Neighborhood Nursing Care

2000 Broadway Street
Redwood City, CA 94063
Phone (650) 365-3645
Fax (650) 365-0521

Memorandum

To: Respite Worker

From: Lucy Brock

Re: Employment

Hello and welcome,

Please fill the application out completely and return to me as soon as possible.
It is very important to also include a …

- ***copy of your Social Security Card*** and
- ***Driver's License or ID CARD*** or
- ***copy of your Birth Certificate if you do not have a Driver's License***.

If you are not a U.S. citizen, I will need a copy of …

- ***your alien card*** and your
- ***INS Authorization to work if your Social Security Card states that it is "Not valid for employment***.

You will need to make an appointment to come in and get your PPD (TB test) from our nurse. As a courtesy and added benefit to you, we will be providing your annual PPD at no charge. I will also need to have each of you …

- ***submit to me a copy of your current CPR/First Aid card.***
- ***If you do not have one, please contact us regarding this***.

If you have any questions, please give us a call.

Thank you for considering Neighborhood Nursing Care.

AN EQUAL OPPORTUNITY EMPLOYER

Consideration is given without discrimination because of race, color, creed, sex, age and national origin, handicap or veteran status. Filling out this application does not guarantee employment.

APPLICATION FOR EMPLOYMENT

NAME (last, first, MI): ____ DATE:________________

ADDRESS: ____ APT. # ________________

CITY: ____ STATE: ____ ZIP:________________

PHONE #: (____) __________ ALT PHONE # (___) __________SOCIAL SECURITY # ________________

POSITION: ______________________ LICENSE #: _____________ EXP. DATE: ________________

If employed by NNC what date are you available to begin work? ________________________________

If you are not a U.S. citizen, do you have legal right to work in the U.S.? ☐ YES ☐ NO

The minimum working age at NNC is 18. In some positions, persons under 18 years may eligible for employment when a valid school work permit is presented.

Can you provide proof that you are over 18 years of age or, if you are under 18, can you provide a valid school work permit? ☐ YES ☐ NO

School Work Permit ☐ YES ☐ NO ☐ NOT NEEDED

Have you ever worked with or had contact with children and/or adults who have developmental or other types of disabilities? ☐ YES ☐ NO

If yes, please describe briefly: ____

____

EMPLOYMENT RECORD (Please list 3 most recent employers)

EMPLOYER'S NAME:____________________________ADDRESS: ____________________________

PHONE #:(____)__________ SUPERVISOR: _____________________JOB TITLE:________________

EMPLOYED FROM: ____/____/____ TO: ____/____/____ REASON FOR LEAVING: __________________

DUTIES: ____SALARY: $_______/HOUR

EMPLOYER'S NAME:____________________________ADDRESS: ____________________________

PHONE #:(____)__________ SUPERVISOR: _____________________JOB TITLE:________________

EMPLOYED FROM: ____/____/____ TO: ____/____/____ REASON FOR LEAVING: __________________

DUTIES: ____SALARY: $_______/HOUR

EMPLOYER'S NAME:____________________________ADDRESS: ____________________________

PHONE #:(____)__________ SUPERVISOR: _____________________JOB TITLE:________________

EMPLOYED FROM: ____/____/____ TO: ____/____/____ REASON FOR LEAVING: __________________

DUTIES: ____SALARY: $_______/HOUR

EDUCATION RECORD: (Include all post high school education. List most recent schools first)

HIGH SCHOOL: _____ GRADE COMPLETED □ 9 □ 10 □ 11 □ 12

SCHOOL NAME: _____ TYPE: _____

CITY: _____ STATE:_____DEGREE TYPE: _____

ATTENDED FROM: ____/____/____ TO: ____/____/____ GRADUATED? ___ YES ___ NO

SCHOOL NAME: _____ TYPE: _____

CITY: _____ STATE:_____DEGREE TYPE: _____

ATTENDED FROM: ____/____/____ TO: ____/____/____ GRADUATED? ___ YES ___ NO

PROFESSIONAL REFERENCES

List two MOST RECENT supervisors or other who is familiar with your work performance.

NAME/TITLE: _____ PHONE: (____)_____

ADDRESS: _____ CITY: _____ STATE: _____

NAME/TITLE: _____ PHONE: (____)_____

ADDRESS: _____ CITY: _____ STATE: _____

PERSONAL REFERENCES (at least one)

(Reference can attest to your character and whom you have known at least five years.)

NAME/TITLE: _____ PHONE: (____)_____

ADDRESS: _____ CITY: _____ STATE: _____

NAME/TITLE: _____ PHONE: (____)_____

ADDRESS: _____ CITY: _____ STATE: _____

HAVE YOU EVER BEEN CONVICTED OF A FELONY WITHIN THE PAST 7 YEARS? (A CONVICTION RECORD IS NOT NECESSARILY A BAR TO EMPLOYMENT. EACH CASE WILL BE GIVEN INDIVIDUAL CONSIDERATION)

☐ **YES** ☐ **NO**

If yes, please provide details below:

_____

_____

_____

_____

EMERGENCY INFORMATION

Employee's Name: _____

Date: _____

In case of emergency, please notify:

Name: _____

Relationship: _____

Tel. Number: _____

Address: _____

_____

AND/OR

Name: _____

Relationship: _____

Tel. Number: _____

Address: _____

_____

Employee Signature: _____

Date: _____

NEIGHBORHOOD NURSING CARE
2000 BROADWAY ST, REDWOOD CITY, CA 94063
(650) 365-3645

EMPLOYEE HEALTH STATEMENT

To my knowledge, I am free of communicable disease and have no physical or emotional conditions, which would adversely affect my job performance.

Signed: _____ Witnessed: _____

Date: _____

NEIGHBORHOOD NURSING CARE

2000 BROADWAY ST. REDWOOD CITY, CA 94063
(650) 365-3645

PROFESSIONAL REFERENCE INQUIRY

Employer's Name & Address

_____

_____

_____

I authorize the above listed employer to furnish NEIGHBORHOOD NURSING CARE with the information requested in this letter.

_____
Print Your Name

_____ _____
Signature of Applicant Date

TO WHOM IT MAY CONCERN:

One of your former employees has applied for respite worker and/or nursing care assignments as an employee of NEIGHBORHOOD NURSING CARE. We ask that you verify and complete this form at your earliest convenience and return it to our office. It is understood that information provided by you will be held in strictest confidence. Thank you for your assistance in this matter.

Name of Applicant _____ Maiden Name _____

Social Security Number _____ Classification _____

Dates of Employment _____

EVALUATION	**ABOVE AVERAGE**				**AVERAGE**			**BELOW AVERAGE**		
Job Knowledge	10	9	8	7	6	5	4	3	2	1
Quality	10	9	8	7	6	5	4	3	2	1
Attitude	10	9	8	7	6	5	4	3	2	1
Dependability	10	9	8	7	6	5	4	3	2	1
Punctuality	10	9	8	7	6	5	4	3	2	1
Personal Appearance	10	9	8	7	6	5	4	3	2	1

PROFESSIONAL REFERENCE INQUIRY **(page 2)**

Reason for Leaving _____

Eligible for reemployment: Yes _____ No _____

If no, please explain: _____

_____

To your knowledge, does the applicant have any disability which would adversely affect the performance of his or her duties? Yes _____ No _____

If yes, please explain: _____

_____

Signature _____

Title _____ Date _____

NEIGHBORHOOD NURSING CARE	POLICY NUMBER: Assessment 5.0
SUBJECT: Suspected Dependent Adult/Elder Abuse	PAGE 1 OF 2
DATE: September 1, 2002	SUPERSEDES:
APPROVED BY:	

I. Policy

Neighborhood Nursing Care complies with the following:

Senate Bill 1210, effective January 1, 1984, requires that individuals who have actual knowledge that an elder (defined as a person 65 and over) whom they observe in their professional capacity or within the scope of their employment has been the victim of physical abuse must report that abuse.

AB238, effective October, 1985, requires that all physical abuse to dependent adults ages 18 to 65 must be reported. Dependent adults include persons dependent on the assistance of others and who are unable to protect themselves due to physical or mental disability.

Sec. 15630 California Welfare and Administrative Code which requires every care custodian, employee and health practitioner of a health care facility shall, as a condition of continued employment sign a statement acknowledging his/her obligation to report instances of elder/adult abuse.

II. Procedure

A. All new employees review the Agency's policies regarding the reporting of Elder and Dependent Adult Abuse and sign a form acknowledging awareness of the policy.

B. All clients are assessed on the initial assessment and on on-going visits for signs and symptoms of abuse.

1. Signs and symptoms of abuse may include, but are not limited to:

a. Physical Abuse: includes direct beatings, sexual assault, unreasonable physical restraint or prolonged deprivation of food or water by individuals who care for the dependent adult or elder or stand in a position of trust with them.

b. Fiduciary Abuse: Misuse of money or property.

c. Neglect/Denial of Needs: Includes failure to provide adequate water, food, clothing; failure to provide medical care for the physical and mental health needs of the person (this does not include instances in which a competent adult person refuses treatment); failure to protect a dependent adult or elder from health and safety hazards; failure to prevent malnutrition.

d. Self-Neglect: Failure to provide for self through inattention or dissipation. The identification of this type of case depends on assessing the elder's ability to choose a life-style versus a recent change in the elder's ability to manage.

e. Psychological/Emotional Abuse: The willful infliction of mental suffering, by a person in a position of trust with that elder, constitutes psychological/emotional abuse. Examples of such abuse are: verbal assaults, threats, instilling fear, humiliation, intimidation, or isolation of an elder. Abandonment: The desertion or willful forsaking of a dependent adult or elder person by any person having the care or custody of that elder under circumstances in which a reasonable person would continue to provide care or custody.

C. Assessment Guidelines

1. Abused elderly persons rarely, or with difficulty, report acts of aggression against themselves by family members or others to whom they are close or dependent upon. This silence makes detection and assessment extremely difficult.
2. Because the elderly are generally more frail and may suffer from chronic problems, accidental injuries may be difficult to distinguish from physical abuse inflicted by others.
3. The client is to be assessed to identify conditions of the person that range from signs of physical neglect to obvious physical injury. The practitioner is to view the appearance of the client prior to removing the clothing and bathing the client.
4. The client is evaluated for observable physical indicators that an abuse situation would generate
   a. Injuries which appear to be inflicted by an object, e.g., cigarette burns, human bite marks; cluster bruises, indicating contact with a hand or instrument; chain burns.
   b. Forced restraint signs: symmetrical injuries, such as rope burns around upper extremities, chain marks, neck burns or bruises that have long circular patterns on the chest, arms, legs or back.
   c. Lacerations or abrasions on the lips, eyes, or other parts of the face. Any laceration or abrasion to the body such as puncture wounds or lacerations which are torn or jagged. The types of wounds often become infected.
   d. Any injury, in any stage of healing.
   e. Head and scalp wounds such as absence of hair in one spot and hemorrhage beneath the scalp which may result from hair pulling.
   f. Injuries that have not been cared for, such as an untreated, deformed wrist fracture.
   g. Other physical manifestations such as signs of malnutrition, dehydration; problems with hearing and vision that have not been medically addressed; soiled clothing, poor hygiene, scabies, pressure ulcers.
5. Behavior indicators are important in attempting to identify a possible abuse victim:
   a. Client behavior indicators:
      - ☐ exhibition of apprehension, fear, anxiety, agitation, withdrawal or wincing when approached;
      - ☐ reluctance to be discharged from the Emergency department;
      - ☐ may appear more comfortable when the caregiver is not present.

   b. Caregiver indicators:
      - ☐ is the client allowed to talk in the presence of the caregiver?
      - ☐ are there inconsistencies in the stories of the client and the caregiver?
      - ☐ are explanations of the injuries reasonable\believable?

D. Reporting Procedure

1. The case manager will refer the case to Adult Protective Services immediately by telephone and complete and send form SOC 341 within 2 working days of the telephone report.
2. In the absence of the case manager, the Director of Client Care Services will initiate the referral and complete the form.
3. The Director of Client Care Services will be informed of all actual or suspected cases.

NEIGHBORHOOD NURSING CARE	POLICY NUMBER: Assessment 6.0
SUBJECT: Suspected Child Abuse	PAGE 1 OF 2
DATE: September 1, 2002	SUPERSEDES:
APPROVED BY:	

I. Policy

All employees comply with the child abuse reporting requirements of California Penal Code, Section 11166. California law requires that health practitioners report all observed or suspected incidents of child abuse or neglect or sexual assault of a minor child (less than 18 years of age), or such cases reported to health practitioners by the child or other person, that have not previously been reported.

Section 11166 of the Penal Code requires any child care custodian, medical practitioner, non-medical practitioner, or employee of a child protective agency who has knowledge of or observes a child in his or her professional capacity or within the scope of his or her employment whom he or she knows or reasonably suspects has been the victim of child abuse to report the known or suspected instance of child abuse to a child protective agency immediately or as soon as practically possible by telephone, and to prepare and send a written report thereof within thirty-six (36) hours of receiving the information concerning the incident.

“Child Care Custodian” includes teachers, administrative officers, supervisors of child welfare and attendance, or certificate pupil personnel, employees of any public or private school; administrators of a public or private day camp; licensed evaluators; public assistance workers; employees of a child care institution, but not limited to, foster parents, group home personnel, and personnel of residential care facilities; and social workers or probation officers.

"Medical Practitioner" includes physicians and surgeons, psychiatrists, psychologists, dentists, residents, interns, podiatrists, chiropractors, licensed nurses, dental hygienists, or any other person who is licensed under Division 2 (commencing with Section 500) of the Business and Professions Code.

"Non-medical practitioner" includes state or county public health employees who treat minors for venereal disease or other condition; coroners; paramedics; marriage, family, or child counselors; and religious practitioners who diagnose, examine, or treat children.

Accordingly, all such cases will be verbally reported to the appropriate agency at the earliest possible time, and a written report (#11166 - Attachment A) will follow within 36 hours.

II. Procedure

A. Child abuse reporting policies are reviewed during the orientation period. The new employee signs a form indicating knowledge of the child abuse reporting policy.

B. Assessment guidelines: Situations which may indicate a further assessment for child abuse include but are not limited to:
   1. Presence of parents who have unrealistic expectations for the child based on the child's current developmental level.
   2. Presence of parents who were abused themselves.
   3. Burns caused from scalding.
   4. An imprint from a hot object on the back, buttocks, or back of the hands.
   5. Fractures that do not correlate with the child's gross motor ability.
   6. Femoral fractures in children under 2 years old.
   7. Rib fractures in infants and children.
   8. CNS signs and symptoms that may indicate a head injury from a violent shaking.

C. Criteria for referral
   1. Physical abuse
   2. Emotional abuse

3. Neglect
4. Sexual abuse categorized as the following:
    a. Sexual contact with family members always implies coercion for purposes of reporting.
    b. Any child less than 14 years old who reports or shows evidence of sexual activity,
    even if he/she claims to have consented.
    c. Any 14 - 16 year old child who reports sexual activity with an individual 10 years or older.
    d. Any child who reports being coerced into sexual activity even if the occurrence was months or years ago.

D. Procedure for Referring a Case
1. Telephone Children's Protective Services with report of abuse within family or by contacts of family.
2. Report to the city police department if child endangerment is evident. A report must be made to one of these agencies, who subsequently will cross report to each other.
3. Send Suspected Child Abuse Report Form SS 8572 to address of applicable agency within 36 hours.

NEIGHBORHOOD NURSING CARE

ACKNOWLEDGEMENT

Child and Elder/Dependent Adult Abuse Reporting Law

The policy and procedure regarding reporting of child and elder abuse is located in the Administrative Policy and Procedure Manual in the Neighborhood Nursing Care's office.

I have read and understand the attached statement regarding child and elder/dependent adult abuse reporting.

_____ _____

Signature Date

CONFIDENTIALITY OF PATIENT EMPLOYEE AND ORGANIZATIONAL INFORMATION

The organization acknowledges both a legal and ethical responsibility to protect the privacy of clients. Consequently, the discriminate or unauthorized review, use or disclosure of personal information, medical or otherwise, from any source regarding any patient is expressly prohibited. Except when required in the regular course of business, the discussion, use transmission or narration, in any form, of any patient information which is obtained in the regular course of your employment is strictly forbidden. Those individuals who also have access to employee information or the organization's financial information are expected to respect and treat the confidentiality of such information in the same manner as that of patient information. Any violation of this policy shall constitute grounds for severe disciplinary action, including possible termination of the offending employee.

CONFIDENTIALITY OF PATIENT INFORMATION

Neighborhood Nursing Care acknowledges both a legal and ethical responsibility to protect the privacy of clients and employees. Consequently, the indiscriminate or unauthorized review, use or disclosure of personal information, medical or otherwise, regarding any patient or employee is expressly prohibited. Except when required in the regular course of business, the discussion, use, transmission or narration in any form of any patient information which is obtained in the regular course of your employment is STRICTLY prohibited. Those individuals who also have access to employee information are expected to respect and treat the confidentiality of such information in the same manner as that of patient information. Any violation of this policy shall constitute grounds for severe disciplinary action, including possible termination of the offending employee.

I have read and understand the significance of this policy and agree to abide by it.

_____ _____

Employee's Signature Date

_____ _____

Employee's Print Name Witness

EQUAL EMPLOYMENT OPPORTUNITY DATA

Completion of this form is entirely voluntary, and all information will remain confidential and will not affect you application for employment. We are required by law to collect this information for equal opportunity employment purposes, and it will not become part of your personnel record if you are hired by this company. The information requested on this form is also required by the regulations of the Department of Fair Employment and Housing. Employers in California are required to keep these records on file for a period of two years. For your protection, employers are ordered to store the records in a location away from your application. The information is for data purposes only, and voluntary on your part. It is understood by Neighborhood Nursing Care that the information given below in no way affects your eligibility for employment or other benefits that Neighborhood Nursing Care offers.

Name: _____ Sex: _____ Date: _____

Position Applied For: _____

Please check the applicable category:

Native American	_____	Hispanic	_____
Black	_____	Filipino	_____
Asian	_____	Polynesian	_____
Caucasian	_____	Mexican American	_____
White Non-Hispanic	_____	Black Non- Hispanic	_____
Other	_____		

Government contractors must take affirmative action to employ and advance certain qualified individuals subject to the Rehabilitation Act of 1973 and the Vietnam Era Veterans Readjustment Act of 1974. Completion of the following information is voluntary, and will assist us in proper placement and reasonable accommodation. If you wish to be identified as qualifying for such placement or accommodation, please check where applicable:

____ Vietnam Era Veteran ____ Individual with Disability

____ Disabled Veteran

To be completed by Employer:

EEO – 1 Category
___1. Registered Nurse
___2. Licensed Vocational Nurse
___3. Certified Nursing Assistant
___4. Occupational Therapist
___5. Home Health Aide
___6. Office and Clerical

Employer information completed by:

Name: _____ Date: _____

Form W-4 (2005)

Purpose. Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay. Because your tax situation may change, you may want to refigure your withholding each year.

Exemption from withholding. If you are exempt, complete only lines 1, 2, 3, 4, and 7 and sign the form to validate it. Your exemption for 2005 expires February 16, 2006. See Pub. 505, Tax Withholding and Estimated Tax.

Note. You cannot claim exemption from withholding if (a) your income exceeds $800 and includes more than $250 of unearned income (for example, interest and dividends) and (b) another person can claim you as a dependent on their tax return.

Basic instructions. If you are not exempt, complete the **Personal Allowances Worksheet** below. The worksheets on page 2 adjust your withholding allowances based on itemized deductions, certain credits, adjustments to income, or two-earner/two-job situations. Complete all worksheets that apply. However, you may claim fewer (or zero) allowances.

Head of household. Generally, you may claim head of household filing status on your tax return only if you are unmarried and pay more than 50% of the costs of keeping up a home for yourself and your dependent(s) or other qualifying individuals. See line **E** below.

Tax credits. You can take projected tax credits into account in figuring your allowable number of withholding allowances. Credits for child or dependent care expenses and the child tax credit may be claimed using the **Personal Allowances Worksheet** below. See Pub. 919, How Do I Adjust My Tax Withholding? for information on converting your other credits into withholding allowances.

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 may owe additional tax.

Two earners/two jobs. If you have a working spouse or more than one job, figure the total number of allowances you are entitled to claim on all jobs using worksheets from only one Form W-4. Your withholding usually will be most accurate when all allowances are claimed on the Form W-4 for the highest paying job and zero allowances are claimed on the others.

Nonresident alien. If you are a nonresident alien, see the Instructions for Form 8233 before completing this Form W-4.

Check your withholding. After your Form W-4 takes effect, use Pub. 919 to see how the dollar amount you are having withheld compares to your projected total tax for 2005. See Pub. 919, especially if your earnings exceed $125,000 (Single) or $175,000 (Married).

Recent name change? If your name on line 1 differs from that shown on your social security card, call 1-800-772-1213 to initiate a name change and obtain a social security card showing your correct name.

Personal Allowances Worksheet (Keep for your records.)

A Enter "1" for **yourself** if no one else can claim you as a dependent . . . . . **A** _____

B Enter "1" if:
- You are single and have only one job; or
- You are married, have only one job, and your spouse does not work; or
- Your wages from a second job or your spouse's wages (or the total of both) are $1,000 or less.

. . **B** _____

C Enter "1" for your **spouse.** But, you may choose to enter "-0-" if you are married and have either a working spouse or more than one job. (Entering "-0-" may help you avoid having too little tax withheld.) . . . . . **C** _____

D Enter number of **dependents** (other than your spouse or yourself) you will claim on your tax return . . . . . **D** _____

E Enter "1" if you will file as **head of household** on your tax return (see conditions under **Head of household** above) . **E** _____

F Enter "1" if you have at least $1,500 of **child or dependent care expenses** for which you plan to claim a credit . . **F** _____
(**Note.** Do **not** include child support payments. See **Pub. 503,** Child and Dependent Care Expenses, for details.)

G **Child Tax Credit** (including additional child tax credit):
- If your total income will be less than $54,000 ($79,000 if married), enter "2" for each eligible child.
- If your total income will be between $54,000 and $84,000 ($79,000 and $119,000 if married), enter "1" for each eligible child plus "1" **additional** if you have four or more eligible children.

G _____

H Add lines A through G and enter total here. (**Note.** This may be different from the number of exemptions you claim on your tax return.) ► **H** _____

For accuracy, complete all worksheets that apply.
- If you plan to **itemize or claim adjustments to income** and want to reduce your withholding, see the **Deductions and Adjustments Worksheet** on page 2.
- If you have **more than one job** or are **married and you and your spouse both work** and the combined earnings from all jobs exceed $35,000 ($25,000 if married) see the **Two-Earner/Two-Job Worksheet** on page 2 to avoid having too little tax withheld.
- If **neither** of the above situations applies, **stop here** and enter the number from line H on line 5 of Form W-4 below.

---------- **Cut here and give Form W-4 to your employer. Keep the top part for your records.** ----------

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

Employee's Withholding Allowance Certificate

► **Whether you are 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. 1545-0010
2005

1 Type or print 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, but legally separated, or spouse is a nonresident alien, check the "Single" box.	
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 1-800-772-1213 for a new card.** ► ☐	

5 Total number of allowances you are claiming (from line **H** above **or** from the applicable worksheet on page 2) **5**

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

7 I claim exemption from withholding for 2005, 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
(Form is not valid unless you sign it.) ► **Date** ►

8 Employer's name and address (Employer: Complete lines 8 and 10 only if sending to the IRS.)	**9** Office code (optional)	**10** Employer identification number (EIN)

Deductions and Adjustments Worksheet

Note. Use this worksheet *only* if you plan to itemize deductions, claim certain credits, or claim adjustments to income on your 2005 tax return.

1	Enter an estimate of your 2005 itemized deductions. These include qualifying home mortgage interest, charitable contributions, state and local taxes, medical expenses in excess of 7.5% of your income, and miscellaneous deductions. (For 2005, you may have to reduce your itemized deductions if your income is over $145,950 ($72,975 if married filing separately). See *Worksheet 3* in Pub. 919 for details.)	**1**	$
2	Enter: { $10,000 if married filing jointly or qualifying widow(er) / $ 7,300 if head of household / $ 5,000 if single or married filing separately }	**2**	$
3	**Subtract** line 2 from line 1. If line 2 is greater than line 1, enter "-0-"	**3**	$
4	Enter an estimate of your 2005 adjustments to income, including alimony, deductible IRA contributions, and student loan interest	**4**	$
5	**Add** lines 3 and 4 and enter the total. (Include any amount for credits from *Worksheet 7* in Pub. 919)	**5**	$
6	Enter an estimate of your 2005 nonwage income (such as dividends or interest)	**6**	$
7	**Subtract** line 6 from line 5. Enter the result, but not less than "-0-"	**7**	$
8	**Divide** the amount on line 7 by $3,200 and enter the result here. Drop any fraction	**8**	
9	Enter the number from the **Personal Allowances Worksheet,** line H, page 1	**9**	
10	**Add** lines 8 and 9 and enter the total here. If you plan to use the **Two-Earner/Two-Job Worksheet,** also enter this total on line 1 below. Otherwise, **stop here** and enter this total on Form W-4, line 5, page 1	**10**	

Two-Earner/Two-Job Worksheet (See *Two earners/two jobs* on page 1.)

Note. Use this worksheet *only* if the instructions under line H on page 1 direct you here.

1	Enter the number from line H, page 1 (or from line 10 above if you used the **Deductions and Adjustments Worksheet**)	**1**	
2	Find the number in **Table 1** below that applies to the **LOWEST** paying job and enter it here	**2**	
3	If line 1 is **more than or equal to** line 2, subtract line 2 from line 1. Enter the result here (if zero, enter "-0-") and on Form W-4, line 5, page 1. **Do not** use the rest of this worksheet	**3**	

Note. If line 1 is *less than* line 2, enter "-0-" on Form W-4, line 5, page 1. Complete lines 4–9 below to calculate the additional withholding amount necessary to avoid a year-end tax bill.

4	Enter the number from line 2 of this worksheet	**4**			
5	Enter the number from line 1 of this worksheet	**5**			
6	**Subtract** line 5 from line 4			**6**	
7	Find the amount in **Table 2** below that applies to the **HIGHEST** paying job and enter it here			**7**	$
8	**Multiply** line 7 by line 6 and enter the result here. This is the additional annual withholding needed			**8**	$
9	Divide line 8 by the number of pay periods remaining in 2005. For example, divide by 26 if you are paid every two weeks and you complete this form in December 2004. Enter the result here and on Form W-4, line 6, page 1. This is the additional amount to be withheld from each paycheck			**9**	$

Table 1: Two-Earner/Two-Job Worksheet

Married Filing Jointly						All Others	
If wages from **HIGHEST** paying job are—	AND, wages from **LOWEST** paying job are—	Enter on line 2 above	If wages from **HIGHEST** paying job are—	AND, wages from **LOWEST** paying job are—	Enter on line 2 above	If wages from **LOWEST** paying job are—	Enter on line 2 above
$0 - $40,000	$0 - $4,000	0	$40,001 and over	30,001 - 36,000	6	$0 - $6,000	0
	4,001 - 8,000	1		36,001 - 45,000	7	6,001 - 12,000	1
	8,001 - 18,000	2		45,001 - 50,000	8	12,001 - 18,000	2
	18,001 and over	3		50,001 - 60,000	9	18,001 - 24,000	3
$40,001 and over	$0 - $4,000	0		60,001 - 65,000	10	24,001 - 31,000	4
	4,001 - 8,000	1		65,001 - 75,000	11	31,001 - 45,000	5
	8,001 - 18,000	2		75,001 - 90,000	12	45,001 - 60,000	6
	18,001 - 22,000	3		90,001 - 100,000	13	60,001 - 75,000	7
	22,001 - 25,000	4		100,001 - 115,000	14	75,001 - 80,000	8
	25,001 - 30,000	5		115,001 and over	15	80,001 - 100,000	9
						100,001 and over	10

Table 2: Two-Earner/Two-Job Worksheet

Married Filing Jointly		All Others	
If wages from **HIGHEST** paying job are—	Enter on line 7 above	If wages from **HIGHEST** paying job are—	Enter on line 7 above
$0 - $60,000	$480	$0 - $30,000	$480
60,001 - 110,000	800	30,001 - 70,000	800
110,001 - 160,000	900	70,001 - 140,000	900
160,001 - 280,000	1,060	140,001 - 320,000	1,060
280,001 and over	1,120	320,001 and over	1,120

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. The Internal Revenue Code requires this information under sections 3402(f)(2)(A) and 6109 and their regulations. Failure to provide a properly completed form will result in your being treated as a single person who claims no withholding allowances; providing fraudulent information may also 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, and the District of Columbia for use in administering their tax laws, and using it 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 time needed to complete this form will vary depending on individual circumstances. The estimated average time is: Recordkeeping, 45 min.; Learning about the law or the form, 12 min.; Preparing the form, 58 min. If you have comments concerning the accuracy of these time estimates or suggestions for making this form simpler, we would be happy to hear from you. You can write to: Internal Revenue Service, Tax Products Coordinating Committee, SE:W:CAR:MP:T:T:SP, 1111 Constitution Ave. NW, IR-6406, Washington, DC 20224. **Do not** send Form W-4 to this address. Instead, give it to your employer.

U.S. Department of Justice
Immigration and Naturalization Service

OMB No. 1115-0136

Employment Eligibility Verification

INSTRUCTIONS

PLEASE READ ALL INSTRUCTIONS CAREFULLY BEFORE COMPLETING THIS FORM.

Anti-Discrimination Notice. It is illegal to discriminate against any individual (other than an alien not authorized to work in the U.S.) in hiring, discharging, or recruiting or referring for a fee because of that individual's national origin or citizenship status. It is illegal to discriminate against work eligible individuals. Employers **CANNOT** specify which document(s) they will accept from an employee. The refusal to hire an individual because of a future expiration date may also constitute illegal discrimination.

Section 1 - Employee. All employees, citizens and noncitizens, hired after November 6, 1986, must complete Section 1 of this form at the time of hire, which is the actual beginning of employment. **The employer is responsible for ensuring that Section 1 is timely and properly completed.**

Preparer/Translator Certification. The Preparer/Translator Certification must be completed if Section 1 is prepared by a person other than the employee. A preparer/translator may be used only when the employee is unable to complete Section 1 on his/her own. However, the employee must still sign Section 1.

Section 2 - Employer. For the purpose of completing this form, the term "employer" includes those recruiters and referrers for a fee who are agricultural associations, agricultural employers or farm labor contractors.

Employers must complete Section 2 by examining evidence of identity and employment eligibility within three (3) business days of the date employment begins. If employees are authorized to work, but are unable to present the required document(s) within three business days, they must present a receipt for the application of the document(s) within three business days and the actual document(s) within ninety (90) days. However, if employers hire individuals for a duration of less than three business days, Section 2 must be completed at the time employment begins. **Employers must record: 1)** document title; **2)** issuing authority; **3)** document number, **4)** expiration date, if any; and **5)** the date employment begins. Employers must sign and date the certification. Employees must present original documents. Employers may, but are not required to, photocopy the document(s) presented. These photocopies may only be used for the verification process and must be retained with the I-9. **However, employers are still responsible for completing the I-9.**

Section 3 - Updating and Reverification. Employers must complete Section 3 when updating and/or reverifying the I-9. Employers must reverify employment eligibility of their employees on or before the expiration date recorded in Section 1. Employers **CANNOT** specify which document(s) they will accept from an employee.

- If an employee's name has changed at the time this form is being updated/ reverified, complete Block A.
- If an employee is rehired within three (3) years of the date this form was originally completed and the employee is still eligible to be employed on the same basis as previously indicated on this form (updating), complete Block B and the signature block.
- If an employee is rehired within three (3) years of the date this form was originally completed and the employee's work authorization has expired **or** if a current employee's work authorization is about to expire (reverification), complete Block B and:
  - examine any document that reflects that the employee is authorized to work in the U.S. (see List A **or** C),
  - record the document title, document number and expiration date (if any) in Block C, and
  - complete the signature block.

Photocopying and Retaining Form I-9. A blank I-9 may be reproduced, provided both sides are copied. The Instructions must be available to all employees completing this form. Employers must retain completed I-9s for three (3) years after the date of hire or one (1) year after the date employment ends, whichever is later.

For more detailed information, you may refer to the INS Handbook for Employers, (Form M-274). You may obtain the handbook at your local INS office.

Privacy Act Notice. The authority for collecting this information is the Immigration Reform and Control Act of 1986, Pub. L. 99-603 (8 USC 1324a).

This information is for employers to verify the eligibility of individuals for employment to preclude the unlawful hiring, or recruiting or referring for a fee, of aliens who are not authorized to work in the United States.

This information will be used by employers as a record of their basis for determining eligibility of an employee to work in the United States. The form will be kept by the employer and made available for inspection by officials of the U.S. Immigration and Naturalization Service, the Department of Labor and the Office of Special Counsel for Immigration Related Unfair Employment Practices.

Submission of the information required in this form is voluntary. However, an individual may not begin employment unless this form is completed, since employers are subject to civil or criminal penalties if they do not comply with the Immigration Reform and Control Act of 1986.

Reporting Burden. We try to create forms and instructions that are accurate, can be easily understood and which impose the least possible burden on you to provide us with information. Often this is difficult because some immigration laws are very complex. Accordingly, the reporting burden for this collection of information is computed as follows: **1)** learning about this form, 5 minutes; **2)** completing the form, 5 minutes; and **3)** assembling and filing (recordkeeping) the form, 5 minutes, for an average of 15 minutes per response. If you have comments regarding the accuracy of this burden estimate, or suggestions for making this form simpler, you can write to the Immigration and Naturalization Service, HQPDI, 425 I Street, N.W., Room 4034, Washington, DC 20536. OMB No. 1115-0136.

EMPLOYERS MUST RETAIN COMPLETED FORM I-9
PLEASE DO NOT MAIL COMPLETED FORM I-9 TO INS

U.S. Department of Justice
Immigration and Naturalization Service

OMB No. 1115-0136

Employment Eligibility Verification

Please read instructions carefully before completing this form. The instructions must be available during completion of this form. ANTI-DISCRIMINATION NOTICE: It is illegal to discriminate against work eligible individuals. Employers CANNOT specify which document(s) they will accept from an employee. The refusal to hire an individual because of a future expiration date may also constitute illegal discrimination.

Section 1. Employee Information and Verification. To be completed and signed by employee at the time employment begins.

Print Name: Last	First	Middle Initial	Maiden Name

Address *(Street Name and Number)*	Apt. #	Date of Birth *(month/day/year)*

City	State	Zip Code	Social Security #

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):

- ☐ A citizen or national of the United States
- ☐ A Lawful Permanent Resident (Alien # A_____)
- ☐ An alien authorized to work until ___/___/___
  (Alien # or Admission #) _____

Employee's Signature	Date *(month/day/year)*

Preparer and/or Translator Certification. *(To be completed and signed if Section 1 is prepared by a person other than the employee.) I attest, under penalty of perjury, that I have assisted in the completion of this form and that to the best of my knowledge the information is true and correct.*

Preparer's/Translator's Signature	Print Name

Address *(Street Name and Number, City, State, Zip Code)*	Date *(month/day/year)*

Section 2. Employer Review and Verification. To be completed and signed by employer. Examine one document from List A OR examine one document from List B and one from List C, as listed on the reverse of this form, and record the title, number and expiration date, if any, of the document(s)

List A	OR	List B	AND	List C
Document title: _____		_____		_____
Issuing authority: _____		_____		_____
Document #: _____		_____		_____
Expiration Date *(if any)*: ___/___/___		___/___/___		___/___/___
Document #: _____				
Expiration Date *(if any)*: ___/___/___				

CERTIFICATION - I attest, under penalty of perjury, that I have examined the document(s) presented by the above-named employee, that the above-listed document(s) appear to be genuine and to relate to the employee named, that the employee began employment on *(month/day/year)* **___/___/___ and that to the best of my knowledge the employee is eligible to work in the United States. (State employment agencies may omit the date the employee began employment.)**

Signature of Employer or Authorized Representative	Print Name	Title

Business or Organization Name	Address *(Street Name and Number, City, State, Zip Code)*	Date *(month/day/year)*

Section 3. Updating and Reverification. To be completed and signed by employer.

A. New Name *(if applicable)*	B. Date of rehire *(month/day/year) (if applicable)*

C. If employee's previous grant of work authorization has expired, provide the information below for the document that establishes current employment eligibility.

Document Title: _____ Document #: _____ Expiration Date (if any): ___/___/___

I attest, under penalty of perjury, that to the best of my knowledge, this employee is eligible 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	Date *(month/day/year)*

LISTS OF ACCEPTABLE DOCUMENTS

LIST A

Documents that Establish Both Identity and Employment Eligibility

1. U.S. Passport (unexpired or expired)
2. Certificate of U.S. Citizenship *(INS Form N-560 or N-561)*
3. Certificate of Naturalization *(INS Form N-550 or N-570)*
4. Unexpired foreign passport, with *I-551 stamp or* attached *INS Form I-94* indicating unexpired employment authorization
5. Permanent Resident Card or Alien Registration Receipt Card with photograph *(INS Form I-151 or I-551)*
6. Unexpired Temporary Resident Card *(INS Form I-688)*
7. Unexpired Employment Authorization Card *(INS Form I-688A)*
8. Unexpired Reentry Permit *(INS Form I-327)*
9. Unexpired Refugee Travel Document *(INS Form I-571)*
10. Unexpired Employment Authorization Document issued by the INS which contains a photograph *(INS Form I-688B)*

OR

LIST B

Documents that Establish Identity

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
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
3. School ID card with a photograph
4. Voter's registration card
5. U.S. Military card or draft record
6. Military dependent's ID card
7. U.S. Coast Guard Merchant Mariner Card
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

AND

LIST C

Documents that Establish Employment Eligibility

1. U.S. social security card issued by the Social Security Administration *(other than a card stating it is not valid for employment)*
2. Certification of Birth Abroad issued by the Department of State *(Form FS-545 or Form DS-1350)*
3. Original or certified copy of a birth certificate issued by a state, county, municipal authority or outlying possession of the United States bearing an official seal
4. Native American tribal document
5. U.S. Citizen ID Card *(INS Form I-197)*
6. ID Card for use of Resident Citizen in the United States *(INS Form I-179)*
7. Unexpired employment authorization document issued by the INS *(other than those listed under List A)*

Illustrations of many of these documents appear in Part 8 of the Handbook for Employers (M-274)