NEW HIRE PACKET

FOR EMPLOYMENT WITH

CHOCTAW STEEL INC.

CHOCTAW STEEL INC.
24501 THOMAS NELSON RD.
FRANKLINTON, LA 70438

OFFICE: 985.848.5370
FAX: 985.848.5340
EMAIL: CHOCTAWSTEEL_JN@YAHOO.COM

PLEASE FILL OUT ENTIRE APPLICATION. BE CERTAIN THAT ALL INFORMATION REQUESTED IS PROVIDED, CORRECT, AND CURRENT. MAKE SURE THAT ALL SIGNATURE LINES ARE SIGNED AND DATED.

Do NOT sign below if you do NOT understand the contents of this entire document.

I hereby agree to comply with any and all policies held by Choctaw Steel Inc. I understand that failure to comply will mean immediate termination from employment.

Employee's Signature:______________________________

Date:______________________________

Employee's Social Security Number:______________________________

Employee's Phone Number:______________________________

Choctaw Steel Inc. Application for Employment

for Rodbusters

Personal Information

Full Legal Name:____

Nickname:____

Legal Address:____

City:____________________ State:____________ Zip:____________

Parish in Which You Reside:______________________________

Birth Date:____________________ Social Security Number:________________

Driver's Liscense or I.D. Number:____________________ Expires:____________

Home phone:____________________Cell:____________________

Alternate way of contacting you:______________________________

Are you a United States citizen? Yes_______ No_______
If hired, can you provide proof that you are legally able to work in the United States? Yes_______ No_______

Do you have a disability? If so, please explain:______________________________

____

Do you speak English?________________ Any other preferred language?________________

Have you ever been convicted of a criminal offense? *Note: An affirmative answer will not necessarily result in disqualification for employment.*

Yes________ No________

If yes, please state the nature of the offense(s), date(s), state and disposition of the offense:________________

____

____

List any relatives or friends employed by Choctaw Steel Inc.:______________________________

____

____

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Employment

Are you presently employed? Yes__________ No__________ If so, when can you be expected to begin employment with Choctaw Steel Inc.?_________________________

Will you be available to stay overnight in a hotel if the job requires? Yes__________ No__________ If not, please explain:____

Do you have any experience in this field? Yes__________ No__________

Can you provide employee references?*Union or non-Union* Yes__________ No__________

Previous Employment Information:

Company Name:____

Company Address:____

Company Phone Number:____

Position Held:____________________ Reason for leaving?____________________________

Dates Employed: From____________ To____________

Company Name:____

Company Address:____

Company Phone Number:____

Position Held:____________________ Reason for leaving?____________________________

Dates Employed: From____________ To____________

Company Name:____

Company Address:____

Company Phone Number:____

Position Held:____________________ Reason for leaving?____________________________

Dates Employed: From____________ To____________

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Personal References

Please list at least two (2) persons NOT related to you who have known you for at least five (5) years.

Reference #1:

Name:____

Address:____

Phone Number: ( ) ________________________________

How you know this person:______________________________

Reference #2:

Name:____

Address:____

Phone Number: ( ) ________________________________

How you know this person:______________________________

Other Information

Is there any information not listed on this application that you feel is relevant to this company, this job, or you being employed by Choctaw Steel Inc.? If so, please explain:____________________

If you did not fill out this application, please give the name and phone number of the person who did and why:________

I hereby swear under penalty of law that all above information is legally correct, and I give Choctaw Steel Inc. permission to verify that all above information is correct.

____________________________________ Date____________________

Signature Required

Thank you for your time, Choctaw Steel Inc. will contact you at the number(s) listed if employment becomes available. Have a blessed day!

PLEASE FILL OUT ENTIRE APPLICATION. BE CERTAIN THAT ALL INFORMATION REQUESTED IS PROVIDED, CORRECT, AND CURRENT. MAKE SURE THAT ALL SIGNATURE LINES ARE SIGNED AND DATED.

POST OFFER-OF-EMPLOYMENT MEDICAL INQUIRY
LOUISIANA

Completion of this report is requested to assist your employer in the knowledge requirement of the Louisiana Second Injury Fund. FAILURE TO ANSWER THE FOLLOWING QUESTIONS TRUTHFULLY MAY RESULT IN THE FORFEITURE OF WORKERS' COMPENSATION BENEFITS UNDER LA. R.S.23:1208.1

Name: ________________________ **Department:** ________________ **Position:** _____________

To the best of your knowledge do you have or have had any of the following medical problems? (For "yes" responses indicate the nature of injury or illness and name of physician in Remarks.)

Answer YES (Y) or NO (N)

___1. **Epilepsy**
___2. **Diabetes**
___3. **Cardiac Disease**
___4. **Arthritis** – list body part(s) affected below
___5. **Amputated foot, leg, hand or arm** or total loss of use thereof
___6. **Loss of sight** of one or both eyes or partial loss of uncorrected vision of more than 75% bilaterally
___7. **Residual disability from Poliomyelitis**
___8. **Cerebral palsy**
___9. **Multiple sclerosis**
___10. **Parkinson's disease**
___11. **Cerebral vascular accident -** Stroke or ruptured blood vessel in the head
___12. **Tuberculosis**
___13. **Silicosis**
___14. **Psychoneurotic disability** following treatment in a recognized medical or mental institution
___15. **Hemophilia**
___16. **Chronic osteomyelitis**
___17. **Ankylosis of joints**
___18. **Hyperinsulism**
___19. **Muscular dystrophy**
___20. **Arteriosclerosis**
___21. **Thrombophlebitis**
___22. **Varicose veins**
___23. **Heavy metal poisoning**
___24. **Ionizing radiation injury**
___25. **Compressed air sequelas**
___26. **Ruptured intervertebral disc**
___27. **Hodgkin's disease**
___28. **Brain damage**
___29. **A spinal fusion** or the surgical removal of an intervertebral disc
___ 30. **Mental retardation, provided the** employee's intelligence quotient is such that he falls in the lowest 2% of the general population. However, it shall not be necessary for the employer to know the employee's actual intelligence quotient.
___ 31. **Any other pre-existing disease condition or impairment which is permanent in nature**
___ 32. **Any workers compensation claims or automobile accidents** – provide details below

Remarks: ____
____
____

Signature of Employee: ____________________________________ **Date:** ____________

Signature of Employer: ____________________________________ **Date:** ____________

This form is to be used only in accordance with ADA guidelines.

WARNING

"PURSUANT TO LSA-RS 23:1208 AND 1208.1 OF THE LOUISIANA WORKERS' COMPENSATION ACT, I UNDERSTAND THAT THE FAILURE TO ANSWER TRUTHFULLY ANY OF THE ABOVE QUESTIONS MAY RESULT IN (1) A FINE OF NOT MORE THAN FIVE HUNDRED DOLLARS OR IMPRISONMENT FOR NOT MORE THEN TWELVE MONTHS, OR BOTH AND (2) A FORFEITURE OF COMPENSATION AND MEDICAL BENEFITS UNDER THE LOUISIANA WORKERS' COMPENSATION ACT."

Has any doctor ever restricted your activities?

☐ YES ☐ NO

If so, please list the medical condition, what type of restrictions placed, whether these restrictions were temporary or permanent, and whether you are presently under these restrictions.

____

____

Have you ever been assessed any percentage of permanent disability to any part of your body for any reason whatsoever?

☐ YES ☐ NO

If so, please explain:

____

____

Are you presently under any medical treatment by a doctor, chiropractor, psychiatrist, psychologist or other health care provider?

☐ YES ☐ NO

If so, please list the medical condition(s) being treated, the name of the doctor(s), field of specialty, and address and telephone number.

____

____

____

Are you presently taking any medication?

☐ YES ☐ NO

If yes, please list the name of the medication, the medical condition being treated, and the name, address and telephone number of the doctor who prescribed the medication.

____

____

____

WARNING

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Have you ever had surgery to any part of your body?

☐ YES ☐ NO

If yes, please list the part(s) of the body operated on, the type of operation performed, the date of the operation, the name of the hospital, if any, where the operation was performed, and the name address and phone number of the doctor performing the surgery.

____

____

____

Have you ever received treatment for your back, neck, knees or lower extremities from a doctor, chiropractor, therapist or other health care provider?

☐ YES ☐ NO

If yes, please list the name, address and phone number of all doctors, chiropractors, therapist or other health care provider who provided such treatment, the dates of the treatment and the diagnosis provided by the doctor, chiropractor, therapist, or other health care provider.

____

____

____

____

Have you ever had an injury that required you to miss time from work?

☐ YES ☐ NO

If yes, please list the type of injury, the amount of time missed from work, whether the condition was fully resolved or if it left you with any impairment, and whether you returned to work.

____

____

____

WARNING

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Are you aware of any condition or injury that might impair or limit your ability to work for this company?

☐ YES ☐ NO

If yes, please describe the condition or injury.

____

____

____

____

I HAVE READ AND FULLY UNDERSTAND THE ABOVE.

SIGNATURE: ____________________________________ **DATE:** ____________________________

1208.1 Employer's inquiry into employee's previous injury claims: forfeiture of benefits

Nothing in this Title shall prohibit an employer from inquiring about previous injuries, disabilities, or other medical conditions and the employee shall answer truthfully; failure to answer truthfully shall result in the employee's forfeiture of benefits under this Chapter. Provided said failure to answer directly relates to the medical condition for which a claim for benefits is made of affects the employer's ability to receive reimbursement from the second injury fund. This section shall not be enforceable unless the written form on which the inquiries about previous medical conditions are made contains a notice advising the employee that his failure to answer truthfully may result in his forfeiture or workers' compensation benefits under R.S. 1208:1. Such notice shall be prominently displayed in bold-faced block lettering of no less than ten-point type.

Choctaw Steel, Inc. New Hire Orientation Checklist

☐ I have read or have had explained the Safety Policy & Program Summary. I have no further questions regarding:

- The Company's Safety Philosophy.
- My safety responsibilities as an employee.
- The disciplinary procedures.

_______**Initial**

☐ I have read or have had explained the Safety Committee portion of the Safety Program:

- I am aware of who is in charge of safety if I have questions.
- I am aware of my ability to report my safety concerns to the Safety Coordinator.
- I am aware that this Company is striving to provide a safe working environment and is committed to my safety and ability to inform the Company of unsafe working environments without fear of reprisal.

_______**Initial**

☐ I have read or have had explained the General Safety Rules as pertain to the Safety Program:

- I am aware of all safety rules and general codes of safe practice.

_______**Initial**

☐ I have read or have had explained the safety policy regarding Hand and Power Tools:

- I am aware that I am required to inspect all tools before I operate the equipment.
- I am aware that I can request training from my supervisor on any tool that I do not know how to operate safely.
- I am aware that if I am unsure of how to operate my tools safely I am to not operate them until I receive proper training and feel that I can operate it safely.
- I am aware that any tool in need of repair or out of compliance is to be reported to my supervisor.

_______**Initial**

☐ I have read or have had explained the process for Accident Reporting & Investigation:

- I understand that I am to immediately report an accident to my supervisor.
- I understand that I am to immediately stop working.
- I understand that if I need medical attention I am to see the clinic or hospital that is affiliated with this Company.
- I understand that if I go to a different doctor or medical facility the Company may have a right to deny or not pay my medical bill.
- I understand that I will be cooperative in any accident investigation.
- I understand that upon any accident I may be tested for drugs and alcohol.
- I understand that if I am present at my place of employment under the influence of drugs and or alcohol that I automatically self-terminate my employment with or without notice of termination by the Company.

_______**Initial**

☐ I have read or have had explained the Emergency Action Plan:

- I understand where my emergency evacuation routes are located.
- I understand that we are to gather at a specific determined place in order to conduct a head count.

_______**Initial**

☐ I have read and or have had explained the Fire Prevention Plan:

- I understand that I am to report any potential fire hazards.
- I am to keep all exits clear and free of obstacles.
- I know where the nearest fire extinguisher is to my workstation.

_______**Initial**

☐ I am aware of the CPR & First Aid portion of the Safety Program:

- I am aware of where the first aid kits are located.
- I am aware that I am to report to management if the first aid kit needs restocked.
- I am aware of who is trained in First Aid and CPR
- I am aware of where the nearest Eye Wash Station is located (if appropriate).
- I am aware that I am to report all injuries immediately to my supervisor.
- I am aware of where our clinic is located and will have someone drive me there in the event of an emergency (or by ambulance if appropriate).

_______**Initial**

☐ I have read or have had explained the Hazard Evaluation portion of the Safety Program:

- I understand that I am to be familiar with the hazards that surround my workstation.
- I understand that I am to report any hazard that may be present in my workstation.
- I understand that it is my responsibility to assist in providing a safe working environment for myself and my co-workers.

_______**Initial**

☐ I have read or have had explained the Bloodborne Pathogens portion of the Safety Program:

- I understand that I am to wear personal protective equipment when dealing with blood or body fluids.
- I understand that I am to properly dispose of any blood, body fluids, or material that has been touched by the blood or fluid.
- I understand that in the event of dealing with a Bloodborne Pathogen situation it is my responsibility to receive post exposure care by the Company's clinic.
- I am aware of where my hand-washing facilities and/or disinfectant are located.

_______**Initial**

☐ I have read or have had explained and understand the Workplace Violence & Harassment policy of the Safety Program:

- I understand The Company has ZERO TOLERANCE for workplace Violence & Harassment.
- Workplace Violence & Harassment includes but is not limited to: intimidation, threats, physical attack, property damage, and includes acts of violence committed by employees, customers, relatives, acquaintances, or strangers against Company employees in the workplace.
- Dangerous weapons are prohibited on Company property or in Company vehicles.

© Safety Services Company

- All employees are encouraged to report to a supervisor any possibility of workplace Violence & Harassment. All reports will be confidential.

_______**Initial**

☐ I have read or have had explained the Electrical Safety portion and the Lockout/Tagout portion of the Company Safety Program:

- I understand that only authorized persons are allowed to deal with electrical repairs and or issues.
- I understand that I am to not touch or in any way use any equipment that is locked out or tagged out.
- I understand that it is my responsibility to report any electrical hazards to a supervisor immediately.

_______**Initial**

☐ I have read or have had explained the Hazard Communication & Material Safety Data Sheet (SDS) portion of the Safety Program:

- I understand what a Material Safety Data Sheet is.
- I have been given an orientation on how to read a SDS.
- I understand that I am to report any Chemical or Hazardous Substance that does not have a label.
- I understand that I can request further training on SDSs.

_______**Initial**

☐ I have read or have had explained the Personal Protective Equipment portion of the Safety Program:

- I understand that I am to wear my personal protective equipment as required by this Company.
- I am aware of what I am required to wear for personal protective equipment at this Company.

_______**Initial**

☐ I am aware of where my Company displays all of the required Employee Rights Postings.

_______**Initial**

☐ I am aware of where my Company "Designated Medical Provider" is located.

_______**Initial**

☐ I am aware that the Safety Program may contain additional written safety Programs in place which require additional training (i.e. Confined Spaces, Fall-Protection, Excavation, Ladders, Scaffolding, Lock-Out/Tag-Out, etc.):

- I understand that I may receive or request further training on any safety issues that may be appropriate for my particular job.
- If I have not received adequate training or feel that I cannot conduct my job safely it is my responsibility to notify my supervisor.

_______**Initial**

My signature certifies and verifies that I have received an orientation and have received or have read the material mentioned in the Company Safety Program. I understand completely the program and have no questions in regards to Company safety policy. I fully understand and am aware that if I have questions regarding the Company Safety Program or my personal safety, I may inquire of my supervisor for additional information and explanation.

____

New Hire Name　　　　Signature　　　　Date

____

Supervisor Name　　　　Signature　　　　Date

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DRUG-FREE WORKPLACE POLICY

Choctaw Steel Inc. intends to help provide a safe and drug-free work environment for our clients and our employees. With this goal in mind and because of the serious drug abuse problem in today's workplace, we are establishing the following policy for existing and future employees of Choctaw Steel Inc.

The Company explicitly prohibits:

- The use, possession, solicitation for, or sale of narcotics or other illegal drugs, alcohol, or prescription medication without a prescription on Company or customer premises or while performing an assignment.
- Being impaired or under the influence of legal or illegal drugs or alcohol away from the Company or customer premises, if such impairment or influence adversely affects the employee's work performance, the safety of the employee or of others, or puts at risk the Company's reputation.
- Possession, use, solicitation for, or sale of legal or illegal drugs or alcohol away from the Company or customer premises, if such activity or involvement adversely affects the employee's work performance, the safety of the employee or of others, or puts at risk the Company's reputation.
- The presence of any detectable amount of prohibited substances in the employee's system while at work, while on the premises of the company or its customers, or while on company business. "Prohibited substances" include illegal drugs, alcohol, or prescription drugs not taken in accordance with a prescription given to the employee.

The Company will conduct drug and/or alcohol testing under any of the following circumstances:

- RANDOM TESTING: Employees may be selected at random for drug and/or alcohol testing at any interval determined by the Company.
- FOR-CAUSE TESTING: The Company may ask an employee to submit to a drug and/or alcohol test at any time it feels that the employee may be under the influence of drugs or alcohol, including, but not limited to, the following circumstances: evidence of drugs or alcohol on or about the employee's person or in the employee's vicinity, unusual conduct on the employee's part that suggests impairment or influence of drugs or alcohol, negative performance patterns, or excessive and unexplained absenteeism or tardiness.
- POST-ACCIDENT TESTING: Any employee involved in an on-the-job accident or injury under circumstances that suggest possible use or influence of drugs or alcohol in the accident or injury event may be asked to submit to a drug and/or alcohol test. "Involved in an on-the-job accident or injury" means not only the one who was or could have been injured, but also any employee who potentially contributed to the accident or injury event in any way.

If an employee is tested for drugs or alcohol outside of the employment context and the results indicate a violation of this policy, or if an employee refuses a request to submit to testing under this policy, the employee may be subject to appropriate disciplinary action, up to and possibly including discharge from employment. In such a case, the employee will be given an opportunity to explain the circumstances prior to any final employment action becoming effective.

I UNDERSTAND AND AGREE TO COMPLY WITH THE DRUG FREE WORKPLACE POLICY HELD BY CHOCTAW STEEL INC. FURTHERMORE, I AGREE TO BE AVAILABLE FOR RANDOM, VOLUNTARY DRUG AND/OR ALCOHOL SCREENINGS AT THE DISCRETION OF CHOCTAW STEEL INC.

______________________	______________________	______________
EMPLOYEE SIGNATURE	PRINT NAME	DATE

EMPLOYEE AGREEMENT AND CONSENT TO DRUG AND/OR ALCOHOL TESTING

I hereby agree, upon a request made under the drug/alcohol testing policy of Choctaw Steel Inc. (the Company), to submit to a drug or alcohol test and to furnish a sample of my urine, breath, and/or blood for analysis. I understand and agree that if I at any time refuse to submit to a drug or alcohol test under company policy, or if I otherwise fail to cooperate with the testing procedures, I will be subject to immediate termination. I further authorize and give full permission to have the Company and/or its company physician send the specimen or specimens so collected to a laboratory for a screening test for the presence of any prohibited substances under the policy, and for the laboratory or other testing facility to release any and all documentation relating to such test to the Company and/or to any governmental entity involved in a legal proceeding or investigation connected with the test. Finally, I authorize the Company to disclose any documentation relating to such test to any governmental entity involved in a legal proceeding or investigation connected with the test.

I understand that only duly-authorized Company officers, employees, and agents will have access to information furnished or obtained in connection with the test; that they will maintain and protect the confidentiality of such information to the greatest extent possible; and that they will share such information only to the extent necessary to make employment decisions and to respond to inquiries or notices from government entities.

I will hold harmless the Company, its company physician, and any testing laboratory the Company might use, meaning that I will not sue or hold responsible such parties for any alleged harm to me that might result from such testing, including loss of employment or any other kind of adverse job action that might arise as a result of the drug or alcohol test, even if a Company or laboratory representative makes an error in the administration or analysis of the test or the reporting of the results. I will further hold harmless the Company, its company physician, and any testing laboratory the Company might use for any alleged harm to me that might result from the release or use of information or documentation relating to the drug or alcohol test, as long as the release or use of the information is within the scope of this policy and the procedures as explained in the paragraph above.

This policy and authorization have been explained to me in a language I understand, and I have been told that if I have any questions about the test or the policy, they will be answered.

I UNDERSTAND THAT THE COMPANY WILL REQUIRE A DRUG SCREEN AND/OR ALCOHOL TEST UNDER THIS POLICY WHENEVER I AM INVOLVED IN AN ON-THE-JOB ACCIDENT OR INJURY UNDER CIRCUMSTANCES THAT SUGGEST POSSIBLE INVOLVEMENT OR INFLUENCE OF DRUGS OR ALCOHOL IN THE ACCIDENT OR INJURY EVENT, AND I AGREE TO SUBMIT TO ANY SUCH TEST.

_________________________________ _______________

Signature of Employee Date

____

Employee's Name - Printed

_________________________________ _______________

Company Representative Date

Form W-4 (2018)

Future developments. For the latest information about any future developments related to Form W-4, such as legislation enacted after it was published, go to *www.irs.gov/FormW4*.

Purpose. Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay. Consider completing a new Form W-4 each year and when your personal or financial situation changes.

Exemption from withholding. You may claim exemption from withholding for 2018 if **both** of the following apply.

- For 2017 you had a right to a refund of **all** federal income tax withheld because you had **no** tax liability, **and**
- For 2018 you expect a refund of **all** federal income tax withheld because you expect to have **no** tax liability.

If you're exempt, complete **only** lines 1, 2, 3, 4, and 7 and sign the form to validate it. Your exemption for 2018 expires February 15, 2019. See Pub. 505, Tax Withholding and Estimated Tax, to learn more about whether you qualify for exemption from withholding.

General Instructions

If you aren't exempt, follow the rest of these instructions to determine the number of withholding allowances you should claim for withholding for 2018 and any additional amount of tax to have withheld. For regular wages, withholding must be based on allowances you claimed and may not be a flat amount or percentage of wages.

You can also use the calculator at ***www.irs.gov/W4App*** to determine your tax withholding more accurately. Consider using this calculator if you have a more complicated tax situation, such as if you have a working spouse, more than one job, or a large amount of nonwage income outside of your job. After your Form W-4 takes effect, you can also use this calculator to see how the amount of tax you're having withheld compares to your projected total tax for 2018. If you use the calculator, you don't need to complete any of the worksheets for Form W-4.

Note that if you have too much tax withheld, you will receive a refund when you file your tax return. If you have too little tax withheld, you will owe tax when you file your tax return, and you might owe a penalty.

Filers with multiple jobs or working spouses. If you have more than one job at a time, or if you're married and your spouse is also working, read all of the instructions including the instructions for the Two-Earners/Multiple Jobs Worksheet before beginning.

Nonwage income. If you have a large amount of nonwage income, such as interest or dividends, consider making estimated tax payments using Form 1040-ES, Estimated Tax for Individuals. Otherwise, you might owe additional tax. Or, you can use the Deductions, Adjustments, and Other Income Worksheet on page 3 or the calculator at *www.irs.gov/W4App* to make sure you have enough tax withheld from your paycheck. If you have pension or annuity income, see Pub. 505 or use the calculator at *www.irs.gov/W4App* to find out if you should adjust your withholding on Form W-4 or W-4P.

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

Personal Allowances Worksheet

Complete this worksheet on page 3 first to determine the number of withholding allowances to claim.

Line C. *Head of household please note:* Generally, you can claim head of household filing status on your tax return only if you're unmarried and pay more than 50% of the costs of keeping up a home for yourself and a qualifying individual. See Pub. 501 for more information about filing status.

Line E. Child tax credit. When you file your tax return, you might be eligible to claim a credit for each of your qualifying children. To qualify, the child must be under age 17 as of December 31 and must be your dependent who lives with you for more than half the year. To learn more about this credit, see Pub. 972, Child Tax Credit. To reduce the tax withheld from your pay by taking this credit into account, follow the instructions on line E of the worksheet. On the worksheet you will be asked about your total income. For this purpose, total income includes all of your wages and other income, including income earned by a spouse, during the year.

Line F. Credit for other dependents. When you file your tax return, you might be eligible to claim a credit for each of your dependents that don't qualify for the child tax credit, such as any dependent children age 17 and older. To learn more about this credit, see Pub. 505. To reduce the tax withheld from your pay by taking this credit into account, follow the instructions on line F of the worksheet. On the worksheet, you will be asked about your total income. For this purpose, total income includes all of

---------------------------- **Separate here and give Form W-4 to your employer. Keep the worksheet(s) for your records.** ----------------------------

Form **W-4**
Department of the Treasury
Internal Revenue Service

Employee's Withholding Allowance Certificate

▶ **Whether you're entitled to claim a certain number of allowances or exemption from withholding is subject to review by the IRS. Your employer may be required to send a copy of this form to the IRS.**

OMB No. 1545-0074

2018

1 Your first name and middle initial	Last name	2 **Your social security number**
Home address (number and street or rural route)	3 ☐ Single ☐ Married ☐ Married, but withhold at higher Single rate. **Note:** If married filing separately, check "Married, but withhold at higher Single rate."	
City or town, state, and ZIP code	4 **If your last name differs from that shown on your social security card, check here. You must call 800-772-1213 for a replacement card.** ▶ ☐	

5 Total number of allowances you're claiming (from the applicable worksheet on the following pages) . . . **5**

6 Additional amount, if any, you want withheld from each paycheck . . . . **6** $

7 I claim exemption from withholding for 2018, and I certify that I meet **both** of the following conditions for exemption.
- Last year I had a right to a refund of **all** federal income tax withheld because I had **no** tax liability, **and**
- This year I expect a refund of **all** federal income tax withheld because I expect to have **no** tax liability.

If you meet both conditions, write "Exempt" here . . . . ▶ **7**

Under penalties of perjury, I declare that I have examined this certificate and, to the best of my knowledge and belief, it is true, correct, and complete.

Employee's signature
(This form is not valid unless you sign it.) ▶ **Date** ▶

8 Employer's name and address (**Employer:** Complete boxes 8 and 10 if sending to IRS and complete boxes 8, 9, and 10 if sending to State Directory of New Hires.)	9 First date of employment	10 Employer identification number (EIN)

Employment Eligibility Verification
Department of Homeland Security
U.S. Citizenship and Immigration Services

USCIS
Form I-9
OMB No. 1615-0047
Expires 08/31/2019

▶ START HERE: Read instructions carefully before completing this form. The instructions must be available, either in paper or electronically, during completion of this form. Employers are liable for errors in the completion of this form.

ANTI-DISCRIMINATION NOTICE: It is illegal to discriminate against work-authorized individuals. Employers **CANNOT** specify which document(s) an employee may present to establish employment authorization and identity. The refusal to hire or continue to employ an individual because the documentation presented has a future expiration date may also constitute illegal discrimination.

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	Other Last Names Used *(if any)*

Address *(Street Number and Name)*	Apt. Number	City or Town	State	ZIP Code

Date of Birth *(mm/dd/yyyy)*	U.S. Social Security Number	Employee's E-mail Address	Employee's Telephone Number
	☐☐☐ - ☐☐ - ☐☐☐☐		

I am aware that federal law provides for imprisonment and/or fines for false statements or use of false documents in connection with the completion of this form.

I attest, under penalty of perjury, that I am (check one of the following boxes):

☐ 1. A citizen of the United States

☐ 2. A noncitizen national of the United States *(See instructions)*

☐ 3. A lawful permanent resident (Alien Registration Number/USCIS Number): ________

☐ 4. An alien authorized to work until (expiration date, if applicable, mm/dd/yyyy): ________
Some aliens may write "N/A" in the expiration date field. *(See instructions)*

Aliens authorized to work must provide only one of the following document numbers to complete Form I-9: An Alien Registration Number/USCIS Number OR Form I-94 Admission Number OR Foreign Passport Number.

1. Alien Registration Number/USCIS Number: ________

OR

2. Form I-94 Admission Number: ________

OR

3. Foreign Passport Number: ________

Country of Issuance: ________

QR Code - Section 1
Do Not Write In This Space

Signature of Employee	Today's Date *(mm/dd/yyyy)*

Preparer and/or Translator Certification (check one):

☐ I did not use a preparer or translator. ☐ A preparer(s) and/or translator(s) assisted the employee in completing Section 1.

(Fields below must be completed and signed when preparers and/or translators assist an employee in completing Section 1.)

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	Today's Date *(mm/dd/yyyy)*

Last Name *(Family Name)*	First Name *(Given Name)*

Address *(Street Number and Name)*	City or Town	State	ZIP Code

STOP *Employer Completes Next Page* STOP

Employment Eligibility Verification
Department of Homeland Security
U.S. Citizenship and Immigration Services

USCIS
Form I-9
OMB No. 1615-0047
Expires 08/31/2019

Section 2. Employer or Authorized Representative Review and Verification

(Employers or their authorized representative must complete and sign Section 2 within 3 business days of the employee's first day of employment. You must physically examine one document from List A OR a combination of one document from List B and one document from List C as listed on the "Lists of Acceptable Documents.")

Employee Info from Section 1	Last Name *(Family Name)*	First Name *(Given Name)*	M.I.	Citizenship/Immigration Status

List A Identity and Employment Authorization	OR	List B Identity	AND	List C Employment Authorization
Document Title		Document Title		Document Title
Issuing Authority		Issuing Authority		Issuing Authority
Document Number		Document Number		Document Number
Expiration Date *(if any)(mm/dd/yyyy)*		Expiration Date *(if any)(mm/dd/yyyy)*		Expiration Date *(if any)(mm/dd/yyyy)*
Document Title		Additional Information		QR Code - Sections 2 & 3 Do Not Write In This Space
Issuing Authority				
Document Number				
Expiration Date *(if any)(mm/dd/yyyy)*				
Document Title				
Issuing Authority				
Document Number				
Expiration Date *(if any)(mm/dd/yyyy)*				

Certification: I attest, under penalty of perjury, that (1) I have examined the document(s) presented by the above-named employee, (2) the above-listed document(s) appear 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.

The employee's first day of employment *(mm/dd/yyyy)*: ______________ ***(See instructions for exemptions)***

Signature of Employer or Authorized Representative	Today's Date *(mm/dd/yyyy)*	Title of Employer or Authorized Representative

Last Name of Employer or Authorized Representative	First Name of Employer or Authorized Representative	Employer's Business or Organization Name

Employer's Business or Organization Address (Street Number and Name)	City or Town	State	ZIP Code

Section 3. Reverification and Rehires *(To be completed and signed by employer or authorized representative.)*

A. New Name *(if applicable)*			B. Date of Rehire *(if applicable)*
Last Name *(Family Name)*	First Name *(Given Name)*	Middle Initial	Date *(mm/dd/yyyy)*

C. If the employee's previous grant of employment authorization has expired, provide the information for the document or receipt that establishes continuing employment authorization in the space provided below.

Document Title	Document Number	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 document(s), the document(s) I have examined appear to be genuine and to relate to the individual.

Signature of Employer or Authorized Representative	Today's Date *(mm/dd/yyyy)*	Name of Employer or Authorized Representative