ADJUNCT, PART-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
- □ Mandatory Disclosures (New Part-Time Employees)
- □ 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
- □ Acknowledgment 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.

Employee Signature	Printed Name	Date

Delgado
Application for Employment

Online Application for Employment -
"Careers @ Delgado"(Preferred):
https://careers.dcc.edu/applicants/jsp/shared/Welcome_css.jsp

"Fillable" Application for Employment -
Paper Form (Accepted Only for Adjunct Faculty):
http://docushare3.dcc.edu/docushare/dsweb/Get/Document-6753

Delgado
COMMUNITY COLLEGE

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.

Employee's Name (Print) Signature Date

Updated 1/2023

Delgado
COMMUNITY COLLEGE

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.)

_____

_____

_____

Signed by: _____ Date: _____
(Employee)

Revised 5/13

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:

Delgado COMMUNITY COLLEGE

Mandatory Disclosures (New Part-Time Employees)

Patient Protection and Affordable Care Act

Employee's Name (please print) _____ **Hire Date** _____

Section 1: Employment at Another LCTCS College or Board Office

Do you hold an additional position at the LCTCS Board Office or any other LCTCS college? _____YES _____NO

Louisiana Community and Technical College System (LCTCS):
Baton Rouge Community College + Bossier Parish Community College + Central Louisiana Technical Community College + Delgado Community College
L. E. Fletcher Technical Community College + Louisiana Delta Community College + Northshore Technical Community College
Northwest Louisiana Technical College + Nunez Community College + River Parishes Community College + South Central Louisiana Technical College
South Louisiana Community College + SOWELA Technical Community College

If Yes, please provide the name(s) of the LCTCS institution(s) and Job title(s):

Institution/College Name	**Position/Job title**

Section 2: Verification of Health Coverage

Do you currently have health coverage through any other LCTCS college? _____YES _____NO

*****IMPORTANT NOTE***** **You *may* be subject to an IRS penalty if you do not have insurance!** *****IMPORTANT NOTE*****

Section 3: Confirmation of Non-Coverage through LCTCS

My signature below acknowledges that I am a Part-Time Employee of Delgado Community College and am working *less than 30 Hours per week* within the LCTCS System; therefore, at this time I am not eligible for health coverage through Delgado or any other LCTCS college.

Employee's Signature **Date**

Human Resources Representative **Date**

Delgado COMMUNITY COLLEGE

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 _____

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: _____

In accordance with La. R.S. 46:2597, this form shall be confidential and filed in a folder separate from the employee's personnel file.

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.[1] 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: (____) _____

[1] 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
☐ ☐ Diabetes	☐ ☐ Cerebral Palsy	☐ ☐ Arthritis	☐ ☐ Heart Disease/Heart Attack
☐ ☐ Silicosis	☐ ☐ Tuberculosis	☐ ☐ Parkinson's	☐ ☐ Congestive Heart Failure
☐ ☐ Varicose Veins	☐ ☐ Multiple Sclerosis	☐ ☐ Brain Damage	☐ ☐ Vision Loss, one or both eyes
☐ ☐ Asbestosis	☐ ☐ Post Traumatic Stress	☐ ☐ Asthma	☐ ☐ Disability from Polio
☐ ☐ Hyperinsulinism	☐ ☐ Osteomyelitis	☐ ☐ Dementia	☐ ☐ Psychoneurotic Disability
☐ ☐ Alzheimer's	☐ ☐ Nervous Disorder	☐ ☐ Thrombophlebitis	☐ ☐ Ruptured or Herniated Disc
☐ ☐ Emphysema	☐ ☐ Muscular Dystrophy	☐ ☐ Arteriosclerosis	☐ ☐ Ankylosis or Joint Stiffening
☐ ☐ Hearing Loss	☐ ☐ Migraine Headaches	☐ ☐ Hodgkin's	☐ ☐ High/Low Blood Pressure
☐ ☐ COPD	☐ ☐ Mental Retardation	☐ ☐ Cancer	☐ ☐ Carpal Tunnel Syndrome
☐ ☐ Hypertension	☐ ☐ Kidney Disorder	☐ ☐ Double Vision	☐ ☐ Compressed Air Sequelae
☐ ☐ Head Injury	☐ ☐ Loss of Use of Limb	☐ ☐ Mental Disorders	☐ ☐ Disease of the Lung
☐ ☐ Epilepsy	☐ ☐ Seizure Disorder	☐ ☐ Hemophilia	☐ ☐ Coronary Artery Disease
☐ ☐ Stroke	☐ ☐ Sickle Cell Disease	☐ ☐ Bleeding Disorder	☐ ☐ 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: _____

TO BE COMPLETED BY EMPLOYEE

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: _____

TO BE COMPLETED BY EMPLOYER REPRESENTATIVE

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	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.

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 *(Family Name)* from Section 1.	First Name *(Given Name)* from **Section 1.**	Middle initial (if any) from **Section 1.**

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 *(mm/dd/yyyy)*
Last Name *(Family Name)*	First Name *(Given Name)*		Middle Initial *(if any)*
Address *(Street Number and Name)*	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 *(mm/dd/yyyy)*
Last Name *(Family Name)*	First Name *(Given Name)*		Middle Initial *(if any)*
Address *(Street Number and Name)*	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 *(mm/dd/yyyy)*
Last Name *(Family Name)*	First Name *(Given Name)*		Middle Initial *(if any)*
Address *(Street Number and Name)*	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 *(mm/dd/yyyy)*
Last Name *(Family Name)*	First Name *(Given Name)*		Middle Initial *(if any)*
Address *(Street Number and Name)*	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 *(Family Name)* from **Section 1.**	First Name *(Given Name)* from **Section 1.**	Middle initial (if any) from **Section 1.**

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)

Date of Rehire *(if applicable)*	New Name *(if applicable)*		
Date *(mm/dd/yyyy)*	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) (mm/dd/yyyy)

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 *(mm/dd/yyyy)*

Additional Information (Initial and date each notation.)

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

Date of Rehire *(if applicable)*	New Name *(if applicable)*		
Date *(mm/dd/yyyy)*	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) (mm/dd/yyyy)

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 *(mm/dd/yyyy)*

Additional Information (Initial and date each notation.)

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

Date of Rehire *(if applicable)*	New Name *(if applicable)*		
Date *(mm/dd/yyyy)*	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) (mm/dd/yyyy)

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 *(mm/dd/yyyy)*

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

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

2023

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.)

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.)

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)

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*.

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 . . . . . **1** $

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 . . . . . **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 . . . . . **2b** $

c Add the amounts from lines 2a and 2b and enter the result on line 2c . . . . . **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. **3**

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) . . . . . **4** $

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 . . . . . **1** $

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

. . . . . **2** $

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-" . . . . . **3** $

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 . . . . **4** $

5 **Add** lines 3 and 4. Enter the result here and in **Step 4(b)** of Form W-4 . . . . . **5** $

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

R-1300 (4/11)

LDR
Contributing to a better quality of life

Employee Withholding Exemption Certificate (L-4)

Louisiana Department of Revenue

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 **L-4**
Louisiana Department of Revenue

Employee's Withholding Allowance Certificate

1. Type or print first name and middle initial	Last name
2. Social Security Number	**3.** Select one ☐ No exemptions or dependents claimed ☐ Single ☐ 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

The following is to be completed by employer.

9. Employer's name and address	**10.** Employer's state withholding account number

LCTCS PAYROLL DIRECT DEPOSIT ENROLLMENT AUTHORIZATION –

Main Bank (Primary Account)

Employee ID:_____ VPDI/Institution Code:_____

Action Type (one): ☐ New ☐ Change ☐ Termination This Option

	PAYROLL CHECK	☐ NON-PAYROLL REIMBURSEMENTS Check box if same as payroll account.
*Account Name: (*Ex: Mr. & Mrs. J. Doe*)		
*Financial Institution:		
*Routing/ABA Number:		
*Account Number:		
*Account Type (*Checking or Savings*)		
*Account Verification	Signature from Institution: _____ Phone Number: _____	Signature from Institution: _____ Phone Number: _____

*Account verification or completion of enrollment form by financial institution is required to assure the accuracy of account data if no voided check or other documentation is provided.

I, _____, authorize and request the Louisiana Community & Technical College to initiate electronic deposits (payroll and non-payroll) to the account(s) at the financial institution I have designated above.

For any funds paid to me which are not due and owing to me, through a pre-note paper check or through direct deposit, I hereby agree and authorize my appointing authority (employer) to adjust the amount next due to me to correct the overpayment, or to recover amount overpaid by reducing my future payroll checks and/or non-payroll reimbursements so that the overpayment will be repaid or recouped within a reasonable number of months (not to exceed 12 months). In the event such electronic transactions are unsuccessful, LCTCS will notify me of the amount to be returned).

It is my responsibility to notify Human Resources, as appropriate, should any changes occur to the account(s) specified. Considering all above conditions are met, this authorization remains in full effect until a written, signed notification to terminate, or another signed form (LCTCSPR20) indicating termination of this option is received from me and the LCTCS payroll department has had reasonable opportunity to act on the termination.

_____ _____ _____

Signature Date Phone where you can be reached between 8:00 a.m. and 5:00 p.m.

*Institution requirements may vary. Contact your human resources representative if you have any questions.

☐ CHECK HERE IF SECONDARY ACCOUNT FORMS ARE ATTACHED.

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.

Delgado COMMUNITY COLLEGE

Education that works!

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**

Delgado COMMUNITY COLLEGE

Education that works!

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 Louisiana Office of Risk Management Training on Blood Borne Pathogens
The Louisiana Office of Risk Management Training on Sexual Harassment
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 a Tobacco-Free College (SF-1373.5D)
The Delgado Community College Policy on a Drug-Free College (SF-2530.1A)
The Delgado Community College Drug and Alcohol Prevention Program
The Delgado Community College Transitional Return to Work Plan (BAA-Y01)

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 Vice Chancellor for Human Resources 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

http://www.dcc.edu/administration/policies/default.aspx

https://www.lctcs.edu/policies

Employee Name / Department **PRINTED**

Employee Signature / Date **SIGNED**

Blood Borne Pathogen rules are in place for your health and safety. By incorporating these rules, along with your agency's policies and procedures, and practicing universal precautions, you can protect yourself against potential exposure to Blood Borne Pathogens and aid in preventing transmission. For questions or clarification about Blood Borne Pathogen information or to review your agency's Blood Borne Pathogens Program, please contact your immediate supervisor.

BLOOD BORNE PATHOGENS
"CHECK FOR UNDERSTNDING"

It is now time to test your knowledge of Blood Borne Pathogens. You must achieve a score of 70% (7 of 10 Questions) or higher to receive credit for this course. Please circle the most correct answer for each question.

1) Which of the following could contain BBP?

A) Urine
B) Semen
C) Bloody Saliva
D) All of the Above

2) The wearing of gloves is an effective alternative to hand washing?

A) True
B) False

3) BBP may enter your system through...

A) Open sore
B) Sexual contact
C) Mucous membrane (i.e. nose, mouth, eyes)
D) Human bite
E) All of the above

4) You should always treat bodily fluids as if they are infectious?

A) True
B) False

5) Smoking, eating, drinking and applying cosmetics is allowed in areas where potential exposure to BBP may occur?

A) True
B) False

6) Sharing infected needles, razors, tooth brushes, or other personal care items is considered an indirect route of transmission for BBP?

- [ ] True
- [ ] False

7) All surfaces, tools, equipment and other objects that come in contact with blood or other potentially infectious materials (OPIM) must be decontaminated and/or sterilized as soon as possible?

- [ ] True
- [ ] False

8) Which of the following are examples of personal protective equipment (PPE)?

- [ ] Gloves
- [ ] Goggles
- [ ] Aprons/gowns
- [ ] Face shields
- [ ] All of the above

9) The "universal" agent that can be used to decontaminate all surfaces of all known Blood Borne Pathogens is a solution of 9 parts water and 1 part bleach.

- [ ] True
- [ ] False

10) It is okay to touch blood if you have known the person it came from for most of your life.

- [ ] True
- [ ] False

By signing this form, I acknowledge that I was presented with training on Blood Borne Pathogens and was given the opportunity to ask questions. I recognize that it is my responsibility to use care and to discuss specific precautions required for my position with my departmental supervisor.

_____	_____	_____
Employee Name	**Department**	**Date**