STAFFORCE
POWERED BY PEOPLE

Application For Employment

Employee Name _____

1. Interview Conducted ☐ **4. Application Sent to PEO** ☐

2. I-9 Completed ☐ **5. Lookout Completed (I-9)** ☐

3. Application Entered ☐ **6. Direct Deposit** ☐

Client: **Start Date:**

Pay: **Bill:** **WC Code:** **Referred By:**

Comments:

Skills & Crafts	**Highest Pay Rate**	**Amount of Experience**	**How Long Ago?**
1			
2			
3			
4			
5			

Application Submitted by: ☐ **Worker** ☐ **Client** ☐ **Other**

Official Use Only, Do Not Fill Out.

PERSONAL INFORMATION

DATE: _____

NAME: _____
(LAST, FIRST, MI)

SS#: _____

PRESENT ADDRESS: _____
(STREET ADDRESS, INCLUDING APT/UNIT NUMBER)

_____
(CITY, STATE, ZIP CODE)

PHONE NUMBERS: **1** **2** **3**
(LIST THE BEST 3 PHONE NUMBERS TO REACH YOU FOR A JOB ASSIGNMENT, **YOU MUST LIST 3 PHONE NUMBERS**)

ARE YOU AT LEAST 18 YEARS OF AGE? **Y** **N** ARE YOU LAWFULLY ELIGIBLE TO WORK? **Y** **N**

HOW DID YOU HEAR ABOUT STAFFORCE? _____

EMPLOYMENT DESIRED

POSITION: _____ SALARY DESIRED: _____

IS THIS YOUR 1ST TIME APPLYING AT STAFFORCE? **Y** **N** DATE AVAILABLE: _____

IF YOU ANSWERED NO TO THE ABOVE QUESTION, WHEN & WHERE DID YOU APPLY? _____

HOW WILL YOU GET TO AND FROM JOB ASSIGNMENTS? _____

EDUCATION	NAME OF SCHOOL CITY AND STATE	YEARS ATTEND	GRADUATED? IF SO, WHEN?	SUBJECTS STUDIED
HIGH SCHOOL				
COLLEGE				
TRADE SCHOOL				

GENERAL

ACTIVITIES/HOBBIES: _____

MILITARY SERVICE? **Y** **N** IF SO, BRANCH? YEARS SERVED? RESERVES? **Y** **N**

CITY, STATE, AND COUNTRY OF YOUR PLACE OF BIRTH: _____ **/** **/**
(CITY) (STATE) (COUNTRY)

HAVE YOU EVER WORKED FOR A TEMPORARY STAFFING AGENCY BEFORE? **Y** **N**

IF SO, LIST THE AGENCIES, IN JACKSONVILLE, YOU HAVE WORKED FOR:

_____

JOB QUALIFICATION WORKSHEET

A clear and full understanding of your background, work history, expectations, and goals will assist our company in placing you on an assignment that best meets your needs based upon your qualifications and any openings that we may have at this time. IT IS IMPORTANT, WHEN COMPLETING THIS PAGE, TO BE AS COMPLETE AND AS ACCURATE AS POSSIBLE.

FORMER EMPLOYMENT

DATE (MONTH & YEAR)	COMPANY NAME, SUPERVISOR, PHONE NUMBER	SALARY	POSITION	REASON FOR LEAVING
START				
END				
START				
END				
START				
END				
START				
END				

WHICH OF THE ABOVE JOBS DID YOU ENJOY THE MOST? _____

WHAT DID YOU LIKE MOST ABOUT THAT JOB? _____

REFERENCES

NAME & PHONE NUMBER	ADDRESS	RELATIONSHIP	YEARS ACQUAINTED
1			
2			
3			

SKILLS AND CRAFTS	HIGHEST PAY RATE EARNED	AMOUNT OF EXPERIENCE	HOW LONG AGO?
1			
2			
3			
4			
5			

CRIMINAL HISTORY

HAVE YOU EVER BEEN CONVICTED, HAD ADJUDIFICATION WITHHELD, OR PLED NO CONTEST TO A CRIME? **Y** **N**
ARE YOU CURRENTLY BEING CHARGED FOR A CRIME NOT YET ADJUDICATED? **Y** **N**
IF YOU ANSWERED YES TO EITHER ABOVE, DESCRIBE THE CHARGES IN DETAIL BELOW (YOU CAN USE THE BACK SIDE)
NOTE: A CRIMINAL OFFENSE WILL NOT NECESSARILY BAR EMPLOYMENT, BUT FAILURE TO DIVULGE WILL BE VIEWED AS A FRAUDULENT APPLICATION AND YOU WILL BE TERMINATED IMMEDIATELY.

APPLICATION DISCLOSURE STATEMENT

I hereby declare that all statements contained in this application are true and correct and understand that false or inaccurate information in the application will be the basis for termination. I hereby authorize STAFFORCE to investigate my background inclusive of criminal records and verify this information. I understand if employed, my employment will not be for any fixed period of time and maybe terminated by the company at any time. I also authorize STAFFORCE to release the information contained herein and its findings and work history of my employment to other firms or persons upon request. I also understand and agree that I may be expected to work on a wide variety of job assignments in the greater Jacksonville area and agree to accept assignments for which I am qualified as they become available. I also understand my failure to report to STAFFORCE, location/address for work will indicate I have quit. I also agree to submit to a drug screen upon request or as specified in STAFFORCE substance abuse policy.

Signature of Applicant_____ Date_____

DRUG SCREEN AUTHORIZATION AND CONSENT

I hereby authorize and give full permission to have STAFFORCE and/or their medical company physician send a specimen of my urine and/or blood to a laboratory for screening test using Substance Abuse & Mental Health Services Administration (S.A.M.H.S.A.)(www.samhsa.gov) standards for the presence of illegal drugs, alcohol, or prescription medication taken without a prescription.

I will hold all parties concerned harmless, meaning I will not sue nor hold responsible for any alleged harm to me or interfering with my obtaining a job or continuing employment due to not submitting to the tests or as a result of the report of the tests. This includes, but not limited to, possible clerical or laboratory error.

This policy and authorization has been explained to me in a language I understand and told if I have any questions they will be answered about the test. I understand this is a legal and binding document, which is binding because STAFFORCE is sending me for the examination and paying for it.

I understand STAFFORCE will require a drug screen test whenever an on the job accident or injury is reported in according with STAFFORCE and this authorization and consent. My refusal to submit to drug testing will be grounds for termination.

Signature of Applicant_____ Date_____

RELEASE OF CRIMINAL RECORDS

I, the undersigned, do hereby authorize STAFFORCE to examine any and all criminal records and arrests on file in the counties in the State of Florida or any other state. In doing so, I understand that I am waiving my right of confidentiality concerning my criminal history.

Signature of Applicant_____ Date_____

_____ _____ _____

Print Name Driver's License Number Social Security Number

_____

Street Address, City, State, Zip Code

STAFFORCE Reliability Standard

PROBLEM

The leading complaint about temporary workers by our customers is: LACK OF RELIABILITY!! This problem manifests itself in three ways:

1. A worker accepts an assignment and then, without communicating with the office, does not show to the assignment.

2. A worker starts an assignment and then stops going without communicating with the office.

3. A worker shows to an assignment and then leaves without communicating a reasonable reason to the office.

These circumstances not only reflect negatively on the worker who is guilty, but they damage the creditability and reputation of all our workers and our company as a whole. We spend an enormous amount of our resources and time assuring our customers and prospects that we are extremely proud of our workforce and have confidence in each and every worker. That includes you! By far and large this effort is severely hampered when we have workers who exercise such poor work ethics.

POLICY RESOLUTION

ANY employee who does not return to an assignment that he or she has been working, for any reason, without communicating first with the office, will have their wages, for the hours they worked, reduced to minimum wage (**$8.65** per hour).

ANY employee who does not go to an assignment after accepting it, without communicating to the office a reasonable excuse in a timely manner, will automatically have their wages reduced to minimum wage (**$8.65** per hour), for the hours worked that week, or have their compensation reduced by up to $2.00 per hour for the next 40 hours of work.

ANY employee who leaves a job without first getting permission from his or her supervisor or the permission of STAFFORCE will have their wages reduced to minimum wage (**$8.65** per hour), for the hours worked that week, or have their compensation reduced up to $2.00 per hour for the next 40 hours of work.

- The degree of punishment per offense is up to the individual STAFFORCE coordinators who assign the workers to their positions. These coordinators hold the right to suspend any worker, for any amount of time, for any of the above infractions.

POLICY OBJECTIVE

Our objective is to never impose these provisions because our workers will maintain their commitments to our customers, their fellow workers, and STAFFORCE. By signing below, you are expressing your understanding and acceptance of the contents of this statement and you Pledge to abide by our Reliability Standards.

Sign:_____ Date:_____

SAFETY AWARENESS POLICY

EMPLOYEE ACKNOWLEDGEMENT

I acknowledge that I have received a copy of STAFFORCE Inc. safety awareness policy. I have either read or have had the policy read to me, and have been offered the opportunity to have my questions answered by management. I understand how and why these rules and guidelines are important to my personal safety and to the safety of my fellow employees. I agree to follow current and future rules and guidelines of the safety policy. I understand that I may be held responsible for damages to equipment and or property if the damage is caused by an unsafe act on my part. I understand that all injuries, no matter how minor, are to be reported to STAFFORCE Inc. within 24 hours of occurrence and failure to do so may result in a denied claim.

The following acts will be considered grounds for disciplinary action up to and including immediate dismissal:

1. Any act of complete disregard of a safety rule or directive.
2. Failure or refusal to wear required safety or protective equipment or clothing.
3. Failure to report an accident or injury involving myself or a fellow worker.
4. Failure to report property or equipment damage or failure.
5. Reporting to work while under the influence of drugs or alcohol, or using drugs or alcohol at work.
6. Removal, defeating, defacing, destroying, or altering a required safety shield, guard or device from a piece of equipment regardless of ownership.

Penalties for Safety Violations

1st Offense: Verbal warning from management or safety department.
2nd Offense: Written warning, placed in employee's personnel record.
3rd Offense: Written warning, suspension without pay at management's discretion.
4th Offense: Written warning, immediate dismissal.

I agree to uphold these conditions for as long as I am an employee with STAFFORCE Inc.

Print Name_____

Signature_____ Date_____

Management_____

GENERAL SAFETY RULES

STAFFORCE has developed these safety rules patterned after the Federal OSHA requirements. Read and become familiar with these rules, and other safety rules that apply to your job.

1. Report an injury to your employer/supervisor immediately.
2. Report any observed unsafe condition to your employer/supervisor.
3. Horseplay is prohibited at all times.
4. The drinking of alcoholic beverages is not permitted on the job. Any employee discovered under the influence of alcohol or drugs will not be permitted to work.
5. If you do not have current First Aid Training, do not move or treat an injured person unless there is an immediate peril, such as profuse bleeding or stoppage of breathing.
6. Appropriate clothing and footwear must be worn on the job at all times.
7. Where there exists the hazard of falling objects, an approved hard hat must be worn.
8. You should not perform any task unless you are trained to do so and are aware of the hazards associated with that task.
9. You may be assigned certain personal protective safety equipment. This equipment should be available for use on the job, be maintained in good condition, and worn when required.
10. Learn safe work practices. When in doubt about performing a task safely, contact your supervisor for instruction and training.
11. The riding of a hoist hook, or on other equipment not designed for such purposes, is prohibited at all times.
12. Never remove or by-pass safety devices.
13. Do not approach operating machinery from the blind side; let the operator see you.
14. Learn where fire extinguishers and first aid kits are located.
15. Maintain a general condition of good housekeeping in all work areas at all times.
16. Obey all traffic regulations when operating vehicles on public highways.
17. When operating or riding in company vehicles or using your personal vehicle for business purposes, the vehicle's seatbelt shall be worn.
18. Be alert to hazards that could affect you and your co-employees.
19. Obey safety signs and tags.
20. Always perform your assigned task in a safe and proper manner; do not take shortcuts. The taking of shortcuts and the ignoring of established safety rules is a leading cause of employee injury.

I certify that I have read and understand and will abide by the above listed safety rules. Failure to do so may be grounds for termination and may disqualify my insurance benefits.

Applicant's Signature _____ Date _____

POLICIES AND PROCEDURES CHECKLIST

- ☐ I understand STAFFORCE takes their responsibility as my employer very seriously and that they have gone to great lengths to provide a safe work environment. If I am injured on the job, STAFFORCE will deal promptly with legitimate claims and they have workers compensation insurance that will pay medical expenses and wages. I also understand that STAFFORCE has extensive experience investigating claims and will fight fraudulent claims with all available resources.

- ☐ If I sustain an injury on the job, I will inform the client and STAFFORCE immediately and STAFFORCE will then coordinate with the client and myself the proper procedures for treatment and reporting of the accident.

- ☐ STAFFORCE has a strict "Substance Abuse Policy," and I have signed a consent form to submit to drug testing. I understand that my failure to comply with this agreement will be grounds for my immediate termination.

- ☐ I understand and will comply with STAFFORCE's safety rules and regulations and hazardous communication program, explained to me in STAFFORCE's orientation.

- ☐ I am telephone accessible and I have reliable transportation.

- ☐ I understand that I am an employee of STAFFORCE and only STAFFORCE or I can terminate my employment. When an assignment ends I must report to STAFFORCE for my next job assignment. Failure to do so or to accept my next job assignment will indicate that I have voluntarily quit and will not be eligible for unemployment benefits.

- ☐ I understand that I am expected to complete any job assignment I accept. I understand that if I do not complete or promptly notify STAFFORCE of my inability to complete the assignment or if I do not report for my assignment, then STAFFORCE may assume that I have voluntarily quit and I will not be eligible for unemployment benefits.

- ☐ If for some unexpected reason, such as an emergency or illness, I cannot go to work or I will be late to work, I will contact STAFFORCE immediately.

- ☐ I understand STAFFORCE's requirements for receiving information, documenting hours worked, the method of providing this information, and the time frame for me to provide this information. I understand STAFFORCE will not recognize or pay for any hours worked by an employee without proper documentation verifying hours worked.

- ☐ I have read and fully understand the above statements regarding STAFFORCE's policies and procedures and agree to the same. I understand that failure to comply with these policies and procedures could lead to my termination and may jeopardize my insurance benefits.

_____ _____

Applicant Date Interviewer Date

MEDICAL OVERVIEW

In order to perform many of the job duties at STAFFORCE, employees are required to perform regular physical activities to include, but not limited to: lifting, pulling, pushing, and climbing. To ensure each employee hired is in top physical shape and able to handle the physical stresses of work, please answer the following questions:

1. Have you ever had a job related accident? Y / N , If you answered Yes, was a workers compensation claim filed? Y / N , If you answered Yes, do you have a doctors release to return to work? Y / N
2. Do you have any physical limitations or current injuries? Y / N , List any:_____
3. Are you currently taking any doctor prescribed medications? Y / N , If you answered Yes, please list your current medications:_____

EMPLOYEE INFORMATION: (to be completed by employee)

Employee Name: _____
Last First M.I.

Address: _____ Apt #: _____

_____ Phone: _____
City State Zip

Social Security Number: _____ Date of Birth: _____
mm/dd/yyyy

I.D. or Driver's License Number: _____ I.D./D.L. Exp Date: _____
mm/dd/yyyy

State License Held: _____ City of Birth: _____

Gender: ☐ Male ☐ Female

Race: ☐ White ☐ African American ☐ Hispanic ☐ Asian/Pacific Islander

☐ American Indian

EMERGENCY CONTACT INFORMATION

Primary Contact: _____ Relationship: _____

Main Phone: _____ Mobile Phone: _____

Secondary Contact: _____ Relationship: _____

Main Phone: _____ Mobile Phone: _____

Email: _____

Form **W-4**
(Rev. December 2020)
Department of the Treasury
Internal Revenue Service

Employee's Withholding Certificate

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

OMB No. 1545-0074

2021

Step 1: Enter Personal Information

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

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

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

Step 2: Multiple Jobs or Spouse Works

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

Do **only one** of the following.

(a) Use the estimator at *www.irs.gov/W4App* for most accurate withholding for this step (and Steps 3–4); **or**

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

(c) If there are only two jobs total, you may check this box. Do the same on Form W-4 for the other job. This option is accurate for jobs with similar pay; otherwise, more tax than necessary may be withheld . . . . . ► ☐

TIP: To be accurate, submit a 2021 Form W-4 for all other jobs. If you (or your spouse) have self-employment income, including as an independent contractor, use the estimator.

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

Step 3: Claim Dependents

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

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

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

Add the amounts above and enter the total here . . . . . **3** $

Step 4 (optional): Other Adjustments

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

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

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

Step 5: Sign Here

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

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

Employers Only

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

Form G-4 (Rev. 01/03/19)

1811004012

STATE OF GEORGIA EMPLOYEE'S WITHHOLDING ALLOWANCE CERTIFICATE

1a. YOUR FULL NAME	1b. YOUR SOCIAL SECURITY NUMBER
2a. HOME ADDRESS (Number, Street, or Rural Route)	2b. CITY, STATE AND ZIP CODE

PLEASE READ INSTRUCTIONS ON REVERSE SIDE BEFORE COMPLETING LINES 3 – 8

3. MARITAL STATUS

(If you do not wish to claim an allowance, enter "0" in the brackets beside your marital status.)

A. Single: Enter 0 or 1.....[ ]

B. Married Filing Joint, both spouses working:
Enter 0 or 1 .....[ ]

C. Married Filing Joint, one spouse working:
Enter 0 or 1 or 2 .....[ ]

D. Married Filing Separate:
Enter 0 or 1 .....[ ]

E. Head of Household:
Enter 0 or 1 .....[ ]

4. DEPENDENT ALLOWANCES [ ]

5. ADDITIONAL ALLOWANCES [ ]
(worksheet below must be completed)

6. ADDITIONAL WITHHOLDING $_____

WORKSHEET FOR CALCULATING ADDITIONAL ALLOWANCES
(Must be completed in order to enter an amount on step 5)

1. COMPLETE THIS LINE ONLY IF USING STANDARD DEDUCTION:
   Yourself: ☐ Age 65 or over ☐ Blind
   Spouse: ☐ Age 65 or over ☐ Blind Number of boxes checked _____ x 1300.....$_____
2. ADDITIONAL ALLOWANCES FOR DEDUCTIONS:

A. Federal Estimated Itemized Deductions (If Itemizing Deductions).....$_____

B. Georgia Standard Deduction (enter one): Single/Head of Household $4,600
Each Spouse $3,000 $_____

C. Subtract Line B from Line A (If zero or less, enter zero).....$_____

D. Allowable Deductions to Federal Adjusted Gross Income .....$_____

E. Add the Amounts on Lines 1, 2C, and 2D .....$_____

F. Estimate of Taxable Income not Subject to Withholding .....$_____

G. Subtract Line F from Line E (if zero or less, stop here).....$_____

H. Divide the Amount on Line G by $3,000. Enter total here and on Line 5 above ..... _____

(This is the maximum number of additional allowances you can claim. If the remainder is over $1,500 round up)

7. LETTER USED (Marital Status A, B, C, D, or E) _____ **TOTAL ALLOWANCES** (Total of Lines 3 - 5) _____
(Employer: The letter indicates the tax tables in Employer's Tax Guide)

8. EXEMPT: (Do not complete Lines 3 - 7 if claiming exempt) **Read the Line 8 instructions on page 2 before completing this section.**

a) I claim exemption from withholding because I incurred no Georgia income tax liability last year **and** I do not expect to have a Georgia income tax liability this year. **Check here** ☐

b) I certify that I am not subject to Georgia withholding because I meet the conditions set forth under the Servicemembers Civil Relief Act as amended by the Military Spouses Residency Relief Act as provided on page 2. My state of residence is _____. My spouse's (servicemember) state of residence is _____ . The states of residence must be the same to be exempt. **Check here** ☐

I certify under penalty of perjury that I am entitled to the number of withholding allowances or the exemption from withholding status claimed on this Form G-4. Also, I authorize my employer to deduct per pay period the additional amount listed above.

Employee's Signature_____ Date _____

Employer: Complete Line 9 and mail entire form only if the employee claims over 14 allowances or exempt from withholding.
If necessary, mail form to: Georgia Department of Revenue, Withholding Tax Unit, 1800 Century Blvd NE, Suite 8200, Atlanta, GA 30345

9. EMPLOYER'S NAME AND ADDRESS: **EMPLOYER'S FEIN:**_____

EMPLOYER'S WH#:_____

Do not accept forms claiming additional allowances unless the worksheet has been completed. Do not accept forms claiming exempt if numbers are written on Lines 3 - 7.

INSTRUCTIONS FOR COMPLETING FORM G-4

Enter your full name, address and social security number in boxes 1a through 2b.

Line 3: Write the number of allowances you are claiming in the brackets beside your marital status.

A. Single – enter 1 if you are claiming yourself
B. Married Filing Joint, both spouses working – enter 1 if you claim yourself
C. Married Filing Joint, one spouse working – enter 1 if you claim yourself or 2 if you claim yourself and your spouse
D. Married Filing Separate – enter 1 if you claim yourself
E. Head of Household – enter 1 if you claim yourself

Line 4: Enter the number of dependent allowances you are entitled to claim.

Line 5: Complete the worksheet on Form G-4 if you claim additional allowances. Enter the number on Line H here.
Failure to complete and submit the worksheet will result in automatic denial on your claim.

Line 6: Enter a specific dollar amount that you authorize your employer to withhold in addition to the tax withheld based on your marital status and number of allowances.

Line 7: Enter the letter of your marital status from Line 3. Enter total of the numbers on Lines 3-5.

Line 8:

a) Check the first box if you qualify to claim exempt from withholding. You can claim exempt if you filed a Georgia income tax return last year and the amount of Line 4 of Form 500EZ or Line 16 of Form 500 was zero, **and** you expect to file a Georgia tax return this year and will not have a tax liability. You can not claim exempt if you did not file a Georgia income tax return for the previous tax year. **Receiving a refund in the previous tax year does not qualify you to claim exempt.**

EXAMPLES: Your employer withheld $500 of Georgia income tax from your wages. The amount on Line 4 of Form 500EZ (or Line 16 of Form 500) was $100. Your tax liability is the amount on Line 4 (or Line 16); therefore, you **do not qualify** to claim exempt.

Your employer withheld $500 of Georgia income tax from your wages. The amount on Line 4 of Form 500EZ (or Line 16 of Form 500) was $0 (zero). Your tax liability is the amount on Line 4 (or Line 16) and you filed a prior year income tax return; therefore you **qualify** to claim exempt.

b) Check the second box if you are not subject to Georgia withholding and meet the conditions set forth under the Servicemembers Civil Relief Act, as amended by the Military Spouses Residency Relief Act. Under the Act, a spouse of a servicemember may be exempt from Georgia income tax on income from services performed in Georgia if:

1. The servicemember is present in Georgia in compliance with military orders;
2. The spouse is in Georgia solely to be with the servicemember;
3. The spouse maintains domicile in another state; and
4. The domicile of the spouse is the same as the domicile of the servicemember.

Additional information for employers regarding the Military Spouses Residency Relief Act:

1. On the W-2 for 2010 and any year thereafter, the employer should not report any of the wages as Georgia wages on the W-2.
2. If the spouse of a servicemember is entitled to the protection of the Military Spouses Residency Relief Act in another state and files a withholding exemption form in such other state, the spouse is required to submit a Georgia Form G-4 so that withholding will occur as is required by Georgia Law when a Georgia domiciliary works in another state and withholding is not required by such other state. If the spouse does not fill out the form, the employer shall withhold Georgia income tax as if the spouse is single with zero allowances.

Worksheet for calculating additional allowances. Enter the information as requested by each line. For Line 2D, enter items such as Retirement Income Exclusion, U.S. Obligations, and other allowable deductions per Georgia Law, see the IT-511 booklet for more information.

Do not complete Lines 3-7 if claiming exempt.

O.C.G.A. § 48-7-102 requires you to complete and submit Form G-4 to your employer in order to have tax withheld from your wages. By correctly completing this form, you can adjust the amount of tax withheld to meet your tax liability. Failure to submit a properly completed Form G-4 will result in your employer withholding tax as though you are single with zero allowances.

Employers are required to mail any Form G-4 claiming more than 14 allowances or exempt from withholding to the Georgia Department of Revenue for approval. Employers will honor the properly completed form as submitted pending notification from the Withholding Tax Unit. Upon approval, such forms remain in effect until changed or until February 15 of the following year. Employers who know that a G-4 is erroneous should not honor the form and should withhold as if the employee is single claiming zero allowances until a corrected form has been received.

Employment Eligibility Verification

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

USCIS
Form I-9
OMB No. 1615-0047
Expires 10/31/2022

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

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

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

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

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

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

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

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

☐ 1. A citizen of the United States

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

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

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

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

1. Alien Registration Number/USCIS Number: _____

OR

2. Form I-94 Admission Number: _____

OR

3. Foreign Passport Number: _____

Country of Issuance: _____

QR Code - Section 1
Do Not Write In This Space

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

Preparer and/or Translator Certification (check one):

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

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

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

Signature of Preparer or Translator	Today's Date *(mm/dd/yyyy)*

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

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

STOP *Employer Completes Next Page* STOP

Employee Pay Selection Record

Personnel Staffing Group, LLC ("Employer") offers two options to receive your pay, Direct Deposit or the Money Network® Service. Please review these options and make your selection below.

Option 1: DIRECT DEPOSIT Employer will pay all of my net pay as selected below ("Direct Deposit") into the account (the "Account") at the financial institution with the routing and account numbers and account type (collectively, "Account Information") I have provided separately to Employer according to Employer's procedure.

Option 2: MONEY NETWORK SERVICE Employer will pay all of my net pay as selected below using the Money Network Service (the "Service") and I may use either of the following options:

Money Network'" Check. The Money Network Check ("Check") is a paycheck that I can easily complete on or after each payday morning wherever I am, eliminating the need to pick up my paycheck, wait for it to be mailed, or pay for it to be cashed. The Check can be deposited into my personal bank account or cashed for free at Money Network check-cashing partners.

Money Network Payroll Debit Card. The Money Network Payroll Debit Card ("Card") provides a dependable, safe, optional, and convenient way to receive and access my pay on and after each payday morning with the following features: (i) eliminates the need to pick up my paycheck, wait for it to be mailed, or pay for it to be cashed; (ii) immediate, worldwide access wherever the Card is accepted for ATM cash withdrawals, bank-branch withdrawals, and store purchases (including "cash back"); (iii) money transfers to a personal or joint checking account; and (iv) free balance inquiries by phone or online. There is no monthly service charge for the Card as long as I am employed by Employer. Many Card transactions are free (and I need never incur a fee to access 100% of my wages, to the penny, using the Service), but there are fees for other transactions. The Terms and Conditions, fee schedule, and other disclosures related to the Service are included in the Service's Welcome Packet. Once I have consented to those terms and contracted for the Service by activating my Service account by following the instructions in the Welcome Packet, I may begin to use the Service.

IHEREBY ELECT TO HAVE MY PAY DISTRIBUTED AS NDICATED:

(REQUIRED; MAKE one CHOICE BY CHECKINGTHE A OR B BOX AND WRITING YOUR NITIALS ABOVE YOUR SELECTION BELOW)

A ☐	*OR*	B ☐
Initials		Initials
DIRECT DEPOSIT		MONEY NETWORK SERVICE

I authorize Employer to pay me by Direct Deposit or the Service, according to the selection I checked and initialed *above.* In case of payment of funds to which I am not entitled, I authorize Employer to withdraw such funds from the Account or the Service. Unless I am already paid by Direct Deposit, I acknowledge that, in order to choose Direct Deposit, I must submit a fully completed Employee Pay Selection Record ("PSR") and Account Information (defined above). The PSR and Account Information must be submitted to Employer within three (3) business days (thirty (30) days in Michigan) of receiving notice to do so. f I fail to satisfy these requirements to be paid by Direct Deposit, I agree that I will be paid using the **Service. <u>However, I understand that I can change my pay selection at any time</u>** in the future by submitting a new PSR and Account Information according to Employer's procedure (subject to the time it takes Employer to implement the change). My election will remain in effect unless Employer and/or Program Manager cancels this arrangement. To help the government fight the funding of terrorism and money laundering activities, Federal law requires financial institutions to verify and record identity information before opening an account such as the account provided when you enroll in the Service. To permit this identification so that my pay to be placed in such an account, I authorize Employer to share my name, address, date of birth, Social Security Number, identification documents, and related personal information with Money Network and the issuing bank.

			EMPLOYER USE ONLY
Signature*	Printed Name*	Date*	Employee ID#

• *Required*

8/20/2014

EMPLOYEE DIRECT DEPOSIT AUTHORIZATION

Employee Name:	**Effective Date:**
Address:	**City / State / Zip:**
Birth Date:	**Social Security Number:**
Phone:	**Email:**

CHOOSE YOUR METHOD OF DIRECT DEPOSIT:

☐ **I request my payroll deduction / direct deposit be placed in the following account(s):**

BANK / CREDIT UNION	BANK ABA#	ACCOUNT#	DEDUCTION AMOUNT / NET PAY	TYPE OF ACCOUNT
	#	#	☐ $_____ or ☐ _____%	☐ Savings ☐ Checking
	#	#	☐ $_____ or ☐ _____%	☐ Savings ☐ Checking

PLEASE PROVIDE A VOIDED CHECK FOR EACH CHECKING ACCOUNT LISTED ABOVE.

AND / OR:

☐ **rapid! PayCard Issuance Authorization Form**

Financial Institution Name: MetaBank®	DEDUCTION AMOUNT / NET PAY
Routing Number: **124085244** Direct Deposit Account Number: **353** ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ (Card ID on front of envelope) *To be assigned and entered by MVP*	☐ $_____ or ☐ 100%

The rapid! PayCard® Visa® Prepaid card is issued by MetaBank®, Member FDIC, pursuant to a license from Visa U.S.A. Inc.

Important Information for opening a Card account: To help the federal government fight the funding of terrorism and money laundering activities, the USA PATRIOT Act requires all financial institutions and their third parties to obtain, verify, and record information that identifies each person who opens a Card account. What this means for you: When you open a Card account, we will ask for your name, address, date of birth, and other information that will allow us to identify you. We may also ask to see your driver's license or other identifying documents.

I authorize MVP to withhold the indicated amount(s), if available, from my pay, and deposit directly into the account(s) shown and/or I hereby authorize MVP to assign a rapid! PayCard and initiate credit entries and any correcting entries to my assigned rapid! PayCard account. The direct deposit(s) will be made on each payday, unless I notify MVP in writing of my intent to cancel. Upon MVP's receipt of a request to cancel a direct deposit authorization, it shall become effective after a reasonable opportunity to act upon it.

In the event funds are deposited erroneously into my account, I authorize MVP to debit my account(s) not to exceed the original amount of the credit.

I understand that MVP reserves the right to refuse any direct deposit request. I also understand that all direct deposits are made through the Automated Clearing House (ACH), and that funds availability is subject to the terms and limitations of the ACH as well as my financial institution.

Note: If sending this form electronically, please type your initials and the last 4 digits of your social security number in the signature field. If sending or faxing a paper copy, please print out and sign your name(s) in the signature box.

Employee Signature: _____ Date: _____