Employee Enrollment Packet

*** CONFIDENTIAL INFORMATION ***

Kymberly Group Payroll Solutions, Inc. is a co-employer of the employees working for its Worksite Employer. As a co-employer, Kymberly Group Payroll Solutions, Inc. is the employer of record for payroll, tax reporting, benefits, workers' compensation insurance, claims management and other administrative functions. The Worksite Employer is responsible for the day-to-day work of the employees.

Instructions for Completion of this Packet

NOTE: This Enrollment Packet should not be completed until a potential employee has received a conditional offer of employment from the Client Company.

PLEASE PRINT CLEARLY

Employee must complete:

Section 1-Employee Info
Section 3-Employee Agreement
Section 4-Workers Compensation Questionnaire
Section 5-EEO Information
Section 6- W4 Form
Section 7- Employment Acknowledgement Agreement
Section 8- Direct Deposit Form
Section 9- Employment Eligibility Verification Form – Form I-9

Employer must complete:

Section 2-Employee Pay Details
Section 5-Employer EEO Information
-Review enrollment for completion
-Submit completed package to KGPS BEFORE the employee begins working.

PLEASE ATTACH LEGIBLE COPIES OF IDENTIFICATION FOR I-9 FORM-SEE LAST PAGE FOR LIST OF ACCEPTABLE DOCUMENTS. THESE ARE TO BE RETAINED BY THE WORKSITE EMPLOYER.

SECTION 1- EMPLOYEE INFORMATION

Worksite Employer: _____

Full Employee Name: _____ Gender: ☐ Male ☐ Female

Date of Birth ___/___/___ SSN# _____ Telephone # _____

Mailing Address: _____

City State Zip Code

E-mail Address: _____

Emergency Contact Name: _____

Relationship: _____ Telephone # _____

SECTION 2 – EMPLOYEE PAY SETUP-TO BE COMPLETED BY EMPLOYEE'S SUPERVISOR / MANAGER

Pay Rate: _____ Job Title: _____ Work State: _____

Supervisor: _____ Work Location/Department: _____

Workers' Comp Code: _____ Drug Test Control #: _____

Check one in each category:

PAY PERIOD:

☐ Weekly ☐ Semi-monthly
☐ Bi-weekly ☐ Monthly

CLASSIFICATION:

☐ Hourly ☐ Commission
☐ Salaried with O/T
☐ Salaried Only

STATUS:

☐ Full time (30hrs/wk)
☐ Part time_____hrs
☐ Temporary
☐ Seasonal

Check all that apply:

☐ Owner ☐ Officer ☐ Key Employee ☐ Highly Compensated

Any garnishment orders, including child support?

☐ Yes ☐ No *If yes, please provide document copies.*

Worksite Employer Hire Date: _____

Kymberly Group Payroll Solutions, Inc. Hire Date: _____

PLEASE MAKE CERTAIN THAT YOU RECEIVE A WORKSITE EMPLOYEE HANDBOOK. ANY QUESTIONS SHOULD BE DIRECTED TO CUSTOMER SERVICE AT (407) 228-6428.

SECTION 3- WORKSITE EMPLOYEE AGREEMENT

In consideration of any offer of employment by Kymberly Group Payroll Solutions, Inc. ("KGPS"), I hereby acknowledge, understand and agree that the following constitute terms and conditions of my employment:

1. **Co-Employment**: KGPS has entered into a co-employment agreement with my Worksite Employer. I will be an employee of both KGPS and my worksite employer. My worksite employer is responsible for hiring, determining my compensation, supervising, scheduling the work to be performed, assessing my performance, handling any disciplinary issues up to and including termination of employment and reporting hours worked to KGPS. KGPS is responsible for administrative tasks such as issuing payroll checks, withholding taxes and administering benefits and workers' compensation claims.

2. **Handbook**: I hereby acknowledge receipt of the KGPS Employee Handbook ("Handbook") and agree to be bound by its terms. I understand that the Handbook does not establish a contract of employment. I further understand that the Handbook can be changed at any time, including its provisions regarding wages, hours, benefits, and terms and conditions of employment. The Handbook does not constitute a guarantee of present or future employment policies.

3. **At Will Empowerment**: I am an at-will employee of both my Worksite Employer and KGPS. This agreement does not constitute a contract of employment nor is my employment for a specific period of time. This means that either KGPS or I may terminate my employment at any time, for any reason or no reason, with or without prior notification according to the statutes of at-will employment. I further understand that there are no representations, warranties, terms, covenants or conditions made by KGPS other than those contained in this Agreement. I understand that neither KGPS nor my Worksite Employer has the authority to change my at-will employment status.

4. **Introductory Period**: I understand that there is a ninety (90) day introductory period. I understand that if I am terminated for unsatisfactory work performance, KGPS will not have its account charged for the full amount of unemployment benefits.

5. **Wage Claim Assignment**: By signing this agreement, I assign to KGPS my right to assert a priority wage claim against my Worksite Employer under 11 U.S.C. 507 (a)(3) in the event that a Bankruptcy Petition is filed under title 11 of the United States Code or by or on behalf of my Worksite Employer.

6. **Benefits**: In the event that my Worksite Employer has a policy providing paid leave benefits such as vacation, sick leave, paid time off or severance pay, my Worksite Employer is solely responsible for paying me any accrued benefits under such policies during employment and at the time of termination.

7. **Termination of Employment**: I Understand that I must contact KGPS Processing Center if my employment at my current worksite is involuntarily ended. I understand that no one at my current worksite has the right to speak to KGPS, as to whether or not I may continue employment with KGPS beyond any involuntary termination from my current worksite location. I further realize that my failure to contact KGPS within two (2) business days of my involuntary termination from my current worksite will be considered as voluntary resignation of my employment with KGPS without regard why my employment ceased at my worksite location. Such voluntary termination may disqualify me from collecting unemployment benefits.

8. **Discrimination and Harassment**: KGPS is a zero-tolerance employer for discrimination or harassment in the workplace. In the event that I am subjected to any type of discrimination, including discrimination based on my race, color, religion, national origin, age, sex, marital status, disability or any other protected class, or subjected to any type of harassment, including sexual harassment, I will immediately notify my worksite supervisor, if possible. Otherwise, I will contact the KGPS Director of Human Resources at (407)228-6428.

9. **Binding Arbitration and Choice of Law**: KGPS and I agree to arbitrate and resolve any and all disputes arising out of my employment by my Worksite Employer and KGPS, through binding arbitration administered by the American Arbitration Association ("AAA") under its Employment Alternate Dispute Resolution rules rather than through litigation. Accordingly, I agree to not bring any claim or suit against KGPS or my Worksite Employer, their supervisors, managers, employers or other agents. I understand that by signing this agreement, I waive my right to trial by jury. Discovery may be initiated by any party for a period of sixty (60) days following the filing of a claim for arbitration. Any award of the AAA may be entered in any Court of appropriate jurisdiction. This agreement to arbitrate does not prohibit me from filing any claim or charge with any state or federal agency that would otherwise take my claim or charge. The laws of the State of Florida shall govern the arbitration and be used to interpret and construe this agreement.

10. **Workers' Compensation**: In recognition of the fact that any work-related injuries which I may sustain are covered by the state workers' compensation laws, and to avoid the circumvention of such laws which may result from suits against my Worksite Employer based on the same injury or injured, and to the extent provided by law, I hereby waive and forever release any rights that I may have to make claims or brings suit against my Worksite Employer and/or KGPS for damages based upon injuries which are covered under such workers' compensation laws. I understand that for purposes of workers' compensation, I am an employee of both KGPS and my Worksite Employer. In the event of injury, I understand that my sole remedy lies in coverage under KGPS's workers' compensation policy.

11. **Injuries:** In the event that I am injured on the job, I will immediately notify KGPS Risk Management Department at (407)228-6428 and my Worksite Employer. I understand that workers' compensation claims may be under managed care, which means that I must seek treatment only as directed by KGPS or the insurance company case manager. I further understand that any unauthorized treatment for an alleged injury will not be reimbursed under any conditions unless the alleged injuries are life threatening.

12. **Drug Testing**: As a condition of employment, I agree to submit to a drug and alcohol test in conjunction with any reported on-the-job injury within twenty-four (24) hours and understand that failure to do so will automatically result in the denial of benefits or payments for the injury. I further understand and agree that I will submit to a drug and alcohol test if I cause or contribute to an on-the-job injury, which results in the injury to others or me. I also understand that my refusal to subject to a drug and alcohol test under these stated conditions may result in my immediate termination.

13. **Summarization of Agreement**: This agreement, along with the Handbook, constitutes the entire understanding between KGPS and me. I understand that neither my Worksite Employer nor KGPS has the authority to modify the terms of this Agreement. If one or more of the provisions of this Agreement are determined to be invalid, illegal or unenforceable, the validity and enforceability of the remaining provisions of this Agreement shall not be in any way affected, impaired or prejudiced.

Print Name: _____ Signature: _____

Date: _____

SECTION 4- WORKERS' COMPENSATION QUESTIONNAIRE

THIS QUESTIONNAIRE SHOULD NOT BE ANSWERED UNLESS THE APPLICANT HAS ACCEPTED A CONDITIONAL OFFER OF EMPLOYMENT AND HAS NOT COMMENCED EMPLOYMENT.

1. Have you ever had a job-related injury?

☐ No (If no, go to question #2)

☐ Yes (if yes, please list all job-related injuries below or attach a separate piece of paper)

Part of body affected:_____ Related to work: ☐ No ☐ Yes

Date of Injury:_____ Status of Claim: ☐ Open ☐ Closed Job Restrictions: ☐ No ☐ Yes

List Restrictions:_____

2. Have you ever had or been treated for any of the following conditions or diseases:	**YES**	**NO**
1. Repetitive Stress Trauma:_____	☐	☐
2. Back or neck problems or injury:_____	☐	☐
3. Head injury:_____	☐	☐
4. Knee Injury: _____	☐	☐
5. Diabetes:_____	☐	☐
6. Alcoholism:_____	☐	☐
7. Drug Addiction:_____	☐	☐
8. Major Illness in past (5) years:_____	☐	☐

SECTION 5- EEO INFORMATION

COMPLETED BT EITHER THE EMPLOYEE VOLUNTAIRILY OR BY EMPLOYER OBSERVATION

Kymberly Group Payroll Solutions, Inc. ("KGPS") and your Worksite Employer are subject to certain governmental recordkeeping and reporting requirements for the administration of civil rights law and regulations. In order to comply with these laws, KGPS invites employees to voluntarily self-identify their race and ethnicity by completing this Data Record.

Submission of this information is voluntary and refusal to provide it will not subject you to any adverse treatment. The information will be kept confidential and will only be used in accordance with the provisions of applicable laws, executive orders and regulations, including those that require the information to be summarized and reported to the federal government for civil rights enforcement. When reported, data will not identify any specific individual.

Again, this information has no impact on any employment decision and is to be completed only ***after*** an offer of employment has been accepted. This information will be kept confidential and is used for no purpose other than EEO reporting.

Employee Name:_____

DATE OF BIRTH: Month_____Day_____Year_____ Gender: ☐ Male ☐ Female

PLEASE CHECK THE APPLICABLE BOX BELOW

☐ White
☐ Black of African American
☐ Hispanic or Latino
☐ American Indian / Alaskan Native
☐ Asian
☐ Native Hawaiian or other Pacific Islander
☐ Two or more races

Form W-4 (2019)

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 2019 if **both** of the following apply.

- For 2018 you had a right to a refund of **all** federal income tax withheld because you had **no** tax liability, **and**
- For 2019 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 2019 expires February 17, 2020. 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 2019 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 not subject to withholding 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 2019. 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 filing jointly 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 not subject to withholding, 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 Additional 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 may 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 may be eligible to claim a child tax credit for each of your eligible children. To qualify, the child must be under age 17 as of December 31, must be your dependent who lives with you for more than half the year, and must have a valid social security number. 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 if you are filing a joint return.

Line F. Credit for other dependents. When you file your tax return, you may be eligible to claim a credit for other dependents for whom a child tax credit can't be claimed, such as a qualifying child who doesn't meet the age or social security number requirement for the child tax credit, or a qualifying relative. To learn more about this credit, see Pub. 972. 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

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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

2019

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 2019, 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 ACKNOWLEDGEMENT AGREEMENT

I hereby acknowledge that I have received this company's Drug Free Workplace Handbook, which includes the company Drug Free Workplace policy, employee assistance information, a listing of drugs being tested for, common over-the-counter medications which may alter a drug test and educational material on substance abuse. I have also been given the opportunity to voluntarily complete a Medication Disclosure Form.

I freely and voluntarily agree and realize that as part of my employment, I may be subjected to future drug and/or alcohol screens for post-accident, reasonable suspicion, job placement, routine fitness-for-duty, return to work, follow-up, and/or random testing at the company's discretion. I understand that a refusal to submit a blood, urinalysis, hair and/or breath test will result in immediate termination from employment. I understand that a tampered or an adulterated drug and/or alcohol specimen will be considered a refusal to test, resulting in immediate termination. I understand that a confirmed positive drug and/or alcohol test will result in immediate termination of employment, but if I am able to successfully complete substance abuse treatment at my expense, and if my job is still available, I may be given one chance to be rehired, upon a negative return to work drug and/or alcohol test. I understand that I will be subject to the company rehabilitation agreement and I will undergo random follow-up drug and/or alcohol tests for a period of 2 years. I understand that a confirmed positive drug and/or alcohol follow up test or any violation of the rehabilitation agreement will result in termination of employment. I understand that this company reserves the right not to offer employment to a former employee who was terminated in violation of this policy, even if a job is available.

I agree to voluntarily submit to a blood, urinalysis, hair and/or breath test for drug and alcohol use as part of my ongoing employment, and I release my employer from any liability resulting from my participation in such a screening. I understand that if I am injured during the course and scope of my employment and I test positive for the presence of alcohol and/or drugs, I may forfeit my eligibility for medical and indemnity benefits under Florida's workers' compensation law (Florida Statutes 440.101, 440.102). I also understand that a refusal to test under this circumstance will automatically result in forfeiture of my eligibility for medical and indemnity benefits and immediate termination from employment. I understand that a confirmed positive drug and/or alcohol test, a tampered with or an adulterated specimen or a refusal to test may result in forfeiture of unemployment benefits under Florida law.

I hereby give my consent to release the results of my blood, urinalysis, hair and/or breath test to the person(s) or department(s) or the specified agent of my employer, including my employer's Workers' Compensation Insurance Company, for the purpose of determining the presence of alcohol and/or other drugs in my body for the duration of my employment. By signing this form, I hereby release to the Company and/or Company's Medical Review Officer the results of the test(s) to which I have consented. I further authorize the Company to discuss the results with medical personnel/physician collecting the specimen, the testing facility, its directors, officers, agents, and employees responsible for administrating the aforementioned test(s) or evaluating the results thereof and any of them herein. I also authorize the Company to discuss the results with its legal advisors and to use the test results as defense to any legal action to which I am party. I further release any testing facility or any physicians who have tested me from any liability arising from a release of any and all results, written reports, medical records, and data concerning my test(s) to the appropriate Employer officials. I agree to have the results released to the Company and/or the Company's Medical Review Officer.

I also understand that the Drug-Free Workplace policy and related documents are not intended to constitute a contract between this employer and myself. As an employee, I understand and agree to abide by this company's Drug Free Workplace policy, under Florida statute 440.101 and 440.102, and have received a written 60-day notification of this program, if applicable.

_____/_____/_____

Employee Signature Print Name Date

As a job applicant, I freely and voluntarily agree to a hair or urinalysis drug screen as part of my application for employment and I understand that a refusal to test, a positive confirmed drug test or a tampered with or an adulterated specimen will disqualify me from employment, even if I have started work pending the results of the drug test. I understand I am still completing the application process and will not officially be an employee until the company receives a negative pre-employment drug test result. If I am employed by this company, I understand and agree to abide by this company's Drug Free Workplace policy, under Florida statute 440.101 and 440.102, as stated above.

_____ /_____/_____

Employee Signature Print Name Date

DIRECT DEPOSIT AUTHORIZATION AND CHANGE REQUEST

Employee Name: _____ **Social Security #:** _____

I hereby authorize Kymberly Group Payroll Solutions, Inc. to initiate credit and/or debit entries (if necessary) and adjustments for any credit entries in error to my account. **Deposit entries are to be made to the following checking accounts, savings accounts, or Rapid! PayCard accounts:**

Depository Account #1

Bank Name: _____ Phone Number: _____

City: _____ State: _____ Zip Code: _____

Routing/Transit Number: _____ Account Number: _____

Type of Account (select one): ☐Checking ☐Savings Select One: ☐Activate New Direct Deposit ☐Cancel Existing Direct Deposit

Amount of Paycheck: _____ or Percentage of Paycheck: _____

Depository Account #2

Bank Name: _____ Phone Number: _____

City: _____ State: _____ Zip Code: _____

Routing/Transit Number: _____ Account Number: _____

Type of Account (select one): ☐Checking ☐Savings ☐Activate New Direct Deposit ☐Cancel Existing Direct Deposit

Amount of Paycheck: _____ or Percentage of Paycheck: _____

Please attached a VOIDED CHECK if depositing to a checking account and/or a VOIDED DEPOSIT TICKET if depositing to a savings account.

☐I wish to request a Rapid! PayCard Visa Payroll Card to use for automatic direct deposit of my paycheck.

☐I do not wish to participate in automatic direct deposit. I wish to receive a live check with each payroll.

This authority is to remain in full force and effect until Kymberly Group Payroll Solutions, Inc. has received written notification from me of its termination within a reasonable time and manner to allow Kymberly Group Payroll Solutions, Inc. to act upon said request. There will be approximately one pay cycle of pre-noting until direct deposit is established. ALL FINAL PAYCHECKS WILL BE ISSUED AS LIVE PHYSICAL CHECKS, NOT DIRECT DEPOSIT.

_____ _____

Employee Signature Date

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**

Document Title
Issuing Authority
Document Number
Expiration Date *(if any)(mm/dd/yyyy)*

Document Title
Issuing Authority
Document Number
Expiration Date *(if any)(mm/dd/yyyy)*

Document Title
Issuing Authority
Document Number
Expiration Date *(if any)(mm/dd/yyyy)*

OR

List B — **Identity**

Document Title
Issuing Authority
Document Number
Expiration Date *(if any)(mm/dd/yyyy)*

AND

List C — **Employment Authorization**

Document Title
Issuing Authority
Document Number
Expiration Date *(if any)(mm/dd/yyyy)*

Additional Information

QR Code - Sections 2 & 3
Do Not Write In This Space

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

LISTS OF ACCEPTABLE DOCUMENTS
All documents must be UNEXPIRED

Employees may present one selection from List A
or a combination of one selection from List B and one selection from List C.

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 a nonimmigrant alien authorized to work for a specific employer because of his or her status: **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 alien's nonimmigrant status 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
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		**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		

Examples of many of these documents appear in Part 13 of the Handbook for Employers (M-274).

Refer to the instructions for more information about acceptable receipts.