Personnel Record & Application Full-time ☐ Part-time ☐ / Check If Temporary ☐

Last Name	First Name	Middle Name	Social Security Number:

Street Address	City	State	Zip Code

Home Phone: _____

Cell Phone: _____

Emergency Contact: _____

Emergency Contact #: _____

Are you a United States Citizen or legally eligible to work in the U.S.? Yes [ ] No [ ] (if hired, you will be required to provide documentation that you are eligible to work in the U.S.)

Are you 18 or over? Yes [ ] No [ ]

Date Of Birth: _____

Driver's License # _____

Title of Position Applying For:	Date Available to Work:

Have you ever pleaded guilty, no contest or been convicted of a felony? [ ] Yes [ ] No If yes, give dates and details:

Answering yes to these questions does not constitute an automatic rejection for employment. Date of the offense, seriousness and nature of the violation, rehabilitation and position applied for will be considered.

Technical or Certificate Programs					

Employment History Please provide the following information for your previous three employers, beginning with the most recent(Please attach an additional page if necessary, do not use "see attached resume".)

Employer:	Dates Employed: From _____ To _____	Job Title:

Address:

Telephone:	Job Duties:
Weekly Pay Start: Finish:	
Reason for Leaving:	

I certify that my answers are true and complete to the best of my knowledge. I authorize you to make such investigations and inquiries of my personal, employment, educational, financial and other related matters as may be necessary for an employment decision. I hereby release employers, schools or individuals from all liability when responding to inquiries in connection with my application.In the event I am employed, I understand that false or misleading information given in my application or interview(s) may result in discharge.

Signature _____ Date _____

OFFICE USE ONLY

Company Name: _____ Job Title: _____

Job Description: _____ W/C Code: _____

Date of Hire: _____ Hours Per Week: _____

Rate of Pay: _____ Full Time: _____ Part Time: _____

Frequency of Pay: Weekly _____ Bi-Weekly _____ Semi Monthly _____ Monthly _____

Form **W-4**

Department of the Treasury
Internal Revenue Service

Employee's Withholding Certificate

Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay.
Give Form W-4 to your employer.
Your withholding is subject to review by the IRS.

OMB No. 1545-0074

2025

Step 1: Enter Personal Information

(a) First name and middle initial	Last name	(b) Social security number
Address		**Does your name match the name on your social security card?** If not, to ensure you get credit for your earnings, contact SSA at 800-772-1213 or go to *www.ssa.gov*.
City or town, state, and ZIP code		

(c) ☐ **Single** or **Married filing separately**
☐ **Married filing jointly** or **Qualifying surviving spouse**
☐ **Head of household** (Check only if you're unmarried and pay more than half the costs of keeping up a home for yourself and a qualifying individual.)

TIP: Consider using the estimator at *www.irs.gov/W4App* to determine the most accurate withholding for the rest of the year if: you are completing this form after the beginning of the year; expect to work only part of the year; or have changes during the year in your marital status, number of jobs for you (and/or your spouse if married filing jointly), dependents, other income (not from jobs), deductions, or credits. Have your most recent pay stub(s) from this year available when using the estimator. At the beginning of next year, use the estimator again to recheck your withholding.

Complete Steps 2–4 ONLY if they apply to you; otherwise, skip to Step 5. See page 2 for more information on each step, who can claim exemption from withholding, and when to use the estimator at *www.irs.gov/W4App*.

Step 2: Multiple Jobs or Spouse Works

Complete this step if you (1) hold more than one job at a time, or (2) are married filing jointly and your spouse also works. The correct amount of withholding depends on income earned from all of these jobs.

Do **only one** of the following.

(a) Use the estimator at *www.irs.gov/W4App* for the most accurate withholding for this step (and Steps 3–4). If you or your spouse have self-employment income, use this option; **or**

(b) Use the Multiple Jobs Worksheet on page 3 and enter the result in Step 4(c) below; **or**

(c) If there are only two jobs total, you may check this box. Do the same on Form W-4 for the other job. This option is generally more accurate than (b) if pay at the lower paying job is more than half of the pay at the higher paying job. Otherwise, (b) is more accurate . . . . . ☐

Complete Steps 3–4(b) on Form W-4 for only ONE of these jobs. Leave those steps blank for the other jobs. (Your withholding will be most accurate if you complete Steps 3–4(b) on the Form W-4 for the highest paying job.)

Step 3: Claim Dependent and Other Credits

If your total income will be $200,000 or less ($400,000 or less if married filing jointly):

Multiply the number of qualifying children under age 17 by $2,000 $ _____

Multiply the number of other dependents by $500 . . . . . $ _____

Add the amounts above for qualifying children and other dependents. You may add to this the amount of any other credits. Enter the total here . . . . . **3** $

Step 4 (optional): Other Adjustments

(a) Other income (not from jobs). If you want tax withheld for other income you expect this year that won't have withholding, enter the amount of other income here. This may include interest, dividends, and retirement income . . . . . **4(a)** $

(b) Deductions. If you expect to claim deductions other than the standard deduction and want to reduce your withholding, use the Deductions Worksheet on page 3 and enter the result here . . . . . **4(b)** $

(c) Extra withholding. Enter any additional tax you want withheld each **pay period** . . **4(c)** $

Step 5: Sign Here

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

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

Employers Only

Employer's name and address	First date of employment	Employer identification number (EIN)

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Future Developments

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

Purpose of Form

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

Exemption from withholding. You may claim exemption from withholding for 2025 if you meet both of the following conditions: you had no federal income tax liability in 2024 **and** you expect to have no federal income tax liability in 2025. You had no federal income tax liability in 2024 if (1) your total tax on line 24 on your 2024 Form 1040 or 1040-SR is zero (or less than the sum of lines 27, 28, and 29), or (2) you were not required to file a return because your income was below the filing threshold for your correct filing status. If you claim exemption, you will have no income tax withheld from your paycheck and may owe taxes and penalties when you file your 2025 tax return. To claim exemption from withholding, certify that you meet both of the conditions above by writing "Exempt" on Form W-4 in the space below Step 4(c). Then, complete Steps 1(a), 1(b), and 5. Do not complete any other steps. You will need to submit a new Form W-4 by February 17, 2026.

Your privacy. Steps 2(c) and 4(a) ask for information regarding income you received from sources other than the job associated with this Form W-4. If you have concerns with providing the information asked for in Step 2(c), you may choose Step 2(b) as an alternative; if you have concerns with providing the information asked for in Step 4(a), you may enter an additional amount you want withheld per pay period in Step 4(c) as an alternative.

When to use the estimator. Consider using the estimator at *www.irs.gov/W4App* if you:

1. Are submitting this form after the beginning of the year;

2. Expect to work only part of the year;

3. Have changes during the year in your marital status, number of jobs for you (and/or your spouse if married filing jointly), or number of dependents, or changes in your deductions or credits;

4. Receive dividends, capital gains, social security, bonuses, or business income, or are subject to the Additional Medicare Tax or Net Investment Income Tax; or

5. Prefer the most accurate withholding for multiple job situations.

TIP: Have your most recent pay stub(s) from this year available when using the estimator to account for federal income tax that has already been withheld this year. At the beginning of next year, use the estimator again to recheck your withholding.

Self-employment. Generally, you will owe both income and self-employment taxes on any self-employment income you receive separate from the wages you receive as an employee. If you want to pay these taxes through withholding from your wages, use the estimator at *www.irs.gov/W4App* to figure the amount to have withheld.

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

Specific Instructions

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

Step 2. Use this step if you (1) have more than one job at the same time, or (2) are married filing jointly and you and your spouse both work. Submit a separate Form W-4 for each job.

Option **(a)** most accurately calculates the additional tax you need to have withheld, while option **(b)** does so with a little less accuracy.

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

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

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

Step 4 (optional).

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

Step 4(b). Enter in this step the amount from the Deductions Worksheet, line 5, if you expect to claim deductions other than the basic standard deduction on your 2025 tax return and want to reduce your withholding to account for these deductions. This includes both itemized deductions and other deductions such as for student loan interest and IRAs.

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

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

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

Note: If more than one job has annual wages of more than $120,000 or there are more than three jobs, see Pub. 505 for additional tables; or, you can use the online withholding estimator at *www.irs.gov/W4App*.

1 **Two jobs.** If you have two jobs or you're married filing jointly and you and your spouse each have one job, find the amount from the appropriate table on page 4. Using the "Higher Paying Job" row and the "Lower Paying Job" column, find the value at the intersection of the two household salaries and enter that value on line 1. Then, **skip** to line 3 . . . . . **1** $

2 **Three jobs.** If you and/or your spouse have three jobs at the same time, complete lines 2a, 2b, and 2c below. Otherwise, skip to line 3.

a Find the amount from the appropriate table on page 4 using the annual wages from the highest paying job in the "Higher Paying Job" row and the annual wages for your next highest paying job in the "Lower Paying Job" column. Find the value at the intersection of the two household salaries and enter that value on line 2a . . . . . **2a** $

b Add the annual wages of the two highest paying jobs from line 2a together and use the total as the wages in the "Higher Paying Job" row and use the annual wages for your third job in the "Lower Paying Job" column to find the amount from the appropriate table on page 4 and enter this amount on line 2b . . . . . **2b** $

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

3 Enter the number of pay periods per year for the highest paying job. For example, if that job pays weekly, enter 52; if it pays every other week, enter 26; if it pays monthly, enter 12, etc. **3**

4 **Divide** the annual amount on line 1 or line 2c by the number of pay periods on line 3. Enter this amount here and in **Step 4(c)** of Form W-4 for the highest paying job (along with any other additional amount you want withheld) . . . . . **4** $

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

1 Enter an estimate of your 2025 itemized deductions (from Schedule A (Form 1040)). Such deductions may include qualifying home mortgage interest, charitable contributions, state and local taxes (up to $10,000), and medical expenses in excess of 7.5% of your income . . . . . **1** $

2 Enter:
- $30,000 if you're married filing jointly or a qualifying surviving spouse
- $22,500 if you're head of household
- $15,000 if you're single or married filing separately

. . . . . **2** $

3 If line 1 is greater than line 2, subtract line 2 from line 1 and enter the result here. If line 2 is greater than line 1, enter "-0-" . . . . . **3** $

4 Enter an estimate of your student loan interest, deductible IRA contributions, and certain other adjustments (from Part II of Schedule 1 (Form 1040)). See Pub. 505 for more information . . . . **4** $

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

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

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

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

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

Married Filing Jointly or Qualifying Surviving Spouse

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	$0 - 9,999	$10,000 - 19,999	$20,000 - 29,999	$30,000 - 39,999	$40,000 - 49,999	$50,000 - 59,999	$60,000 - 69,999	$70,000 - 79,999	$80,000 - 89,999	$90,000 - 99,999	$100,000 - 109,999	$110,000 - 120,000
$0 - 9,999	$0	$0	$700	$850	$910	$1,020	$1,020	$1,020	$1,020	$1,020	$1,020	$1,020
$10,000 - 19,999	0	700	1,700	1,910	2,110	2,220	2,220	2,220	2,220	2,220	2,220	3,220
$20,000 - 29,999	700	1,700	2,760	3,110	3,310	3,420	3,420	3,420	3,420	3,420	4,420	5,420
$30,000 - 39,999	850	1,910	3,110	3,460	3,660	3,770	3,770	3,770	3,770	4,770	5,770	6,770
$40,000 - 49,999	910	2,110	3,310	3,660	3,860	3,970	3,970	3,970	4,970	5,970	6,970	7,970
$50,000 - 59,999	1,020	2,220	3,420	3,770	3,970	4,080	4,080	5,080	6,080	7,080	8,080	9,080
$60,000 - 69,999	1,020	2,220	3,420	3,770	3,970	4,080	5,080	6,080	7,080	8,080	9,080	10,080
$70,000 - 79,999	1,020	2,220	3,420	3,770	3,970	5,080	6,080	7,080	8,080	9,080	10,080	11,080
$80,000 - 99,999	1,020	2,220	3,420	4,620	5,820	6,930	7,930	8,930	9,930	10,930	11,930	12,930
$100,000 - 149,999	1,870	4,070	6,270	7,620	8,820	9,930	10,930	11,930	12,930	14,010	15,210	16,410
$150,000 - 239,999	1,870	4,240	6,640	8,190	9,590	10,890	12,090	13,290	14,490	15,690	16,890	18,090
$240,000 - 259,999	2,040	4,440	6,840	8,390	9,790	11,100	12,300	13,500	14,700	15,900	17,100	18,300
$260,000 - 279,999	2,040	4,440	6,840	8,390	9,790	11,100	12,300	13,500	14,700	15,900	17,100	18,300
$280,000 - 299,999	2,040	4,440	6,840	8,390	9,790	11,100	12,300	13,500	14,700	15,900	17,100	18,300
$300,000 - 319,999	2,040	4,440	6,840	8,390	9,790	11,100	12,300	13,500	14,700	15,900	17,170	19,170
$320,000 - 364,999	2,040	4,440	6,840	8,390	9,790	11,100	12,470	14,470	16,470	18,470	20,470	22,470
$365,000 - 524,999	2,790	6,290	9,790	12,440	14,940	17,350	19,650	21,950	24,250	26,550	28,850	31,150
$525,000 and over	3,140	6,840	10,540	13,390	16,090	18,700	21,200	23,700	26,200	28,700	31,200	33,700

Single or Married Filing Separately

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	$0 - 9,999	$10,000 - 19,999	$20,000 - 29,999	$30,000 - 39,999	$40,000 - 49,999	$50,000 - 59,999	$60,000 - 69,999	$70,000 - 79,999	$80,000 - 89,999	$90,000 - 99,999	$100,000 - 109,999	$110,000 - 120,000
$0 - 9,999	$200	$850	$1,020	$1,020	$1,020	$1,370	$1,870	$1,870	$1,870	$1,870	$1,870	$2,040
$10,000 - 19,999	850	1,700	1,870	1,870	2,220	3,220	3,720	3,720	3,720	3,720	3,890	4,090
$20,000 - 29,999	1,020	1,870	2,040	2,390	3,390	4,390	4,890	4,890	4,890	5,060	5,260	5,460
$30,000 - 39,999	1,020	1,870	2,390	3,390	4,390	5,390	5,890	5,890	6,060	6,260	6,460	6,660
$40,000 - 59,999	1,220	3,070	4,240	5,240	6,240	7,240	7,880	8,080	8,280	8,480	8,680	8,880
$60,000 - 79,999	1,870	3,720	4,890	5,890	7,030	8,230	8,930	9,130	9,330	9,530	9,730	9,930
$80,000 - 99,999	1,870	3,720	5,030	6,230	7,430	8,630	9,330	9,530	9,730	9,930	10,130	10,580
$100,000 - 124,999	2,040	4,090	5,460	6,660	7,860	9,060	9,760	9,960	10,160	10,950	11,950	12,950
$125,000 - 149,999	2,040	4,090	5,460	6,660	7,860	9,060	9,950	10,950	11,950	12,950	13,950	14,950
$150,000 - 174,999	2,040	4,090	5,460	6,660	8,450	10,450	11,950	12,950	13,950	15,080	16,380	17,680
$175,000 - 199,999	2,040	4,290	6,450	8,450	10,450	12,450	13,950	15,230	16,530	17,830	19,130	20,430
$200,000 - 249,999	2,720	5,570	7,900	10,200	12,500	14,800	16,600	17,900	19,200	20,500	21,800	23,100
$250,000 - 399,999	2,970	6,120	8,590	10,890	13,190	15,490	17,290	18,590	19,890	21,190	22,490	23,790
$400,000 - 449,999	2,970	6,120	8,590	10,890	13,190	15,490	17,290	18,590	19,890	21,190	22,490	23,790
$450,000 and over	3,140	6,490	9,160	11,660	14,160	16,660	18,660	20,160	21,660	23,160	24,660	26,160

Head of Household

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	$0 - 9,999	$10,000 - 19,999	$20,000 - 29,999	$30,000 - 39,999	$40,000 - 49,999	$50,000 - 59,999	$60,000 - 69,999	$70,000 - 79,999	$80,000 - 89,999	$90,000 - 99,999	$100,000 - 109,999	$110,000 - 120,000
$0 - 9,999	$0	$450	$850	$1,000	$1,020	$1,020	$1,020	$1,020	$1,870	$1,870	$1,870	$1,890
$10,000 - 19,999	450	1,450	2,000	2,200	2,220	2,220	2,220	3,180	4,070	4,070	4,090	4,290
$20,000 - 29,999	850	2,000	2,600	2,800	2,820	2,820	3,780	4,780	5,670	5,690	5,890	6,090
$30,000 - 39,999	1,000	2,200	2,800	3,000	3,020	3,980	4,980	5,980	6,890	7,090	7,290	7,490
$40,000 - 59,999	1,020	2,220	2,820	3,830	4,850	5,850	6,850	8,050	9,130	9,330	9,530	9,730
$60,000 - 79,999	1,020	3,030	4,630	5,830	6,850	8,050	9,250	10,450	11,530	11,730	11,930	12,130
$80,000 - 99,999	1,870	4,070	5,670	7,060	8,280	9,480	10,680	11,880	12,970	13,170	13,370	13,570
$100,000 - 124,999	1,950	4,350	6,150	7,550	8,770	9,970	11,170	12,370	13,450	13,650	14,650	15,650
$125,000 - 149,999	2,040	4,440	6,240	7,640	8,860	10,060	11,260	12,860	14,740	15,740	16,740	17,740
$150,000 - 174,999	2,040	4,440	6,240	7,640	8,860	10,860	12,860	14,860	16,740	17,740	18,940	20,240
$175,000 - 199,999	2,040	4,440	6,640	8,840	10,860	12,860	14,860	16,910	19,090	20,390	21,690	22,990
$200,000 - 249,999	2,720	5,920	8,520	10,960	13,280	15,580	17,880	20,180	22,360	23,660	24,960	26,260
$250,000 - 449,999	2,970	6,470	9,370	11,870	14,190	16,490	18,790	21,090	23,280	24,580	25,880	27,180
$450,000 and over	3,140	6,840	9,940	12,640	15,160	17,660	20,160	22,660	25,050	26,550	28,050	29,550

Employment Eligibility Verification

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

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

START HERE: Employers must ensure the form instructions are available to employees when completing this form. Employers are liable for failing to comply with the requirements for completing this form. See below and the Instructions.

ANTI-DISCRIMINATION NOTICE: All employees can choose which acceptable documentation to present for Form I-9. Employers cannot ask employees for documentation to verify information in **Section 1**, or specify which acceptable documentation employees must present for **Section 2** or Supplement B, Reverification and Rehire. Treating employees differently based on their citizenship, immigration status, or national origin may be illegal.

Section 1. Employee Information and Attestation: Employees must complete and sign Section 1 of Form I-9 no later than the first day of employment, but not before accepting a job offer.

Last Name (Family Name)	First Name (Given Name)	Middle Initial (if any)	Other Last Names Used (if any)

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

Date of Birth (mm/dd/yyyy)	U.S. Social Security Number	Employee's Email Address	Employee's Telephone Number

I am aware that federal law provides for imprisonment and/or fines for false statements, or the use of false documents, in connection with the completion of this form. I attest, under penalty of perjury, that this information, including my selection of the box attesting to my citizenship or immigration status, is true and correct.

Check one of the following boxes to attest to your citizenship or immigration status (See page 2 and 3 of the instructions.):

- ☐ 1. A citizen of the United States
- ☐ 2. A noncitizen national of the United States (See Instructions.)
- ☐ 3. A lawful permanent resident (Enter USCIS or A-Number.)
- ☐ 4. A noncitizen (other than **Item Numbers 2.** and **3.** above) authorized to work until (exp. date, if any)

If you check **Item Number 4.**, enter one of these:

USCIS A-Number	OR	Form I-94 Admission Number	OR	Foreign Passport Number and Country of Issuance

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

If a preparer and/or translator assisted you in completing Section 1, that person MUST complete the Preparer and/or Translator Certification on Page 3.

Section 2. Employer Review and Verification: Employers or their authorized representative must complete and sign Section 2 within three business days after the employee's first day of employment, and must physically examine, or examine consistent with an alternative procedure authorized by the Secretary of DHS, documentation from List A OR a combination of documentation from List B and List C. Enter any additional documentation in the Additional Information box; see Instructions.

	List A	OR	List B	AND	List C
Document Title 1					
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					
Document Title 2 (if any)					
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					
Document Title 3 (if any)					
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					

Additional Information

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

Certification: I attest, under penalty of perjury, that (1) I have examined the documentation presented by the above-named employee, (2) the above-listed documentation appears to be genuine and to relate to the employee named, and (3) to the best of my knowledge, the employee is authorized to work in the United States.

First Day of Employment (mm/dd/yyyy):

Last Name, First Name and Title of Employer or Authorized Representative	Signature of Employer or Authorized Representative	Today's Date (mm/dd/yyyy)

Employer's Business or Organization Name	Employer's Business or Organization Address, City or Town, State, ZIP Code

For reverification or rehire, complete Supplement B, Reverification and Rehire on Page 4.

LISTS OF ACCEPTABLE DOCUMENTS

All documents containing an expiration date must be unexpired.
* Documents extended by the issuing authority are considered unexpired.
Employees may present one selection from List A or a
combination of one selection from List B and one selection from List C.
Examples of many of these documents appear in the Handbook for Employers (M-274).

LIST A Documents that Establish Both Identity and Employment Authorization	OR	LIST B Documents that Establish Identity	AND	LIST C Documents that Establish Employment Authorization
1. U.S. Passport or U.S. Passport Card		**1.** Driver's license or ID card issued by a State or outlying possession of the United States provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		**1.** A Social Security Account Number card, unless the card includes one of the following restrictions: **(1)** NOT VALID FOR EMPLOYMENT **(2)** VALID FOR WORK ONLY WITH INS AUTHORIZATION **(3)** VALID FOR WORK ONLY WITH DHS AUTHORIZATION
2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551)		**2.** ID card issued by federal, state or local government agencies or entities, provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		**2.** Certification of report of birth issued by the Department of State (Forms DS-1350, FS-545, FS-240)
3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa		**3.** School ID card with a photograph		**3.** Original or certified copy of birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal
4. Employment Authorization Document that contains a photograph (Form I-766)		**4.** Voter's registration card		**4.** Native American tribal document
5. For an individual temporarily authorized to work for a specific employer because of his or her status or parole: **a.** Foreign passport; and **b.** Form I-94 or Form I-94A that has the following: **(1)** The same name as the passport; and **(2)** An endorsement of the individual's status or parole as long as that period of endorsement has not yet expired and the proposed employment is not in conflict with any restrictions or limitations identified on the form.		**5.** U.S. Military card or draft record		**5.** U.S. Citizen ID Card (Form I-197)
		6. Military dependent's ID card		**6.** Identification Card for Use of Resident Citizen in the United States (Form I-179)
		7. U.S. Coast Guard Merchant Mariner Card		**7.** Employment authorization document issued by the Department of Homeland Security For examples, see **Section 7** and **Section 13** of the M-274 on **uscis.gov/i-9-central**. The Form I-766, Employment Authorization Document, is a List A, **Item Number 4.** document, not a List C document.
		8. Native American tribal document		
		9. Driver's license issued by a Canadian government authority		
		For persons under age 18 who are unable to present a document listed above:		
		10. School record or report card		
		11. Clinic, doctor, or hospital record		
		12. Day-care or nursery school record		
6. Passport from the Federated States of Micronesia (FSM) or the Republic of the Marshall Islands (RMI) with Form I-94 or Form I-94A indicating nonimmigrant admission under the Compact of Free Association Between the United States and the FSM or RMI				

Acceptable Receipts

May be presented in lieu of a document listed above for a temporary period.
For receipt validity dates, see the M-274.

• Receipt for a replacement of a lost, stolen, or damaged List A document. • Form I-94 issued to a lawful permanent resident that contains an I-551 stamp and a photograph of the individual. • Form I-94 with “RE” notation or refugee stamp issued to a refugee.	**OR**	Receipt for a replacement of a lost, stolen, or damaged List B document.	Receipt for a replacement of a lost, stolen, or damaged List C document.

*Refer to the Employment Authorization Extensions page on **I-9 Central** for more information.

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

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

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

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

Instructions: This supplement must be completed by any preparer and/or translator who assists an employee in completing Section 1 of Form I-9. The preparer and/or translator must enter the employee's name in the spaces provided above. Each preparer or translator must complete, sign, and date a separate certification area. Employers must retain completed supplement sheets with the employee's completed Form I-9.

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

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

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

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

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

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

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

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

Supplement B,
Reverification and Rehire (formerly Section 3)

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

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

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

Instructions: This supplement replaces Section 3 on the previous version of Form I-9. Only use this page if your employee requires reverification, is rehired within three years of the date the original Form I-9 was completed, or provides proof of a legal name change. Enter the employee's name in the fields above. Use a new section for each reverification or rehire. Review the Form I-9 instructions before completing this page. Keep this page as part of the employee's Form I-9 record. Additional guidance can be found in the Handbook for Employers: Guidance for Completing Form I-9 (M-274)

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

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

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

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

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

Additional Information (Initial and date each notation.)

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

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

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

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

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

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

Additional Information (Initial and date each notation.)

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

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

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

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

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

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

Additional Information (Initial and date each notation.)

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

DIRECT DEPOSIT INSTRUCTIONS

Any employees that would like to enroll in the payroll direct deposit option would need to submit the direct deposit form and one of the following items:

1) Letter from their financial institution on their letterhead with the employee's name, account number and routing number.
2) Copy of a voided check.
3) An employee currently using a debit card for their direct deposit will need to submit a form from the issuing institution with the employee's name, account number and routing number. These forms normally come with the debit card that the employee would like their payroll checks loaded to.

Our direct deposit process for the employee's first check is one penny is deposited into the employee's account and the remainder of their wages is paid via a live paper check. Once the employee's penny is credited to their account, they will need to notify J Solutions and their next check will go 100% direct deposit.

Employee Information for Direct Deposit

Please print legibly

Employee Name: _____ Social Security No.: _____

What Portion of Net Pay Would You Like Deposited?

You may have all or part of your paycheck deposited directly to your bank account(s).

Select one of the following options to indicate the portion of your total paycheck you want deposited.

◯ 100% of Net Pay ◯ Indicated Percent _____% ◯ Indicated Dollar Amount $_____

How Do You Want The Direct Deposit Made?

Please identify up to four bank accounts where you want your check deposited, and indicate the amount or percentage of your paycheck you want deposited in each account.

Account for the Balance of the Direct Deposit Amount:	**Account for the Balance of the Direct Deposit Amount:**
Bank Name:	Bank Name:
Bank Routing Number:	Bank Routing Number:
Bank Account Number:	Bank Account Number:
Type of Account: Checking ◯ Savings ◯	Type of Account: Checking ◯ Savings ◯
◯ The remainder of the check will be automatically	Indicate Deposit Amount for this Account: (select one)
deposited in this account	◯ Percent of Direct Deposit Amount _____%
	◯ Selected Dollar Amount $_____

Account for the Balance of the Direct Deposit Amount:	**Account for the Balance of the Direct Deposit Amount:**
Bank Name:	Bank Name:
Bank Routing Number:	Bank Routing Number:
Bank Account Number:	Bank Account Number:
Type of Account: Checking ◯ Savings ◯	Type of Account: Checking ◯ Savings ◯
Indicate Deposit Amount for this Account: (select one)	Indicate Deposit Amount for this Account: (select one)
◯ Percent of Direct Deposit Amount _____%	◯ Percent of Direct Deposit Amount _____%
◯ Selected Dollar Amount $_____	◯ Selected Dollar Amount $_____

Signature _____ Date _____

Receipt of Sexual Harassment Policy

It is the Client Company's policy to prohibit harassment of any employee by any Supervisor, employee, customer or vendor on the basis of sex or gender. The purpose of this policy is not to regulate personal morality within the Client Company. It is to ensure that at the Client Company all employees are free from sexual harassment. While it is not easy to define precisely what types of conduct could constitute sexual harassment and there is a wide range of behavior that may violate this policy even if such behavior does not violate the law, examples of prohibited behavior include unwelcome sexual advances, requests for sexual favors, obscene gestures, displaying sexually graphic magazines, calendars or posters, sending sexually explicit e-mails, text messages and other verbal or physical
conduct of a sexual nature, such as uninvited touching of a sexual nature or sexually related comments. Depending upon the circumstances, improper conduct also can include sexual joking, vulgar or offensive conversation or jokes, commenting about an employee's physical appearance, conversation about your own or someone else's sex life, or teasing or other conduct directed toward a person because of his or her gender which is sufficiently severe or pervasive to create an unprofessional and hostile working environment.

If you feel that you have been subjected to conduct which violates this policy, you should immediately report the matter to your Supervisor. If you are unable for any reason to contact this person, or if you have not received a satisfactory response within five (5) business days after reporting any incident of what you perceive to be harassment, please contact the next level Manager. Note: If your Supervisor or next level Manager is the person toward whom the complaint is directed, you should contact any higher-level Manager in your reporting chain. Employees may also contact the ADP Total Source Employee Service Center at (800) 554-1802 if they are uncomfortable for any reason using the above procedure. Every report of perceived harassment will be fully investigated and corrective action will be taken where appropriate. All complaints will be kept confidential to the extent possible, but confidentiality cannot be guaranteed. In addition, the Client Company will not allow any form of retaliation against individuals who report unwelcome conduct to management or who cooperate in the investigations of such reports in accordance with this policy. If you feel you have been subjected to any such retaliation, report it in the same manner you would report a claim of perceived harassment under this policy. Violation of this policy including any improper retaliatory conduct will result in disciplinary action, up to and including discharge. All employees must cooperate with all investigations.

Employee's Printed Name:_____ Position: _____

Employee's Signature:_____Date:_____

The signed original copy of this acknowledgement it will remain in your personnel file in the PEO company office.

Receipt of Non-Harassment Policy

It is the PEO and Client Company's policy to prohibit intentional and unintentional harassment of any individual by another person on the basis of any protected classification including, but not limited to, race, color, national origin, disability, religion, marital status, veteran status, sexual orientation or age. The purpose of this policy is not to regulate our employees' personal morality, but to ensure that in the workplace, no one harasses another individual.

If an employee feels that he or she has been subjected to conduct which violates this policy, he or she should immediately report the matter to the Manager. If the employee is unable for any reason to contact this person, or if the employee has not received a satisfactory response within five (5) business days after reporting any incident of what the employee perceives to be harassment, the employee should contact the Head of Human Resources. If the person toward whom the complaint is directed is one of the individuals indicated above, the employee should contact any higher-level manager in his or her reporting hierarchy. Employees may also contact the ADP Total Source Employee Service Center at (800) 554-1802 if they are uncomfortable for any reason using the above procedure. Every report of perceived harassment will be fully investigated and corrective action will be taken where appropriate. All complaints will be kept confidential to the extent possible, but confidentiality cannot be guaranteed. In addition, the Client Company will not allow any form of retaliation against individuals who report unwelcome conduct to management or who cooperate in the investigations of such reports in accordance with this policy.

If an employee feels he or she has been subjected to any such retaliation, he or she should report it in the same manner in which the employee would report a claim of perceived harassment under this policy. Violation of this policy including any improper retaliatory conduct will result in disciplinary action, up to and including discharge. All employees must cooperate with all investigations.

I have read and I understand ELEMENTALE Enterprises, Inc.'s Non-Harassment Policy.

Employee's Printed Name: _____ Position: _____

Employee's Signature: _____ Date: _____

The signed original copy of this acknowledgement it will remain in your personnel file in the PEO company office.

AGREEMENT REGARDING CONFIDENTIAL INFORMATION, INVENTIONS AND PROPRIETARY DEVELOPMENTS

_____
Employee Name

I understand that this agreement is not a promise or a contract for employment by ELEMENTALE ENTERPRISES Incorporated (ELEMENTALE ENTERPRISES). The agreement is however a requirement for employment with ELEMENTALE ENTERPRISES.

This Agreement concerns trade secrets, confidential business and technical information, and know-how not generally known to the public, (hereinafter 'Confidential Information'), which is acquired or produced by me in connection with my employment by ELEMENTALE ENTERPRISES. Confidential Information may include, without limitation, information on ELEMENTALE ENTERPRISES organizations, staffing, finance, the performance or compensation of employee's other than myself, research and development, manufacturing and marketing, as well as information which ELEMENTALE ENTERPRISES receives from others under an obligation of confidentiality. I agree:
to use such information only in the performance of ELEMENTALE ENTERPRISES duties;
to hold such information in confidence and trust; and
to use all reasonable precautions to assure that such information is not disclosed to unauthorized persons or used in an unauthorized manner both during and after my employment with ELEMENTALE ENTERPRISES.

This Agreement also concerns inventions and discoveries (whether or not patentable). designs, works of authorship, mask works. improvements, data, processes, computer programs and software (hereinafter called 'Proprietary Developments') that are conceived or made by me alone or with others while I am employed by ELEMENTALE ENTERPRISES and that relate to the research and development or the business of ELEMENTALE ENTERPRISES, or that result from work performed by me for ELEMENTALE ENTERPRISES. Such Proprietary Developments are the sole property of ELEMENTALE ENTERPRISES, and I agree:
to disclose them promptly to ELEMENTALE ENTERPRISES;
to assign them to ELEMENTALE ENTERPRISES: and
to execute all documents and cooperate with ELEMENTALE ENTERPRISES in all necessary activities to obtain patent, copyright, mask works and/or trade secret protection in all countries at ELEMENTALE ENTERPRISES's expense.
In compliance with prevailing provisions of relevant state statutes, this Agreement does not apply to an invention for which no equipment, supplies, facility, or trade secret information of the employer was used and which was developed entirely on the employee's own time, unless (a) the invention relates (i) to the business of ELEMENTALE ENTERPRISES, or (ii) to ELEMENTALE ENTERPRISES's actual or demonstrably anticipated research or development, or (iii) the invention results from any work performed by the employee for ELEMENTALE ENTERPRISES.

1 agree to honor any valid disclosure or use restrictions on Confidential Information known to me and received from any former employers or any other parties prior to my employment by ELEMENTALE ENTERPRISES, and I agree not to bring onto the premises of ELEMENTALE ENTERPRISES any such information in whatever physical form without prior written consent of such former employers or other parties.

The product of all work performed by me during and within the scope of my ELEMENTALE ENTERPRISES employment including, without limitation, any reports, documents, drawings, computer programs, devices and models, will be the property of ELEMENTALE ENTERPRISES. ELEMENTALE ENTERPRISES will have the sole right to use, sell, license, publish or otherwise disseminate or transfer rights in such a work product.

I will not remove any ELEMENTALE ENTERPRISES property from ELEMENTALE ENTERPRISES promises without ELEMENTALE ENTERPRISES's permission.

Upon termination of my employment with ELEMENTALE ENTERPRISES, I will return all ELEMENTALE ENTERPRISES property to ELEMENTALE ENTERPRISES unless ELEMENTALE ENTERPRISES's written permission to keep it is obtained.

The provisions of this Agreement will be separately construed. If any of them is held to be unenforceable, the remaining provisions will not be affected.

_____ Date: _____
Employee Signature

PAYROLL DEDUCTION AUTHORIZATION

I authorize the PEO Company, to deduct from my wages the following: local, state, and federal taxes; any court ordered payments; any deductions required by state or federal law; deductions for loss or damage to any uniforms, machinery, merchandise, equipment, tools, vehicles, or other property provided by PEO Company which I do not return or which are not returned in good condition; any unpaid loans or advances which I owe to PEO Company and, any personal expenses or charges owed by me to PEO Company.

In addition, I authorize the full unpaid amount of any such charges or expenses to be deducted from my final paycheck on the termination of my employment with PEO Company.

I acknowledge that I have received, read, and understand the contents of this PEO Company policies and safety program. If unable to read, the contents of the safety program have been read and explained to me by my supervisor. I understand that my compliance with all stated PEO Company policies, including safety, is a condition of continued employment with this PEO Company.

_____

Employee Name (printed)

_____ _____

Employee Signature Date

RECEIPT OF DRUG TESTING POLICY AND CONSENT TO DRUG TESTING

It is the policy of the Client Company that the use of alcohol, illegal drugs or inhalants will not be tolerated. Although the Client Company recognizes that many such products have legitimate uses, it is the policy of the Client Company not to tolerate misuse or abuse of industrial solvents, aerosol propellants, paint thinners, lacquer thinners, paints, lacquers, dopes, or any other similar product which could be used to produce an intoxicated state by inhalation of its vapors or gases (which will be called "inhalants" in this document). The Client Company maintains a list of all such substances which may be used, or with which its workers or contractors may come in contact in the course of their work. The presence of detectable residues to off other industrial solvents, aerosol propellants, paint thinners, lacquer thinners, paints, lacquers, dopes (this list is by way of example only, and does not constitute a complete statement of all products or substances which may be abused by inhalation) is cause for immediate dismissal without notice. Consumption of alcohol or use of illegal drugs during working hours or in such a way as to leave a detectable trace of alcohol or illegal drugs in the body is cause for immediate dismissal without notice.

I understand that the Client Company policy prohibits any Employee from engaging in work or being on Client Company premises or the premises of any Client with a detectable level of alcohol, any illegal or controlled drug, drug by-product or drug metabolite or inhalant or by-product of metabolite of an inhalant in the body, including in the breath, blood, urine or hair. This policy does not apply to the proper use of medication prescribed for me by a physician.

I understand that it is a condition of, but not a guarantee or promise of, employment, continued employment, advancement or promotion that I follow the Client Company's policies on drugs, alcohol and inhalants, and the policies of any Client Company where I may be assigned. I understand that I may be asked to participate in drug, alcohol and inhalant testing ("Testing") to determine whether I comply with such policies.

I understand that I may refuse to participate in any Testing required by the Client Company or the Client Company, but I understand and agree that my failure to participate in testing will be cause of immediate termination, and that I will not be eligible to be re-hired. If I participate in Testing, my signature or mark below indicates my consent to the taking of samples of my breath, hair, blood, urine or other bodily fluids and the analysis of such samples by a laboratory selected by the Client Company, without charge to me. I consent to the disclosure of all negative and confirmed positive test results to the Client Company and any Client Company where I may be assigned.

I agree that I will disclose the names of any prescription or over-the-counter medications which I may be taking at the time of testing or may have taken within the thirty (30) days immediately prior to Testing. If my failure to disclose such medications causes positive results which must be confirmed and if the Client Company elects to have the results confirmed by further and more specific laboratory tests, I agree that I will furnish any further samples which may be required in order to perform the confirmatory test and reimburse the Client Company for the actual costs of such screening test and confirmation. I understand that I may refuse to participate in further Testing and/or refuse to reimburse the Client Company for expenses incurred in confirmatory analysis, but I

understand and agree that my failure to participate in Testing or to agree to reimburse the Client Company will be cause for immediate termination, and that I will not be eligible to be re-hired.

I understand that I may be required to participate in Testing, after the occurrence of any on-the-job event that did or could have resulted in personal injury or property damage, or for any other reasonable cause. I understand that a confirmed positive test for the presence of drugs or alcohol is grounds for the immediate termination of my employment for cause.

As a consideration of my employment, continued employment, advancement or promotion with the Client Company, I waive, and agree to release and hold harmless both the Client Company and any Client Company, and any testing laboratory along with their agents and employees from any claim or cause of action arising out of the taking of a sample of my breath, blood, urine, hair or other bodily fluids, arising out of the test, or arising out of the disclosure of negative and confirmed positive test results.

DEFINITION: The following definition applies to this and all other Client Company policies unless another definition is expressly indicated in the policy.

Premises means, except as otherwise limited in this definition or applicable law, ALL PLACES AND VEHICLES owned, leased, used, controlled by, or otherwise under the dominion of the Client Company, or where Employees are engaged in work on behalf of, or service to, the Client Company. Premises specifically include parking lots and sidewalks and other surrounding areas in the vicinity of any Client Company Premises. A personal vehicle used on Client Company Business is subject to this policy and to inspection, search or testing for the enforcement of this policy while the vehicle is in use on Client Company Business. Where a person to be searched is not an employee of the Client Company, this definition shall be limited to the real estate, improvements, vehicles and trailers actually owned, possessed, or otherwise under the dominion of the Client Company, not including any public roads, parking areas, sidewalks or other such areas surrounding such real estate and improvements.

_____
Employee Name (printed)

_____ _____
Employee Signature Date

RECEIPT OF EMPLOYMENT SEPARATION ACKNOWLEDEGMENT

Regardless of the type of separation, it is the employee's responsibility to report to the PEO Company in order to conduct a complete exit interview. This interview must take place within three (3) calendar days from the last paid day of employment. During this interview the employee will return all files, documents, equipment, keys, or other property belonging to the client company. The employee will be interviewed and a complete review of the departing assignment will be conducted by the PEO Company for any possible reassignment of employment. All final paychecks for hours worked will be paid on the pay day following the separation date. Accrued unused paid leave will be included in the final paycheck.

Any employee who separates in good standing may re-employ provided they are qualified for the position they are applying for. Any person re-employed with at least one-year time & service and who is re-employed within three months of separation will keep all accumulated time & service.

_____

Employee Name (printed)

_____ _____

Employee Signature Date

RECEIPT OF HANDBOOK ACKNOWLEDGEMENT

I acknowledge that I have read and understand the contents of this policy. If I am unable to read, I acknowledge that the contents have been read and explained to me. I understand there is a copy of the Employee Manual available for further review located at the Client Company office and the PEO Company office. The Client Company may change or withdraw any of the policies at its sole discretion, at any time and without advance notice. I understand that compliance with all Client Company policies is a condition of, but not a guarantee or promise of my employment and continued employment with the Client Company. I further understand that my failure to comply immediately and fully with Client Company policies will result in disciplinary action, which may include immediate termination for cause.

_____

Employee Name (printed)

_____ _____

Employee Signature Date

BERNIEPORTAL
A Bernard Health Production

How to Enroll in BerniePortal

How do I login?

1. **A BerniePortal account has been created for you!**
2. **You will login at www.bernieportal.com/en/login with the following credentials:**
    a. **Username:** Your email address. Your broker will let you know which address to use.
    b. **Password:** This will be the last 4 digits of your SSN and the two digits of your birth month.
        • E.g.: Last 4 digits of SSN is "1234" and birth month is June; password is "123406."

What do I do next?

1. **Verify your information on the Personal Information screen when you login.**
2. **Enroll in benefits.**
    a. List your spouse and dependents (if applicable).
    b. If you don't know one of their SSNs use "111-11-1111."
    c. Elect or waive each coverage: health, dental, & vision.
    d. Confirm your elections, sign with your mouse & select "I Agree."
3. **You're finished! You can login to your BerniePortal account anytime to view your elections.**

3 Tips for electing benefits

1. **Use the sidebar on the left to navigate among the benefit types.**
2. **Use the cart on the right to budget your elections.**
3. **Use the sidebar on the left if you need to review/adjust your elections.**

Forgot your password?

1. **Go to www.bernieportal.com**
2. **Click Login**
3. **Click Forgot Password**
4. **Type in email address**
5. **Submit**

Benefits provided and managed by

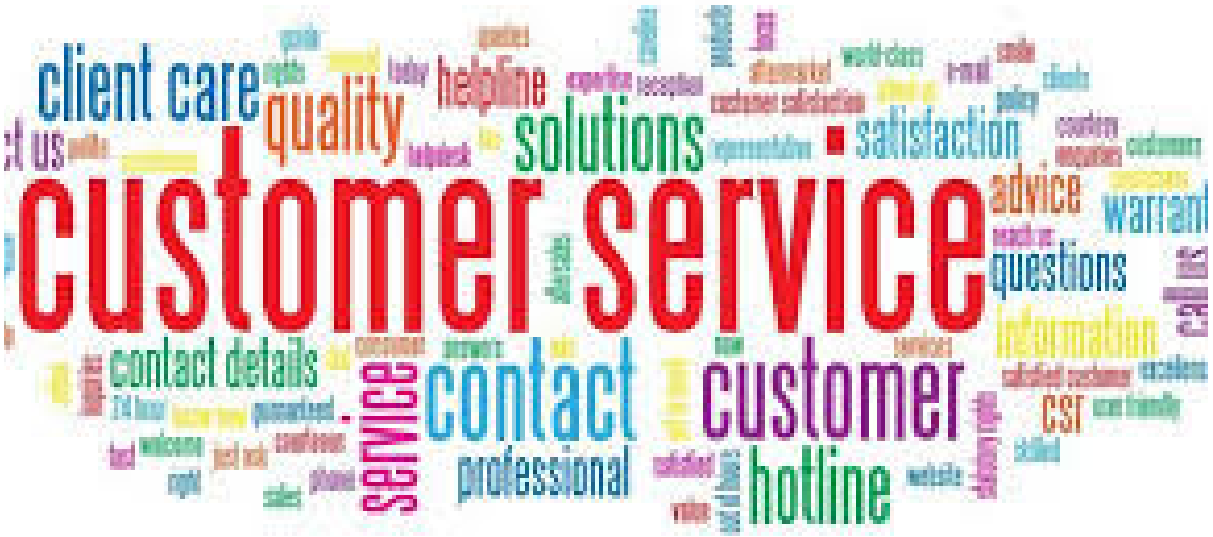
J Solutions, Inc.
Professional Employer Organization

2025 Employee Benefits Guide

Plan Year: **January 1, 2025— December 31, 2025**

2955 Harrison Street, Suite 203A Beaumont, TX 77702 * 409-924-8900
www.jsolutions.us

The information in this Benefits Guide is presented for illustrative purposes and is based on information provided by the employer. The text contained in this Summary was taken from various summary plan descriptions and benefit information. While every effort was taken to accurately report your benefits, discrepancies, or errors are always possible. In case of discrepancy between the Benefits Summary and the actual plan documents, the actual plan documents will prevail. All information is confidential, pursuant to the Health Insurance Portability and Accountability Act of 1996. If you have any questions about this summary, please contact your manager.



That is why at J Solutions, Inc. we are committed to an employee benefit program that helps our employees stay healthy, feel secure, and maintain a work/life balance.

Please refer to Bernie Portal for all employee deduction amounts.

Eligibility

Eligibility

Full-time employees working at least 30 hours per week and their eligible dependents may participate in the Benefits Program.

Generally, dependents are defined as:

- Your spouse
- Dependent "child" up to age 26 (Child means the employee's natural child or adopted child and any other child as defined in the certificate of coverage)
- Your disabled children of any age (see contract for further information)

Making Election Changes During the Year

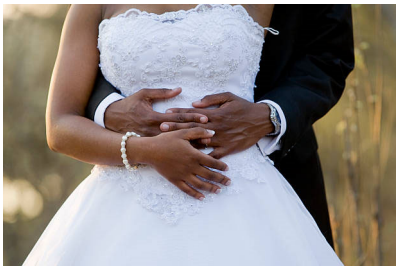
In most cases, your benefit elections remain in effect until the next annual open enrollment period. You will not be able to make any plan changes unless you experience a change in life status.

Qualifying Life Events

Events described in IRS regulations allow you to make a change to your benefit coverage if you experience any of the following:

- Marriage or divorce
- Death
- Birth or adoption of a dependent
- Change in employment status
- Dependent satisfying or ceasing to satisfy the plan's eligibility requirements
- Loss of or significant change to your current coverage
- Judgment, decree or court order
- Enrollment / ceasing to be enrolled in Medicare or Medicaid
- Ceasing to be enrolled in Children's Health Insurance Program (CHIP)

You have 30 days from the date of the event to report and update your benefits changes.



Employee Acknowledgements

I acknowledge once enrollment is closed, I will verify my elections and dependents with the carrier(s) for the upcoming plan year. I will notify HR if changes are necessary.

If electing an HMO Plan:

Please use the "Find a BCBS HMO PCP" document attached for instructions on how to select a Primary Care Physician (PCP). Enter the PCP ID in the required field below. A PCP is required for an HMO plan. To change your PCP, contact BCBS using the information on the back of your ID card.

If a PCP is required for the selected plan and is NOT provided at the time of enrollment, one will be assigned for you.

Please note, there are time restrictions to make a PCP change and referrals from your PCP are required to see a Specialist

Medical Benefits - Option 1 BCBS MTBEE032 Plan HMO

Our medical benefits are administered through BlueCross BlueShield. We encourage all members to register as a member once you have your ID card, by logging on to www.bcbstx.com. The charts below give a brief look at the benefits when you use in-network and out-of-network providers. ***(For additional information please refer to your policy.)*** To find a doctor or hospital, please visit www.bcbstx.com and select your chosen network or call the customer service number on your ID card and a representative will assist you.

Selection of an HMO plan requires you to choose an HMO Primary Care Physician at the time of application. ****REFERRALS FROM YOUR PCP ARE REQUIRED TO SEE A SPECIALIST****

Blue Advantage		
Medical Benefit	Network	Non-Network
Calendar Year Deductible **Individual** **Family**	 $3,500 $10,500	 Not Covered Not Covered
Coinsurance (after Deductible)	30%	Not Covered
Out of Pocket Maximum **Individual** **Family**	 $7,900 $15,800	 Not Covered Not Covered
Office Visit **PCP** **Specialist**	 $35 copay $70 copay	 Not Covered
Preventive Care	No charge	Not Covered
Lab/X-Ray	30% after deductible	Not Covered
Complex Imaging **MRI, PET/CT Scans, etc.**	30% after deductible	Not Covered
Outpatient	30% after deductible	Not covered
Hospitalization	30% after deductible	Not Covered
Emergency Room	$500 per visit , plus 30% after deductible	
Urgent Care	$75 copay	Not Covered
Prescription Drug Coverage **Multi-Tier / Specialty Drug**	$0/$10/$50/$100/$150/$250 for HEB, Walgreens and Walmart. Otherwise $10/$20/$70/$120/$150/$250	Not Covered

Medical Benefits - Option 2 BCBS MTBCP028 Plan PPO

Our medical benefits are administered through BlueCross BlueShield. We encourage all members to register as a member once you have your ID card, by logging on to www.bcbstx.com. The charts below give a brief look at the benefits when you use in-network and out-of-network providers.

(For additional information please refer to your policy.) To find a doctor or hospital, please visit www.bcbstx.com and select your chosen network or call the customer service number on your ID card and a representative will assist you.

Blue Choice		
Medical Benefit	Network	Non-Network
Calendar Year deductible **Individual** **Family**	$3,000 $9,000	$10,000 $20,000
Coinsurance (after deductible)	20%	40%
Out of Pocket Maximum **Individual** **Family**	$8,150 $16,300	Unlimited Unlimited
Office Visit **PCP** **Specialist**	$35 copay $70 copay	40% after deductible
Preventive Care	No charge	40% after deductible
Lab/X-Ray	No charge	40% after deductible
Complex Imaging **MRI, PET/CT Scans, etc.**	20% after deductible	40% after deductible
Hospitalization	20% after deductible	40% after deductible
Emergency Room	$500 per visit plus 20% after deductible	
Urgent Care	$75 copay	40% after deductible
Prescription drug Coverage **Multi-Tier / Specialty drug**	$0/$10/$50/$100/$150/$250 for HEB, Walgreens and Walmart. Otherwise $10/$20/$70/$120/$150/$250	$10/$20/$70/$120/$150/$250 plus 50% additional charge

Medical Benefits - Option 3 BCBS MTBCP006H Plan HSA

Our medical benefits are administered through BlueCross BlueShield. We encourage all members to register as a member once you have your ID card, by logging on to www.bcbstx.com. The charts below give a brief look at the benefits when you use in-network and out-of-network providers.

(For additional information please refer to your policy.) To find a doctor or hospital, please visit www.bcbstx.com and select your chosen network or call the customer service number on your ID card and a representative will assist you.

Blue Choice		
Medical Benefit	Network	Non-Network
Calendar Year deductible **Individual** **Family**	 $4,000 $8,000	 $8,000 $16,000
Coinsurance (after deductible)	0%	30%
Out of Pocket Maximum **Individual** **Family**	 $4,000 $8,000	 Unlimited Unlimited
Office Visit **PCP** **Specialist**	 No charge after deductible No charge after deductible	 30% after deductible 30% after deductible
Preventive Care	No charge	30% after deductible
Lab/X-Ray	No charge after deductible	30% after deductible
Complex Imaging **MRI, PET/CT Scans, etc.**	No charge after deductible	30% after deductible
Hospitalization	No charge after deductible	30% after deductible
Emergency Room	No charge after deductible	
Urgent Care	No charge after deductible	30% after deductible
Prescription drug Coverage **Multi-Tier / Specialty drug**	No charge after deductible Preferred Pharmacies: HEB, Walgreens and Walmart.	No charge after deductible plus additional 50% charge

Health Savings Account

Employees enrolled in an eligible health plan can save for anticipated medical, dental and vision expenses on a pre-tax basis.

Who is eligible to participate? Employees who work 30 hours or more per week.

- **Your HSA account features:**
- **No minimum deposit**
- **All accounts receive a debit card**
- **Unlimited withdrawals allowed each month for qualified medical expenses.**
- **Pays Interest**
- **Free Mobile and Online Banking**
- **No minimum balance requirement or monthly maintenance fee**
- **Optional investment choices available for balances over $2,000. There is a small monthly fee for this account. Customer may make unlimited trades unless otherwise noted**

2025 Regulatory Limits for Contributions and Deductibles

	2025
Individual Maximum Contribution	**$4,300**
Family Maximum Contribution	**$8,550**
Age 55 Catch-Up Contribution	**$1,000**

Health Savings Account

Your health savings account (HSA) may reimburse:

- Qualified medical expenses incurred by the account beneficiary and his or her spouse and dependents;
- COBRA premiums;
- Health insurance premiums while receiving unemployment benefits;
- Qualified long-term care premiums*; and
- Any health insurance premiums paid, other than for a Medicare supplemental policy, by individuals age 65 or older.

Distributions made from an HSA to reimburse the account beneficiary for eligible expenses are excluded from gross income.

Qualified Medical Expenses

The Internal Revenue Service (IRS) defines qualified medical care expenses as amounts paid for the diagnosis, cure or treatment of a disease, and for treatments affecting any part or function of the body. The expenses must be primarily to alleviate a physical or mental defect or illness.

This list is not all-inclusive; additional expenses may qualify, and the items listed below are subject to change in accordance with IRS regulations. For more information or clarification on individual list items, refer to Publication 502 or consult a tax professional.

- Abortion
- Acupuncture
- Alcoholism
- Ambulance
- Annual Physical Examination
- Artificial Limb
- Artificial Teeth
- Bandages
- Birth Control Pills
- Body Scan
- Braille Books and Magazines
- Breast Pumps and Supplies
- Breast Reconstruction Surgery
- Capital Expenses
- Car
- Chiropractor
- Christian Science Practitioner
- Contact Lenses
- Crutches
- Dental Treatment
- Diagnostic Devices
- Disabled Dependent Care Expenses
- Drug Addiction
- Drugs
- Eye Exam
- Eyeglasses
- Eye Surgery
- Fertility Enhancement
- Founder's Fee
- Guide Dog or Other Service Animal
- Health Maintenance Organization HMO
- Hearing Aids
- Home Care
- Home Improvements
- Hospital Services
- Insurance Premiums
- Intellectually and Developmentally Disabled
- Laboratory Fees
- Lactation Expenses
- Lead-Based Paint Removal
- Learning Disability
- Legal Fees
- Lifetime Care—Advance Payments
- Lodging
- Long-Term Care
- Meals
- Medical Conferences
- Medical Information Plan
- Medicines
- Nursing Home
- Nursing Services
- Operations
- Optometrist
- Organ Donors
- Osteopath
- Oxygen
- Physical Examination
- Psychiatric Care
- Pregnancy Test Kit
- Prosthesis
- Psychoanalysis
- Psychologist
- Special Education
- Sterilization
- Stop-Smoking Programs
- Surgery
- Telephone
- Television
- Therapy
- Transplants
- Transportation
- Trips
- Tuition
- Vasectomy
- Vision Correction Surgery
- Weight-Loss Program
- Wheelchair
- Wig
- X-ray

Plans that do not allow reimbursement of all eligible medical expenses as defined by the IRS and Department of Treasury must customize this brochure prior to use.

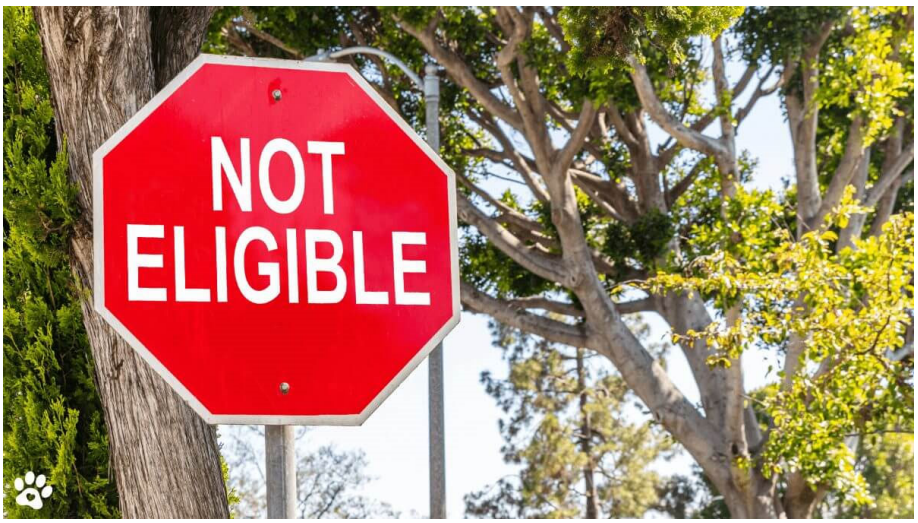
Source: www.irs.gov

Examples of Ineligible H.S.A Expenses

The products and services listed below are examples of expenses **NOT** eligible for payment under your **Health Savings Account**, according to the Internal Revenue Service. Typically, expenses for items that promote general health are not eligible expenses. Please note that this list is not all-inclusive and is subject to change.

Listed below are some services and expenses that are not eligible for reimbursement. This list is not all- inclusive:

- Baby Sitting, Childcare, and Nursing Services for a Normal, Healthy Baby
- Controlled Substances
- Cosmetic Surgery
- Dancing Lessons
- Diaper Service
- Electrolysis or Hair Removal
- Flexible Spending Account
- Funeral Expenses
- Future Medical Care
- Hair Transplant
- Health Club Dues
- Health Savings Accounts
- Household Help
- Illegal Operations and Treatments
- Insurance Premiums
- Maternity Clothes
- Medical Savings Account (MSA)
- Medicines and Drugs From Other Countries
- Nonprescription Drugs and Medicines
- Nutritional Supplements
- Personal Use Items
- Swimming Lessons
- Teeth Whitening
- Veterinary Fees
- Weight Loss Program



Dental Benefits

We offer a dental PPO plan through BCBS of Texas which allows you to see any provider you would like to see. ***(For a complete list of services and prices, please refer to your policy.)*** To find a Dentist or facility, please go to: www.bcbstx.com and choose the PPO network.

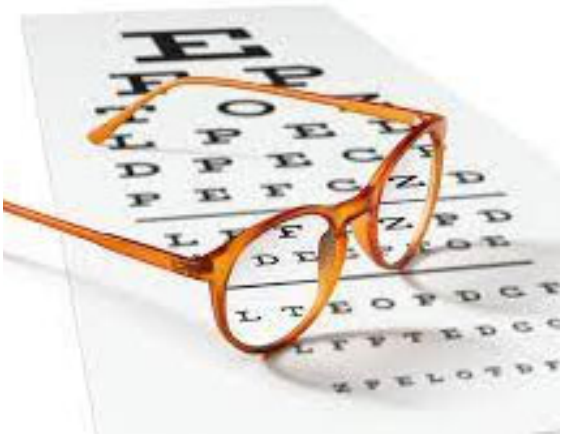
Dental PPO	
Policy Year Deductible **Individual / Family**	$50 / $150
Annual Benefit Maximum	$2000
Preventive • Diagnostic Evaluations • Preventive Services • Diagnostic Radiographs • Sealants • Space Maintainers	Covered in full, Deductible Waived
Basic • Basic Restorative Services • Non-Surgical Extractions • Non-Surgical Periodontal Services • Adjunctive Services • Endodontic Services • Oral Surgery Services • Surgical Periodontal Services	20% after Deductible
Major Major Restorative Services Prosthodontic Services Implants Miscellaneous Restorative and Prosthodontics Services	50% after Deductible
Orthodontia Adult/Child orthodontia - Plan pays 50 percent (no deductible) of the covered orthodontia services.	50% $2,000 per Child Lifetime

Vision Benefits

Our vision plan is through BCBS of Texas for the upcoming plan year.

For additional information, please refer to your policy.) To find a Doctor or facility, please go to: www.bcbstx.com or you can call the customer service number on your ID card.

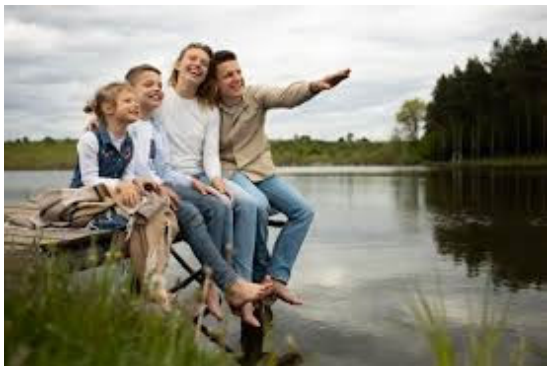
Vision PPO In-Network Benefits	
Vision Exam Copay **Materials Copay**	$10 $10
Lenses **(Single/Bifocal/Trifocal/Lenticular)**	Covered in full after materials copay
Contact Lenses **(Elective)**	$150 plan allowance Contacts are in lieu of glasses
Contact Lenses **(Medically Necessary)**	Covered in full after materials copay
Frames	Up to $150 allowance
Frequency of Services	
Vision Exam	Every 12 months
Lenses (Eyeglasses and Contacts)	Every 12 months
Frames	Every 12 months



Life and AD&D Benefits

Our employee benefits package provides all full-time employees with $15,000 of basic life/AD&D insurance through Humana at no cost to the employee.

Please contact the HR department to gain access of the Basic Life with Accidental Death and Dismemberment claim form.



Employee	$15,000 flat amount – paid by employer
Age Reductions	35% benefit reduction at age 65 Additional 15% reduction at age 70
Waiver of Premium	If you are totally disabled for at least six consecutive months prior to age 60, you can continue life insurance coverage and waive the premium. Waiver ends at age 65.
Accidental Death & Dismemberment (AD&D)	Death as a result of an accident – your beneficiary will receive an additional $15,000 Benefits are available due to bodily injury resulting in loss of vision, hearing or a limb. See your plan certificate for full details.

Remember to update your beneficiary form if your circumstances have changed throughout the year.

Seek advice from your attorney before listing a minor as a primary or contingent beneficiary.

Voluntary Life

Full-time employees are provided with the option to purchase Voluntary Life coverage for yourself, spouse and/or children through Guardian. You must purchase the coverage for yourself in order to cover your dependents. Guarantee issue amounts are only available for an employee's enrollment when initially eligible. If you are adding voluntary life or increasing your current amount, an Evidence of Insurability statement will be required.

Please complete and return a beneficiary change form if you do not recall your initial beneficiary designation or if you would like to change it at this time.

Employee Benefit	$25,000 increments to a maximum of $100,000
Spouse Benefit	$5,000 increments to a maximum of $25,000
Child Benefit	Your dependent children age 14 days to 26 age. $1,000 increments to a maximum of $10,000
Guarantee Issue:	The guarantee issue means you are not required to answer health questions to qualify for coverage up to and including the specified amount, when you sign up for coverage during the initial enrollment period**.** **Employee: $100,000** **Spouse: $25,000** **Child: $10,000**
Age Reduction	Benefits are reduced by a certain percentage as an employee ages 35% at age 65, 60% at age 70, 75% at age 75, 85% at age 80

Who do I contact with questions or claim issues?

CORE
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• EST. 1988 •

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