PERSONNEL DATA SHEET

For the Employee to Complete

Employee Name:

Birthdate: Home Telephone Number:

Home Address:

City:

If your mailing address is other than your home address, please include here:

Mailing Address:

Do you live and work in the same state? ☐Yes ☐No

If no, in what state do you work:

Are you subject to any city or local income taxes? ☐Yes ☐No

If yes, please provide the city and/or locales:

Driver's License Number: State of Issuance:

Please provide us with information on who to contact in the event of an emergency:

Name: Phone:

Relationship:

Employee Name:

☐ New Hire ☐ Re-Hire to Worksite Employer

The position is (check all that apply)

☐ Non-exempt	☐ Exempt
☐ Commission only	☐ Salary plus commission
☐ Tipped Employee	☐ Full-Time (30 hours per week or more)
☐ Temporary	☐ Part-time (less than 30 hours per week)
☐ Seasonal	☐ Standard Hours

Occupation Category:

☐ Official/Management	☐ Professional	
☐ **Technician**	☐ **Sales**	
☐ Office/Clerical	☐ **Craft Worker (skilled)**	
☐ Operative (semi-skilled)	☐ **Laborer (unskilled**	☐ **Service Worker**

Position/Title File Number

Rate of Pay: Department

Pay Cycle: ☐ weekly ☐ bi-weekly (26 pay periods/yr)

☐ monthly ☐ semi-monthly (24 pay periods/yr)

If you are participating in the Drug Free Workplace Policy, or if this is a position requiring a pre-employment drug test under the DOT or state law, please provide chain of custody number:

Chain of Custody Number:

Benefits Class Code:

Signature of authorized representative or worksite employer:

Title **Date**

W/C Code:

(PLEASE PRINT AND COMPLETELY ANSWER ALL QUESTIONS)

Michael Page and its Clients fully subscribe to the principles of Equal Employment Opportunity. It is our policy to provide employment, compensation, and other benefits related to employment based on qualifications, without regard to race, color, religion, national origin, ancestry, age, sex, gender (including gender identity and gender expression), sexual orientation, veteran status, mental or physical disability, genetic information, marital status, medical condition or AIDS/HIV status, pregnancy, or any other basis prohibited by federal, state, or local law. In accordance with requirements of the Americans With Disabilities Act, it is our policy to provide reasonable accommodation upon request during the application process to eligible applicants in order that they may be given a full and fair opportunity to be considered for employment, provided that such accommodation does not constitute an undue hardship on the Company. As Equal Opportunity Employers, we intend to comply fully with applicable federal and State employment laws and the information requested on this application will only be used for purposes consistent with those laws. Applications are only accepted for positions currently available and will only be considered for thirty (30) days from today's date or until the position applied for is filled, whichever first occurs.

POSITION APPLIED FOR: _____ DATE: _____

PERSONAL DATA:

Salary Expectations: _____

_____

Last Name First Middle

_____

Street Address Apt. # City State/Zip Code Telephone #

Are you at least 18 years old? _____ If not, state your age for child labor law purposes only _____

Are there any days, shifts or hours you will not work? ____ If yes, please explain: _____

_____

Are you available for out of town work? _____ Will you work overtime, if required? _____

When will you be able to start work? _____

_____

How did you learn of our Company? _____

If referral, who were you referred by? _____

Have you ever applied or worked here before? ☐Yes ☐No If yes, provide dates: _____

Have you ever applied or worked at MP TotalSource before? ☐Yes ☐No
If yes, provide dates: _____

Are you legally authorized to work in the United States? ☐Yes ☐No

Will you now or in the future require sponsorship for employment status (e.g., H-1B visa status)?

☐ Yes ☐ No

Note: The Federal Immigration and Reform and Control Act of 1986 requires that an INS Employment Eligibility Verification "Form I-9" be completed for every new hire and that within 3 business days of beginning work every new hire must present to the employer documentation establishing his/her identity and authorization to work. **This federal requirement must be satisfied as a condition of employment.**

Are you able to perform the essential functions of the job for which you are applying, either with or without reasonable accommodation?

☐ Yes ☐ No

Have you been convicted of a felony within the last seven years? (Exclude convictions that have been sealed, expunged or legally statutorily eradicated; any arrest for which a pretrial diversion program has been successfully completed; and exclude convictions for marijuana-related offenses for personal use more than two years old) ☐ Yes ☐ No

Date of Conviction: _____

Note: Answering "yes" does not automatically exclude you from further consideration for the position. If yes, please explain on the Additional Comments page 1 describing the nature of the crime(s), the date, and place and number of convictions, the facts or circumstances surrounding the offense or conduct, and the legal disposition of the case. Michael Page will undertake an individualized assessment whether the offense is relevant to the duties of the position applied for (including the nature, gravity, date and circumstances of the offense, and the nature of the job sought to ensure that its policy as applied is job-related and consistent with business necessity.)

Have you been convicted within the last seven years of misappropriation of funds, embezzlement, or similar for other dishonest conduct; or an offense involving the use of a weapon; for burglary, robbery, breaking and entering or theft; or physical assault or other violent crime (excluding convictions that have been sealed, expunged or statutorily eradicated; any misdemeanor conviction for which probation has successfully been completed or otherwise discharged and the case has been judicially dismissed; and any arrest for which a pretrial diversion program has been successfully completed)?

☐ Yes ☐ No If yes, please explain on the additional comments page and describe the nature of the crime(s), the date, and place and number of convictions, the facts or circumstances surrounding the offense or conduct, and the legal disposition of the case.

Note: Answering "yes" does not automatically exclude you from further consideration for the position Michael Page will undertake an individualized assessment whether the offense is relevant to the duties of the position applied for (including the nature, gravity, date and circumstances of the offense, and the nature of the job sought to ensure that its policy as applied is job-related and consistent with business necessity.)

DRIVING RECORD: (Answer only if driving is a requirement of the job for which you are applying)

Do you have a valid driver's license? ☐ Yes ☐ No State_____ License No._____
Have you had any tickets? _____ If yes, please explain _____
Has your license ever been suspended or revoked? _____ If yes, please explain _____
Do you have any DUI or DWI convictions? _____ If yes, please state when you were convicted and explain

RESIDENCES: (Please provide your addresses of residence for the past seven years beginning with the most recent address. If you need more space, please use Additional Comments section)			
Street Address	City, State, Zip Code	From	To
Street Address	City, State, Zip Code	From	To
Street Address	City, State, Zip Code	From	To
Street Address	City, State, Zip Code	From	To

EDUCATION: (May or may not be considered depending on job applied for)

Describe any educational degree, skills, training, or experience you believe are relevant to the job applied for:

Name, City and State of Educational Institution	Graduated? Yes No	If no Degree, Credits Earned	Type of Degree Received or Expected	Major	Minor	Grade Point Overall GPA
High School						
College or University						
Technical/GED/Other						
Licenses, Certification/Other						

EMPLOYMENT HISTORY:

(Please complete for all full-time or part-time employment beginning with the most recent employer.)

Company Name | Tel #

Address | Dates Employed | From | To

Name of Supervisor | May we contact this employer for a reference? ☐ Yes ☐ No | Rate of Pay | Start | Last

State job titles and describe job duties | Reason for Leaving

Company Name | Tel #

Address | Dates Employed | From | To

Name of Supervisor | May we contact this employer for a reference? ☐ Yes ☐ No | Rate of Pay | Start | Last

State job titles and describe job duties | Reason for Leaving

Company Name | Tel #

Address | Dates Employed | From | To

Name of Supervisor | May we contact this employer for a reference? ☐ Yes ☐ No | Rate of Pay | Start | Last

State job titles and describe job duties | Reason for Leaving

Please explain any gaps in your employment history? _____

_____

Have you ever been discharged or forced to resign? _____

_____

Did you receive any discipline in the last 12 months of active employment? _____
If yes, explain: _____
Were you given a performance evaluation within the last 12 months of active employment? _____
If yes, what was the range of scores used and what was your score? _____
Have you signed any non-compete or non-solicit agreement with any other employer that might restrict you from working for this company? _____
If so, please explain: _____
(You may be required to furnish a copy of the agreement)

MILITARY: **(Complete only if you served in the military)**

Describe any military skills, training or experience you believe are relevant to the job applied for or any special skills or abilities as a result of service in the military: _____

_____

_____

APPLICANT'S ACKNOWLEDGMENT

I certify that I have not knowingly withheld any information that might adversely affect my chances for employment and that the answers given herein are true and complete to the best of my knowledge. I understand that any misrepresentations, omissions of facts or answers in any application document will disqualify me from further consideration for employment. I further understand that, if employed, any misrepresentations or omissions of facts in any application document will be cause for my dismissal at any time without prior notice; regardless of the time elapsed before discovery.

I understand that, if employed, my employment is not for a specific term and may be terminated by me or my Employer(s) with or without notice or cause. I further understand that no oral promise, Employer(s) policy, custom, business practice or other procedure (including the Employee Handbook or any personnel manuals) constitute an employment contract or modification of the at-will employment relationship between me and the Employer(s). I further understand that my at-will employment status can only be changed in a written agreement signed by the CEO of Michael Page.

I understand that I may be required to submit additional documentation to be considered for employment based the position sought. For example, I may be required to take job-related tests, take a driver's examination; submit to a background investigation; or take a pre-employment drug test. If I am offered employment or start work before any required test is completed, my employment is contingent on a satisfactory result on all required tests. I authorize Michael Page and its clients to release the results of background checks (if any) and my pre-employment drug/alcohol test (if any). Any information on this application and any relevant information about me to each other and to other Michael Page clients for whom I have applied for employment and who have a need to know this information, and release Michael Page and its clients from any and all claims related to the lawful release of this information.

I acknowledge that this application will remain active for 30 days from this date. If I have not heard from the Company at the conclusion of this 30 day period, it is my responsibility to complete a new application if I still wish to be considered for employment.

Signature: _____ Date: _____

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CONFIDENTIAL INFORMATION AND NON-DISCLOSURE AGREEMENT

In consideration of and as a condition to my entering into or continuing an employment relationship with Michael Page International, Inc. and/or entities that they own, control or is affiliated with, or their successors in business ("MPI"), and the compensation paid therefore:

1. Confidentiality

I acknowledge that in the course and scope of my relationship with MPI I will have access to certain information, whether or not originated by me, which is used in MPI's businesses and (i) is proprietary to, about or created by MPI; (ii) gives the MPI some competitive business advantage or the opportunity of obtaining such advantage; (iii) the disclosure of which could be detrimental to the interests of MPI; (iv) is designated as confidential information or trade secrets by MPI, or from all the relevant circumstances should reasonably be assumed by me to be confidential and proprietary to MPI; or (v) is not generally known by non-MPI personnel (hereinafter, "Confidential Information").

Such Confidential Information includes, but is not limited to, the following types of information and other information of a similar nature (whether or not reduced to writing or designated as "confidential"): (i) the production processes, formulae, design concepts, specifications, techniques and methods of any type related to MPI's services; (ii) MPI's internal personnel and financial information, candidate names, and other candidate information, purchasing and internal cost information, internal services and operational manuals, timesheets, computer files (including, but not limited to, e-mails, Microsoft Word files, and Excel files), and the manner and methods of conducting MPI's business (including, but not limited to, all forms and manuals); (iii) marketing and development plans, price and cost data, price and fee amounts, pricing and billing policies, quoting procedures, marketing techniques and methods of obtaining business, forecasts and forecast assumptions, and future plans and potential strategies of MPI that have been or are being discussed; (iv) names of clients and their representatives, contracts and their contents and parties, client services, client billing records, client work-in-progress reports, data provided by clients, client work papers, financial statements, tax returns and the type, quantity, specifications, and history of services purchased, leased, licensed, or received by clients of MPI; and (v) information from any MPI candidate database (including but not limited to Profile 7) or any other database that any employee developed regarding customers/clients while in the employ of MPI, including contact lists maintained on LinkedIn or other similar websites.

I acknowledge that all such Confidential Information is proprietary to MPI and is a special, valuable, and unique asset of the business of MPI, and that my giving service as an employee creates a relationship of confidence and trust between MPI and me with respect to the Confidential Information. In recognition thereof, I agree that during the period I am serving as an employee of MPI or thereafter: (i) I will not at any time disclose directly or indirectly to any person or entity or use for my own benefit any such Confidential Information; (ii) I will restrict the disclosure of such Confidential Information to those MPI employees and contractors with a need to know to perform services on behalf of MPI and who have agreed to be bound by similar confidentiality restrictions; (iii) I will take all reasonable precautions to prevent inadvertent disclosure of such Confidential Information; (iv) I will not at any time use, copy, or transfer such Confidential Information

other than as strictly necessary to perform services on behalf of MPI; and (v) I will take all reasonable precautions to prevent inadvertent use, copying, or transfer of such Confidential Information.

This confidentiality provision does not apply to information which: (i) was already rightfully known to me prior to the time that it is disclosed to me hereunder; (ii) is in or has entered the public domain through no breach of this Agreement or other wrongful act; or (iii) has been rightfully received by me from a third party not under obligation of confidentiality to MPI and without breach of this Agreement (hereinafter, "Non-Confidential Information"). I agree that I have described all Non-Confidential Information known to me as of the date of execution of this Agreement in Exhibit A ("Description of Information and Client Relationships"), attached and incorporated hereto, and further agree to keep Exhibit A current by immediately submitting to Roberto Machado, in writing, any future disclosure of information to me conforming to the definition of Non-Confidential Information set forth above.

2. Third-Party Information

I hereby recognize that MPI has received and/or in the future may receive confidential information from third parties, subject to a duty on MPI's part to maintain the confidentiality of such information and to use it only for certain limited purposes. I hereby agree that I owe MPI and such third parties, during the term of my employment with MPI and thereafter, a duty to hold all such confidential information of third parties in the strictest confidence and not to disclose it to any person or entity (except as necessary in carrying out my work for MPI consistent with MPI's agreement with such third party) or to use it for the benefit of anyone other than for MPI to such third party (consistent with MPI's agreement with such third party), without the express written authorization of an officer of MPI.

3. Return of Confidential Material

All documents, including, but not limited to, forms, notebooks, notes, memoranda, records, diagrams, timesheets, bulletins, formulae, reports, computer programs and files (including, but not limited to, e-mails), client lists, candidate lists or memorializations of any kind coming into my possession or kept by me in connection with my employment with MPI are the exclusive property of MPI. I shall return to MPI all such documents and other materials (including, but not limited to, electronic files, computer disks, e-mail messages, candidate and client names and lists stored on any database or on LinkedIn® or other websites or social networking accounts that were developed in connection with and/or as a result of my employment with MPI, and log-in credentials for those accounts) upon termination of my employment, whether or not for cause and whatever the reason, or at any time MPI may so request, unless specific written consent is obtained from an officer of MPI to retain any such record. At MPI's request, I will certify the deletion of any lists or names of any clients or candidates developed in connection with and/or as a result of my employment with MPI from my LinkedIn® account or similar website or database or contact information software. I understand that all such records, whether developed by me or others, are and will remain the property of MPI.

4. Non-Solicitation of MPI'S Clients

To ensure the protection of the MPI'S Confidential Information, I agree that I will not, without the express written consent of Roberto Machado, for a period of one (1) year immediately following termination of my employment with MPI for any reason, either directly or indirectly solicit, or attempt to solicit, any clients, business, or patrons of MPI upon whom I called or whom I serviced or solicited or with whom I became acquainted as a result of my employment with MPI for the purpose of selling or providing to such client, business, or patron any services or product of the kind which is sold or provided by MPI.

5. Non-Solicitation of Employees

I acknowledge that MPI has a protectable interest in maintaining an undisrupted workplace. In support of this interest, and in further consideration for my entering an employment relationship with MPI, I am required to and agree that for one year (1) year after termination of my employment relationship with MPI for any reason I will not, on behalf of myself or on behalf of any other person, company, business, or corporation, directly or indirectly solicit, divert, or take away any of the employees of MPI or any of its affiliates or subsidiaries.

6. Others' Trade Secrets/Other Obligations

I agree that MPI is engaging me as an employee for my skills and abilities and not for any tangible or intangible items or proprietary information obtained by me from my former employers. In performing my duties as an employee of MPI, I agree that I will exercise my best effort to avoid infringing on any third party's intellectual property rights. I represent that my performance of all the terms of this Agreement and as an employee of MPI does not and will not breach any agreement to keep in confidence proprietary information or trade secrets acquired by me in confidence or in trust prior to my entering into an employee relationship with MPI, and I will not disclose to MPI, or induce MPI to use, any confidential or proprietary information or material belonging to any previous employer or others. I agree not to enter into any agreement, either written or oral, in conflict herewith. I further acknowledge that MPI from time to time may have agreements with other persons or entities which impose obligations or restrictions on MPI regarding the confidential nature of work thereunder. I agree to be bound by all such obligations and restrictions and to take all action necessary to discharge the obligations of MPI thereunder.

7. Waiver/Notice

No waiver by MPI of any breach by me of any of the provisions of this Agreement shall be deemed a waiver of any preceding or succeeding breach of the same or any other provisions hereof. No such waiver shall be effective unless in writing and then only to the extent expressly set forth therein. Any notice required or provided to be given under this Agreement shall be sufficient if in writing, sent by first class mail, to my residence in the case of notice to me or to its principal office in the case of MPI. Any such notice shall be effective upon delivery if it is hand delivered, upon receipt if it is transmitted by wire or facsimile, or upon the expiration of forty-eight (48) hours after deposit in the United States mail if mailed.

8. Injunctive Relief/Attorneys' Fees

I agree that it would be difficult to measure the damage to MPI from any breach by me of the covenants set forth herein in this Agreement, that injury to MPI from any such breach would be impossible to calculate, and that money damages would therefore be an inadequate remedy for any such breach. Accordingly, I agree that if I breach any provision in this Agreement, MPI shall be entitled, in addition to all other remedies it may have, to injunctions or other appropriate orders to restrain any such breach without showing or proving any actual damage to MPI. I agree that if any action or law or in equity is necessary to enforce the terms of this Agreement, the prevailing party shall be entitled to reasonable attorneys' fees, costs, and expenses in addition to any other relief to which such prevailing party may be entitled.

9. Successors/Assignment

This Agreement shall inure to the benefit of the successors and assigns of MPI, and shall be binding upon my heirs, assigns, administrators, and representatives. Except as otherwise expressly provided herein, any and all rights, duties, and benefits herein may not (by operation of law or otherwise) be assigned or delegated by me but may be so assigned or delegated by MPI.

10. Governing Law/Severability

This Agreement will be governed and construed in accordance with the laws of the State of California without regard to the conflicts of laws or principles thereof. If any provision of this Agreement is held invalid or unenforceable by a court of competent jurisdiction, I agree that such invalidity shall not affect the validity of the remaining provisions of this Agreement and further agree to substitute for the invalid provision a valid provision which most closely approximates the intent and economic effect of the invalid provision.

11. Integration/Modification

I agree that this Agreement contains my entire agreement with MPI on the subject matter of this Agreement, superseding any previous oral or written communications, representations, understandings, or agreements with MPI or any officer or representative thereof.

12. Acknowledgement

I have carefully reviewed this contract and agree to and accept its terms and conditions. I understand that this Agreement contains material restrictions on my right to disclose or use, during or subsequent to my employment relationship with MPI, information learned or developed by me during my employment with MPI and that if I have any questions or reservations, I should consult with an attorney and have had an opportunity to do so.

I acknowledge that I have read and understand this Agreement and agree to the terms of this Agreement. Furthermore, I acknowledge receipt of a copy of this Agreement.

_____ Dated:_____

Employee's Signature

_____

Employee's Printed Name

_____ Dated:_____

Michael Page International, Inc.

EXHIBIT A

DESCRIPTION OF INFORMATION AND CLIENT RELATIONSHIPS

Description/ Name of Client	**Date of Creation/ Establishment of Relationship**

The foregoing constitutes all Non-Confidential Information of the undersigned pursuant to Paragraph 1 of the Confidential Information Agreement.

_____ Dated:_____

Employee's Signature

_____

Employee's Printed Name

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SUBSTANCE ABUSE POLICY

Alcohol and illegal drugs in the workplace pose a danger to us all. Illegal drugs, as referred to in this policy, include drugs that are not legally obtainable, as well as drugs that are legally obtainable but used for illegal or unauthorized purposes. They impair safety and health, promote crime, lower productivity and impair our ability to provide high quality service. For these reasons, we cannot and will not tolerate the illegal use of drugs or alcohol abuse by any of our employees. We expect all employees to report for work free from these effects and to be able to fully perform their job duties.

All Company locations are hereby declared to be drug and alcohol free workplaces. This means that while on Company premises and while conducting business-related activities off Company premises, you may not be under the influence of illegal drugs or alcohol. "Illegal drugs" include all forms of narcotics, hallucinogens, depressants, stimulants, or other drugs (including medical marijuana) whose possession or transfer is prohibited by law. Additionally, all employees are prohibited from unlawfully manufacturing, distributing, possessing, using or being under the influence of alcohol or any illegal drugs while at work. The use of illegal drugs or alcohol outside the workplace that affects your ability to work is also prohibited. The legal use of prescribed drugs is permitted on the job only if it does not impair your ability to perform the essential functions of the job effectively and in a safe manner that does not endanger other individuals in the workplace. If you are taking prescribed medications that may affect your attentiveness, cause drowsiness, or otherwise impair your abilities, please notify your supervisor or Human Resources of this fact so modifications to job duties can be made if appropriate. Any employee violating the above Policy may be subject to dismissal/termination for the first offense. Your adherence to this Policy is a condition of employment. Employees who attend a Company-sponsored function in which alcohol is served are expected to use good judgment and moderation so as to avoid becoming intoxicated.

In compliance with the Drug-Free Workplace Act of 1988, an employee convicted of a criminal drug statute for a violation occurring in the workplace must inform the Company of any such conviction (including pleas of "guilty" and "nolo contendere") within five (5) working days of the conviction's occurrence. Failure to inform the Company of such a conviction subjects the employee to disciplinary action up to and including dismissal/termination for the first offense. This provision in no way limits the right of the Company to discipline any employee pursuant to any other Company Policy or practice.

If you have a drug or alcohol problem that has not resulted in and is not the immediate subject of disciplinary action, you may request approval to take unpaid time off to participate in a rehabilitation or treatment

program. Leave may be granted if you agree to abstain from use of the problem substance, you abide by all Company policies, rules, and prohibitions relating to conduct in the workplace, and if granting the leave will not cause the Company undue hardship. Employees with questions or concerns about substance dependency or abuse are encouraged to discuss these matters with their supervisor or the Human Resources Generalist to receive assistance or referrals to appropriate resources in the community.

My signature below indicates that I have read and understood the Substance Abuse Policy.

_____

Employee Name

_____

Employee Signature

_____

Date

Standard Conditions for Recruitment Services
Standard Conditions for Temporary Workers

1. All and any business undertaken by Michael Page International ("MP") is transacted subject to the terms and conditions hereinafter set out.

2. The types of work and expected rates of pay to be sought on behalf of the work seeker ("Temporary Worker") are outlined in the Candidate Confirmation. Final terms and conditions will be issued at the commencement of an assignment, detailing the actual rate of pay and the type of work to be undertaken.

3. If, in respect of any assignment, the Temporary Worker is required by law, any professional body or by the Client to hold any qualifications and/or authorizations, the Temporary Worker shall provide MP with:

   a) up to date copies of such qualifications or authorizations: and

   b) the names of two referees (who are not relatives of the Temporary Worker) who the Temporary Worker agrees that MP may approach for the purpose of obtaining references about the Temporary Worker. The Temporary Worker also consents to the disclosure of such qualifications, authorizations and/or references by MP to the Client. The Temporary Worker further waives any rights or claims the Temporary Worker has or may have against MP, its agents, employees, and representatives and fully releases MP from any and all liability, claims, or damages that may directly or indirectly result from the use, disclosure or release of any such employment information, whether such information is favorable or unfavorable to the Temporary Worker.

4. MP shall pay to the Temporary Worker wages calculated at an hourly rate, to be determined prior to the commencement of the assignment, subject to deductions for which MP is required by law to make. The standard payment interval will be weekly with any alternative interval being notified prior to the individual assignment. The Temporary Worker shall be required to provide time sheets signed by the Client agreeing the hours worked by the Temporary Worker on a weekly basis. In addition, the Temporary Worker shall promptly comply with any other rule or request (either from the Client or MP) to provide information and/or documentation in respect of the hours worked by the Temporary Worker. . MP will not withhold payment of the Temporary Worker's wages through reason of non-receipt of payments from the Client.

5. The Temporary Worker shall at all times when services are due to a Client comply with the following conditions:

   a) Not to engage in any conduct detrimental to the interests of the Client;

   b) To be present during the times or for the total number of hours during each day and/or week as may be agreed with the Client.

   c) To take all reasonable steps to safeguard his/her own safety and the safety of any other person who may be affected by his/her actions at work;

   d) To comply with any rules or obligations relating to discipline and/or health and safety in force from time to time at the premises where services are performed to the extent that they are reasonably applicable;

   e) To comply with all reasonable instructions and requests regarding the scope of the agreed services made by the Client;

   f) Not to at any time during or after any assignment divulge or make known to any person or any competitor of the Client, nor use for his/her own or any other person's benefit any confidential information (which shall remain the property of the Client) in relation to the trade secrets, operations and business affairs of the Client. Further to immediately surrender all documents, samples, tools and equipment provided by the Client on the cessation of the assignment.

6. All intellectual property conceived or made by the Temporary Worker (either alone or with others) in the course of any assignment shall belong to the Client and the Temporary Worker agrees to assign all its interest in any such intellectual property to the Client or its nominee. If requested to do so, the Temporary Worker shall execute any documentation which the Client shall deem necessary to give effect to this provision.

7. The Temporary Worker shall immediately inform MP and the Client should there be any reason or circumstance under which it would be detrimental to the interests of MP the Client or the Temporary Worker for the assignment to continue.

8. The Temporary Worker is requested to advise MP of any other assignment or vacancies that he/she may have been informed of by the Client. The Temporary Worker is requested to inform MP of any offer of extended assignment or permanent employment with the Client. If an offer of employment, arising from an assignment or secondment is made within twelve months then the Temporary Worker is requested to advise MP of his/her employment.

9. MP shall be under no obligation to provide work for the Temporary Worker and this Agreement creates no obligation on MP to provide the Temporary Worker with a specified number of hours work in any day or any week.

10. MP may terminate this agreement without notice at any time and for any reason at MP's sole discretion and instruct the Temporary Worker to end an assignment with a Client at any time. The Temporary Worker may similarly terminate his employment with MP at any time..

11. The Temporary Worker should not engage in any conduct, which is detrimental to the interests of MP, would negatively affect MP's relationship with the Client or is likely to bring MP into disrepute.

12. The Temporary Worker having any complaint in connection with the temporary work, or the conduct of or relations with the Client or any employee of the Client should present a complaint in writing to a Director or Senior Manager of the Company.

13. MP does not accept any responsibility and shall not be liable for any loss or damage suffered by the Temporary Worker as a result of this assignment being terminated by either MP or the Client.

I acknowledge that I have read this document, fully understand it, and voluntarily agree to its provisions.

Printed Name: _____

Signature:_____Date:_____

I understand that Michael Page International has a specific policy concerning rest breaks and meal periods for its California non-exempt employees. I acknowledge that I will take rest breaks and meal periods during my workday as follows:

REST BREAKS

I understand I am entitled to a 10-minute paid rest break for every four hours that I work. It is my responsibility to take my rest break during my shift and to let my supervisor know if I have been prevented from taking any rest break.

MEAL PERIODS

I understand that I am entitled to an uninterrupted, duty-free, unpaid 30-minute meal period if I work five or more hours in a day. I understand that I am entitled to a second uninterrupted, duty-free, unpaid 30-minute meal period if I work more than ten hours in a day. I understand that I may voluntarily waive my 30-minute meal periods under certain circumstances described below. By checking the box (or boxes) below, I agree to waive my 30-minute meal periods under the specified conditions:

- ☐ **I understand that if I work 6 hours or less in a shift, I may waive my 30-minute meal period. I understand that taking a duty-free meal period of at least 30 minutes is *mandatory* on days that I work more than six hours and that if I am unable to take a meal period because of workload, I must immediately inform my supervisor so that appropriate arrangements can be made. By checking this box and signing this waiver, I hereby understand and agree that I am freely and voluntarily consenting to waive my 30-minute meal period whenever I work 6 hours or less.**

- ☐ **I understand that if I work between 10 hours and 12 hours in a shift, I may waive my second 30-minute period, but only if I have taken my first 30-minute meal period. By checking this box and signing this waiver, I hereby understand and agree that I am freely and voluntarily consenting to waive my second 30-minute meal period for days on which I work between 10 and 12 hours and have taken my first 30 minute meal period.**

I understand that I may not work through my meal period(s) in order to come in late or leave early. I understand that my refusal to take, or my failure to take, my first meal periods during workdays on which I work more than 6 hours and my second meal periods during workdays on which I work more than 12 hours will subject me to discipline, up to and including termination of employment.

I understand that I may revoke this waiver on any given day by advising my supervisor in writing before my shift begins or by actually taking a 30-minute meal period on a day when I could have waived it. If I revoke this waiver on a given day by notifying my supervisor in writing or by actually taking a 30-minute meal period, I understand that my revocation will be valid for that day only.

I also understand that I may revoke this waiver as a whole at any time by giving reasonable notice to Human Resources in writing.

Name

Signature Date

Supervisor Signature Date

Michael Page

"DESIGNATED PERSON" FORM
FOR PAID SICK LEAVE

Under the San Francisco Paid Sick Leave Ordinance, employees may use paid sick leave when they or a member of their family are ill or injured or for the purpose of receiving medical care, treatment, or diagnosis.

In addition to using paid sick leave as specified above, if an employee has no spouse or registered domestic partner, he or she may designate one person for whom the employee may use paid sick leave to aid or care for the person.

Employers must offer the opportunity to make a designation no later than 30 work hours after the date paid sick leave begins to accrue. Employees have 10 work days to make this designation, and thereafter do not have the right to make or change the designation until next offered by the employer. Employers must offer the opportunity to make or change the designation on an annual basis, again with a window of 10 work days for the employee to make or change the designation.

Employee Name:

Name of Designated Person:

I certify that I have no spouse or registered domestic partner. I designate the person listed above as my Designated Person for whom I may use paid sick leave pursuant to the San Francisco Paid Sick Leave Ordinance. I understand that if I have a spouse or registered domestic partner in the future, I will no longer be able to use paid sick leave to care for my Designated Person.

Employee Signature:	**Date**:

ARBITRATION AGREEMENT

This Arbitration Agreement ("Agreement") is made as of _____(date) by and between _____("Employee") and Michael Page International ("Employer" or "Company").

The parties to this Agreement agree to arbitrate any dispute, claim, or controversy ("claim") they may have against each other, including their current and former agents, owners, officers, directors, or employees, which arises from the employment relationship between Employee and Employer or the termination thereof.

Claims covered by this Agreement include, but are not limited to, claims of employment discrimination and harassment under Title VII of the Civil Rights Act, as amended, the California Fair Employment & Housing Act, the California Family Rights Act, the Age Discrimination in Employment Act, as amended, the Americans with Disabilities Act, 42 U.S.C. section 1981, claims brought under the Employment Retirement Income Security Act, the California Uniform Trade Secrets Act, the California Labor Code, and claims for breach of employment contract or the implied covenant of good faith and fair dealing, wrongful discharge, or tortious conduct (whether intentional or negligent), including claims of misappropriation, fraud, conversion, interference with economic advantage or contract, breach of fiduciary duty, invasion of privacy or defamation, misrepresentation, fraud, infliction of emotional distress, but excluding claims for workers' compensation benefits to remedy work-related injury or illness. THE PARTIES UNDERSTAND AND AGREE THAT THEY ARE WAIVING THEIR RIGHTS TO BRING SUCH CLAIMS TO COURT, INCLUDING THE RIGHT TO A JURY TRIAL. THE PARTIES FURTHER UNDERSTAND AND AGREE THAT CLAIMS MUST BE BROUGHT IN AN INDIVIDUAL CAPACITY AND NOT AS A PLAINTIFF OR CLASS MEMBER IN ANY PURPORTED CLASS OR REPRESENTATIVE PROCEEDING, AND EACH THEREFORE WAIVES ANY RIGHT TO PARTICIPATE IN A CLASS OR REPRESENTATIVE ACTION INVOLVING CLAIMS SUBJECT TO ARBITRATION.

The only claims excluded from final and binding arbitration shall be (i) claims that Employee may have for workers' compensation or unemployment benefits; and (ii) claims for injunctive or other equitable relief for violation or threatened violation of the confidentiality or intellectual property obligations contained in the Confidential Information and Non-Disclosure Agreement between you and the Company.

The arbitration shall be conducted in California by a neutral arbitrator in accordance with the Employment Arbitration Rules and Mediation Procedures issued by the American Association (AAA),which are available online at http://www.adr.org.. The Employer will pay the arbitrator's fee for the proceeding, as well as any room or other charges by AAA. Either party may file pre-hearing motions directed at the legal sufficiency of a claim or defense equivalent to a demurrer or summary judgment prior to the arbitration hearing.

The arbitrator will issue a detailed written decision and award, resolving the dispute. The arbitrator's written opinion and award shall decide all issues submitted and set forth the legal principle(s) supporting each part of the opinion.

The decision or award of the arbitrator shall be final and binding upon the parties. The arbitrator shall have the power to award any type of legal or equitable relief that would be available in a court of competent jurisdiction including, but not limited to attorneys' fees and punitive damages when such damages and fees are available under the applicable statute and/or judicial authority. Any arbitral award may be entered as a judgment or order in any court of competent jurisdiction. The parties agree that any relief or recovery to which they are entitled arising out of the employment relationship or cessation thereof shall be limited to that awarded by the arbitrator.

Nothing in this Agreement precludes Employee from filing a charge or from participating in an administrative investigation of a charge before any appropriate government agency. However, Employee understands and agrees that Employee cannot obtain any monetary relief or recovery from such a proceeding.

The parties agree to file any demand for arbitration within the time limit established by the applicable statute of limitations for the asserted claims or within one year of the conduct that forms the basis of the claim if no statutory limitation is applicable. Failure to demand arbitration within the prescribed time period shall result in waiver of said claims.

Neither the terms nor the conditions described in this Agreement are intended to create a contract of employment for a specific duration of time or to limit the circumstances under which the parties' employment relationship may be terminated. Since employment with the Employer is voluntarily entered into, Employee is free to resign at any time. Similarly, the Employer may terminate the employment relationship without cause or notice at any time.

This Agreement shall be governed by and shall be interpreted and enforced in accordance with the Federal Arbitration Act. The terms of this Agreement shall not be orally modified. This Agreement can be modified only by a written document signed by the Chief Executive Officer of the Employer and the Employee.

A court or other entity construing this Agreement should administer, modify, or interpret it to the extent and such manner as to render it enforceable. If, for any reason, this Agreement is declared unenforceable and cannot be administered, interpreted, or modified to be enforceable, the parties agree to waive any right they may have to a jury trial with respect to any dispute or claim relating to employment, termination from employment, or any terms and conditions of employment with the Employer.

I have been advised of my right to consult with counsel regarding this Agreement. I ALSO UNDERSTAND THAT BY ENTERING INTO THIS AGREEMENT, I AM WAIVING ANY RIGHT TO A TRIAL BY JURY.

EMPLOYEE	EMPLOYER
_____	_____
Signature	Signature
_____	_____
Date	Date
_____	_____
Print Name	Print Name
	_____
	Title

4812-7497-6530, v. 1

3259336

Michael Page

DIRECT DEPOSIT AUTHORIZATION FORM			
I authorize you to deposit my net pay automatically to my account(s) specified below each payday by initiating credit entries to my account electronically or by any other commercially accepted method, and I authorize the financial institution named below to credit the same to my account. If funds to which I am not entitled are deposited to my account, I authorize you to direct the financial institution to return said funds by any such method and I authorize the financial institution to debit the same to my account. This authority will remain in effect until you have received written notice from me of its cancellation in such time and manner as to afford you and the financial institution a reasonable opportunity to act on it.			
■ **You must attach a cancelled or voided check, or a savings deposit slip to this form in order to process your request for direct deposit.** ■ **Once the form is received it will take 2 pay periods for direct deposit to commence.** ■ **If this is a change or cancellation, please be specific on the comments section below.**			
Employee Name (please print):			
Social Security Number:			
Financial Institution: Street Address: City, State, Zip Code:			
Account Number:		ABA/Routing # (9 digits):	
Select One:	Checking ☐		Savings ☐
Is this a Full Deposit:	Yes ☐	No ☐	Partial Deposit Amount: $
Financial Institution: Street Address: City, State, Zip Code:			
Account Number:		ABA/Routing #:	
Select One:	Checking ☐		Savings ☐
Is this a Full Deposit:	Yes ☐	No ☐	Partial Deposit Amount: $
Comments:			

IMPORTANT: Direct Deposit **WILL NOT** take effect without a cancelled or voided check (checking account), or a savings deposit slip (savings account).

NOTE: Your Savings account number is usually different from your Checking account number.

Signature: _____

Date: _____

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DI Claim Management Offices

Alameda.....1600 Harbor Bay Parkway, Ste. 120
(write to: PO Box 1857, Oakland, CA 94604-1857)

Chico ..... 645 Salem Street
(write to: PO Box 8190, Chico, CA 95927-8190)

Chino Hills.. 15315 Fairfield Ranch Road, Ste. 100
(write to: PO Box 60006, City of Industry, CA 91716-0006)

Fresno ..... 2550 Mariposa Mall, Rm. 1080A
(write to: PO Box 32, Fresno, CA 93707-0032)

Long Beach ... 4300 Long Beach Blvd., Ste. 600
(write to: PO Box 469, Long Beach, CA 90801-0469)

Los Angeles .....888 S. Figueroa Street, Ste. 200
(write to: PO Box 513096, Los Angeles, CA 90051-1096)

N. Los Angeles...15400 Sherman Way, Rm. 500
(write to: PO Box 10402, Van Nuys, CA 91410-0402)

San Bernardino.....371 West 3rd Street
(write to: PO Box 731, San Bernardino, CA 92402-0731)

San Diego..9246 Lightwave Avenue, Bldg. A, Ste. 300
(write to: PO Box 120831, San Diego, CA 92112-0831)

San Francisco ..... 745 Franklin Street, Rm. 300
(write to: PO Box 193534, San Francisco, CA 94119-3534)

San Jose..... 297 West Hedding Street
(write to: PO Box 637, San Jose, CA 95106-0637)

Santa Ana.. 605 West Santa Ana Blvd., Bldg. 28, Rm. 735
(write to: PO Box 1466, Santa Ana, CA 92702-1466)

Santa Barbara ..... 128 East Ortega Street
(write to: PO Box 1529, Santa Barbara, CA 93102-1529)

Santa Rosa..... 606 Healdsburg Avenue
(write to: PO Box 700, Santa Rosa, CA 95402-0700)

Stockton ..... 528 North Madison Street
(write to: PO Box 201006, Stockton, CA 95201-9006)

STATE OF CALIFORNIA

LABOR AND WORKFORCE DEVELOPMENT AGENCY

EMPLOYMENT DEVELOPMENT DEPARTMENT

This pamphlet is for general information only, and does not have the force and effect of the law, rule or regulation.

EDD is an equal opportunity employer/program. Auxiliary aids and services are available upon request to individuals with disabilities. Requests for services, aids, and/or alternate formats need to be made by calling DI at 1-800-480-3287 (voice), or TTY 1-800-563-2441, or PFL at 1-877-238-4373 or TTY 1-800-445-1312.

Employment Development Department
State of California

DISABILITY INSURANCE PROVISIONS

Disability is any illness or injury, either physical or mental, that prevents you from doing your regular or customary work. Disability also includes elective surgery, pregnancy, childbirth, or related medical conditions.

Disability Insurance (DI) is a component of the State Disability Insurance (SDI) Program and is designed to partially replace wages you lost because of a disability that was not caused by your work. (See "Other Programs" on reverse for job-related disabilities.)

SDI taxes are paid by those California workers who are covered by the SDI program. Tax rates may vary from year to year. For current rates, contact the Employment Development Department (EDD) DI Customer Service at 1-800-480-3287 or EDD Employment Tax Customer Service at 1-888-745-3886.

DI Plans

- State Plan. DI's state plan is covered in this brochure.
- Voluntary Plan. This is a private plan, approved by the Director of EDD, which may be substituted for the State Plan. Employers and employee groups may establish voluntary plans if the majority of employees and the employer agree to do so. If you are covered by a voluntary plan, the provisions of this brochure may not apply to you. Obtain information about your coverage and file a voluntary plan claim through your employer.
- Elective Coverage. Employers and self-employed persons, including general partners, may elect coverage. However, the method of computing benefits for elective coverage participants is not the same as for mandatory rate payers. The cost of participating, which is set annually, can be obtained from your local EDD Employment Tax Customer Service Office.

  Elective Coverage claims are filed in the same manner as State Plan claims; however, there are some differences in eligibility requirements from those listed in this pamphlet. For additional information or to apply for coverage, contact EDD DI Customer Service at 1-800-480-3287 or EDD Employment Tax Customer Service at 1-888-745-3886.

How to Claim State Plan Benefits

1. Request a claim form:
   - By telephone: **1-800-480-3287**
   - By Internet: **www.edd.ca.gov**
   - By TTY (teletypewriter for deaf, hearing-impaired and speech-impaired persons only): **1-800-563-2441 for DI or 1-800-445-1312 for PFL.**
   - By mail: EDD, Disability Insurance, P.O. Box 13140, Sacramento, CA 95813-3140
   - In person by visiting any of the DI offices listed under "Disability Insurance Office Locations."
   - California State government employees covered by SDI should telephone **1-866-352-7675.**
2. Fill out and sign the "Claimant's Statement." Print clearly, and be sure that your answers are complete and correct because errors may delay payments.
3. Have your doctor complete the "Physician/Practitioner's Certificate." Usually a claim cannot begin more than seven days before you were examined by or under the care of a certifying physician/practitioner. Certification may be made by a licensed medical or osteopathic physician and surgeon, nurse practitioner, chiropractor, dentist, podiatrist, optometrist, designated psychologist, or an authorized medical officer of a United States Government facility. Certification may also be made by a licensed nurse-midwife or licensed midwife for disabilities related to normal pregnancy or childbirth.
4. Mail your claim form within 49 days from the first day you were disabled. If your claim is late, you may lose benefits unless your explanation of the delay is accepted as reasonable.

How Benefits Are Paid

- The SDI Program is designed to serve you by mail or online. You do not need to appear in person to apply for or receive benefits.

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- When your claim is received, you may be contacted by mail or by telephone for additional information if needed. Most claims are processed within 14 days.
- The first seven days of your disability claim are a "non payable" waiting period.

Benefits are paid as quickly as possible after all information to determine eligibility is received. If you meet all eligibility requirements, benefits will be authorized. If you are eligible for further benefits, you will be sent additional benefits automatically or sent a "continued claim" certification form for you to complete for the next benefit period. Usually these benefit periods will be in two week intervals. However, the DI program pays benefits based on daily eligibility within a seven-day calendar week. Partial weeks are paid at a daily rate. This rate is one-seventh of your weekly benefit amount. Please allow ten days from the date you mail a certification for receipt of your payment.

How Your Benefit Rate is Determined

Your benefit amounts are based on wages paid to you during a specific 12-month **base period**, which is determined by the date your claim begins. Therefore, you should carefully consider when to start your claim since this may affect your weekly benefit rate, your maximum benefit amount, and the period of your benefit eligibility.

Only the wages in your **base period** that were subject to the disability insurance tax can be used in computing your benefits. To qualify, you must have earned at least $300 during your base period. The month in which your claim begins determines which four consecutive quarters must be used.

If your claim begins in:

- **January, February, or March, your base period is the 12 months ending last September 30.** (Example: A claim beginning February 14, 2011, uses a base period of October 1, 2009, through September 30, 2010.)
- **April, May, or June, your base period is the 12 months ending last December 31.** (Example: A claim beginning June 20, 2011, uses a base period of January 1, 2009, through December 31, 2010.)
- **July, August, or September, your base period is the 12 months ending last March 31.** (Example: A claim beginning September 27, 2011, uses a base period of April 1, 2010, through March 31, 2011.)
- **October, November, or December, your base period is the 12 months ending last June 30.** (Example: A claim beginning November 2, 2011, uses a base period of July 1, 2010, through June 30, 2011.)

Exceptions: If your claim is determined to be invalid, but you were unemployed and seeking work for 60 days or more in any quarter of your base period, you may be able to substitute wages paid in prior quarters.

In addition, you may be entitled to substitute wages paid in prior quarters either to make your claim valid or to increase your benefit amount, if during your base period you:

- were in the military service.
- received Workers' Compensation benefits.
- did not work because of a labor dispute.

If your situation fits any of the above, include a note with your claim form.

Wage Continuation. If your employer continues to pay you wages while you are disabled, your DI benefits may be affected. DI benefits plus wages cannot exceed your regular weekly wage. Your DI benefits will not be affected by any vacation pay you may receive.

Maximum Benefits. The maximum benefit amount is 52 times the weekly rate, but not more than your total base period wages. Exception: For employers and self-employed individuals who elect SDI coverage, the maximum benefit amount is 39 times the weekly rate.

In addition, benefits are payable only for a limited period to a resident in an alcoholic recovery home or drug-free residential facility that is both licensed and certified by the state in which the facility is located. However, disabilities related to or caused by acute or chronic alcoholism or drug abuse, being medically treated, do not have this limitation.

Pregnancy. As with any medical condition, your disability period begins the first day you are unable to do your regular or customary work. DI benefits are based on the period of time your physician/practitioner certifies you are unable to do your regular or customary work. Do NOT send in your claim for pregnancy-related disability benefits until the date your physician/practitioner certifies you are disabled.

NOTE: For information on Paid Family Leave bonding benefits, see the "Other Programs" section of this brochure.

You May Not be Eligible for Benefits

- If you are receiving Unemployment Insurance or Paid Family Leave benefits.
- If you are not working or looking for work at the time you become disabled.
- If you are in custody due to conviction of a crime.
- If your full wages are paid.
- If you are receiving Workers' Compensation at a weekly rate equal to or greater than the DI rate. If Workers' Compensation benefits are paid at a lower rate than your DI rate, you may be paid the difference.
- For the amount of time a claim is late (without good cause).
- If you make a false statement or fail to report a material fact. (A 30 percent penalty may be assessed if benefits are overpaid because you willfully withheld a material fact or made a false statement.)
- If you fail to attend an independent medical examination when requested. (Fees for such examinations are paid by EDD.)

The California Unemployment Insurance Code provides for penalties consisting of fines, imprisonment, and loss of benefit rights for fraud against the DI system.

Your Rights. You are entitled to:

- Know the reason and basis for any decision that affects your benefits.
- Appeal any decision about your eligibility for benefits. (Appeals must be sent to the DI office in writing.)
- A hearing of your appeal before an Administrative Law Judge (ALJ). You may further appeal the ALJ's decision to the California Unemployment Insurance Appeals Board and the courts.
- Privacy. Information about your claim will be kept confidential except for the purposes allowed by law.

Your Obligations. You are responsible to:

- Complete your claim and other forms correctly, completely, and truthfully.
- Mail your claim and other forms in the time limits shown on the forms. If you are late and you believe you have a good reason for being late, you should include a written explanation of the reason(s) with the form.
- Contact DI if you do not understand a question or how to answer it.
- Include your name and Social Security number on all letters to DI.

Contact DI

- By **telephone**: 1-800-480-3287 (English) or 1-866-658-8646 (Spanish).
- By **U.S. mail:** addressed to the office handling your claim and on the Internet at **http://www.edd.ca.gov/Disability/Contact_SDI.htm#bylocation**. If you do not have a current claim, you may write to any DI Claim Management Office.
- By **TTY** (teletypewriter for deaf, hearing-impaired, and speech-impaired persons only): **1-800-563-2441**.
- By **Internet**: **http://www.edd.ca.gov/About_EDD/Contact_EDD.htm**
- **In person** by visiting any of the DI offices listed under "Disability Insurance Office Locations."

Other Programs

IF YOU ARE **INJURED ON THE JOB** or become ill as a result of your occupation, notify your employer.

IF YOU ARE **ABLE AND AVAILABLE TO WORK** but unemployed, contact the Unemployment Insurance Program of EDD at **1-800-300-5616 (TTY 1-800-815-9387).**

IF YOU NEED HELP IN **FINDING WORK, JOB TRAINING, RETRAINING,** or other services in order to return to work, visit your local one-stop career center listed in the white pages of your telephone directory and on the Internet at: **www.servicelocator.org**

IF YOUR **DISABILITY IS PERMANENT** or is expected to continue for a year or more, contact the U.S. Social Security Administration at **1-800-772-1213 (TTY 1-800-325-0778)** or on the Internet at: **www.ssa.gov**

IF A FAMILY MEMBER TAKES TIME OFF FROM WORK TO **CARE FOR YOU**, contact EDD's **Paid Family Leave** program at **1-877-238-4373.**

IF YOU TAKE TIME OFF FROM WORK TO **BOND WITH A NEW CHILD,** including newly adopted or newly placed foster children or those of your registered domestic partner, contact EDD's **Paid Family Leave** program at **1-877-238-4373 or TTY 1-800-445-1312.**

NOTE: A Paid Family Leave bonding claim form will be sent automatically with the final benefit payment to new mothers receiving DI benefits.

IF YOU ARE A **VICTIM OF A CRIME**, call the California Victims Compensation Program at **1-800-777-9229.** TTY users may contact the Program via **TTY at 1-800-735-2929 (English)** or **TTY at 1-800-855-3000 (Spanish).** You may also contact your county Victim/Witness Assistance Center.

QUESTIONS ABOUT **SPOUSAL OR PARENTAL SUPPORT** obligations should be directed to the District Attorney's Office for the county that issued the court order.

QUESTIONS ABOUT **CHILD SUPPORT** obligations should be directed to the Department of Child Support Services at **1-866-249-0773.**

Fast facts about Paid Family Leave

- Provides benefits but does not provide job protection or return rights.
- Provides eligible workers with partial wage replacement when taking time off work to care for a child, parent, parent-in-law, grandparent, grandchild, sibling, spouse, or registered domestic partner.
- Covers employees who are covered by SDI (or a voluntary plan in lieu of SDI).
- Offers up to six weeks of benefits in a 12-month period.
- Provides benefits of approximately 55 percent of lost wages.
- PFL benefits are considered taxable income.

In California, it's the law.

Paid Family Leave

Benefits

The time to care. 1-877-238-4373

To apply online or for more information, visit:

www.edd.ca.gov/disability

Phone number: 1-877-238-4373

- Press 1 for English.
- Press 2 for Spanish.
- Press 3 for Cantonese.
- Press 4 for Vietnamese.
- Press 5 for Armenian.
- Press 6 for Tagalog.
- Press 7 for Punjabi.

TTY: 1-800-445-1312
(This number does not accept voice calls).

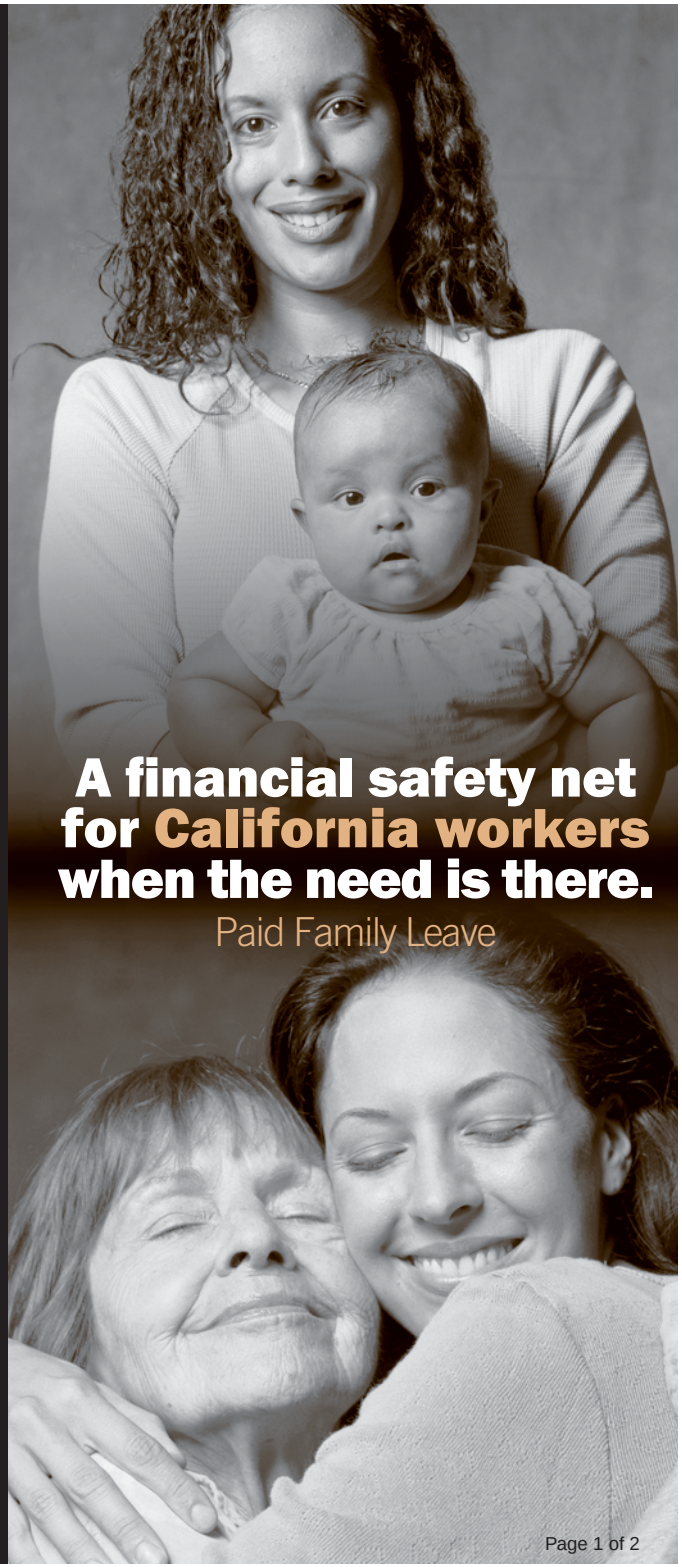
State of California

The EDD is an equal opportunity employer/program. Auxiliary aids and services are available upon request to individuals with disabilities. Requests for services, aids, and/or alternate formats need to be made by calling 1-877-238-4373 (voice) or TTY 1-800-445-1312.

This pamphlet is for general information only and does not have the force and effect of law, rule or regulation.

EDD Employment Development Department
State of California

DE 2511 Rev. 9 (7-14) **(INTERNET)**



A financial safety net for California workers when the need is there.

Paid Family Leave

Paid Family Leave benefits for California workers

There may be times in the life of a working person when they need to care for a loved one. Whether it's a working parent bonding with a newborn or an employee caring for a seriously ill child, parent, parent-in-law, grandparent, grandchild, sibling, spouse, or registered domestic partner. California's Paid Family Leave (PFL) was created for these times (**Note**: Registered domestic partners must meet requirements and register with the California Secretary of State to be eligible for benefits).

A program benefiting you and your family

California leads the nation as the first state to make it easier for employees to balance the demands of the workplace and family care needs at home. PFL benefits are based on the claimant's (care provider's) past quarterly earnings. For more information regarding maximum benefit amounts paid, read the *Disability Insurance (DI) and Paid Family Leave (PFL) Weekly Benefit Amounts in Dollar Increments* form, DE 2589, at **www.edd.ca.gov/disability**.

Paid Family Leave for California employees

PFL benefits do not provide job protection or return rights. Job protection **may** be provided **if** your employer is subject to the federal Family Medical Leave Act and the California Family Rights Act. Notify your employer of the reason for taking leave in a manner consistent with your company's leave policy.

To qualify for PFL benefits, you must meet the following requirements:

- Be covered by State Disability Insurance (SDI) (or a voluntary plan in lieu of SDI) and have earned at least $300 in your base period from which deductions were withheld.
- Supply medical information supporting your claim that the care recipient has a serious health condition and requires your care.
- Submit your claim no earlier than nine days, but no later than 49 days, after the first day your family care leave began.
- Provide documentation to support a claim for bonding with a new biological, adopted, or foster child.
- Use up to two weeks of any earned but unused vacation leave or paid time off, if required by your employer, prior to the initial receipt of benefits.
- Serve a seven-day unpaid waiting period before benefits begin for each different care recipient within the 12-month period.

You may not be eligible for benefits if:

- You are receiving Disability Insurance, Unemployment Insurance, or Workers' Compensation benefits.
- You are not working or looking for work at the time you begin your family care leave.
- You are not suffering a loss of wages.
- The need for care is not supported by the certificate of a treating physician/practitioner.
- You are in custody due to conviction of a crime.

You are entitled to:

- Know the reason and basis for decisions affecting your benefits.
- Appeal decisions about your eligibility for benefits. (Appeals must be sent to PFL in writing.)

(INTERNET)

- A hearing of your appeal before an Administrative Law Judge. Decisions may be further appealed to the California Unemployment Insurance Appeals Board and the courts.
- Privacy-Information about your claim will be kept confidential except for the purposes allowed by law.

Apply for benefits

Apply for PFL benefits online at **www.edd.ca.gov/disability.** Employers and physicians/practitioners can submit claim information through SDI Online. You may also file a paper form. To request a claim form visit **www.edd.ca.gov/disability.**

If you are currently receiving DI pregnancy-related benefits, it is not necessary to request a PFL claim form. Claim filing information will be sent through your SDI Online account or via mail when your pregnancy-related disability claim ends.

Contact Paid Family Leave

For questions about PFL benefits, please visit **www.edd.ca.gov/disability.**

Phone number: 1-877-238-4373

- **Press 1 for English.**
- **Press 2 for Spanish.**
- **Press 3 for Cantonese.**
- **Press 4 for Vietnamese.**
- **Press 5 for Armenian.**
- **Press 6 for Tagalog.**
- **Press 7 for Punjabi.**

TTY: 1-800-445-1312 (This number does not accept voice calls).

For more information, visit **www.edd.ca.gov/disability.**

Claim forms should be mailed to PFL at:
P.O. Box 997017, Sacramento, CA 95799-7017

TIME OF HIRE PAMPHLET

This pamphlet, or a similar one that has been approved by the Administrative Director, must be given to all newly hired employees in the State of California. Employers and claims administrators may use the content of this document and put their logos and additional information on it. The content of this pamphlet applies to all industrial injuries that occur on or after January 1, 2013.

WHAT IS WORKERS' COMPENSATION?

If you get hurt on the job, your employer is required by law to pay for workers' compensation benefits. You could get hurt by:

One event at work. Examples: hurting your back in a fall, getting burned by a chemical that splashes on your skin, getting hurt in a car accident while making deliveries.

—or—

Repeated exposures at work. Examples: hurting your wrist from using vibrating tools, losing your hearing because of constant loud noise.

—or—

Workplace crime. Examples: you get hurt in a store robbery, physically attacked by an unhappy customer.

Discrimination is illegal

It is illegal under Labor Code section 132a for your employer to punish or fire you because you:

- File a workers' compensation claim
- Intend to file a workers' compensation claim
- Settle a workers' compensation claim
- Testify or intend to testify for another injured worker.

If it is found that your employer discriminated against you, he or she may be ordered to return you to your job. Your employer may also be made to pay for lost wages, increased workers' compensation benefits, and costs and expenses set by state law.

WHAT ARE THE BENEFITS?

- **Medical care**: Paid for by your employer to help you recover from an injury or illness caused by work. Doctor visits, hospital services, physical therapy, lab tests and x-rays are some of the medical services that may be provided. These services should be necessary to treat your injury. There are limits on some services such as physical and occupational therapy and chiropractic care.

- **Temporary disability benefits**: Payments if you lose wages because your injury prevents you from doing your usual job while recovering. The amount you may get is up to two-thirds of your wages. There are minimum and maximum payment limits set by state law. You will be paid every two weeks if you are eligible. For most injuries, payments may not exceed 104 weeks within five years from your date of injury. Temporary disability (TD) stops when you return to work, or when the doctor releases you for work, or says your injury has improved as much as it's going to.

- **Permanent disability benefits**: Payments if you don't recover completely. You will be paid every two weeks if you are eligible. There are minimum and maximum weekly payment rates established by state law. The amount of payment is based on:

    - Your doctor's medical reports
    - Your age
    - Your occupation

- **Supplemental job displacement benefits**: This is a voucher for up to $6,000 that you can use for retraining or skill enhancement at an approved school, books, tools, licenses or certification fees, or other resources to help you find a new job. You are eligible for this voucher if:

    - You have a permanent disability.
    - Your employer does not offer regular, modified, or alternative work, within 60 days after the claims administrator receives a doctor's report saying you have made a maximum medical recovery.

- **Death benefits**: Payments to your spouse, children or other dependents if you die from a job injury or illness. The amount of payment is based on the number of dependents. The benefit is paid every two weeks at a rate of at least $224 per week. In addition, workers' compensation provides a burial allowance.

OTHER BENEFITS

You may file a claim with the Employment Development Department (EDD) to get state disability benefits when workers' compensation benefits are delayed, denied, or have ended. There are time restrictions so for more information contact the local office of EDD or go to their web site www.edd.ca.gov.

If your injury results in a permanent disability (PD) and the state determines that your PD benefit is disproportionately low compared to your earning loss, you may qualify for additional money from the Department of Industrial Relation's special earnings loss supplement program also known as the return to work program. If you have questions or think you qualify, contact the Information & Assistance Unit by going to www.dwc.ca.gov and looking under "Workers'

Compensation programs and units" for the "Information & Assistance Unit" link or visit the DIR web site at www.dir.ca.gov.

Workers' compensation fraud is a crime
Any person who makes or causes to be made any knowingly false statement in order to obtain or deny workers' compensation benefits or payments is guilty of a felony. If convicted, the person will have to pay fines up to $150,000 and/or serve up to five years in jail.

WHAT SHOULD I DO IF I HAVE AN INJURY?

Report your injury to your employer

Tell your supervisor right away no matter how slight the injury may be. Don't delay – there are time limits. You could lose your right to benefits if your employer does not learn of your injury within 30 days. If your injury or illness is one that develops over time, report it as soon as you learn it was caused by your job.

If you cannot report to the employer or don't hear from the claims administrator after you have reported your injury, contact the claims administrator yourself.

Workers' compensation insurance company or if employer is self-insured, person responsible for handling the claim is:

AIG

Address: P.O. Box 25977 Shawnee Mission, KS 66225

Phone: 877-802-5246

You may be able to find the name of your employer's workers' compensation insurer at www.caworkcompcoverage.com. If no coverage exists or coverage has expired, contact the Division of Labor Standards Enforcement at www.dir.ca.gov/DLSE as all employees must be covered by law.

Get emergency treatment if needed

If it's a medical emergency, go to an emergency room right away. Tell the medical provider who treats you that your injury is job related. Your employer may tell you where to go for follow up treatment.

Emergency telephone number: Call 911 for an ambulance, fire department or police. For non-emergency medical care, contact your employer, the workers' compensation claims administrator or go to this facility:

_____.

Fill out DWC 1 claim form and give it to your employer

Your employer must give you a DWC 1 claim form within one working day after learning about your injury or illness. Complete the employee portion, sign and give it back to your employer. Your employer will then file your claim with the claims administrator. Your employer must authorize treatment within one working day of receiving the DWC 1 claim form.

If the injury is from repeated exposures, you have one year from when you realized your injury was job related to file a claim.

In either case, you may receive up to $10,000 in employer-paid medical care until your claim is either accepted or denied. The claims administrator has up to 90 days to decide whether to accept or deny your claim. Otherwise your case is presumed payable.

Your employer or the claims administrator will send you "benefit notices" that will advise you of the status of your claim.

MORE ABOUT MEDICAL CARE

What is a Primary Treating Physician (PTP)?

This is the doctor with overall responsibility for treating your injury or illness. He or she may be:

- The doctor you name in writing *before* you get hurt on the job
- A doctor from the medical provider network (MPN)
- The doctor chosen by your employer during the first 30 days of injury if your employer does not have an MPN or
- The doctor you chose after the first 30 days if your employer does not have an MPN.

What is a Medical Provider Network (MPN)?

An MPN is a select group of health care providers who treat injured workers. Check with your employer to see if they are using an MPN.

If you have not named a doctor before you get hurt and your employer is using an MPN, you will see an MPN doctor. After your first visit, you are free to choose another doctor from the MPN list.

What is Predesignation?

Predesignation is when you name your regular doctor to treat you if you get hurt on the job. The doctor must be a medical doctor (M.D.), doctor of osteopathic medicine (D.O.) or a medical group with an M.D. or D.O. You must name your doctor in writing *before* you get hurt or become ill.

You may predesignate a doctor if you have health care coverage for non-work injuries and illnesses. The doctor must have:

- Treated you
- Maintained your medical history and records before your injury and
- Agreed to treat you for a work-related injury or illness before you get hurt or become ill.

You may use the "predesignation of personal physician" form included with this pamphlet. After you fill in the form, be sure to give it to your employer.

If your employer does not have an approved MPN, you may name your chiropractor or acupuncturist to treat you for work related injuries. The notice of personal chiropractor or acupuncturist must be in writing *before* you get hurt. You may use the form included in this pamphlet. After you fill in the form, be sure to give it to your employer.

With some exceptions, state law does not allow a chiropractor to continue as your treating physician after 24 visits. Once you have received 24 chiropractic visits, if you still require medical treatment, you will have to select a new physician who is not a chiropractor. The term "chiropractic visit" means any chiropractic office visit, regardless of whether the services performed involve chiropractic manipulation or are limited to evaluation and management.

Exceptions to the prohibition on a chiropractor continuing as your treating physician after 24 visits include postsurgical physical medicine visits prescribed by the surgeon, or physician designated by the surgeon, under the postsurgical component of the Division of Workers' Compensation's Medical Treatment Utilization Schedule, or if your employer has authorized additional visits in writing.

WHAT IF THERE IS A PROBLEM?

If you have a concern, speak up. Talk to your employer or the claims administrator handling your claim and try to solve the problem. If this doesn't work, get help by trying the following:

Contact the Division of Workers' Compensation (DWC) Information and Assistance (I&A) Unit
All 24 DWC offices throughout the state provide information and assistance on rights, benefits and obligations under California's workers' compensation laws. I&A officers help resolve disputes without formal proceedings. Their goal is to get you full and timely benefits. Their services are free.

To contact the nearest I&A Unit, go to www.dwc.ca.gov and under "Workers' Compensation programs and units", click on "Information & Assistance Unit." At this site you will find fact sheets, guides and information to help you.

The nearest I&A Unit is located at:

Address: _____

Phone number: 800-736-7401

Consult with an attorney

Most attorneys offer one free consultation. If you decide to hire an attorney, his or her fees may be taken out of some of your benefits. For names of workers' compensation attorneys, call the State Bar of California at (415) 538-2120 or go to their website at www.californiaspecialist.org. You may get a list of attorneys from your local I&A Unit or look in the yellow pages.

Warning

Your employer may not pay workers' compensation benefits if you get hurt in a voluntary off-duty recreational, social or athletic activity that is not part of your work-related duties.

Additional rights

You may also have other rights under the Americans with Disabilities Act (ADA) or the Fair Employment and Housing Act (FEHA). For additional information, contact FEHA at (800) 884-1684 or the Equal Employment Opportunity Commission (EEOC) at (800) 669-4000.

The information contained in this pamphlet conforms to the informational requirements found in Labor Code sections 3551 and 3553 and California Code of Regulation, Title 8, sections 9880 and 9883. This document is approved by the Division of Workers' Compensation administrative director.

Revised 6/17/14 and effective for dates of injuries on or after 1/1/13

PREDESIGNATION OF PERSONAL PHYSICIAN

In the event you sustain an injury or illness related to your employment, you may be treated for such injury or illness by your personal medical doctor (M.D.), doctor of osteopathic medicine (D.O.) or medical group if:

- on the date of your work injury you have health care coverage for injuries or illnesses that are not work related;
- the doctor is your regular physician, who shall be either a physician who has limited his or her practice of medicine to general practice or who is a board-certified or board-eligible internist, pediatrician, obstetrician-gynecologist, or family practitioner, and has previously directed your medical treatment, and retains your medical records;
- your "personal physician" may be a medical group if it is a single corporation or partnership composed of licensed doctors of medicine or osteopathy, which operates an integrated multispecialty medical group providing comprehensive medical services predominantly for nonoccupational illnesses and injuries;
- prior to the injury your doctor agrees to treat you for work injuries or illnesses;
- prior to the injury you provided your employer the following in writing: (1) notice that you want your personal doctor to treat you for a work-related injury or illness, and (2) your personal doctor's name and business address.

You may use this form to notify your employer if you wish to have your personal medical doctor or a doctor of osteopathic medicine treat you for a work-related injury or illness and the above requirements are met.

NOTICE OF PREDESIGNATION OF PERSONAL PHYSICIAN

Employee: Complete this section.

To: _____ (name of employer) If I have a work-related injury or illness, I choose to be

treated by: _____
(name of doctor, (M.D., D.O.,) or medical group)
_____(street address, city, state, ZIP)

_____(telephone number)

Employee Name (please print):
_____

Employee's Address:
_____

Name of Insurance Company, Plan, or Fund providing health coverage for nonoccupational injuries or illnesses:

_____

Employee's Signature _____Date: _____

Physician: I agree to this Predesignation:

Signature: _____ _____Date: _____
(Physician or Designated Employee of the Physician or Medical Group)

The physician is not required to sign this form, however, if the physician or designated employee of the physician or medical group does not sign, other documentation of the physician's agreement to be predesignated will be required pursuant to Title 8, California Code of Regulations, section 9780.1(a)(3).

§ 9783.1. DWC Form 9783.1 Notice of Personal Chiropractor or Personal Acupuncturist.

NOTICE OF PERSONAL CHIROPRACTOR OR PERSONAL ACUPUNCTURIST

If your employer or your employer's insurer does not have a Medical Provider Network, you may be able to change your treating physician to your personal chiropractor or acupuncturist following a work-related injury or illness. In order to be eligible to make this change, you must give your employer the name and business address of a personal chiropractor or acupuncturist in writing prior to the injury or illness. Your claims administrator generally has the right to select your treating physician within the first 30 days after your employer knows of your injury or illness. After your claims administrator has initiated your treatment with another doctor during this period, you may then, upon request, have your treatment transferred to your personal chiropractor or acupuncturist.

NOTE: If your date of injury is January 1, 2004 or later, a chiropractor cannot be your treating physician after you have received 24 chiropractic visits unless your employer has authorized additional visits in writing. The term "chiropractic visit" means any chiropractic office visit, regardless of whether the services performed involve chiropractic manipulation or are limited to evaluation and management. Once you have received 24 chiropractic visits, if you still require medical treatment, you will have to select a new physician who is not a chiropractor. This prohibition shall not apply to visits for postsurgical physical medicine visits prescribed by the surgeon, or physician designated by the surgeon, under the postsurgical component of the Division of Workers' Compensation's Medical Treatment Utilization Schedule.

You may use this form to notify your employer of your personal chiropractor or acupuncturist.

Your Chiropractor or Acupuncturist's Information:

_____

(name of chiropractor or acupuncturist)

_____

(street address, city, state, zip code)

_____

(telephone number)

Employee Name **(please print**):

_____

Employee's Address:

_____

Employee's Signature _____ Date: _____

July 2014

UN FOLLETO PARA EL NUEVO EMPLEADO

Este folleto, o uno similar que ha sido aprobado por el Director Administrativo, debe ser dado a todos los empleados recién contratados en el estado de California. Los empleadores y administradores de reclamos pueden utilizar el contenido de este documento y incluir sus logos e información adicional en ello. El contenido de este folleto se aplica a todas las lesiones laborales que ocurren en o después del 1 de enero 2013.

¿QUÉ ES LA COMPENSACIÓN DE TRABAJADORES?

Si usted se lesiona en el trabajo, su empleador por ley está obligado a pagarle los beneficios de compensación de trabajadores. Usted podría lesionarse por:

Un incidente en el trabajo. Ejemplos: lastimarse la espalda al caerse, quemarse con un producto químico que le salpique la piel, lesionarse en un accidente de tránsito mientras hace entregas.

— o —

Exposiciones repetidas en el trabajo. Ejemplos: lastimarse la muñeca por hacer movimientos repetitivos, perder la audición debido a la presencia de ruidos fuertes y constantes.

— o —

Crimen en el lugar de trabajo. Ejemplos: se lesiona en un robo de una tienda, físicamente atacado por un cliente disgustado.

La discriminación es ilegal

Es ilegal bajo el Código Laboral 132a que su empleador lo castigue o despida porque usted:

- Presenta un reclamo de compensación de trabajadores
- Tiene la intención de presentar un reclamo de compensación de trabajadores
- Finaliza un reclamo de compensación de trabajadores
- Testifica o tiene la intención de testificar para otro trabajador lesionado.

Si se determina que su empleador discriminó contra usted, él o ella pueden ser ordenados a regresarlo a su trabajo. Su empleador también puede ser obligado a pagar por salarios perdidos, aumentos en beneficios de compensación de trabajadores además de costos y gastos establecidos por la ley estatal.

¿CUÁLES SON LOS BENEFICIOS?

- **Atención médica**: Pagado por su empleador para ayudarle a recuperarse de una lesión o enfermedad causada por el trabajo. Visitas al médico, servicios de hospital, terapia física, exámenes de laboratorio y rayos X son algunos servicios médicos que pueden ser proporcionados. Estos servicios deben ser necesarios para tratar su lesión. Hay límites en algunos servicios como terapia física y ocupacional y cuidado quiropráctico.

- **Beneficios por incapacidad temporal**: Pagos que usted recibe por los salarios perdidos si su lesión le impide hacer su trabajo usual mientras se recupera. La cantidad que puede recibir es hasta dos tercios de su salario. Hay límites de pagos mínimos y máximos establecidos por la ley estatal. Será pagado cada dos semanas si es elegible. Para la mayoría de las lesiones, los pagos no pueden exceder más de 104 semanas dentro de cinco anos después de su lesión. La Incapacidad Temporal *(Temporary Disability- TD)* termina cuando usted regresa a trabajar o cuando su médico le permite regresar a trabajar o indica que su lesión ha mejorado lo mejor posible.

- **Beneficios por incapacidad permanente**: Pagos si no se recupera completamente. Se le pagará cada dos semanas si es elegible. Hay tasas de pago semanales mínimas y máximas establecidas por la ley estatal. La cantidad de pago está basada en:
  - El informe médico de su doctor
  - Su edad
  - Su ocupación

- **Beneficios suplementarios por la pérdida de trabajo**: Este es un vale de hasta $6,000 que usted puede utilizar para pagar por reentrenamiento/capacitación o mejoramiento de habilidades en una escuela aprobada por el estado, libros, herramientas, honorarios de certificación o licenciatura u otros recursos para ayudarle a encontrar un nuevo trabajo. Usted es elegible para este vale si:
  - Usted tiene una incapacidad permanente
  - Su empleador no le ofrece trabajo regular, modificado o alternativo dentro de 60 días después de que el administrador de reclamos recibe un informe médico indicando que ha llegado a una máxima recuperación médica.

- **Beneficios por Muerte**: Pagos a su cónyuge, hijos u otros dependientes si usted muere debido a una lesión o enfermedad de trabajo. La cantidad del pago está basada en el número de dependientes. El beneficio es pagado cada dos semanas a una tasa de por lo menos $224 por semana. Adicionalmente, el seguro de compensación de trabajadores proporciona una cantidad para el entierro.

OTROS BENEFICIOS

Usted puede presentar un reclamo con el Departamento del Desarrollo de Empleo *(Employment Development Department- EDD)* para obtener beneficios de incapacidad estatal cuando los beneficios del programa de compensación de trabajadores son demorados, negados o han terminado. Hay plazos específicos así que para más información comuníquese con la oficina local del *EDD* o vaya a su sitio web en www.edd.ca.gov.

Si su lesión resulta en una incapacidad permanente y el estado determina que su beneficio de *PD* es desproporcionadamente bajo comparado a su pérdida de ingresos, usted puede calificar para dinero

adicional del programa de Pérdida de Ingresos Especiales Suplementarios del Departamento de Relaciones Industriales *(Department of Industrial Relations- DIR)* que también es conocido como el Programa del Regreso al Trabajo. Si tiene preguntas o piensa que califica, comuníquese con la Unidad de Información y Asistencia yendo a www.dwc.ca.gov y busque el enlace "*Information & Assistance Unit*" bajo la sección *Workers' compensation programs & units"* o visite la página web del *DIR* en www.dir.ca.gov.

El fraude de compensación de trabajadores es un crimen

Cualquier persona que hace o causa que se haga una declaración intencionadamente falsa para obtener o negar beneficios o pagos de compensación de trabajadores es culpable de una felonía. Si condenado, la persona tendrá que pagar multas de hasta $150,000 y/o cumplir hasta cinco años de cárcel.

¿QUÉ DEBO HACER SI ME LESIONO EN EL TRABAJO?

Informe a su empleador sobre la lesión que ha sufrido

Dígale inmediatamente a su supervisor no importa que tan leve sea la lesión. No demore – hay plazos específicos. Usted puede perder su derecho a beneficios si su empleador no se entera de su lesión dentro de 30 días. Si su lesión o enfermedad se desarrolló gradualmente, infórmelo tan pronto como se entere que fue causada por su trabajo.

Si usted no puede informarle al empleador o no ha escuchado del administrador de reclamos después de haber reportado su lesión, comuníquese con el administrador de reclamos usted mismo.

La compañía del seguro de compensación de trabajadores, o si el empleador está auto asegurado, la persona responsable por la administración del reclamo es:

AIG

Dirección: P.O. Box 25977 Shawnee Mission, KS 66225

Número de teléfono: 877-802-5246

Puede poder encontrar el nombre de la compañía del seguro de compensación de trabajadores en www.caworkcompcoverage.com. Si no hay cobertura o si la cobertura ha expirado, comuníquese con la División para el Cumplimiento de las Normas Laborales en www.dir.ca.gov/DLSE ya que por ley, todos los empleados deben ser cubiertos.

Obtenga tratamiento de emergencia si es necesario

Si es una emergencia médica, vaya a una sala de emergencia inmediatamente. Dígale al proveedor médico que le atiende que su lesión está relacionada con su trabajo. Su empleador le puede decir dónde ir para continuar con su tratamiento.

Número de teléfono de emergencia: Llame al 911 para una ambulancia, el departamento de bomberos o la policía. Para cuidado médico que no es urgente, contacte a su empleador, administrador de reclamos de compensación de trabajadores o vaya a esta instalación: _____.

Llene el formulario de reclamo DWC 1 y déselo a su empleador

Su empleador debe darle un Formulario de reclamo DWC 1 dentro de un día laboral después de enterarse de su lesión o enfermedad. Complete la sección del empleado, fírmelo y regréselo a su empleador. Su empleador entonces presentará su reclamo al administrador de reclamos. Su empleador debe autorizar tratamiento dentro de un día laboral después de recibir el formulario DWC 1.

Si la lesión es debida a exposiciones repetidas, usted tiene un año de cuando usted se da cuenta que su lesión está relacionada con su trabajo para presentar un reclamo.

En cualquier caso, puede recibir hasta $10,000 en cuidado médico pagado por su empleador hasta que su reclamo sea aceptado o negado. El administrador de reclamos tiene hasta 90 días para decidir si acepta o niega su reclamo. De otra manera, se supondrá que su caso es pagadero.

Su empleador o administrador de reclamos le enviará "Avisos de beneficios" que le informarán sobre el estado de su reclamo.

MÁS ACERCA DE ATENCIÓN MÉDICA

¿Qué es un médico primario *(Primary Treating Physician- PTP)*?

Es el médico que tiene la responsabilidad total sobre el tratamiento para su lesión o enfermedad. Él o ella pueden ser:

- El médico que usted denomina por escrito *antes* de que se lesione en el trabajo
- Un médico de la red de proveedores médicos *(Medical Provider Network- MPN)*
- El médico escogido por su empleador durante los primeros 30 días después de su lesión si su empleador no tiene una *MPN* o
- El médico que usted escogió después de los primeros 30 días después de su lesión si su empleador no tiene una *MPN*.

¿Qué es una red de proveedores médicos *(Medical Provider Network- MPN)*?

Una *MPN* es un grupo selecto de proveedores de cuidado médico que dan tratamiento médico a trabajadores lesionados. Consulte con su empleador para ver si están usando una *MPN*.

Si usted no ha denominado a un médico antes de lesionarse y su empleador está usando una *MPN*, usted verá a un médico de la *MPN*. Después de su primera visita, está libre para escoger otro médico de la lista de la *MPN*.

¿Qué es la designación previa?

La designación previa es cuando usted denomina a su médico particular para que lo atienda si usted se lastima en el trabajo. El médico debe ser un doctor en medicina *(M.D.)*, doctor en medicina osteopatía *(D.O.)* o un grupo médico con un *M.D.* o *D.O.* Debe denominar a su médico por escrito *antes* de que usted se lastime o enferme.

Usted puede designar de antemano a un médico si usted tiene plan de seguro médico para enfermedades y lesiones no relacionadas con el trabajo. El médico debe haberle:

- Atendido
- Mantenido su expediente/historial médico antes de su lesión y
- Indicado que está de acuerdo en atenderlo para una lesión o enfermedad de trabajo antes de que usted se lastime o enferme.

Usted puede usar el formulario "Designación previa de médico particular" incluido con este folleto para denominar a su médico. Después de llenar el formulario, asegúrese de dárselo a su empleador.

Si su empleador no tiene una *MPN* aprobada, usted puede denominar a su quiropráctico o acupunturista para que lo atienda para sus lesiones de trabajo. El aviso de quiropráctico o acupunturista personal debe ser por escrito *antes* de lastimarse. Puede utilizar el formulario incluido en este folleto. Después de llenar el formulario, asegúrese de dárselo a su empleador.

Con algunas excepciones, la ley estatal no permite que un quiropráctico siga siendo su médico que lo atiende después de 24 consultas. Una vez que haya recibido 24 consultas quiroprácticas, si aún necesita tratamiento médico, usted tendrá que escoger un nuevo médico que no sea quiropráctico. El término "consulta quiropráctica" significa cualquier consulta en un consultorio quiropráctica, sin importar si los servicios cumplidos conllevan manipulación quiropráctica o se limitan a evaluación y manejo.

Las excepciones a la prohibición a que un quiropráctico siga siendo su médico que lo atiende incluyen consultas por medicina física pos-quirúrgica prescrita por el cirujano o médico designado por el cirujano, bajo el componente pos-quirúrgico del Catálogo de Utilización de Tratamientos Médicos o MTUS de la División de Compensación de Trabajadores, o si su empleador ha autorizado consultas adicionales por escrito.

¿QUÉ SI HAY ALGÚN PROBLEMA?

Si tiene alguna inquietud, diga algo. Hable con su empleador o con el administrador de reclamos encargado de su reclamo para tratar de resolver el problema. Si esto no funciona, consiga ayuda intentando lo siguiente:

Comuníquese con la Unidad de Información y Asistencia *(Information & Assistance- I&A)* de la División de Compensación de Trabajadores *(Division of Workers' Compensation- DWC)*

Todas de las 24 oficinas de la *DWC* alrededor del estado proporcionan información y asistencia sobre derechos, beneficios y obligaciones de acuerdo a las leyes de compensación de trabajadores en California. Los oficiales de *I&A* ayudan a resolver disputas sin entablar juicio. Su meta es de conseguirle beneficios completos y a tiempo. Los servicios son gratis.

Para comunicarse con la más cercana Unidad de *I&A*, vaya a www.dwc.ca.gov y bajo la sección *"Workers' compensation programs and units."* haga clic en el enlace *"Information & Assistance Unit."* En este sitio encontrará hojas de información, guías e información para ayudarle.

La más cercana unidad de *I&A* está ubicada en:

Dirección: _____.

Número de teléfono: 800-736-7401_____.

Consulte con un abogado

La mayoría de los abogados ofrecen una consulta gratis. Si decide retener a un abogado, sus honorarios pueden ser tomados de algunos de sus beneficios. Para nombres de abogados de compensación de trabajadores, llame al Colegio de Abogados *(State Bar Association)* de California al (415) 538-2120 o vaya a la página web en www.californiaspecialist.org. Puede conseguir una lista de abogados de su Unidad de *I&A* local o consulte las páginas amarillas.

Advertencia

Es posible que su empleador no pague beneficios de compensación de trabajadores si se lastima en una actividad voluntaria fuera de su trabajo, recreativa, social o atlética que no sea parte de sus deberes laborales.

Derechos adicionales

Usted también puede tener otros derechos bajo la Ley de Estadounidenses con Discapacidades *(Americans with Disabilities Act- ADA)* o la Ley de Igualdad en el Empleo y la Vivienda *(Fair Employment and Housing Act- FEHA)*. Para información adicional, comuníquese con FEHA al (800) 884-1684 o la Comisión para la Igualdad de Oportunidades en el Empleo *(Equal Employment Opportunity Commission- EEOC)* al (800) 669-3362.

La información contenida en este folleto se conforma a los requisitos de información encontrados en las secciones 3551 y 3553 del Código Laboral y las secciones 9880 y 9883 del Título 8, Código de Regulaciones de California. Este documento está aprobado por el director administrativo de la División de Compensación de Trabajadores.

Revisado 12/20/12 y efectivo para fecha de lesiones en o después del 1/1/13.

Julio 2014

DESIGNACIÓN PREVIA DE MÉDICO PARTICULAR

En caso de que usted sufra una lesión o enfermedad relacionada con su empleo, usted puede recibir tratamiento médico por esa lesión o enfermedad de su médico particular (M.D.), médico osteópata (D.O.) o grupo médico si:

- usted tiene un plan de salud grupal
- el médico es su médico familiar o de cabecera, que será un médico que ha limitado su práctica médica a medicina general o que es un internista certificado o elegible para certificación, pediatra, gineco-obstreta, o médico de medicina familiar y que previamente ha estado a cargo de su tratamiento médico y tiene su expediente médico
- su "médico particular" puede ser un grupo médico si es una corporación o sociedad o asociación compuesta de doctores certificados en medicina u osteopatía, que opera un integrado grupo médico multidisciplinario que predominantemente proporciona amplios servicios médicos para lesiones y enfermedades no relacionadas con el trabajo.
- antes de la lesión su médico está de acuerdo a proporcionarle tratamiento médico para su lesión o enfermedad de trabajo
- antes de la lesión usted le proporcionó a su empleador por escrito lo siguiente: (1) notificación de que quiere que su médico particular le brinde tratamiento para una lesión o enfermedad de trabajo y (2) el nombre y dirección comercial de su médico particular.

Puede utilizar este formulario para notificarle a su empleador que desea que su médico particular o médico osteópata lo atienda para una lesión o enfermedad de trabajo y que los requisitos mencionados arriba han sido cumplidos.

NOTICIA DE DESIGNACIÓN PREVIA DE MÉDICO PARTICULAR

Empleado: Llene esta sección.

A: _____ (nombre del empleador) Si tengo una lesión o enfermedad de trabajo, yo elijo ser atendido por:

_____
(nombre del médico)(M.D., D.O., o grupo médico)

_____(dirección, ciudad, estado, código postal)

_____(número de teléfono)

Nombre del Empleado (en letras de molde, por favor):

Domicilio del Empleado:

_____

Firma del Empleado_____Fecha:_____

Médico: Estoy de acuerdo con esta Designación Previa:

Firma: _____Fecha:_____
(Médico o Empleado designado por el Médico o Grupo Médico)

El médico no está obligado a firmar este formulario, sin embargo, si el médico o empleado designado por el médico o grupo médico no firma, será necesario presentar documentación sobre el consentimiento del médico de ser designado previamente de acuerdo al Código de Reglamentos de California, Título 8, sección 9780.1(a) (3).

Julio 2014

AVISO DE QUIROPRÁCTICO PERSONAL O ACUPUNTURISTA PERSONAL

Si su empleador o la compañía de seguros de su empleador no tiene una Red de Proveedores Médicos establecida, posiblemente puede cambiar su médico que lo está atendiendo a su quiropráctico o acupunturista personal después de una lesión o enfermedad de trabajo. Para hacer este cambio, usted debe darle por escrito a su empleador el nombre y la dirección comercial de un quiropráctico o acupunturista personal antes de la lesión o enfermedad. Generalmente, su administrador de reclamos tiene el derecho de elegir al médico que le proporcionará el tratamiento dentro de los primeros 30 días después de que su empleador sepa de su lesión o enfermedad. Después de que su administrador de reclamos ha iniciado su tratamiento con otro médico durante este tiempo, puede entonces usted, bajo petición, transferir su tratamiento a su quiropráctico o acupunturista personal.

Puede utilizar este formulario para notificarle a su empleador de su quiropráctico o acupunturista personal.

La ley estatal no permite que un quiropráctico siga como su médico después de 24 visitas.

Información sobre su Quiropráctico o Acupunturista:

_____

(nombre del quiropráctico o acupunturista)

_____

(dirección, ciudad, estado, código postal)

_____

(número de teléfono)

_____

Nombre del Empleado **(en letras de molde, por favor)**:

_____

Domicilio del Empleado:

Firma del Empleado_____Fecha:_____

Julio 2014

Michael Page

DIRECT DEPOSIT AUTHORIZATION FORM			
I authorize you to deposit my net pay automatically to my account(s) specified below each payday by initiating credit entries to my account electronically or by any other commercially accepted method, and I authorize the financial institution named below to credit the same to my account. If funds to which I am not entitled are deposited to my account, I authorize you to direct the financial institution to return said funds by any such method and I authorize the financial institution to debit the same to my account. This authority will remain in effect until you have received written notice from me of its cancellation in such time and manner as to afford you and the financial institution a reasonable opportunity to act on it.			
■ **You must attach a cancelled or voided check, or a savings deposit slip to this form in order to process your request for direct deposit.** ■ **Once the form is received it will take 2 pay periods for direct deposit to commence.** ■ **If this is a change or cancellation, please be specific on the comments section below.**			
Employee Name (please print):			
Social Security Number:			
Financial Institution: Street Address: City, State, Zip Code:			
Account Number:		ABA/Routing # (9 digits):	
Select One:	Checking ☐		Savings ☐
Is this a Full Deposit:	Yes ☐	No ☐	Partial Deposit Amount: $
Financial Institution: Street Address: City, State, Zip Code:			
Account Number:		ABA/Routing #:	
Select One:	Checking ☐		Savings ☐
Is this a Full Deposit:	Yes ☐	No ☐	Partial Deposit Amount: $
Comments:			

IMPORTANT: Direct Deposit **WILL NOT** take effect without a cancelled or voided check (checking account), or a savings deposit slip (savings account).

NOTE: Your Savings account number is usually different from your Checking account number.

Signature: _____

Date: _____

NOTICE TO EMPLOYEE

Labor Code section 2810.5

EMPLOYEE

Employee Name: _____

Start Date: _____

EMPLOYER

Legal Name of Hiring Employer: Michael Page

Is hiring employer a staffing agency/business (e.g., Temporary Services Agency; Employee Leasing Company; or Professional Employer Organization [PEO])? □ Yes ☐ No

Other Names Hiring Employer is "doing business as" (if applicable):

_____

Physical Address of Hiring Employer's Main Office:

405 Lexington Ave, 28th Floor New York, NY 10174

Hiring Employer's Mailing Address (if different than above):

_____

Hiring Employer's Telephone Number: 212-661-4800

If the hiring employer is a staffing agency/business (above box checked "Yes"), the following is the other entity for whom this employee will perform work:

Name: Michael Page

Physical Address of Main Office: 16 Maiden Lane, 5th Floor, San Francisco, CA 94108

Mailing Address: Same as Physical

Telephone Number: 415-926-7400

WAGE INFORMATION

Rate(s) of Pay: _____ Overtime Rate(s) of Pay: _____

Rate by (check box): □ Hour □ Shift □ Day □ Week □ Salary □ Piece rate □ Commission

□ Other (provide specifics): _____

Does a written agreement exist providing the rate(s) of pay? (check box) □ Yes ☐ No

If yes, are all rate(s) of pay and bases thereof contained in that written agreement? □ Yes ☐ No

Allowances, if any, claimed as part of minimum wage (including meal or lodging allowances):

_____

(If the employee has signed the acknowledgment of receipt below, it does not constitute a "voluntary written agreement" as required under the law between the employer and employee in order to credit any meals or lodging against the minimum wage. Any such voluntary written agreement must be evidenced by a separate document.)

Regular Payday: _____

WORKERS' COMPENSATION

Insurance Carrier's Name: AON Global Client Network

Address: 199 Water Street New York, NY 10038

Telephone Number: 212-479-3735

Policy No.: WC 025842606

□ Self-Insured (Labor Code 3700) and Certificate Number for Consent to Self-Insure: _____

ACKNOWLEDGMENT OF RECEIPT
(Optional)

(PRINT NAME of Employer representative)	(PRINT NAME of Employee)
(SIGNATURE of Employer representative)	(SIGNATURE of Employee)
(Date)	(Date)

The employee's signature on this notice merely constitutes acknowledgment of receipt.

Labor Code section 2810.5(b) requires that the employer notify you in writing of any changes to the information set forth in this Notice within seven calendar days after the time of the changes, unless one of the following applies: (a) All changes are reflected on a timely wage statement furnished in accordance with Labor Code section 226; (b) Notice of all changes is provided in another writing required by law within seven days of the changes.

Form W-4 (2016)

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. If you are exempt, complete **only** lines 1, 2, 3, 4, and 7 and sign the form to validate it. Your exemption for 2016 expires February 15, 2017. See Pub. 505, Tax Withholding and Estimated Tax.

Note: If another person can claim you as a dependent on his or her tax return, you cannot claim exemption from withholding if your income exceeds $1,050 and includes more than $350 of unearned income (for example, interest and dividends).

Exceptions. An employee may be able to claim exemption from withholding even if the employee is a dependent, if the employee:

- Is age 65 or older,
- Is blind, or
- Will claim adjustments to income; tax credits; or itemized deductions, on his or her tax return.

The exceptions do not apply to supplemental wages greater than $1,000,000.

Basic instructions. If you are not exempt, complete the **Personal Allowances Worksheet** below. The worksheets on page 2 further adjust your withholding allowances based on itemized deductions, certain credits, adjustments to income, or two-earners/multiple jobs situations.

Complete all worksheets that apply. However, you may claim fewer (or zero) allowances. For regular wages, withholding must be based on allowances you claimed and may not be a flat amount or percentage of wages.

Head of household. Generally, you can claim head of household filing status on your tax return only if you are unmarried and pay more than 50% of the costs of keeping up a home for yourself and your dependent(s) or other qualifying individuals. See Pub. 501, Exemptions, Standard Deduction, and Filing Information, for information.

Tax credits. You can take projected tax credits into account in figuring your allowable number of withholding allowances. Credits for child or dependent care expenses and the child tax credit may be claimed using the **Personal Allowances Worksheet** below. See Pub. 505 for information on converting your other credits into withholding allowances.

Nonwage income. If you have a large amount of nonwage income, such as interest or dividends, consider making estimated tax payments using Form 1040-ES, Estimated Tax for Individuals. Otherwise, you may owe additional tax. If you have pension or annuity income, see Pub. 505 to find out if you should adjust your withholding on Form W-4 or W-4P.

Two earners or multiple jobs. If you have a working spouse or more than one job, figure the total number of allowances you are entitled to claim on all jobs using worksheets from only one Form W-4. Your withholding usually will be most accurate when all allowances are claimed on the Form W-4 for the highest paying job and zero allowances are claimed on the others. See Pub. 505 for details.

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

Check your withholding. After your Form W-4 takes effect, use Pub. 505 to see how the amount you are having withheld compares to your projected total tax for 2016. See Pub. 505, especially if your earnings exceed $130,000 (Single) or $180,000 (Married).

Future developments. Information about any future developments affecting Form W-4 (such as legislation enacted after we release it) will be posted at *www.irs.gov/w4*.

Personal Allowances Worksheet (Keep for your records.)

A	Enter "1" for **yourself** if no one else can claim you as a dependent	**A** _____
B	Enter "1" if: • You are single and have only one job; or • You are married, have only one job, and your spouse does not work; or • Your wages from a second job or your spouse's wages (or the total of both) are $1,500 or less.	**B** _____
C	Enter "1" for your **spouse.** But, you may choose to enter "-0-" if you are married and have either a working spouse or more than one job. (Entering "-0-" may help you avoid having too little tax withheld.)	**C** _____
D	Enter number of **dependents** (other than your spouse or yourself) you will claim on your tax return	**D** _____
E	Enter "1" if you will file as **head of household** on your tax return (see conditions under **Head of household** above)	**E** _____
F	Enter "1" if you have at least $2,000 of **child or dependent care expenses** for which you plan to claim a credit (**Note:** Do **not** include child support payments. See Pub. 503, Child and Dependent Care Expenses, for details.)	**F** _____
G	**Child Tax Credit** (including additional child tax credit). See Pub. 972, Child Tax Credit, for more information. • If your total income will be less than $70,000 ($100,000 if married), enter "2" for each eligible child; then **less** "1" if you have two to four eligible children or **less** "2" if you have five or more eligible children. • If your total income will be between $70,000 and $84,000 ($100,000 and $119,000 if married), enter "1" for each eligible child	**G** _____
H	Add lines A through G and enter total here. (**Note:** This may be different from the number of exemptions you claim on your tax return.) ►	**H** _____

For accuracy, complete all worksheets that apply.

- If you plan to **itemize** or **claim adjustments to income** and want to reduce your withholding, see the **Deductions and Adjustments Worksheet** on page 2.
- If you are **single and have more than one job** or are **married and you and your spouse both work** and the combined earnings from all jobs exceed $50,000 ($20,000 if married), see the **Two-Earners/Multiple Jobs Worksheet** on page 2 to avoid having too little tax withheld.
- If **neither** of the above situations applies, **stop here** and enter the number from line H on line 5 of Form W-4 below.

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

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

Employee's Withholding Allowance Certificate

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

OMB No. 1545-0074

2016

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, but legally separated, or spouse is a nonresident alien, check the "Single" box.	
	City or town, state, and ZIP code	**4** **If your last name differs from that shown on your social security card, check here. You must call 1-800-772-1213 for a replacement card.** ► ☐	

5	Total number of allowances you are claiming (from line **H** above **or** from the applicable worksheet on page 2)	**5**	
6	Additional amount, if any, you want withheld from each paycheck	**6**	$
7	I claim exemption from withholding for 2016, 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 lines 8 and 10 only if sending to the IRS.)	**9** Office code (optional)	**10** Employer identification number (EIN)

Deductions and Adjustments Worksheet

Note: Use this worksheet *only* if you plan to itemize deductions or claim certain credits or adjustments to income.

1	Enter an estimate of your 2016 itemized deductions. These include qualifying home mortgage interest, charitable contributions, state and local taxes, medical expenses in excess of 10% (7.5% if either you or your spouse was born before January 2, 1952) of your income, and miscellaneous deductions. For 2016, you may have to reduce your itemized deductions if your income is over $311,300 and you are married filing jointly or are a qualifying widow(er); $285,350 if you are head of household; $259,400 if you are single and not head of household or a qualifying widow(er); or $155,650 if you are married filing separately. See Pub. 505 for details	1	$
2	Enter: { $12,600 if married filing jointly or qualifying widow(er); $9,300 if head of household; $6,300 if single or married filing separately }	2	$
3	**Subtract** line 2 from line 1. If zero or less, enter "-0-"	3	$
4	Enter an estimate of your 2016 adjustments to income and any additional standard deduction (see Pub. 505)	4	$
5	**Add** lines 3 and 4 and enter the total. (Include any amount for credits from the *Converting Credits to Withholding Allowances for 2016 Form W-4* worksheet in Pub. 505.)	5	$
6	Enter an estimate of your 2016 nonwage income (such as dividends or interest)	6	$
7	**Subtract** line 6 from line 5. If zero or less, enter "-0-"	7	$
8	**Divide** the amount on line 7 by $4,050 and enter the result here. Drop any fraction	8	
9	Enter the number from the **Personal Allowances Worksheet,** line H, page 1	9	
10	**Add** lines 8 and 9 and enter the total here. If you plan to use the **Two-Earners/Multiple Jobs Worksheet,** also enter this total on line 1 below. Otherwise, **stop here** and enter this total on Form W-4, line 5, page 1	10	

Two-Earners/Multiple Jobs Worksheet (See *Two earners or multiple jobs* on page 1.)

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

1	Enter the number from line H, page 1 (or from line 10 above if you used the **Deductions and Adjustments Worksheet**)	1	
2	Find the number in **Table 1** below that applies to the **LOWEST** paying job and enter it here. **However,** if you are married filing jointly and wages from the highest paying job are $65,000 or less, do not enter more than "3"	2	
3	If line 1 is **more than or equal to** line 2, subtract line 2 from line 1. Enter the result here (if zero, enter "-0-") and on Form W-4, line 5, page 1. **Do not** use the rest of this worksheet	3	

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

4	Enter the number from line 2 of this worksheet	4	
5	Enter the number from line 1 of this worksheet	5	
6	**Subtract** line 5 from line 4	6	
7	Find the amount in **Table 2** below that applies to the **HIGHEST** paying job and enter it here	7	$
8	**Multiply** line 7 by line 6 and enter the result here. This is the additional annual withholding needed	8	$
9	Divide line 8 by the number of pay periods remaining in 2016. For example, divide by 25 if you are paid every two weeks and you complete this form on a date in January when there are 25 pay periods remaining in 2016. Enter the result here and on Form W-4, line 6, page 1. This is the additional amount to be withheld from each paycheck	9	$

Table 1

Married Filing Jointly		All Others	
If wages from **LOWEST** paying job are—	Enter on line 2 above	If wages from **LOWEST** paying job are—	Enter on line 2 above
$0 - $6,000	0	$0 - $9,000	0
6,001 - 14,000	1	9,001 - 17,000	1
14,001 - 25,000	2	17,001 - 26,000	2
25,001 - 27,000	3	26,001 - 34,000	3
27,001 - 35,000	4	34,001 - 44,000	4
35,001 - 44,000	5	44,001 - 75,000	5
44,001 - 55,000	6	75,001 - 85,000	6
55,001 - 65,000	7	85,001 - 110,000	7
65,001 - 75,000	8	110,001 - 125,000	8
75,001 - 80,000	9	125,001 - 140,000	9
80,001 - 100,000	10	140,001 and over	10
100,001 - 115,000	11		
115,001 - 130,000	12		
130,001 - 140,000	13		
140,001 - 150,000	14		
150,001 and over	15		

Table 2

Married Filing Jointly		All Others	
If wages from **HIGHEST** paying job are—	Enter on line 7 above	If wages from **HIGHEST** paying job are—	Enter on line 7 above
$0 - $75,000	$610	$0 - $38,000	$610
75,001 - 135,000	1,010	38,001 - 85,000	1,010
135,001 - 205,000	1,130	85,001 - 185,000	1,130
205,001 - 360,000	1,340	185,001 - 400,000	1,340
360,001 - 405,000	1,420	400,001 and over	1,600
405,001 and over	1,600		

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 who claims no withholding allowances; 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 possessions 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.

Instructions for Employment Eligibility Verification

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

USCIS
Form I-9
OMB No. 1615-0047
Expires 03/31/2016

Read all instructions carefully before completing this form.

Anti-Discrimination Notice. It is illegal to discriminate against any work-authorized individual in hiring, discharge, recruitment or referral for a fee, or in the employment eligibility verification (Form I-9 and E-Verify) process based on that individual's citizenship status, immigration status or national origin. Employers **CANNOT** specify which document(s) they will accept from an employee. The refusal to hire an individual because the documentation presented has a future expiration date may also constitute illegal discrimination. For more information, call the Office of Special Counsel for Immigration-Related Unfair Employment Practices (OSC) at 1-800-255-7688 (employees), 1-800-255-8155 (employers), or 1-800-237-2515 (TDD), or visit www.justice.gov/crt/about/osc.

What Is the Purpose of This Form?

Employers must complete Form I-9 to document verification of the identity and employment authorization of each new employee (both citizen and noncitizen) hired after November 6, 1986, to work in the United States. In the Commonwealth of the Northern Mariana Islands (CNMI), employers must complete Form I-9 to document verification of the identity and employment authorization of each new employee (both citizen and noncitizen) hired after November 27, 2011. Employers should have used Form I-9 CNMI between November 28, 2009 and November 27, 2011.

General Instructions

Employers are responsible for completing and retaining Form I-9. For the purpose of completing this form, the term "employer" means all employers, including those recruiters and referrers for a fee who are agricultural associations, agricultural employers, or farm labor contractors.

Form I-9 is made up of three sections. Employers may be fined if the form is not complete. Employers are responsible for retaining completed forms. Do not mail completed forms to U.S. Citizenship and Immigration Services (USCIS) or Immigration and Customs Enforcement (ICE).

Section 1. Employee Information and Attestation

Newly hired employees must complete and sign Section 1 of Form I-9 **no later than the first day of employment**. Section 1 should never be completed before the employee has accepted a job offer.

Provide the following information to complete Section 1:

Name: Provide your full legal last name, first name, and middle initial. Your last name is your family name or surname. If you have two last names or a hyphenated last name, include both names in the last name field. Your first name is your given name. Your middle initial is the first letter of your second given name, or the first letter of your middle name, if any.

Other names used: Provide all other names used, if any (including maiden name). If you have had no other legal names, write "N/A."

Address: Provide the address where you currently live, including Street Number and Name, Apartment Number (if applicable), City, State, and Zip Code. Do not provide a post office box address (P.O. Box). Only border commuters from Canada or Mexico may use an international address in this field.

Date of Birth: Provide your date of birth in the mm/dd/yyyy format. For example, January 23, 1950, should be written as 01/23/1950.

U.S. Social Security Number: Provide your 9-digit Social Security number. Providing your Social Security number is voluntary. However, if your employer participates in E-Verify, you must provide your Social Security number.

E-mail Address and Telephone Number (Optional): You may provide your e-mail address and telephone number. Department of Homeland Security (DHS) may contact you if DHS learns of a potential mismatch between the information provided and the information in DHS or Social Security Administration (SSA) records. You may write "N/A" if you choose not to provide this information.

All employees must attest in Section 1, under penalty of perjury, to their citizenship or immigration status by checking one of the following four boxes provided on the form:

1. **A citizen of the United States**
2. **A noncitizen national of the United States:** Noncitizen nationals of the United States are persons born in American Samoa, certain former citizens of the former Trust Territory of the Pacific Islands, and certain children of noncitizen nationals born abroad.
3. **A lawful permanent resident:** A lawful permanent resident is any person who is not a U.S. citizen and who resides in the United States under legally recognized and lawfully recorded permanent residence as an immigrant. The term "lawful permanent resident" includes conditional residents. If you check this box, write either your Alien Registration Number (A-Number) or USCIS Number in the field next to your selection. At this time, the USCIS Number is the same as the A-Number without the "A" prefix.
4. **An alien authorized to work:** If you are not a citizen or national of the United States or a lawful permanent resident, but are authorized to work in the United States, check this box.

   If you check this box:

   a. Record the date that your employment authorization expires, if any. Aliens whose employment authorization does not expire, such as refugees, asylees, and certain citizens of the Federated States of Micronesia, the Republic of the Marshall Islands, or Palau, may write "N/A" on this line.

   b. Next, enter your Alien Registration Number (A-Number)/USCIS Number. At this time, the USCIS Number is the same as your A-Number without the "A" prefix. If you have not received an A-Number/USCIS Number, record your Admission Number. You can find your Admission Number on Form I-94, "Arrival-Departure Record," or as directed by USCIS or U.S. Customs and Border Protection (CPB).

   (1) If you obtained your admission number from CBP in connection with your arrival in the United States, then also record information about the foreign passport you used to enter the United States (number and country of issuance).

   (2) If you obtained your admission number from USCIS *within the United States*, or you entered the United States without a foreign passport, you must write "N/A" in the Foreign Passport Number and Country of Issuance fields.

Sign your name in the "Signature of Employee" block and record the date you completed and signed Section 1. By signing and dating this form, you attest that the citizenship or immigration status you selected is correct and that you are aware that you may be imprisoned and/or fined for making false statements or using false documentation when completing this form. To fully complete this form, you must present to your employer documentation that establishes your identity and employment authorization. Choose which documents to present from the Lists of Acceptable Documents, found on the last page of this form. You must present this documentation no later than the third day after beginning employment, although you may present the required documentation before this date.

Preparer and/or Translator Certification

The Preparer and/or Translator Certification must be completed if the employee requires assistance to complete Section 1 (e.g., the employee needs the instructions or responses translated, someone other than the employee fills out the information blocks, or someone with disabilities needs additional assistance). The employee must still sign Section 1.

Minors and Certain Employees with Disabilities (Special Placement)

Parents or legal guardians assisting minors (individuals under 18) and certain employees with disabilities should review the guidelines in the *Handbook for Employers: Instructions for Completing Form I-9 (M-274)* on **www.uscis.gov/I-9Central** before completing Section 1. These individuals have special procedures for establishing identity if they cannot present an identity document for Form I-9. The special procedures include **(1)** the parent or legal guardian filling out Section 1 and writing "minor under age 18" or "special placement," whichever applies, in the employee signature block; and **(2)** the employer writing "minor under age 18" or "special placement" under List B in Section 2.

Section 2. Employer or Authorized Representative Review and Verification

Before completing Section 2, employers must ensure that Section 1 is completed properly and on time. Employers may not ask an individual to complete Section 1 before he or she has accepted a job offer.

Employers or their authorized representative must complete Section 2 by examining evidence of identity and employment authorization within 3 business days of the employee's first day of employment. For example, if an employee begins employment on Monday, the employer must complete Section 2 by Thursday of that week. However, if an employer hires an individual for less than 3 business days, Section 2 must be completed no later than the first day of employment. An employer may complete Form I-9 before the first day of employment if the employer has offered the individual a job and the individual has accepted.

Employers cannot specify which document(s) employees may present from the Lists of Acceptable Documents, found on the last page of Form I-9, to establish identity and employment authorization. Employees must present one selection from List A **OR** a combination of one selection from List B and one selection from List C. List A contains documents that show both identity and employment authorization. Some List A documents are combination documents. The employee must present combination documents together to be considered a List A document. For example, a foreign passport and a Form I-94 containing an endorsement of the alien's nonimmigrant status must be presented together to be considered a List A document. List B contains documents that show identity only, and List C contains documents that show employment authorization only. If an employee presents a List A document, he or she should **not** present a List B and List C document, and vice versa. If an employer participates in E-Verify, the List B document must include a photograph.

In the field below the Section 2 introduction, employers must enter the last name, first name and middle initial, if any, that the employee entered in Section 1. This will help to identify the pages of the form should they get separated.

Employers or their authorized representative must:

1. Physically examine each original document the employee presents to determine if it reasonably appears to be genuine and to relate to the person presenting it. The person who examines the documents must be the same person who signs Section 2. The examiner of the documents and the employee must both be physically present during the examination of the employee's documents.
2. Record the document title shown on the Lists of Acceptable Documents, issuing authority, document number and expiration date (if any) from the original document(s) the employee presents. You may write "N/A" in any unused fields.

   If the employee is a student or exchange visitor who presented a foreign passport with a Form I-94, the employer should also enter in Section 2:

   a. The student's Form I-20 or DS-2019 number (Student and Exchange Visitor Information System-SEVIS Number); **and** the program end date from Form I-20 or DS-2019.
3. Under Certification, enter the employee's first day of employment. Temporary staffing agencies may enter the first day the employee was placed in a job pool. Recruiters and recruiters for a fee do not enter the employee's first day of employment.
4. Provide the name and title of the person completing Section 2 in the Signature of Employer or Authorized Representative field.
5. Sign and date the attestation on the date Section 2 is completed.
6. Record the employer's business name and address.
7. Return the employee's documentation.

Employers may, but are not required to, photocopy the document(s) presented. If photocopies are made, they should be made for **ALL** new hires or reverifications. Photocopies must be retained and presented with Form I-9 in case of an inspection by DHS or other federal government agency. Employers must always complete Section 2 even if they photocopy an employee's document(s). Making photocopies of an employee's document(s) cannot take the place of completing Form I-9. Employers are still responsible for completing and retaining Form I-9.

Unexpired Documents

Generally, only unexpired, original documentation is acceptable. The only exception is that an employee may present a certified copy of a birth certificate. Additionally, in some instances, a document that appears to be expired may be acceptable if the expiration date shown on the face of the document has been extended, such as for individuals with temporary protected status. Refer to the *Handbook for Employers: Instructions for Completing Form I-9 (M-274)* or I-9 Central (www.uscis.gov/I-9Central) for examples.

Receipts

If an employee is unable to present a required document (or documents), the employee can present an acceptable receipt in lieu of a document from the Lists of Acceptable Documents on the last page of this form. Receipts showing that a person has applied for an initial grant of employment authorization, or for renewal of employment authorization, are not acceptable. Employers cannot accept receipts if employment will last less than 3 days. Receipts are acceptable when completing Form I-9 for a new hire or when reverification is required.

Employees must present receipts within 3 business days of their first day of employment, or in the case of reverification, by the date that reverification is required, and must present valid replacement documents within the time frames described below.

There are three types of acceptable receipts:

1. A receipt showing that the employee has applied to replace a document that was lost, stolen or damaged. The employee must present the actual document within 90 days from the date of hire.
2. The arrival portion of Form I-94/I-94A with a temporary I-551 stamp and a photograph of the individual. The employee must present the actual Permanent Resident Card (Form I-551) by the expiration date of the temporary I-551 stamp, or, if there is no expiration date, within 1 year from the date of issue.
3. The departure portion of Form I-94/I-94A with a refugee admission stamp. The employee must present an unexpired Employment Authorization Document (Form I-766) or a combination of a List B document and an unrestricted Social Security card within 90 days.

When the employee provides an acceptable receipt, the employer should:

1. Record the document title in Section 2 under the sections titled List A, List B, or List C, as applicable.
2. Write the word "receipt" and its document number in the "Document Number" field. Record the last day that the receipt is valid in the "Expiration Date" field.

By the end of the receipt validity period, the employer should:

1. Cross out the word "receipt" and any accompanying document number and expiration date.
2. Record the number and other required document information from the actual document presented.
3. Initial and date the change.

See the *Handbook for Employers: Instructions for Completing Form I-9 (M-274)* at **www.uscis.gov/I-9Central** for more information on receipts.

Section 3. Reverification and Rehires

Employers or their authorized representatives should complete Section 3 when reverifying that an employee is authorized to work. When rehiring an employee within 3 years of the date Form I-9 was originally completed, employers have the option to complete a new Form I-9 or complete Section 3. When completing Section 3 in either a reverification or rehire situation, if the employee's name has changed, record the name change in Block A.

For employees who provide an employment authorization expiration date in Section 1, employers must reverify employment authorization on or before the date provided.

Some employees may write "N/A" in the space provided for the expiration date in Section 1 if they are aliens whose employment authorization does not expire (e.g., asylees, refugees, certain citizens of the Federated States of Micronesia, the Republic of the Marshall Islands, or Palau). Reverification does not apply for such employees unless they chose to present evidence of employment authorization in Section 2 that contains an expiration date and requires reverification, such as Form I-766, Employment Authorization Document.

Reverification applies if evidence of employment authorization (List A or List C document) presented in Section 2 expires. However, employers should not reverify:

1. U.S. citizens and noncitizen nationals; or
2. Lawful permanent residents who presented a Permanent Resident Card (Form I-551) for Section 2.

Reverification does not apply to List B documents.

If both Section 1 and Section 2 indicate expiration dates triggering the reverification requirement, the employer should reverify by the earlier date.

For reverification, an employee must present unexpired documentation from either List A or List C showing he or she is still authorized to work. Employers CANNOT require the employee to present a particular document from List A or List C. The employee may choose which document to present.

To complete Section 3, employers should follow these instructions:

1. Complete Block A if an employee's name has changed at the time you complete Section 3.
2. Complete Block B with the date of rehire if you rehire an employee within 3 years of the date this form was originally completed, and the employee is still authorized to be employed on the same basis as previously indicated on this form. Also complete the "Signature of Employer or Authorized Representative" block.
3. Complete Block C if:
   a. The employment authorization or employment authorization document of a current employee is about to expire and requires reverification; or
   b. You rehire an employee within 3 years of the date this form was originally completed and his or her employment authorization or employment authorization document has expired. (Complete Block B for this employee as well.)

   To complete Block C:
   a. Examine either a List A or List C document the employee presents that shows that the employee is currently authorized to work in the United States; and
   b. Record the document title, document number, and expiration date (if any).
4. After completing block A, B or C, complete the "Signature of Employer or Authorized Representative" block, including the date.

   For reverification purposes, employers may either complete Section 3 of a new Form I-9 or Section 3 of the previously completed Form I-9. Any new pages of Form I-9 completed during reverification must be attached to the employee's original Form I-9. If you choose to complete Section 3 of a new Form I-9, you may attach just the page containing Section 3, with the employee's name entered at the top of the page, to the employee's original Form I-9. If there is a more current version of Form I-9 at the time of reverification, you must complete Section 3 of that version of the form.

What Is the Filing Fee?

There is no fee for completing Form I-9. This form is not filed with USCIS or any government agency. Form I-9 must be retained by the employer and made available for inspection by U.S. Government officials as specified in the **"USCIS Privacy Act Statement"** below.

USCIS Forms and Information

For more detailed information about completing Form I-9, employers and employees should refer to the *Handbook for Employers: Instructions for Completing Form I-9 (M-274)*.

You can also obtain information about Form I-9 from the USCIS Web site at www.uscis.gov/I-9Central, by e-mailing USCIS at **I-9Central@dhs.gov**, or by calling **1-888-464-4218**. For TDD (hearing impaired), call **1-877-875-6028**.

To obtain USCIS forms or the *Handbook for Employers*, you can download them from the USCIS Web site at www.uscis.gov/forms. You may order USCIS forms by calling our toll-free number at **1-800-870-3676**. You may also obtain forms and information by contacting the USCIS National Customer Service Center at **1-800-375-5283**. For TDD (hearing impaired), call **1-800-767-1833**.

Information about E-Verify, a free and voluntary program that allows participating employers to electronically verify the employment eligibility of their newly hired employees, can be obtained from the USCIS Web site at www.dhs.gov/E-Verify, by e-mailing USCIS at **E-Verify@dhs.gov** or by calling **1-888-464-4218**. For TDD (hearing impaired), call **1-877-875-6028.**

Employees with questions about Form I-9 and/or E-Verify can reach the USCIS employee hotline by calling **1-888-897-7781**. For TDD (hearing impaired), call **1-877-875-6028.**

Photocopying and Retaining Form I-9

A blank Form I-9 may be reproduced, provided all sides are copied. The instructions and Lists of Acceptable Documents must be available to all employees completing this form. Employers must retain each employee's completed Form I-9 for as long as the individual works for the employer. Employers are required to retain the pages of the form on which the employee and employer enter data. If copies of documentation presented by the employee are made, those copies must also be kept with the form. Once the individual's employment ends, the employer must retain this form for either 3 years after the date of hire or 1 year after the date employment ended, whichever is later.

Form I-9 may be signed and retained electronically, in compliance with Department of Homeland Security regulations at 8 CFR 274a.2.

USCIS Privacy Act Statement

AUTHORITIES: The authority for collecting this information is the Immigration Reform and Control Act of 1986, Public Law 99-603 (8 USC 1324a).

PURPOSE: This information is collected by employers to comply with the requirements of the Immigration Reform and Control Act of 1986. This law requires that employers verify the identity and employment authorization of individuals they hire for employment to preclude the unlawful hiring, or recruiting or referring for a fee, of aliens who are not authorized to work in the United States.

DISCLOSURE: Submission of the information required in this form is voluntary. However, failure of the employer to ensure proper completion of this form for each employee may result in the imposition of civil or criminal penalties. In addition, employing individuals knowing that they are unauthorized to work in the United States may subject the employer to civil and/or criminal penalties.

ROUTINE USES: This information will be used by employers as a record of their basis for determining eligibility of an employee to work in the United States. The employer will keep this form and make it available for inspection by authorized officials of the Department of Homeland Security, Department of Labor, and Office of Special Counsel for Immigration-Related Unfair Employment Practices.

Paperwork Reduction Act

An agency may not conduct or sponsor an information collection and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. The public reporting burden for this collection of information is estimated at 35 minutes per response, including the time for reviewing instructions and completing and retaining the form. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to: U.S. Citizenship and Immigration Services, Regulatory Coordination Division, Office of Policy and Strategy, 20 Massachusetts Avenue NW, Washington, DC 20529-2140; OMB No. 1615-0047. **Do not mail your completed Form I-9 to this address.**

Employment Eligibility Verification

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

USCIS
Form I-9
OMB No. 1615-0047
Expires 03/31/2016

▶START HERE. Read instructions carefully before completing this form. The instructions must be available during completion of this form.
ANTI-DISCRIMINATION NOTICE: It is illegal to discriminate against work-authorized individuals. Employers **CANNOT** specify which document(s) they will accept from an employee. The refusal to hire 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 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	E-mail Address	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):

☐ A citizen of the United States

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

☐ A lawful permanent resident (Alien Registration Number/USCIS Number): _____

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

*For aliens authorized to work, provide your Alien Registration Number/USCIS Number **OR** Form I-94 Admission Number:*

1. Alien Registration Number/USCIS Number: _____

OR

2. Form I-94 Admission Number: _____

If you obtained your admission number from CBP in connection with your arrival in the United States, include the following:

Foreign Passport Number: _____

Country of Issuance: _____

Some aliens may write "N/A" on the Foreign Passport Number and Country of Issuance fields. (*See instructions*)

3-D Barcode
Do Not Write in This Space

Signature of Employee:	Date *(mm/dd/yyyy)*:

Preparer and/or Translator Certification *(To be completed and signed if Section 1 is prepared by a person other than the employee.)*

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

Signature of Preparer or Translator:			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

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 examine a combination of one document from List B and one document from List C as listed on the "Lists of Acceptable Documents" on the next page of this form. For each document you review, record the following information: document title, issuing authority, document number, and expiration date, if any.)

Employee Last Name, First Name and Middle Initial from Section 1:

List A Identity and Employment Authorization	OR	List B Identity	AND	List C Employment Authorization
Document Title:		Document Title:		Document Title:
Issuing Authority:		Issuing Authority:		Issuing Authority:
Document Number:		Document Number:		Document Number:
Expiration Date *(if any)(mm/dd/yyyy)*:		Expiration Date *(if any)(mm/dd/yyyy)*:		Expiration Date *(if any)(mm/dd/yyyy)*:
Document Title:				
Issuing Authority:				
Document Number:				
Expiration Date *(if any)(mm/dd/yyyy)*:				
Document Title:				
Issuing Authority:				
Document Number:				
Expiration Date *(if any)(mm/dd/yyyy)*:				

3-D Barcode 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	Date *(mm/dd/yyyy)*	Title of Employer or Authorized Representative
Last Name *(Family Name)* First Name *(Given Name)*		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)* Last Name *(Family Name)* First Name *(Given Name)* Middle Initial	**B.** Date of Rehire *(if applicable) (mm/dd/yyyy)*:

C. If employee's previous grant of employment authorization has expired, provide the information for the document from List A or List C the employee presented that establishes current 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:	Date *(mm/dd/yyyy)*:	Print 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 Birth Abroad issued by the Department of State (Form FS-545)
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.** Certification of Report of Birth issued by the Department of State (Form DS-1350)
4. Employment Authorization Document that contains a photograph (Form I-766)		**4.** Voter's registration card		**4.** Original or certified copy of birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal
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.** Native American tribal document
		6. Military dependent's ID card		**6.** U.S. Citizen ID Card (Form I-197)
		7. U.S. Coast Guard Merchant Mariner Card		**7.** Identification Card for Use of Resident Citizen in the United States (Form I-179)
		8. Native American tribal document		**8.** Employment authorization document issued by the Department of Homeland Security
		9. Driver's license issued by a Canadian government authority		
		For persons under age 18 who are unable to present a document listed above:		
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		**10.** School record or report card		
		11. Clinic, doctor, or hospital record		
		12. Day-care or nursery school record		

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

Refer to Section 2 of the instructions, titled "Employer or Authorized Representative Review and Verification," for more information about acceptable receipts.

The following 4 pages only need to be filled out if employee wants different withholding arrangements for state taxes, e.g., the employee is in a California registered domestic partnership and wants to have payroll tax deductions determined as a married individual.

EDD Employment Development Department
State of California

This form can be used to manually compute your withholding allowances, or you can electronically compute them at **www.taxes.ca.gov/de4.pdf**

EMPLOYEE'S WITHHOLDING ALLOWANCE CERTIFICATE

Type or Print Your Full Name	Your Social Security Number
Home Address (Number and Street or Rural Route)	Filing Status Withholding Allowances ☐ SINGLE or MARRIED (with two or more incomes) ☐ MARRIED (one income) ☐ HEAD OF HOUSEHOLD
City, State, and ZIP Code	

1. Number of allowances for Regular Withholding Allowances, Worksheet A _____
   Number of allowances from the Estimated Deductions, Worksheet B _____
   Total Number of Allowances (A + B) when using the California Withholding Schedules for 2012 _____
   OR
2. Additional amount of state income tax to be withheld each pay period (if employer agrees), Worksheet C _____
   OR
3. I certify under penalty of perjury that I am not subject to California withholding. I meet the conditions set forth under the Service Member Civil Relief Act, as amended by the Military Spouses Residency Relief Act. (Check box here) ☐

Under the penalties of perjury, I certify that the number of withholding allowances claimed on this certificate does not exceed the number to which I am entitled or, if claiming exemption from withholding, that I am entitled to claim the exempt status.

Signature _____ Date _____

Employer's Name and Address	California Employer Account Number

cut here

Give the top portion of this page to your employer and keep the remainder for your records.

YOUR CALIFORNIA PERSONAL INCOME TAX MAY BE UNDERWITHHELD IF YOU DO NOT FILE THIS DE 4 FORM.

IF YOU RELY ON THE FEDERAL FORM W-4 FOR YOUR CALIFORNIA WITHHOLDING ALLOWANCES, YOUR CALIFORNIA STATE PERSONAL INCOME TAX MAY BE UNDERWITHHELD AND YOU MAY OWE MONEY AT THE END OF THE YEAR.

PURPOSE: This certificate, DE 4, is for **California Personal Income Tax (PIT) withholding** purposes only. The DE 4 is used to compute the amount of taxes to be withheld from your wages, by your employer, to accurately reflect your state tax withholding obligation.

You should complete this form if either:

(1) You claim a different marital status, number of regular allowances, or different additional dollar amount to be withheld for California PIT withholding than you claim for federal income tax withholding or,

(2) You claim additional allowances for estimated deductions.

THIS FORM WILL NOT CHANGE YOUR FEDERAL WITHHOLDING ALLOWANCES.

The federal Form W-4 is applicable for California withholding purposes if you wish to claim the same marital status, number of regular allowances, and/or the same additional dollar amount to be withheld for state and federal purposes. However, federal tax brackets and withholding methods do not reflect state PIT withholding tables. **If you rely on the number of withholding allowances you claim on your Form W-4 withholding allowance certificate for your state income tax withholding, you may be significantly underwithheld.** This is particularly true if your household income is derived from more than one source.

CHECK YOUR WITHHOLDING: After your Form W-4 and/or DE 4 takes effect, compare the state income tax withheld with your estimated total annual tax. For state withholding, use the worksheets on this form, and for federal withholding use the Internal Revenue Service (IRS) Publication 919 or federal withholding calculations.

EXEMPTION FROM WITHHOLDING: If you wish to claim exempt, complete the federal Form W-4. You may claim exempt from withholding California income tax if you did not owe any federal income tax last year and you do not expect to owe any federal income tax this year. The exemption automatically expires on February 15 of the next year. If you continue to qualify for the exempt filing status, a new Form W-4 designating EXEMPT must be submitted before February 15. If you are not having federal income tax withheld this year but expect to have a tax liability next year, the law requires you to give your employer a new Form W-4 by December 1.

EXEMPTION FROM WITHOLDING (continued): Under the Service Member Civil Relief Act, as amended by the Military Spouses Residency Relief Act, you may be exempt from California income tax on your wages if (i) your spouse is a member of the armed forces present in California in compliance with military orders; (ii) you are present in California solely to be with your spouse; and (iii) you maintain your domicile in another state. If you claim exemption under this act, check the box on Line 3. You may be required to provide proof of exemption upon request.

IF YOU NEED MORE DETAILED INFORMATION, SEE THE INSTRUCTIONS THAT CAME WITH YOUR LAST CALIFORNIA INCOME TAX RETURN OR CALL THE FRANCHISE TAX BOARD.

IF YOU ARE CALLING FROM WITHIN THE UNITED STATES	800-852-5711 (voice) 800-822-6268 (TTY)
IF YOU ARE CALLING FROM OUTSIDE THE UNITED STATES (Not Toll Free)	916-845-6500

The *California Employer's Guide* (DE 44) provides the income tax withholding tables. This publication may be found on the Employment Development Department's (EDD) website at **www.edd.ca.gov/Payroll_Taxes/Forms_and_Publications.htm**. To assist you in calculating your tax liability, please visit the Franchise Tax Board's website at: **www.ftb.ca.gov/individuals/index.shtml**.

NOTIFICATION: Your employer is required to send a copy of your DE 4 to the Franchise Tax Board (FTB) if it meets either of the following two conditions:

- You claim more than 10 withholding allowances.
- You claim exemption from state or federal income tax withholding and your employer expects your usual weekly wages to exceed $200 per week.

IF THE IRS INSTRUCTS YOUR EMPLOYER TO WITHHOLD FEDERAL INCOME TAX BASED ON A CERTAIN WITHHOLDING STATUS, YOUR EMPLOYER IS REQUIRED TO USE THE SAME WITHHOLDING STATUS FOR STATE INCOME TAX WITHHOLDING IF YOUR WITHHOLDING ALLOWANCES FOR STATE PURPOSES MEET THE REQUIREMENTS LISTED UNDER "NOTIFICATION." IF YOU FEEL THAT THE FEDERAL DETERMINATION IS NOT CORRECT FOR STATE WITHHOLDING PURPOSES, YOU MAY REQUEST A REVIEW.

To do so, write to:

W-4 Unit
Franchise Tax Board MS F180
P.O. Box 2952
Sacramento, CA 95812-2952
Fax: 916-843-1094

Your letter should contain the basis of your request for review. You will have the burden of showing the federal determination incorrect for state withholding purposes. The FTB will limit its review to that issue. The FTB will notify both you and your employer of its findings. Your employer is then required to withhold state income tax as instructed by FTB. In the event FTB or IRS finds there is no reasonable basis for the number of withholding exemptions that you claimed on your Form W-4/DE 4, you may be subject to a penalty.

PENALTY: You may be fined $500 if you file, with no reasonable basis, a DE 4 that results in less tax being withheld than is properly allowable. In addition, criminal penalties apply for willfully supplying false or fraudulent information or failing to supply information requiring an increase in withholding. This is provided for by Section 19176 of the California Revenue and Taxation Code.

INSTRUCTIONS — 1 — ALLOWANCES*

When determining your withholding allowances, you must consider your personal situation:
— Do you claim allowances for dependents or blindness?
— Are you going to itemize your deductions?
— Do you have more than one income coming into the household?

TWO-EARNER/TWO-JOBS: When earnings are derived from more than one source, underwithholding may occur. If you have a working spouse or more than one job, it is best to check the box "SINGLE or MARRIED (with two or more incomes)." Figure the total number of allowances you are entitled to claim on all jobs using only one DE 4 form. Claim allowances with one employer. Do not claim the same allowances with more than one employer. Your withholding will usually be most accurate when all allowances are claimed on the DE 4 or Form W-4 filed for the highest paying job and zero allowances are claimed for the others.

MARRIED BUT NOT LIVING WITH YOUR SPOUSE: You may check the "Head of Household" marital status box if you meet all of the following tests:
(1) Your spouse will not live with you at any time during the year;
(2) You will furnish over half of the cost of maintaining a home for the entire year for yourself and your child or stepchild who qualifies as your dependent; and
(3) You will file a separate return for the year.

HEAD OF HOUSEHOLD: To qualify, you must be unmarried or legally separated from your spouse and pay more than 50% of the costs of maintaining a home for the entire year for yourself and your dependent(s) or other qualifying individuals. Cost of maintaining the home includes such items as rent, property insurance, property taxes, mortgage interest, repairs, utilities, and cost of food. It does not include the individual's personal expenses or any amount which represents value of services performed by a member of the household of the taxpayer.

WORKSHEET A — REGULAR WITHHOLDING ALLOWANCES

(A) Allowance for yourself — enter 1	(A)	
(B) Allowance for your spouse (if not separately claimed by your spouse) — enter 1	(B)	
(C) Allowance for blindness — yourself — enter 1	(C)	
(D) Allowance for blindness — your spouse (if not separately claimed by your spouse) — enter 1	(D)	
(E) Allowance(s) for dependent(s) — do not include yourself or your spouse	(E)	
(F) Total — add lines (A) through (E) above	(F)	

INSTRUCTIONS — 2 — ADDITIONAL WITHHOLDING ALLOWANCES

If you expect to itemize deductions on your California income tax return, you can claim additional withholding allowances. Use Worksheet B to determine whether your expected estimated deductions may entitle you to claim one or more additional withholding allowances. Use last year's FTB 540 form as a model to calculate this year's withholding amounts.

Do not include deferred compensation, qualified pension payments or flexible benefits, etc., that are deducted from your gross pay but are not taxed on this worksheet.

You may reduce the amount of tax withheld from your wages by claiming one additional withholding allowance for each $1,000, or fraction of $1,000, by which you expect your estimated deductions for the year to exceed your allowable standard deduction.

WORKSHEET B — ESTIMATED DEDUCTIONS

1. Enter an estimate of your itemized deductions for California taxes for this tax year as listed in the schedules in the FTB 540 form		1.
2. Enter $7,538 if married filing joint with two or more allowances, unmarried head of household, or qualifying widow(er) with dependent(s) or $3,769 if single or married filing separately, dual income married, or married with multiple employers	–	2.
3. Subtract line 2 from line 1, enter difference	=	3.
4. Enter an estimate of your adjustments to income (alimony payments, IRA deposits)	+	4.
5. Add line 4 to line 3, enter sum	=	5.
6. Enter an estimate of your nonwage income (dividends, interest income, alimony receipts)	–	6.
7. If line 5 is greater than line 6 (if less, see below); Subtract line 6 from line 5, enter difference	=	7.
8. Divide the amount on line 7 by $1,000, round any fraction to the nearest whole number Enter this number on line 1 of the DE 4. Complete Worksheet C, if needed.		8.
9. If line 6 is greater than line 5; Enter amount from line 6 (nonwage income)		9.
10. Enter amount from line 5 (deductions)		10.
11. Subtract line 10 from line 9, enter difference Complete Worksheet C		11.

*Wages paid to registered domestic partners will be treated the same for state income tax purposes as wages paid to spouses for California Personal Income Tax (PIT) withholding and PIT wages. This new law does not impact federal income tax law. A registered domestic partner means an individual partner in a domestic partner relationship within the meaning of Section 297 of the Family Code. For more information, please call our Taxpayer Assistance Center at 888-745-3886.

WORKSHEET C — TAX WITHHOLDING AND ESTIMATED TAX

1. Enter estimate of total wages for tax year 2012 . . . . . 1. _____
2. Enter estimate of nonwage income (line 6 of Worksheet B) . . . . . 2. _____
3. Add line 1 and line 2. Enter sum . . . . . 3. _____
4. Enter itemized deductions or standard deduction (line 1 or 2 of Worksheet B, whichever is largest) . . . . 4. _____
5. Enter adjustments to income (line 4 of Worksheet B) . . . . . 5. _____
6. Add line 4 and line 5. Enter sum . . . . . 6. _____
7. Subtract line 6 from line 3. Enter difference . . . . . 7. _____
8. Figure your tax liability for the amount on line 7 by using the 2012 tax rate schedules below . . . . . 8. _____
9. Enter personal exemptions (line F of Worksheet A x $112.20) . . . . . 9. _____
10. Subtract line 9 from line 8. Enter difference . . . . . 10. _____
11. Enter any tax credits. (See FTB Form 540) . . . . . 11. _____
12. Subtract line 11 from line 10. Enter difference. This is your total tax liability . . . . . 12. _____
13. Calculate the tax withheld and estimated to be withheld during 2012. Contact your employer to request the amount that will be withheld on your wages based on the marital status and number of withholding allowances you will claim for 2012. Multiply the estimated amount to be withheld by the number of pay periods left in the year. Add the total to the amount already withheld for 2012 . . . . . 13. _____
14. Subtract line 13 from line 12. Enter difference. If this is less than zero, you do not need to have additional taxes withheld . . . . . 14. _____
15. Divide line 14 by the number of pay periods remaining in the year. Enter this figure on line 2 of the DE 4 . . 15. _____

NOTE: Your employer is not required to withhold the additional amount requested on line 2 of your DE 4. If your employer does not agree to withhold the additional amount, you may increase your withholdings as much as possible by using the "single" status with "zero" allowances. If the amount withheld still results in an underpayment of state income taxes, you may need to file quarterly estimates on Form 540-ES with the FTB to avoid a penalty.

THESE TABLES ARE FOR CALCULATING WORKSHEET C AND FOR 2012 ONLY

SINGLE OR MARRIED WITH DUAL EMPLOYERS

IF THE TAXABLE INCOME IS		COMPUTED TAX IS		
OVER	BUT NOT OVER	OF AMOUNT OVER . . .		PLUS*
$0	$7,316	1.100%	$0	$0.00
$7,316	$17,346	2.200%	$7,316	$80.48
$17,346	$27,377	4.400%	$17,346	$301.14
$27,377	$38,004	6.600%	$27,377	$742.50
$38,004	$48,029	8.800%	$38,004	$1,443.88
$48,029	$1,000,000	10.230%	$48,029	$2,326.08
$1,000,000	and over	11.330%	$1,000,000	$99,712.71

MARRIED FILING JOINT OR QUALIFYING WIDOW(ER) TAXPAYERS

IF THE TAXABLE INCOME IS		COMPUTED TAX IS		
OVER	BUT NOT OVER	OF AMOUNT OVER . . .		PLUS*
$0	$14,632	1.100%	$0	$0.00
$14,632	$34,692	2.200%	$14,632	$160.95
$34,692	$54,754	4.400%	$34,692	$602.27
$54,754	$76,008	6.600%	$54,754	$1,485.00
$76,008	$96,058	8.800%	$76,008	$2,887.76
$96,058	$1,000,000	10.230%	$96,058	$4,652.16
$1,000,000	and over	11.330%	$1,000,000	$97,125.43

UNMARRIED HEAD OF HOUSEHOLD TAXPAYERS

IF THE TAXABLE INCOME IS		COMPUTED TAX IS		
OVER	BUT NOT OVER	OF AMOUNT OVER . . .		PLUS*
$0	$14,642	1.100%	$0	$0.00
$14,642	$34,692	2.200%	$14,642	$161.06
$34,692	$44,721	4.400%	$34,692	$602.16
$44,721	$55,348	6.600%	$44,721	$1,043.44
$55,348	$65,376	8.800%	$55,348	$1,744.82
$65,376	$1,000,000	10.230%	$65,376	$2,627.28
$1,000,000	and over	11.330%	$1,000,000	$98,239.32

*marginal tax

IF YOU NEED MORE DETAILED INFORMATION, SEE THE INSTRUCTIONS THAT CAME WITH YOUR LAST CALIFORNIA INCOME TAX RETURN OR CALL FRANCHISE TAX BOARD:

IF YOU ARE CALLING FROM WITHIN THE UNITED STATES — 800-852-5711 (voice), 800-822-6268 (TTY)

IF YOU ARE CALLING FROM OUTSIDE THE UNITED STATES (Not Toll Free) — 916-845-6500

The DE 4 information is collected for purposes of administering the Personal Income Tax law and under the authority of Title 22 of the California Code of Regulations and the Revenue and Taxation Code, including Section 18624. The Information Practices Act of 1977 requires that individuals be notified of how information they provide may be used. Further information is contained in the instructions that came with your last California income tax return.