Yes No

What is the medical condition for which you have restrictions? \_\_\_\_\_

2. Are you presently treating with a doctor, chiropractor, psychiatrist, psychologist or other health-care provider? Yes No

Please list the medical condition being treated: \_\_\_\_\_

Doctor's Name: \_\_\_\_\_ Specialty: \_\_\_\_\_

Doctor's Address: \_\_\_\_\_

3. If you are currently taking prescription medication other than those listed on the Explanation Page, please complete the requested information below.

Medication: \_\_\_\_\_ Prescribing Doctor: \_\_\_\_\_

Medication: \_\_\_\_\_ Prescribing Doctor: \_\_\_\_\_

4. Have you ever had an on the job accident? Yes No

If you answered "YES," please provide the date for each injury and the nature of the injury:

\_\_\_\_\_

How long were you on compensation? \_\_\_\_\_

Name of Employer: \_\_\_\_\_

5. Has a doctor recommended a surgical procedure, which has not been completed prior to this date, including but not limited to knee, hip or shoulder replacement? Yes No

If you answered YES, please provide:

Recommended surgery: \_\_\_\_\_

Approximate date of recommendation: \_\_\_\_\_

Doctor's Name: \_\_\_\_\_ Specialty: \_\_\_\_\_

Doctor's Address: \_\_\_\_\_

Employee Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Employer Representative: \_\_\_\_\_ Date: \_\_\_\_\_

**EMPLOYEE WARNING**

**FAILURE TO ANSWER TRUTHFULLY AND/OR CORRECTLY TO ANY OF THE QUESTIONS ON THIS FORM MAY RESULT IN A FORFEITURE OF ANY AND ALL WORKERS COMPENSATION BENEFITS UNDER La. R.S. 23:1208.1.**

I have completed this form honestly and to the best of my knowledge. I understand that providing false information or omitting pertinent information could result in loss of my workers compensation benefits should I become injured on the job.

Employee Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Employee Printed Name: \_\_\_\_\_

**EMPLOYER WARNING**

**PURSUANT TO La. R.S. 23:1208 OF THE LOUISIANA WORKERS' COMPENSATION ACT, IT SHALL BE UNLAWFUL FOR A PERSON, FOR THE PURPOSE OF OBTAINING OR DEFEATING ANY BENEFIT PAYMENT UNDER THE PROVISIONS OF THIS CHAPTER, EITHER FOR HIMSELF OR FOR ANY OTHER PERSON, TO WILLFULLY MAKE A FALSE STATEMENT OR REPRESENTATION. PENALTIES FOR VIOLATIONS INCLUDE IMPRISONMENT, FINES, AND/OR THE FORFEITURE OF BENEFITS.**

You must certify the following:

1. That I am an authorized representative of the employer designated to obtain and review the information provided by the employee on this questionnaire;
2. That I have provided the employee with as many copies of the Explanation Page as needed and have confirmed the number of and labeled the pages of this questionnaire;
3. That I have provided assistance to the employee (if requested) in responding to the questions on this questionnaire;
4. That the information sought by this authorization is made on an applicant for employment only after a conditional job offer has been made and accepted, or on a current employee; and
5. That the information obtained in the authorization will **NOT** be used to discriminate in any manner against the individual who is the subject of this authorization on any basis, in violation of the Americans with Disabilities Act of 1990, 42 U.S.C. §12101, *et seq.*, or any other state or federal law;
6. That if requested, a photocopy of this fully completed and signed form will be provided to the employee.

Employer Representative Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Employer Representative Printed Name: \_\_\_\_\_

Title: \_\_\_\_\_

# **Form I-9** **Employment Eligibility Verification**

*“PAPER” I-9 FORM Version on the following pages.*

*TO DOWNLOAD “FILLABLE” I-9 FORM Version and  
Full Instructions go to:  
<https://www.uscis.gov/i-9>*



# 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
Date of Birth (mm/dd/yyyy)		U.S. Social Security Number		Employee's Email Address		Employee's Telephone Number
<p><b>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.</b></p>		Check one of the following boxes to attest to your citizenship or immigration status (See page 2 and 3 of the instructions.):				
		<input type="checkbox"/> 1. A citizen of the United States				
		<input type="checkbox"/> 2. A noncitizen national of the United States (See Instructions.)				
		<input type="checkbox"/> 3. A lawful permanent resident (Enter USCIS or A-Number.)				
<input type="checkbox"/> 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)	Additional Information			
Issuing Authority	<input type="checkbox"/> Check here if you used an alternative procedure authorized by DHS to examine documents.			
Document Number (if any)				
Expiration Date (if any)				
Document Title 3 (if any)				
Issuing Authority				
Document Number (if any)				
Expiration Date (if any)				
<b>Certification:</b> 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
<ol style="list-style-type: none"> <li>1. U.S. Passport or U.S. Passport Card</li> <li>2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551)</li> <li>3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa</li> <li>4. Employment Authorization Document that contains a photograph (Form I-766)</li> <li>5. For an individual temporarily authorized to work for a specific employer because of his or her status or parole:               <ol style="list-style-type: none"> <li>a. Foreign passport; and</li> <li>b. Form I-94 or Form I-94A that has the following:                   <ol style="list-style-type: none"> <li>(1) The same name as the passport; and</li> <li>(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.</li> </ol> </li> </ol> </li> <li>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</li> </ol>	OR	<ol style="list-style-type: none"> <li>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</li> <li>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</li> <li>3. School ID card with a photograph</li> <li>4. Voter's registration card</li> <li>5. U.S. Military card or draft record</li> <li>6. Military dependent's ID card</li> <li>7. U.S. Coast Guard Merchant Mariner Card</li> <li>8. Native American tribal document</li> <li>9. Driver's license issued by a Canadian government authority</li> <li style="text-align: center;"><b>For persons under age 18 who are unable to present a document listed above:</b></li> <li>10. School record or report card</li> <li>11. Clinic, doctor, or hospital record</li> <li>12. Day-care or nursery school record</li> </ol>	AND	<ol style="list-style-type: none"> <li>1. A Social Security Account Number card, unless the card includes one of the following restrictions:               <ol style="list-style-type: none"> <li>(1) NOT VALID FOR EMPLOYMENT</li> <li>(2) VALID FOR WORK ONLY WITH INS AUTHORIZATION</li> <li>(3) VALID FOR WORK ONLY WITH DHS AUTHORIZATION</li> </ol> </li> <li>2. Certification of report of birth issued by the Department of State (Forms DS-1350, FS-545, FS-240)</li> <li>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</li> <li>4. Native American tribal document</li> <li>5. U.S. Citizen ID Card (Form I-197)</li> <li>6. Identification Card for Use of Resident Citizen in the United States (Form I-179)</li> <li>7. Employment authorization document issued by the Department of Homeland Security               <p style="margin-left: 20px;">For examples, see <a href="#">Section 7</a> and <a href="#">Section 13</a> of the M-274 on <a href="http://uscis.gov/i-9-central">uscis.gov/i-9-central</a>.</p> <p style="margin-left: 20px;">The Form I-766, Employment Authorization Document, is a List A, <b>Item Number 4</b>, document, not a List C document.</p> </li> </ol>
<p><b>Acceptable Receipts</b></p> <p>May be presented in lieu of a document listed above for a temporary period.</p> <p>For receipt validity dates, see the M-274.</p>				
<ul style="list-style-type: none"> <li>• Receipt for a replacement of a lost, stolen, or damaged List A document.</li> <li>• Form I-94 issued to a lawful permanent resident that contains an I-551 stamp and a photograph of the individual.</li> <li>• Form I-94 with "RE" notation or refugee stamp issued to a refugee.</li> </ul>	OR	<ul style="list-style-type: none"> <li>• Receipt for a replacement of a lost, stolen, or damaged List B document.</li> </ul>	AND	<ul style="list-style-type: none"> <li>• Receipt for a replacement of a lost, stolen, or damaged List C document.</li> </ul>

\*Refer to the Employment Authorization Extensions page on [I-9 Central](#) for more information.



# Supplement A, Preparer and/or Translator Certification for Section 1

**Department of Homeland Security  
U.S. Citizenship and Immigration Services**

**USCIS  
Form I-9  
Supplement A  
OMB No. 1615-0047  
Expires 07/31/2026**

Last Name ( <i>Family Name</i> ) from Section 1.	First Name ( <i>Given Name</i> ) from Section 1.	Middle initial (if any) from Section 1.
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**Instructions:** This supplement must be completed by any preparer and/or translator who assists an employee in completing Section 1 of Form I-9. The preparer and/or translator must enter the employee's name in the spaces provided above. Each preparer or translator must complete, sign, and date a separate certification area. Employers must retain completed supplement sheets with the employee's completed Form I-9.

**I attest, under penalty of perjury, that I have assisted in the completion of Section 1 of this form and that to the best of my knowledge the information is true and correct.**

Signature of Preparer or Translator		Date ( <i>mm/dd/yyyy</i> )	
Last Name ( <i>Family Name</i> )	First Name ( <i>Given Name</i> )	Middle Initial ( <i>if any</i> )	
Address ( <i>Street Number and Name</i> )	City or Town	State	ZIP Code

**I attest, under penalty of perjury, that I have assisted in the completion of Section 1 of this form and that to the best of my knowledge the information is true and correct.**

Signature of Preparer or Translator		Date ( <i>mm/dd/yyyy</i> )	
Last Name ( <i>Family Name</i> )	First Name ( <i>Given Name</i> )	Middle Initial ( <i>if any</i> )	
Address ( <i>Street Number and Name</i> )	City or Town	State	ZIP Code

**I attest, under penalty of perjury, that I have assisted in the completion of Section 1 of this form and that to the best of my knowledge the information is true and correct.**

Signature of Preparer or Translator		Date ( <i>mm/dd/yyyy</i> )	
Last Name ( <i>Family Name</i> )	First Name ( <i>Given Name</i> )	Middle Initial ( <i>if any</i> )	
Address ( <i>Street Number and Name</i> )	City or Town	State	ZIP Code

**I attest, under penalty of perjury, that I have assisted in the completion of Section 1 of this form and that to the best of my knowledge the information is true and correct.**

Signature of Preparer or Translator		Date ( <i>mm/dd/yyyy</i> )	
Last Name ( <i>Family Name</i> )	First Name ( <i>Given Name</i> )	Middle Initial ( <i>if any</i> )	
Address ( <i>Street Number and Name</i> )	City or Town	State	ZIP Code



# Supplement B, Reverification and Rehire (formerly Section 3)

**Department of Homeland Security  
U.S. Citizenship and Immigration Services**

**USCIS  
Form I-9  
Supplement B**  
OMB No. 1615-0047  
Expires 07/31/2026

Last Name ( <i>Family Name</i> ) from Section 1.	First Name ( <i>Given Name</i> ) from Section 1.	Middle initial (if any) from Section 1.
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**Instructions:** This supplement replaces Section 3 on the previous version of Form I-9. Only use this page if your employee requires reverification, is rehired within three years of the date the original Form I-9 was completed, or provides proof of a legal name change. Enter the employee's name in the fields above. Use a new section for each reverification or rehire. Review the Form I-9 Instructions before completing this page. Keep this page as part of the employee's Form I-9 record. Additional guidance can be found in the [Handbook for Employers: Guidance for Completing Form I-9 \(M-274\)](#)

<b>Date of Rehire</b> ( <i>if applicable</i> )	<b>New Name</b> ( <i>if applicable</i> )		
Date ( <i>mm/dd/yyyy</i> )	Last Name (Family Name)	First Name (Given Name)	Middle Initial

**Reverification:** If the employee requires reverification, your employee can choose to present any acceptable List A or List C documentation to show continued employment authorization. Enter the document information in the spaces below.

Document Title	Document Number (if any)	Expiration Date (if any) ( <i>mm/dd/yyyy</i> )
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**I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented documentation, the documentation I examined appears to be genuine and to relate to the individual who presented it.**

Name of Employer or Authorized Representative	Signature of Employer or Authorized Representative	Today's Date ( <i>mm/dd/yyyy</i> )
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Additional Information (Initial and date each notation.)

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

<b>Date of Rehire</b> ( <i>if applicable</i> )	<b>New Name</b> ( <i>if applicable</i> )		
Date ( <i>mm/dd/yyyy</i> )	Last Name (Family Name)	First Name (Given Name)	Middle Initial

**Reverification:** If the employee requires reverification, your employee can choose to present any acceptable List A or List C documentation to show continued employment authorization. Enter the document information in the spaces below.

Document Title	Document Number (if any)	Expiration Date (if any) ( <i>mm/dd/yyyy</i> )
----------------	--------------------------	--

**I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented documentation, the documentation I examined appears to be genuine and to relate to the individual who presented it.**

Name of Employer or Authorized Representative	Signature of Employer or Authorized Representative	Today's Date ( <i>mm/dd/yyyy</i> )
---	--	------------------------------------

Additional Information (Initial and date each notation.)

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

<b>Date of Rehire</b> ( <i>if applicable</i> )	<b>New Name</b> ( <i>if applicable</i> )		
Date ( <i>mm/dd/yyyy</i> )	Last Name (Family Name)	First Name (Given Name)	Middle Initial

**Reverification:** If the employee requires reverification, your employee can choose to present any acceptable List A or List C documentation to show continued employment authorization. Enter the document information in the spaces below.

Document Title	Document Number (if any)	Expiration Date (if any) ( <i>mm/dd/yyyy</i> )
----------------	--------------------------	--

**I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented documentation, the documentation I examined appears to be genuine and to relate to the individual who presented it.**

Name of Employer or Authorized Representative	Signature of Employer or Authorized Representative	Today's Date ( <i>mm/dd/yyyy</i> )
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Additional Information (Initial and date each notation.)

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

# **Employee Withholding Allowance Certificate** **(W-4) Form**

*“PAPER” W-4 FORM Version on the following pages.*

*TO DOWNLOAD “FILLABLE” W-4 FORM Version go to:*

<https://www.irs.gov/pub/irs-pdf/fw4.pdf>

# 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.

**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 <a href="http://www.ssa.gov">www.ssa.gov</a> .
City or town, state, and ZIP code		
(c) <input type="checkbox"/> Single or Married filing separately		
<input type="checkbox"/> Married filing jointly or Qualifying surviving spouse		
<input type="checkbox"/> 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.)		

**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, other details, and privacy.

**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) Reserved for future use.
- (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

**TIP:** If you have self-employment income, see page 2.

**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.)

<b>Step 3:</b> <b>Claim Dependent and Other Credits</b>	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 . . . . .	<b>3</b>	\$ _____
<b>Step 4 (optional):</b> <b>Other Adjustments</b>	(a) <b>Other income (not from jobs).</b> 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 . . . . .	<b>4(a)</b>	\$ _____
	(b) <b>Deductions.</b> 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 . . . . .	<b>4(b)</b>	\$ _____
	(c) <b>Extra withholding.</b> Enter any additional tax you want withheld each <b>pay period</b> . . . . .	<b>4(c)</b>	\$ _____

<b>Step 5:</b> <b>Sign Here</b>	Under penalties of perjury, I declare that this certificate, to the best of my knowledge and belief, is true, correct, and complete.		
	_____ <b>Employee's signature</b> (This form is not valid unless you sign it.)		_____ <b>Date</b>

<b>Employers Only</b>	Employer's name and address	First date of employment	Employer identification number (EIN)

## General Instructions

Section references are to the Internal Revenue Code.

### Future Developments

For the latest information about developments related to Form W-4, such as legislation enacted after it was published, go to [www.irs.gov/FormW4](http://www.irs.gov/FormW4).

### Purpose of Form

Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay. If too little is withheld, you will generally owe tax when you file your tax return and may owe a penalty. If too much is withheld, you will generally be due a refund. Complete a new Form W-4 when changes to your personal or financial situation would change the entries on the form. For more information on withholding and when you must furnish a new Form W-4, see Pub. 505, Tax Withholding and Estimated Tax.

**Exemption from withholding.** You may claim exemption from withholding for 2023 if you meet both of the following conditions: you had no federal income tax liability in 2022 **and** you expect to have no federal income tax liability in 2023. You had no federal income tax liability in 2022 if (1) your total tax on line 24 on your 2022 Form 1040 or 1040-SR is zero (or less than the sum of lines 27, 28, and 29), or (2) you were not required to file a return because your income was below the filing threshold for your correct filing status. If you claim exemption, you will have no income tax withheld from your paycheck and may owe taxes and penalties when you file your 2023 tax return. To claim exemption from withholding, certify that you meet both of the conditions above by writing "Exempt" on Form W-4 in the space below Step 4(c). Then, complete Steps 1(a), 1(b), and 5. Do not complete any other steps. You will need to submit a new Form W-4 by February 15, 2024.

**Your privacy.** If you have concerns with Step 2(c), you may choose Step 2(b); if you have concerns with Step 4(a), you may enter an additional amount you want withheld per pay period in Step 4(c).

**Self-employment.** Generally, you will owe both income and self-employment taxes on any self-employment income you receive separate from the wages you receive as an employee. If you want to pay income and self-employment taxes through withholding from your wages, you should enter the self-employment income on Step 4(a). Then compute your self-employment tax, divide that tax by the number of pay periods remaining in the year, and include that resulting amount per pay period on Step 4(c). You can also add half of the annual amount of self-employment tax to Step 4(b) as a deduction. To calculate self-employment tax, you generally multiply the self-employment income by 14.13% (this rate is a quick way to figure your self-employment tax and equals the sum of the 12.4% social security tax and the 2.9% Medicare tax multiplied by 0.9235). See Pub. 505 for more information, especially if the sum of self-employment income multiplied by 0.9235 and wages exceeds \$160,200 for a given individual.

**Nonresident alien.** If you're a nonresident alien, see Notice 1392, Supplemental Form W-4 Instructions for Nonresident Aliens, before completing this form.

## Specific Instructions

**Step 1(c).** Check your anticipated filing status. This will determine the standard deduction and tax rates used to compute your withholding.

**Step 2.** Use this step if you (1) have more than one job at the same time, or (2) are married filing jointly and you and your spouse both work.

If you (and your spouse) have a total of only two jobs, you may check the box in option (c). The box must also be checked on the Form W-4 for the other job. If the box is checked, the standard deduction and tax brackets will be cut in half for each job to calculate withholding. This option is roughly accurate for jobs with similar pay; otherwise, more tax than necessary may be withheld, and this extra amount will be larger the greater the difference in pay is between the two jobs.



**Multiple jobs.** Complete Steps 3 through 4(b) on only one Form W-4. Withholding will be most accurate if you do this on the Form W-4 for the highest paying job.

**Step 3.** This step provides instructions for determining the amount of the child tax credit and the credit for other dependents that you may be able to claim when you file your tax return. To qualify for the child tax credit, the child must be under age 17 as of December 31, must be your dependent who generally lives with you for more than half the year, and must have the required social security number. You may be able to claim a credit for other dependents for whom a child tax credit can't be claimed, such as an older child or a qualifying relative. For additional eligibility requirements for these credits, see Pub. 501, Dependents, Standard Deduction, and Filing Information. You can also include **other tax credits** for which you are eligible in this step, such as the foreign tax credit and the education tax credits. To do so, add an estimate of the amount for the year to your credits for dependents and enter the total amount in Step 3. Including these credits will increase your paycheck and reduce the amount of any refund you may receive when you file your tax return.

### Step 4 (optional).

**Step 4(a).** Enter in this step the total of your other estimated income for the year, if any. You shouldn't include income from any jobs or self-employment. If you complete Step 4(a), you likely won't have to make estimated tax payments for that income. If you prefer to pay estimated tax rather than having tax on other income withheld from your paycheck, see Form 1040-ES, Estimated Tax for Individuals.

**Step 4(b).** Enter in this step the amount from the Deductions Worksheet, line 5, if you expect to claim deductions other than the basic standard deduction on your 2023 tax return and want to reduce your withholding to account for these deductions. This includes both itemized deductions and other deductions such as for student loan interest and IRAs.

**Step 4(c).** Enter in this step any additional tax you want withheld from your pay **each pay period**, including any amounts from the Multiple Jobs Worksheet, line 4. Entering an amount here will reduce your paycheck and will either increase your refund or reduce any amount of tax that you owe.

Step 2(b) – Multiple Jobs Worksheet (Keep for your records.)



If you choose the option in Step 2(b) on Form W-4, complete this worksheet (which calculates the total extra tax for all jobs) on only ONE Form W-4. Withholding will be most accurate if you complete the worksheet and enter the result on the Form W-4 for the highest paying job. To be accurate, submit a new Form W-4 for all other jobs if you have not updated your withholding since 2019.

Note: If more than one job has annual wages of more than \$120,000 or there are more than three jobs, see Pub. 505 for additional tables.

- 1 Two jobs. If you have two jobs or you're married filing jointly and you and your spouse each have one job, find the amount from the appropriate table on page 4. Using the "Higher Paying Job" row and the "Lower Paying Job" column, find the value at the intersection of the two household salaries and enter that value on line 1. Then, skip to line 3
2 Three jobs. If you and/or your spouse have three jobs at the same time, complete lines 2a, 2b, and 2c below. Otherwise, skip to line 3.
a Find the amount from the appropriate table on page 4 using the annual wages from the highest paying job in the "Higher Paying Job" row and the annual wages for your next highest paying job in the "Lower Paying Job" column. Find the value at the intersection of the two household salaries and enter that value on line 2a
b Add the annual wages of the two highest paying jobs from line 2a together and use the total as the wages in the "Higher Paying Job" row and use the annual wages for your third job in the "Lower Paying Job" column to find the amount from the appropriate table on page 4 and enter this amount on line 2b
c Add the amounts from lines 2a and 2b and enter the result on line 2c
3 Enter the number of pay periods per year for the highest paying job. For example, if that job pays weekly, enter 52; if it pays every other week, enter 26; if it pays monthly, enter 12, etc.
4 Divide the annual amount on line 1 or line 2c by the number of pay periods on line 3. Enter this amount here and in Step 4(c) of Form W-4 for the highest paying job (along with any other additional amount you want withheld)

Step 4(b) – Deductions Worksheet (Keep for your records.)



- 1 Enter an estimate of your 2023 itemized deductions (from Schedule A (Form 1040)). Such deductions may include qualifying home mortgage interest, charitable contributions, state and local taxes (up to \$10,000), and medical expenses in excess of 7.5% of your income
2 Enter: { \$27,700 if you're married filing jointly or a qualifying surviving spouse; \$20,800 if you're head of household; \$13,850 if you're single or married filing separately }
3 If line 1 is greater than line 2, subtract line 2 from line 1 and enter the result here. If line 2 is greater than line 1, enter "-0-"
4 Enter an estimate of your student loan interest, deductible IRA contributions, and certain other adjustments (from Part II of Schedule 1 (Form 1040)). See Pub. 505 for more information
5 Add lines 3 and 4. Enter the result here and in Step 4(b) of Form W-4

Privacy Act and Paperwork Reduction Act Notice. We ask for the information on this form to carry out the Internal Revenue laws of the United States. Internal Revenue Code sections 3402(f)(2) and 6109 and their regulations require you to provide this information; your employer uses it to determine your federal income tax withholding. Failure to provide a properly completed form will result in your being treated as a single person with no other entries on the form; providing fraudulent information may subject you to penalties. Routine uses of this information include giving it to the Department of Justice for civil and criminal litigation; to cities, states, the District of Columbia, and U.S. commonwealths and territories for use in administering their tax laws; and to the Department of Health and Human Services for use in the National Directory of New Hires. We may also disclose this information to other countries under a tax treaty, to federal and state agencies to enforce federal nontax criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism.

You are not required to provide the information requested on a form that is subject to the Paperwork Reduction Act unless the form displays a valid OMB control number. Books or records relating to a form or its instructions must be retained as long as their contents may become material in the administration of any Internal Revenue law. Generally, tax returns and return information are confidential, as required by Code section 6103.

The average time and expenses required to complete and file this form will vary depending on individual circumstances. For estimated averages, see the instructions for your income tax return.

If you have suggestions for making this form simpler, we would be happy to hear from you. See the instructions for your income tax return.

**Married Filing Jointly or Qualifying Surviving Spouse**

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	\$0 - 9,999	\$10,000 - 19,999	\$20,000 - 29,999	\$30,000 - 39,999	\$40,000 - 49,999	\$50,000 - 59,999	\$60,000 - 69,999	\$70,000 - 79,999	\$80,000 - 89,999	\$90,000 - 99,999	\$100,000 - 109,999	\$110,000 - 120,000
\$0 - 9,999	\$0	\$0	\$850	\$850	\$1,000	\$1,020	\$1,020	\$1,020	\$1,020	\$1,020	\$1,020	\$1,870
\$10,000 - 19,999	0	930	1,850	2,000	2,200	2,220	2,220	2,220	2,220	2,220	3,200	4,070
\$20,000 - 29,999	850	1,850	2,920	3,120	3,320	3,340	3,340	3,340	3,340	4,320	5,320	6,190
\$30,000 - 39,999	850	2,000	3,120	3,320	3,520	3,540	3,540	3,540	4,520	5,520	6,520	7,390
\$40,000 - 49,999	1,000	2,200	3,320	3,520	3,720	3,740	3,740	4,720	5,720	6,720	7,720	8,590
\$50,000 - 59,999	1,020	2,220	3,340	3,540	3,740	3,760	4,750	5,750	6,750	7,750	8,750	9,610
\$60,000 - 69,999	1,020	2,220	3,340	3,540	3,740	4,750	5,750	6,750	7,750	8,750	9,750	10,610
\$70,000 - 79,999	1,020	2,220	3,340	3,540	4,720	5,750	6,750	7,750	8,750	9,750	10,750	11,610
\$80,000 - 99,999	1,020	2,220	4,170	5,370	6,570	7,600	8,600	9,600	10,600	11,600	12,600	13,460
\$100,000 - 149,999	1,870	4,070	6,190	7,390	8,590	9,610	10,610	11,660	12,860	14,060	15,260	16,330
\$150,000 - 239,999	2,040	4,440	6,760	8,160	9,560	10,780	11,980	13,180	14,380	15,580	16,780	17,850
\$240,000 - 259,999	2,040	4,440	6,760	8,160	9,560	10,780	11,980	13,180	14,380	15,580	16,780	17,850
\$260,000 - 279,999	2,040	4,440	6,760	8,160	9,560	10,780	11,980	13,180	14,380	15,580	16,780	18,140
\$280,000 - 299,999	2,040	4,440	6,760	8,160	9,560	10,780	11,980	13,180	14,380	15,870	17,870	19,740
\$300,000 - 319,999	2,040	4,440	6,760	8,160	9,560	10,780	11,980	13,470	15,470	17,470	19,470	21,340
\$320,000 - 364,999	2,040	4,440	6,760	8,550	10,750	12,770	14,770	16,770	18,770	20,770	22,770	24,640
\$365,000 - 524,999	2,970	6,470	9,890	12,390	14,890	17,220	19,520	21,820	24,120	26,420	28,720	30,880
\$525,000 and over	3,140	6,840	10,460	13,160	15,860	18,390	20,890	23,390	25,890	28,390	30,890	33,250

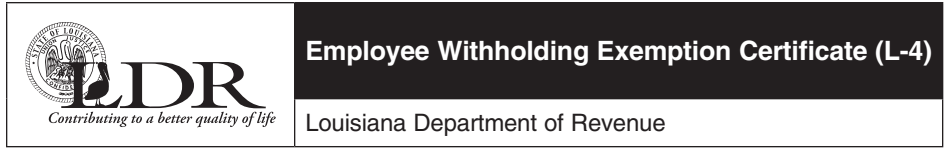
**Single or Married Filing Separately**

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	\$0 - 9,999	\$10,000 - 19,999	\$20,000 - 29,999	\$30,000 - 39,999	\$40,000 - 49,999	\$50,000 - 59,999	\$60,000 - 69,999	\$70,000 - 79,999	\$80,000 - 89,999	\$90,000 - 99,999	\$100,000 - 109,999	\$110,000 - 120,000
\$0 - 9,999	\$310	\$890	\$1,020	\$1,020	\$1,020	\$1,860	\$1,870	\$1,870	\$1,870	\$1,870	\$2,030	\$2,040
\$10,000 - 19,999	890	1,630	1,750	1,750	2,600	3,600	3,600	3,600	3,600	3,760	3,960	3,970
\$20,000 - 29,999	1,020	1,750	1,880	2,720	3,720	4,720	4,730	4,730	4,890	5,090	5,290	5,300
\$30,000 - 39,999	1,020	1,750	2,720	3,720	4,720	5,720	5,730	5,890	6,090	6,290	6,490	6,500
\$40,000 - 59,999	1,710	3,450	4,570	5,570	6,570	7,700	7,910	8,110	8,310	8,510	8,710	8,720
\$60,000 - 79,999	1,870	3,600	4,730	5,860	7,060	8,260	8,460	8,660	8,860	9,060	9,260	9,280
\$80,000 - 99,999	1,870	3,730	5,060	6,260	7,460	8,660	8,860	9,060	9,260	9,460	10,430	11,240
\$100,000 - 124,999	2,040	3,970	5,300	6,500	7,700	8,900	9,110	9,610	10,610	11,610	12,610	13,430
\$125,000 - 149,999	2,040	3,970	5,300	6,500	7,700	9,610	10,610	11,610	12,610	13,610	14,900	16,020
\$150,000 - 174,999	2,040	3,970	5,610	7,610	9,610	11,610	12,610	13,750	15,050	16,350	17,650	18,770
\$175,000 - 199,999	2,720	5,450	7,580	9,580	11,580	13,870	15,180	16,480	17,780	19,080	20,380	21,490
\$200,000 - 249,999	2,900	5,930	8,360	10,660	12,960	15,260	16,570	17,870	19,170	20,470	21,770	22,880
\$250,000 - 399,999	2,970	6,010	8,440	10,740	13,040	15,340	16,640	17,940	19,240	20,540	21,840	22,960
\$400,000 - 449,999	2,970	6,010	8,440	10,740	13,040	15,340	16,640	17,940	19,240	20,540	21,840	22,960
\$450,000 and over	3,140	6,380	9,010	11,510	14,010	16,510	18,010	19,510	21,010	22,510	24,010	25,330

**Head of Household**

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	\$0 - 9,999	\$10,000 - 19,999	\$20,000 - 29,999	\$30,000 - 39,999	\$40,000 - 49,999	\$50,000 - 59,999	\$60,000 - 69,999	\$70,000 - 79,999	\$80,000 - 89,999	\$90,000 - 99,999	\$100,000 - 109,999	\$110,000 - 120,000
\$0 - 9,999	\$0	\$620	\$860	\$1,020	\$1,020	\$1,020	\$1,020	\$1,650	\$1,870	\$1,870	\$1,890	\$2,040
\$10,000 - 19,999	620	1,630	2,060	2,220	2,220	2,220	2,850	3,850	4,070	4,090	4,290	4,440
\$20,000 - 29,999	860	2,060	2,490	2,650	2,650	3,280	4,280	5,280	5,520	5,720	5,920	6,070
\$30,000 - 39,999	1,020	2,220	2,650	2,810	3,440	4,440	5,440	6,460	6,880	7,080	7,280	7,430
\$40,000 - 59,999	1,020	2,220	3,130	4,290	5,290	6,290	7,480	8,680	9,100	9,300	9,500	9,650
\$60,000 - 79,999	1,500	3,700	5,130	6,290	7,480	8,680	9,880	11,080	11,500	11,700	11,900	12,050
\$80,000 - 99,999	1,870	4,070	5,690	7,050	8,250	9,450	10,650	11,850	12,260	12,460	12,870	13,820
\$100,000 - 124,999	2,040	4,440	6,070	7,430	8,630	9,830	11,030	12,230	13,190	14,190	15,190	16,150
\$125,000 - 149,999	2,040	4,440	6,070	7,430	8,630	9,980	11,980	13,980	15,190	16,190	17,270	18,530
\$150,000 - 174,999	2,040	4,440	6,070	7,980	9,980	11,980	13,980	15,980	17,420	18,720	20,020	21,280
\$175,000 - 199,999	2,190	5,390	7,820	9,980	11,980	14,060	16,360	18,660	20,170	21,470	22,770	24,030
\$200,000 - 249,999	2,720	6,190	8,920	11,380	13,680	15,980	18,280	20,580	22,090	23,390	24,690	25,950
\$250,000 - 449,999	2,970	6,470	9,200	11,660	13,960	16,260	18,560	20,860	22,380	23,680	24,980	26,230
\$450,000 and over	3,140	6,840	9,770	12,430	14,930	17,430	19,930	22,430	24,150	25,650	27,150	28,600





**Purpose:** Complete form L-4 so that your employer can withhold the correct amount of state income tax from your salary.

**Instructions:** Employees who are subject to state withholding should complete the personal allowances worksheet indicating the number of withholding personal exemptions in Block A and the number of dependency credits in Block B.

- Employees must file a new withholding exemption certificate within 10 days if the number of their exemptions decreases, except if the change is the result of the death of a spouse or a dependent.
- Employees may file a new certificate any time the number of their exemptions increases.
- Line 8 should be used to increase or decrease the tax withheld for each pay period. Decreases should be indicated as a negative amount.

Penalties will be imposed for willfully supplying false information or willful failure to supply information that would reduce the withholding exemption.

This form must be filed with your employer. If an employee fails to complete this withholding exemption certificate, the employer must withhold Louisiana income tax from the employee's wages without exemption.

**Note to Employer:** Keep this certificate with your records. If you believe that an employee has improperly claimed too many exemptions or dependency credits, please forward a copy of the employee's signed L-4 form with an explanation as to why you believe that the employee improperly completed this form and any other supporting documentation. The information should be sent to the Louisiana Department of Revenue, Criminal Investigations Division, PO Box 2389, Baton Rouge, LA 70821-2389.

**Block A**

- Enter "0" to claim neither yourself nor your spouse, and check "No exemptions or dependents claimed" under number 3 below. You may enter "0" if you are married, and have a working spouse or more than one job to avoid having too little tax withheld.
- Enter "1" to claim yourself, and check "Single" under number 3 below. If you did not claim this exemption in connection with other employment, or if your spouse has not claimed your exemption. Enter "1" to claim one personal exemption if you will file as head of household, and check "Single" under number 3 below.
- Enter "2" to claim yourself and your spouse, and check "Married" under number 3 below.

A.

**Block B**

- Enter the number of dependents, not including yourself or your spouse, whom you will claim on your tax return. If no dependents are claimed, enter "0."

B.

Cut here and give the bottom portion of certificate to your employer. Keep the top portion for your records.

Form <b>L-4</b> Louisiana Department of Revenue	<h2 style="margin: 0;">Employee's Withholding Allowance Certificate</h2>		
1. Type or print first name and middle initial	Last name		
2. Social Security Number	3. Select one <input type="checkbox"/> No exemptions or dependents claimed <input type="checkbox"/> Single <input type="checkbox"/> Married		
4. Home address (number and street or rural route)			
5. City	State	ZIP	
6. Total number of exemptions claimed in Block A			6.
7. Total number of dependents claimed in Block B			7.
8. Increase or decrease in the amount to be withheld each pay period. Decreases should be indicated as a negative amount.			8.

I declare under the penalties imposed for filing false reports that the number of exemptions and dependency credits claimed on this certificate do not exceed the number to which I am entitled.

Employee's signature	Date
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**The following is to be completed by employer.**

9. Employer's name and address	10. Employer's state withholding account number
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**STATEMENT OF UNDERSTANDING  
LCTCS RECOUPMENT OF OVERPAYMENTS POLICY**

My signature below indicates understanding of the LCTCS Recoupment of Overpayments Policy. I understand that if overpaid, the overpayment may be recouped in a future pay period after notification from the agency, in according with the LCTCS policy.

I understand that should there be an outstanding overpayment from a prior state agency, t I must disclose this outstanding overpayment to the LCTCS at time of employment by the LCTCS and that, upon notification of such outstanding overpayment, the LCTCS is required to work with such prior state agency in recoupment of such outstanding overpayment.

I understand that I am required to work with the LCTCS on the recoupment of any overpayment while in active employment. I understand that should there be an outstanding overpayment by the LCTCS at time of future termination of employment, that I am required to work with the LCTCS, and any future state agency with which I am employed, in recoupment of any outstanding overpayment.

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

## PUBLIC RECORDS REQUEST AUTHORIZATION

As per Louisiana law, (see below) I authorize Delgado Community College (the College) to maintain confidentiality of all my personal contact information—including my cellular/mobile telephone number, e-mail address, home telephone number, and home address information—and to NOT disclose this information when the College receives a public records request.

\_\_\_\_\_  
Employee Printed Name  
\_\_\_\_\_  
Employee Signature  
\_\_\_\_\_  
Date

### **La. R.S. 44:11 (“Confidential nature of certain personnel records; exceptions”)**

A. Notwithstanding anything contained in this Chapter or any other law to the contrary, the following items in the personnel records of a public employee of any public body shall be confidential:

- (1) The home telephone number of the public employee where such employee has chosen to have a private or unlisted home telephone number because of the nature of his occupation with such body.
- (2) The home telephone number of the public employee where such employee has requested that the number be confidential.
- (3) The home address of the public employee where such employee has requested that the address be confidential.
- (4) The name and account number of any financial institution to which the public employee's wages or salary are directly deposited by an electronic direct deposit payroll system or other direct deposit payroll system.

B. The provisions of R.S. 44:11(A)(3) shall not apply to the personnel records of a city or parish school board to the extent that the home address of any employee of a city or parish school board shall be made available to recognized educational groups.

C. Notwithstanding any other provision of this Chapter, the social security number and financial institution direct deposit information as contained in the personnel records of a public employee of any public body shall be confidential. However, when the employee's social security number or financial institution direct deposit information is required to be disclosed pursuant to any other provision of law, including such purposes as child support enforcement, health insurance, and retirement reporting, the social security number or financial institution direct deposit information of the employee shall be disclosed pursuant to such provision of law.

D. Notwithstanding anything contained in this Chapter or any other law to the contrary, all medical records, claim forms, insurance applications, requests for the payment of benefits, and all other health records of public employees, public officials, and their dependents in the personnel records of any public body shall be confidential. However, nothing in this Chapter shall be intended to limit access to employee records under the Code of Civil Procedure or Code of Evidence.

E. The provisions of Paragraph (A)(3) of this Section shall not apply to the home address of a member of the Firefighters' Retirement System if that information is requested by a member of the Louisiana Legislature, an agency or employer reporting information to the system, or a recognized association of system members.

## CONFIDENTIALITY AGREEMENT

Employee/Contractor/Student/Volunteer

As an employee/student/volunteer, I understand that in the course of my work for Delgado Community College ("College"), I may have access to confidential, proprietary or personal information regarding faculty, staff, students, parents, alumni, vendors, the College and/or any minor enrolled in a College program. Such confidential information may be verbal, on paper, contained in software, visible on screen displays, in computer readable form, or otherwise, and may include, but is not limited to, medical/health, financial, employment, contractual, or institutional data.

I hereby affirm that I will not in any way access, use, remove, disclose, copy, release, sell, loan, alter or destroy any confidential information except as authorized within the scope of my duties with Delgado Community College. As an employee/contractor/student/volunteer, I must comply with applicable local, state and federal laws and College policies. I have a duty to safeguard and retain the confidentiality of all confidential information. Upon termination of my affiliation with Delgado Community College, or earlier as instructed by the College, I will return to the College all copies of all materials containing confidential information.

I understand that I will be held responsible for my misuse or unauthorized disclosure of confidential information, including the failure to safeguard my information access codes or devices. My obligations under this Agreement are effective as of this day and will continue after my affiliation with Delgado Community College concludes. Violation of these rules will result in discipline, which may include, but is not limited to, discharge from employment, expulsion from the College and or criminal prosecution under appropriate state and federal laws.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Date

**Please Indicate Your Status:**

- Employee**
- Contractor**
- Student**
- Volunteer**

## ACKNOWLEDGEMENT OF TRAINING AND POLICIES

Pursuant to Louisiana Division of Administration, Office of Risk Management, Loss Prevention Manual 20130701 (*Effective July 1, 2013*), I have received training on and reviewed the written policies for the following areas:

[The Louisiana Code of Government Ethics \(LSA-R.S. 42:1101 et seq.\)](#)  
[The Delgado Community College Policy on Bloodborne Pathogens \(SF-1373.3A\)](#)  
[The Delgado Community College Policy on Control of Hazardous Materials \(SF-1373.3A\)](#)  
[The Delgado Community College Policy on Campus Sexual Misconduct \(AD-1732.1A\)](#)  
[The Delgado Community College Policy on Violence in the Workplace \(SF-1733.1A\)](#)  
[The Delgado Community College Policy on Tobacco-Free College \(SF-1373.5D\)](#)  
[The Delgado Community College Policy on a Drug-Free College \(SF-2530.1A\)](#)  
[The Delgado Community College Policy on Social Media \(AD-008\)](#)  
[The Delgado Community College Policy on Drug and Alcohol Prevention and Awareness](#)  
[The Delgado Community College Transitional Return to Work Plan \(BAA-Y01\)](#)  
[The Delgado Community College Persons with Disabilities \(AD-1468.1\)](#)

You may view all DCC Policies here: <http://www.dcc.edu/administration/policies/default.aspx>

Policy [6.003 Leave for Unclassified Employees](#)  
Policy [6.011 Harassment, Discrimination and Retaliation](#)  
Policy [6.016 Employment Relationship](#)  
Policy [6.018 Outside Employment of LCTCS Employees](#)  
Policy [6.023 American with Disabilities Act: Employees and Students](#)

You may view all LCTCS Policies here: <https://www.lctcs.edu/policies>

I acknowledge that I have had the opportunity to ask questions about these trainings and policies, and I understand that any future questions that I may have will be answered by the Chief Human Resources Officer or his or her designated representative upon request. I agree to and will comply with the policies, procedures, and other guidelines set forth in these policies. I understand that the State of Louisiana, the Louisiana Community & Technical Colleges System (LCTCS), and/or Delgado Community College reserve(s) the right to change, modify, or abolish any or all of the policies, benefits, rules, and regulations contained or described in these policies and programs as it deems appropriate at any time, with or without notice. I am aware that more information on any of these policies is available at any time online at:

<https://www.doa.la.gov/Pages/orm/Training.aspx>  
<http://www.dcc.edu/title-ix/responsible-employees.aspx>  
<https://www.lctcs.edu/policies>

My signature below acknowledges receipt and review of the Delgado Community College and Louisiana Community & Technical College System (LCTCS) policies.

**ACKNOWLEDGEMENT:**

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Department