PERSONNEL FILE AUDIT TOOL

Employee Name: _____ Title: _____Date of Hire: _____

FROM OFFICE	FROM EMPLOYEES
EMPLOYMENT APPLICATION	RESUME
INDEPENDENT CONTRACTOR CONTRACT	2 REFERENCES
CONTRACT ANNUAL REVIEW (IND CONTRACT ONLY)	EMERGENCY CONTACT INFORMATION
INTERVIEW REVIEW FORM	DIPLOMA/DEGREE/TRANSCRIPT OR CERTIFICATE
ORIENTATION CHECKLIST	LICENSE COPY with ON-LINE VERIFICATION
JOB ACCEPTANCE STATEMENT	SOCIAL SECURITY CARD or ACCEPTABLE VERIFICATION OF RIGHT TO WORK IN THE UNITED STATES PER I-9
JOB DESCRIPTION	CPR CARD
AO EVALUATIONS/PERFORMANCE EVALUATION (YEARLY)	DRIVER'S LICENSE
SKILLS COMPETENCY EVALUATIONS FOR DIRECT CARE EMPLOYEES (ON HIRE AND YEARLY)	AUTO INSURANCE
ON-SITE JOINT VISIT YEARLY FOR DIRECT CARE EMPLOYEES	STATE SPECIFIC IN-SERVICE REQUIREMENTS **(HIV (ORIGINAL 4HR AND UPDATE)/OSHA/ DOMESTIC VIOLENCE/ALZHEIMERS/MEDICAL ERRORS**
IN-SERVICES REQUIRED ON HIRE AND ANNUALLY ***(Direct Care Givers – Bloodborne Pathogens, Medical Device Reporting, Infection Control, TB, Respiratory Disorders, HIPAA, Cultural Diversity, Emergency Preparedness, How to Handle Complaints/ Grievances, Communication Barriers, Corporate Compliance, Workplace/ Patient Safety (OSHA), Ethics, Patient Rights and Responsibilities)***	PROFESSIONAL LIABILITY INSURANCE-current (Contract employees only)
BIOMEDICAL WASTE TRAINING (PART A & B)	PHYSICAL-FREE OF COMMUNICABLE DISEASE STATEMENT (2yrs)
CONFLICT OF INTEREST STATEMENT	ANNUALI TB RESULTS/ TB. BAMT OR CHEST X-RAY RESULTS
E-SIGNATURE STATEMENT (for field staff)	IMMUNIZATIONS

CHNP

HealthQuest
Home Health Agency

IN-SERVICES REQUIRED ON HIRE AND ANNUALLY (***office staff – infection control, HIPAA, cultural diversity, emergency/ disaster training, how to handle complaints/ grievances, communication barriers, corporate compliance, workplace/patient safety (OSHA), ethics, patient rights and responsibilities)***	PAYROLL FORMS (W4- or 1099/DIRECT DEPOSIT FORM)
SIGNED ACKNOWLEDGEMENT OF EMPLOYEE HANDBOOK	COVID19 VACCINATION CARD/ COVID TEST (IF ANY NOT REQUIRED)
TB QUESTIONNAIRE ON YEARS BETWEEN CHEST X-RAYS (ON-HIRE & YEARLY)	
HEPATITIS DECLINATION/ACCEPTANCE FORM	
CRIMINAL HISTORY BACKGROUND FORMS AND RESULTS	
OIG and SEX OFFENDER CLEARANCE	
I – 9 NATURALIZATION FORM	

Name of Person Completing the Audit: _____

Name of Auditor: _____ Date of Audit: _____

Signature and Title of Auditor: _____

CHAP

EMPLOYMENT APPLICATION

All prospective employees will receive consideration without discrimination because of race, color, creed, age, natural origin, or handicap. All information provided herein will be kept confidential.

PERSONAL

_____ _____
Last Name **First** **Middle** **Date**

_____ _____
Street Address **Home Phone**

_____ _____
City, State, Zip Code **Business Phone**

Emergency contact (person not living with you)_____

Have you ever applied for employment with this Agency? _____Yes _____ No

How many hours a week are you available for work? _____

Are you legally eligible for employment in the United States? _____Yes _____ No

How did you learn of our organization? _Online Ad _____Agency employee _
Other

Are you willing to work: _____Evenings? _____ Weekends?

Position applying for: _____

EDUCATION:

School Name	Location of School	Course of Study	Degree/Diploma
College:			
_____	_____	_____	_____
_____	_____	_____	_____
Vo-Tech or Trade:			
_____	_____	_____	_____
_____	_____	_____	_____
High School:			
_____	_____	_____	_____
_____	_____	_____	_____
Other:			
_____	_____	_____	_____
_____	_____	_____	_____

Employment:

List the last five years employment history, starting with the most recent employer.

1. Company Name: _____ Telephone: _____

Address: _____ Dates of Employment: _____

_____ From_____ To _____

City State Zip Code Starting Pay: _____

Job Title and Describe your work: _____ Reason for leaving:_____

_____ _____

2. Company Name: _____ Telephone: _____

Address: _____ Dates of Employment: _____

_____ From_____ To _____

City State Zip Code Starting Pay: _____

Job Title and Describe your work: _____ Reason for leaving:_____

_____ _____

3. Company Name: _____ Telephone: _____

Address: _____ Dates of Employment: _____

_____ From_____ To _____

City State Zip Code Starting Pay: _____

Job Title and Describe your work: _____ Reason for leaving:_____

Was your last name different from your present name during the above listed jobs? Yes_____ No_____

If yes, what was your name? _____

Are you currently employed? Yes _____ No _____

Do you have reliable transportation? Yes _____No _____

PROFESSIONAL REFERENCES

Persons who can furnish information about job performance

1. Name: _____Telephone:_____

Address: _____

2. Name: _____Telephone:_____

Address: _____

3. Name: _____Telephone:_____

Address: _____

GENERAL

Have you ever been convicted of a crime in the past 5 years, barring employment in a Home Care and community support Agency? Yes _____ No _____

Conviction will not necessarily disqualify an applicant from employment.

If yes, describe in full: _____

_____

_____

_____

Are you capable of performing the job set forth in the job description?

Yes___No____If you answered No, which job requirement can you not meet?

_____

_____

_____

CREDENTIALS/SPECIALIZED SKILLS & QUALIFICATIONS/EQUIPMENT OPERATED

List all states in which licensed giving registration and expiration date. Summarize special job-related skills and qualification acquired from employment or other experience**.**

_____
_____
_____
_____
_____
_____

PLEASE READ ALL STATEMENTS BELOW BEFORE SIGNING THIS APPLICATION:

I certify that the facts contained in this application are true and complete to the best of my knowledge and understand, that, if employed, falsified statements on this application SHALL BE GROUNDS FOR DISMISSAL

I Authorize complete investigation of all statements contained herein and herby give my full permission for the Agency to contact and fully discuss my background and history with all persons and entities listed above to give the Agency any and all information concerning my previous employment and any information they may have, and release all former employees and others listed above from all liability for any damage that my result from furnishing the same to the Agency.

This Agency performs random drug screening and prohibits the use of illegal drugs. I understand that I will be subject to random drug screening and failure to submit or pass drug screening may result in dismissal for cause. By signing this application, I agree to submit to random drug screening as requested.

I understand and agree that, if hired, my employment is for no definite period arid may, regardless of the date of payment of my wages and salary, be terminated at any time for any lawful reason, without prior notice and with or without cause.

This application for employment shall be considered active for a period of time not to exceed 45 days. Any applicant wishing to be considered for employment beyond this time period shall inquire as to whether or not applications are being accepted at that time**.**

I understand that a criminal background check will be performed for any position that has direct access to patients/clients or their personnel/medical information. By signing this application, I give permission for a criminal background check to be performed. I understand that if offered a position my employment may be conditional or terminated based on the results of my criminal background check.

DATE: ____ SIGNATURE _____

APPLICANT REFERENCE CHECK (1)

To Whom It May Concern:

The applicant named below has submitted an application for employment with our firm. Please verify employment and rate the performance of this candidate. This information will not be given to the employee.

To be filled out by applicant:

Applicant Name**:** _____ Date of Application**:** _____

Previous Employer: _____ Contact Person: _____

Address: _____ Phone: ( ) _____

I hereby authorize the following information to be released for all previous employers listed. I release you and all persons and organizations from all claims and liabilities of any nature from any information given.

Applicant's Signature: _____ Date: _____

To be completed by previous employer:

Date of employment: From: _____ to: _____Position Held: _____

Would you rehire this individual? Yes ___ No _____

Responsibilities:

_____

_____

Reason for Leaving:

_____

_____

Rate of Pay: (weekly/biweekly/salary): _____+_____

Additional comments (training/skills)

_____

Reference check performed by_____

APPLICANT REFERENCE CHECK (2)

To Whom It May Concern:

The applicant named below has submitted an application for employment with our firm. Please verify employment and rate the performance of this candidate. This information will not be given to the employee.

To be filled out by applicant:

Applicant Name**:** _____ Date of Application**:** _____

Previous Employer: _____ Contact Person: _____

Address: _____ Phone: ( ) _____

Fax: ( ) _____

I hereby authorize the following information to be released for all previous employers listed. I release you and all persons and organizations from all claims and liabilities of any nature from any information given.

Applicant's Signature: _____ Date: _____

To be completed by previous employer:

Date of employment: From: _____ to: _____Position Held: _____

Would you rehire this individual? Yes ___ No _____

Responsibilities:

_____

_____

Reason for Leaving:

_____

_____

Rate of Pay: (weekly/biweekly/salary): _____+_____

Additional comments (training/skills) _____

Reference check performed by_____ _____

EMPLOYEE EMERGENCY CONTACT INFORMATION

Employee Name: _____

Current Address: _____

Home Phone: _____ Cell Phone: _____

*In case of emergency, please contact:

Name: _____ Phone: _____

Relationship: _____ Address: _____

_____

*Please notify this Agency immediately if any of the emergency contact information changes.

ORIENTATION AND ANNUAL TRAINING CHECKLIST

Items with an asterisk (*) and in bold type are for direct care staff only

Orientation Program			
	Check		Check
Agency Mission, Vision and Plan and Organizational Chart		***Bloodborne Pathogens/Exposure Control Plan**	
***Types of Care/Service Provided by the Agency including Information Provided to Clients Regarding Charges**		***TB and Infectious Control Plan**	
Personnel Policies, Job Descriptions and Professional Boundaries of All Disciplines		***Medical Device and Safety Hazard Reporting**	
Cultural diversity		***Advance Directives**	
Emergency/Disaster Preparedness		***Administrative Policy and Supervision of Staff**	
Complaints and Grievances		***Identifying Abuse, Neglect and Exploitation**	
HIPAA		**Fraud, Abuse and Whistleblowing**	
Infection Control		***Quality Assurance or QAPI**	
***Handwashing and Bag Technique**		***Documentation, Recordkeeping including OASIS if applicable**	
Communication Barriers		***Understanding Alzheimer's and Dementia**	
Workplace/Patient Safety and OSHA Including Hazard Communication Plan		***Incident /Occurrence Reporting**	
Patient Rights and Responsibilities		Employee Handbook Review	
Corporate Compliance		ID Badge Issued	
Ethics			

Print Name:_____ Title:_____

Signature:_____ Date:_____

Trainer Name:_____ Title:_____

Signature:_____ Date:_____

JOB ACCEPTANCE STATEMENT

I have read, understand, and agree to the terms specified in this job description for the position I presently hold. A copy of this job description has been given to me.

I further understand that this job description may be reviewed at any time and that I will be provided with a revised copy.

Employee Signature_____ Date_____

OCCUPATIONAL THERAPY ASSISTANT- FL.

Policy: JD-016.1

- **TITLE OF IMMEDIATE SUPERVISOR: SUPERVISING OCCUPATIONAL THERAPIST**
- **RISK OF EXPOSURE TO BLOODBORNE PATHOGENS – MODERATE/LOW**

DUTIES
Retains licensure in the state of Florida to practice as an Occupational Therapy Assistant. (See Qualifications).
Comply with applicable laws and regulations.
Assist in implementing occupational therapy services as directed by the Occupational Therapist (OT) and prescribed by a physician, physician assistant, or advanced practice registered nurse, acting within their scope of practice.
Assist in evaluating the patient's level of function by applying diagnostic and therapeutic procedures.
Perform routine visits with a focus on Activities of Daily Living (ADLs), fine motor skills, and upper and lower body strengthening as directed by the Occupational Therapist (OT)
Assist in developing the care/service plan and updating under the supervising therapist's direction.
Assist the patient with occupational therapy exercises and safe practices as directed by the OT.
Observe and record activities and findings in the clinical record.
Reinforce education of the patient and family regarding occupational therapy exercises and safe practices as directed by OT.
Respect and protect the patient’s rights including refusal of services, confidentiality, and privacy.
Report to the supervising occupational therapist and physician, physician assistant, or advanced practice registered nurse the patient's reaction to treatment and any changes in the patient's condition, or when there are deviations from the plan of care.
Keep the Governing Body, Administration, Management, and staff informed of current organizational, community, and industry trends.

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Policy: JD-016.2

Coordinate and liaise with appropriate affiliate departments, disciplines, and committees.
Informs the occupational therapist, Clinical Manager, and staff of any status changes in the patient.
Seek and encourage input from other administrative and service personnel.
Provide input to the supervising occupational therapist, Clinical Manager and other management and program areas for appropriate services operations and administration.
Represent the Agency to other groups, other agencies, and the general public.
RESPONSIBILITIES
Assist the OT with input related to development or needed changes to the patient's Plan of Care.
Consult, plan, and work with the supervising OT and administrative Staff in policy formulation and program development and implementation, including matters of staffing for the Agency.
Assist with facilitating appropriate and adequate staffing.
Participate in staff development, including orientation, in-service education, and continuing education as required by their profession.
Inform supervisor of visit observations and any status changes in the patient.
Attend and be punctual for patient visits/services and Agency meetings, education, training, or patient conferences.
Assist and provide input to the Administrator and other management and program areas for appropriate services operations and administration.
Assist with submission and completion of documentation of services on a timely basis in accordance with laws, regulations and as per agency protocol.
Keep the Administrator, supervising OT, and other management staff informed of Agency and affiliate developments, needs, etc., and encourages their participation in problem solving, at the organization and community levels.

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Participate in staff development, including orientation, in-service education, and continuing education as required by the Agency and the individual's profession.

Policy: JD-016.3

Assist in the evaluation of community needs and plans appropriate programs/services.
Act as the Agency representative in providing services according to the Mission, Vision, and Philosophy.
Participate in selective conferences, and workshops, to promote knowledge in community health trends, job performance efficiency, and overall professional growth.
Participate with other health, civic, educational, and professional groups, as directed.
Represent the Agency in community and civic organizations, on occasion.
Assist and participate in organizational improvement activities as requested.
Establish personal goals and objectives for advancement.
JOB CONDITIONS
The position requires meeting deadlines and requires patient care visits in their homes.
The position requires assistance with lifting patients, moving home furniture and equipment.
Home visits will involve sitting, standing, bending, or stooping, and walking, as well as telephone communication.
This position requires travel by car to patient's homes and local, out-of-town, or state seminars, conferences, or meetings. Plane travel may be required for longer distances at the discretion of the Administrator.
This position requires the ability to communicate well, both verbally and in writing in English.
EQUIPMENT OPERATION
The position requires the ability to utilize a PC or tablet, calculator, cell phone, multi-line telephone, and other related office equipment including paper documents.
COMPANY INFORMATION
Has access to patient medical records as needed to provide patient services.

Healthquest Home Health Care

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Policy: JD-016.4

QUALIFICATIONS
1. Education with an associate degree from an accredited school plus NBCOT certification.
2. Must: a. Be licensed in the state of Florida to assist in the practice occupational therapy pursuant to 468.209 F.S. b. Meet the occupational therapist education program requirements required in the Condition of Participation §484.115(g) if providing services to Medicare beneficiaries.
3. Must have completed the requirements to practice as an occupational therapy assistant in the state of Florida.
4. Ability to demonstrate self-confidence, and positive attitude, toward self and others and maintains commitment and enthusiasm to goal achievement.
5. Ability to develop and implement improvement in areas of their job and/or profession.
6. Ability to identify, and evaluate, personal strengths and weaknesses, of self and others.
7. Ability to objectively interact, guide or direct, without personal bias toward individuals.
8. Must have a current Basic Life Support (BLS) certification.
9. Must have completed a criminal background check.

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Policy: JD-016.5

JOB ACCEPTANCE STATEMENT:

I acknowledge receiving and reviewing the job description for the position of

_____.

I have read and understand the responsibilities of the position. I agree to perform the duties to the best of my ability.

I understand that my job description may change at any time, and I will receive a copy of the updated document.

Employee Name (Print)

Employee Signature Date

Supervisor Signature Date

Healthquest Home Health Care

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Acknowledgement of Employee Handbook

We are glad to have you as a member of our team. As a team member at Healthquest, Inc. you are an essential part of a team effort. We hope that you will find your position with the Company rewarding, challenging and productive. Every Employee has an important role in our operation, and we value the ability and experience you bring with you to the organization. You, and other Employees, are vital to the success. Our Employee Handbook provides guidance to our agency policies as follows.

Nature of Employment/Patient & Business Relations	Policy & Procedures Statement
Equal Employment Opportunity/ Non-Discrimination Policy	Corporate Compliance
Immigration Compliance and I-9 Form Compliance	Abuse & Neglect Policy
Introductory Period/Orientation Period	Non-Disclosure of Patient Healthcare Information/ HIPAA
Use and return of Company Property	Attendance & Punctuality Policy/Call out Policy
Complaint & Grievance & Policy Against Retaliation	PTO/Sick Day/Overtime/Holidays/Bereavement Leave/FLMA Leave of Absence
Conflict of Interest/ Standard of Business Ethics and Conduct	Jury Duty/Voting Time Off/Military Leave
Dress Code & Professional Image	Policy on Job Descriptions
Office Hours/On Call Hours & 24/7 Availability of an RN	Employment of relatives
Open Door Policy	Communication Methods (email, Tiger Connect Text, Bulletin Board)
Employee Classifications/Categories	Employee Health and Dental Coverage Eligibility and time frame to apply
Time recording/Time Sheet Submission/Mileage Reimbursement	Continuation of Health Coverage under COBRA
Expense Report and Receipts Submission	Safety in the Workplace/Non-Violence Workplace
Payroll/ Pay Periods/Payroll Deductions/Direct Deposit/Payroll Correction	PPE Availability and PPE for Safety and Infection Control Statement
Appropriate Conduct: ● General Work Rule/Field Practice Statement ● Discrimination & Harassment Policy ● Rules of Conduct/ Prohibited Conduct ● Sexual Harassment Policy ● Drug & Alcohol Policy /Drug free workplace/Drug Testing Policy ● Employee Responsibility/Reporting Misconduct Procedures ● Receipt of gifts/ No Borrowing Money from Patient's, Families, Co-Workers/Theft & Embezzlement	Emergency Plan/ Emergency Closings In-Services/Education Electronic Signature/ Password protection Information Management/Computer usage & Safety Termination of Employment/Voluntary resignation Workers Compensation /Reporting Procedure/Report of First Injury/ Approved Physician Panel Confidentiality and Protection of Protected Health Information
I acknowledge that I have received my personal copy of the Employee Handbook and understand that I am responsible to read and adhere to all of its contents. I also understand that if I do not understand something that I will refer to the Handbook to seek guidance, as well as going to my direct supervisor or the agency Administrator for further information or clarification of all policies.	

Employee Signature:_____ **Date:**_____

Agency Representative Signature:_____ **Date:**_____

Employee Copy

INDIVIDUAL STATEMENT REGARDING CONFLICT OF INTEREST

I have read and am fully familiar with the Agency's policy statement regarding conflict of interest. I am not presently involved in any transaction, investment, or other matter in which I would profit or gain directly or indirectly as a result of my membership on the Agency's Board of Directors or its committees, (if applicable), and/or my employment with the Agency. I will disclose all known relationships that may present a conflict of interest. Furthermore, I agree to immediately disclose any such interest or outside employment which may occur in accordance with the requirements of the policy and agree to abstain from any vote or action regarding the Agency's business that might result in any profit or gain, directly or indirectly for myself.

The following are conflicts of interest or potential conflicts of interest relating to my affiliation with the Agency.

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

_____ _____
Name (Please Print) Signature

_____
Date

INDIVIDUAL STATEMENT REGARDING CONFLICT OF INTEREST

I have read and am familiar with the Agency's policy statement regarding conflict of interest. I am not presently involved in any transaction, investment, or other matter in which I would profit or gain directly or indirectly as a result of my membership on the agency's Board or Directors of its committees, (if applicable), and/or my employment with the Agency. I will disclose all known relationships that may present a conflict of interest. Furthermore I agree to immediately disclose any such interest or outside employment which may occur in accordance with the requirements of the policy and agree to abstain from any vote or action regarding the agency's business that might result an any profit or gain, directly or indirectly

Acknowledgment of Confidentiality

The Health Insurance Portability and Accountability Act ensures the patient's right to privacy of Protected Health Information to be maintained at all times. Any information related to the care of patients through Healthquest INC will be held as confidential. All information, written or verbal will be disclosed only to appropriate health care personnel, appropriate staff, those with "a need to know basis," or to individuals that patient requests.

The following are conflicts of interest or potential conflicts of interest relating to my affiliation with the Agency.

_____

_____

_____

_____ _____

Name (Please Print) Signature

_____

Date

CONFIDENTIALITY OF PROTECTED HEALTH INFORMATION

It is both Agency's and the employee's responsibility to ensure that every patient's health information is protected at all times. By signing below, you are indicating the acknowledgement of HIPPA and understand that thorough orientation of the agency's policy regarding patient's Protected Health Information will be Provided to you upon hire.

I understand that I may be handling Protected Health Information. I further understand that there are specific guidelines associated for use and disclosure of Protected Health Information. The agency has sanctions and fines for all individuals falling to comply with HIPPA Rule and Regulations. I will protect all Electronics Records including passwords as outlined in the HIPPA manual.

Employee:_____ Date:_____

PROTECTION OF HEALTH INFORMATION

There are specific guidelines to ensure a patient's Protected Health Information is kept private. I understand that my employment with the agency involves handling Protected Health Information. I will ensure patient's records are protected by enforcing the following measures:

- Patient Protected Health Information will be transported in a protected travel chart when traveling.
- When transmitting and receiving a fax involving Protected Health Information, I will ensure that is conducted in a private area
- Patient Protected Health Information will be returned to the agency upon acknowledgement of the patient being discharged.

I pledge to make every effort to keep patient's Protected Health Information protected at all times.

Employee:_____ Date:_____

Corporate Compliance Policy

Acknowledgment of Receipt and Understanding

As you know, our Home Health Care Agency and our Staff members have always been committed to providing exceptional health care and upholding ethical conduct standards and legal compliance

Our policy formally and clearly states that there is a zero tolerance to any form of fraud or misconduct. This agency believes that every employee or agent plays a key and active role in maintaining its image and reputation.

I hereby acknowledge that I have apprised of and agree to comply with the Agency's Corporate Compliance Policy. I understand that in no way does this create an obligation or contract of employment and that I, as well as the Agency, have the right to end the employment relationship at any time

Employee Name (print)_____

Employee Signature_____

Date_____.

HIPAA CONFIDENTIALITY AGREEMENT

EMPLOYEE CONFIDENTIALITY AGREEMENT OF PATIENT HEALTH INFORMATION AND PERSONAL INFORMATION in accordance with HIPAA REGULATIONS

For good consideration and as an inducement for:

_____(employer) to employ _____(employee), the undersigned Employee hereby agrees not to directly or indirectly use, manipulate or copy compete any Protected Health Information (PHI), to include personal health information or personal contact information (address, phone, email address, etc.) with the business of the Agency and its successors and assigns during the period of employment. Misuse of PHI or personal contact information will result in termination and report with action to HIPAA federal agencies. Fines related to civil and criminal offences for gross misconduct with the above information are the direct responsibility of said employee.

The Employee acknowledges that the Agency shall or may in reliance of this agreement provide Employee access to trade secrets, customers and other confidential data and good will. Employee agrees to retain said information as confidential and not to use said information on his or her own behalf or disclose the same to any third party or for their own personal or monetary gain.

The Employee agrees to not copy and to return all such Agency supplied Information immediately upon termination of employment. Further employees agree not to solicit any of the customers or employees of the employer for any purpose for a period of two years after termination.

This agreement shall be binding upon and inure to the benefit of the parties, their successors, assigns, and personal representatives.

Signed this _____ day of _____ 20____

Agency_____

Signature_____

Employee Name_____

Employee Signature_____

FIELD EMPLOYEE STANDARDS AND PROCEDURES

This Agency requires adherence to the following Standards and Procedures:

1. All employees are expected to dress in a manner appropriate to the health care environment, or as directed by the patient/family. This includes personal hygiene, jewelry, hair and makeup.
2. **Please do not smoke in the presence of a patient.**
3. Always wear your ID Badge.
4. You are expected to arrive on time to all assignment that you have accepted. However, if an emergency or any situation should cause you to be five minutes late, or more or to be totally absent from the assignment you must notify the Agency immediately.
   PLEASE DO NOT CALL YOUR PATIENT DIRECTLY. You may call the Agency 24 hours a day if you need to cancel or reschedule your assignment. **A NO-CALL, NO-SHOW IS GROUNDS FOR TERMINATION!**
5. If you have any problem, incident or accident on the job, do not discuss it with the patient, but call the Agency immediately.
6. If the patient asks you to stay longer than your assignment or to leave earlier, you must call the Agency first, for approval.
7. Paraprofessional personnel (i.e. Aides) hereby acknowledge that they **WILL NOT, UNDER ANY CONDITIONS, DISPENSE OR ADMINISTER ANY MEDICATION.**
8. **UNDER NO CIRCUMSTANCES** are you to ask for, or accept any money from your patient, or take home property that belongs to the patient.
9. There shall not be any involvement with the patient's financial affairs (i.e. check writing).
10. You are expected to honor the confidentiality of any patient information which is obtained in the regular course of your employment.
11. No personal telephone calls should be made or received by you while on assignment.
12. Please do not discuss your pay or any other personal affairs with the patient/family.
13. As an employee of this Agency, you are not authorized to accept any direct employment that may be offered to you by your patient/family. If you are requested to do so, please have the patient contact us.
14. **It is imperative that all signed notes and documentation including Daily Log, be filled out properly and returned to the office as per your schedule.** If the patient/client is unable to sign your note, a family member or responsible party may sign.
15. During the course of employment, this Agency's proprietary materials (i.e. forms, medical records) will be used only in connection with employment and will not be disclosed to anyone without authorization from the Agency.

Employee Signature_____ Date_____

ELECTRONIC DOCUMENTATION AND SIGNATURE AUTHENTICITY AGREEMENT

I understand that Agency staff may use electronic signatures on all computer-generated documentation. An electronic signature will serve as authentication on patient record documents and other agency documents generated in the electronic system.

For the purpose of the computerized medical record and other documentation for agency purposes, I acknowledge my use of the Signature Passcode and my Login authentication password will serve as my legal signature. I further understand that the Administrator issues employee passwords and the Signature Passcode's are issued by the software application.

Signature Passcodes and passwords will be changed on an as needed basis if system security is breached. I understand that prior to exporting documentation to the agency server, I am required to review and authenticate, by use of electronic signature, my documentation on the field-based or office computer. (OASIS Comprehensive Assessments will not require electronic signature until required information is obtained, which may be up to five days after the corresponding MO date i.e.: MOO30, MOO32 etc.) I understand that: I cannot divulge my login password, Signature Passcode, I must exit the computerized application at the end of each working day or whenever the computer is not in my immediate possession, I must type in (rather than save) the login password that allows me access to the agency computer network, and my Signature Passcode. I must review all of my documentation online prior to submitting to the agency server.

_____ _____

Employee Signature Date

TB TARGETED MEDICAL QUESTIONNAIRE AND RISK FORM

_____
Employee Printed Name

1. Have you ever had a positive TB skin test or history of TB infection? _____
   If the answer is YES, please answer the following:
2. Have you ever had the BCG vaccine? _____
3. Do you have prolonged or recurrent fever? _____
4. Have you recently lost weight? _____
5. Do you have a chronic cough? _____
6. Do you cough up blood? _____
7. Do you have sweating at night? _____
8. Do you have any of the following risk factors?
   - _____ a. Silicosis (Lung Disease)
   - _____ b. Gastrectomy
   - _____ c. Intestinal Bypass
   - _____ d. Weight 10% or more below ideal body weight
   - _____ e. Chronic Renal Disease
   - _____ f. Diabetes Mellitus
   - _____ g. Prolonged high-dose corticosteroid therapy or other Immunosuppressive therapy
   - _____ h. Hematologic Disorder i.e. leukemia or lymphoma
   - _____ i. Exposure to HIV or AIDS
   - _____ j. Other malignancies

Baseline Individual TB Risk Assessment

Answer “Yes” or “No”. Employee should be considered at risk for TB if any of the following statements are marked “Yes”.

_____ Temporary or permanent residence of > 1 month in a country with a high TB rate (any country other than the U.S., Canada, Australia, New Zealand, and those in Northern or Western Europe)

_____ Current or planned immunosuppression, including HIV infection, organ transplant recipient, treatment with a TNF alpha antagonist, chronic steroids, or other immunosuppressive medication.

_____ Close contact with someone who has had infectious TB disease since the last TB test

_____ _____
Employee Signature Date

_____ _____
Reviewed by Signature Date

HEPATITIS VACCINE REQUIREMENT

I _____ acknowledge that I am at risk of exposure or have been unknowingly exposed to Hepatitis B as a result of my employment and acknowledge that the Agency will arrange for me to receive the Hepatitis vaccine at no cost to myself. It is my decision to:

☐ Request that I receive the Hepatitis vaccine

☐ Refuse the Hepatitis vaccine and HOLD HARMLESS THE AGENCY. I understand that by declining the vaccine I continue to be at risk of acquiring Hepatitis B, a serious disease. If, in the future, I continue to have occupational exposure to blood or other potentially infectious materials, and I want to be vaccinated with Hepatitis B vaccine, I can receive the vaccine series at no charge to me.

☐ Provide written proof of immunity (attach)

☐ Provide written proof of previous vaccination (attach)

☐ Provide written proof of medical contraindication (attach)

Signature: _____ Date: _____

Biomedical Waste Training Program Attendance & Acknowledgment Form

Agency Name: HEALTHQUEST, INC.
Agency Address: 1851 W. INDIANTOWN RD STE 101 JUPITER, FL 33458
Phone Number: 561-776-7771

Training Title: Biomedical Waste Handling & Disposal Training
Training Date: ____ / ____ / _____
Training Location: IN OFFICE
Trainer Name / Title: RUTH JARAMILLO/ADMINISTRATOR

Training Overview:
Safe handling, segregation, storage, transport, and disposal of biomedical waste in compliance with regulations including OSHA Bloodborne Pathogens Standard.

Employee Acknowledgment:
I acknowledge attendance of Biomedical Waste Training and agree to follow all safety procedures and policies.

Employee Name (Print)	Job Title	Signature	Date

STATEMENT OF GOOD HEALTH/FREE OF COMMUNICABLE DISEASE

Explanation and Instruction:

Our company policy requires all employees who have direct contact with patients in the home setting to submit a statement from an appropriately licensed health care professional, based on an exam performed within the last twelve months. The employee must show no apparent signs or symptoms of communicable disease.

Statement to be signed by a Physician or appropriately licensed Healthcare professional.

_____was examined by me on _____. He/She is in adequate health to perform home health duties and show no apparent signs or symptoms of communicable disease.

_____ _____
Professional Signature Date

_____

_____
Address

_____
Phone number

A PPD test was done in this office on_____ by_____.

and read on _____ by_____.

Rt. Forearm____ Lt. forearm____

Result: _____ If redness present, size/description _____

Manufacturer name:_____ Lot number:_____

Form **W-9**
(Rev. March 2024)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

Go to *www.irs.gov/FormW9* for instructions and the latest information.

Give form to the requester. Do not send to the IRS.

Before you begin. For guidance related to the purpose of Form W-9, see *Purpose of Form*, below.

Print or type. See ***Specific Instructions*** on page 3.

1 Name of entity/individual. An entry is required. (For a sole proprietor or disregarded entity, enter the owner's name on line 1, and enter the business/disregarded entity's name on line 2.)

2 Business name/disregarded entity name, if different from above.

3a Check the appropriate box for federal tax classification of the entity/individual whose name is entered on line 1. Check only **one** of the following seven boxes.

☐ Individual/sole proprietor ☐ C corporation ☐ S corporation ☐ Partnership ☐ Trust/estate

☐ LLC. Enter the tax classification (C = C corporation, S = S corporation, P = Partnership) . . . . _____

Note: Check the "LLC" box above and, in the entry space, enter the appropriate code (C, S, or P) for the tax classification of the LLC, unless it is a disregarded entity. A disregarded entity should instead check the appropriate box for the tax classification of its owner.

☐ Other (see instructions) _____

3b If on line 3a you checked "Partnership" or "Trust/estate," or checked "LLC" and entered "P" as its tax classification, and you are providing this form to a partnership, trust, or estate in which you have an ownership interest, check this box if you have any foreign partners, owners, or beneficiaries. See instructions . . . . . ☐

4 Exemptions (codes apply only to certain entities, not individuals; see instructions on page 3):

Exempt payee code (if any) _____

Exemption from Foreign Account Tax Compliance Act (FATCA) reporting code (if any) _____

(Applies to accounts maintained outside the United States.)

5 Address (number, street, and apt. or suite no.). See instructions.

Requester's name and address (optional)

6 City, state, and ZIP code

7 List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on line 1 to avoid backup withholding. For individuals, this is generally your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the instructions for Part I, later. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN*, later.

Note: If the account is in more than one name, see the instructions for line 1. See also *What Name and Number To Give the Requester* for guidelines on whose number to enter.

Social security number

☐☐☐ – ☐☐ – ☐☐☐☐

or

Employer identification number

☐☐ – ☐☐☐☐☐☐☐

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me); and
2. I am not subject to backup withholding because (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding; and
3. I am a U.S. citizen or other U.S. person (defined below); and
4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and, generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions for Part II, later.

Sign Here **Signature of U.S. person** **Date**

General Instructions

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

Future developments. For the latest information about developments related to Form W-9 and its instructions, such as legislation enacted after they were published, go to *www.irs.gov/FormW9*.

What's New

Line 3a has been modified to clarify how a disregarded entity completes this line. An LLC that is a disregarded entity should check the appropriate box for the tax classification of its owner. Otherwise, it should check the "LLC" box and enter its appropriate tax classification.

New line 3b has been added to this form. A flow-through entity is required to complete this line to indicate that it has direct or indirect foreign partners, owners, or beneficiaries when it provides the Form W-9 to another flow-through entity in which it has an ownership interest. This change is intended to provide a flow-through entity with information regarding the status of its indirect foreign partners, owners, or beneficiaries, so that it can satisfy any applicable reporting requirements. For example, a partnership that has any indirect foreign partners may be required to complete Schedules K-2 and K-3. See the Partnership Instructions for Schedules K-2 and K-3 (Form 1065).

Purpose of Form

An individual or entity (Form W-9 requester) who is required to file an information return with the IRS is giving you this form because they

must obtain your correct taxpayer identification number (TIN), which may be your social security number (SSN), individual taxpayer identification number (ITIN), adoption taxpayer identification number (ATIN), or employer identification number (EIN), to report on an information return the amount paid to you, or other amount reportable on an information return. Examples of information returns include, but are not limited to, the following.

• Form 1099-INT (interest earned or paid).

• Form 1099-DIV (dividends, including those from stocks or mutual funds).

• Form 1099-MISC (various types of income, prizes, awards, or gross proceeds).

• Form 1099-NEC (nonemployee compensation).

• Form 1099-B (stock or mutual fund sales and certain other transactions by brokers).

• Form 1099-S (proceeds from real estate transactions).

• Form 1099-K (merchant card and third-party network transactions).

• Form 1098 (home mortgage interest), 1098-E (student loan interest), and 1098-T (tuition).

• Form 1099-C (canceled debt).

• Form 1099-A (acquisition or abandonment of secured property).

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN.

Caution: If you don't return Form W-9 to the requester with a TIN, you might be subject to backup withholding. See *What is backup withholding*, later.

By signing the filled-out form, you:

1. Certify that the TIN you are giving is correct (or you are waiting for a number to be issued);

2. Certify that you are not subject to backup withholding; or

3. Claim exemption from backup withholding if you are a U.S. exempt payee; and

4. Certify to your non-foreign status for purposes of withholding under chapter 3 or 4 of the Code (if applicable); and

5. Certify that FATCA code(s) entered on this form (if any) indicating that you are exempt from the FATCA reporting is correct. See *What Is FATCA Reporting*, later, for further information.

Note: If you are a U.S. person and a requester gives you a form other than Form W-9 to request your TIN, you must use the requester's form if it is substantially similar to this Form W-9.

Definition of a U.S. person. For federal tax purposes, you are considered a U.S. person if you are:

• An individual who is a U.S. citizen or U.S. resident alien;

• A partnership, corporation, company, or association created or organized in the United States or under the laws of the United States;

• An estate (other than a foreign estate); or

• A domestic trust (as defined in Regulations section 301.7701-7).

Establishing U.S. status for purposes of chapter 3 and chapter 4 withholding. Payments made to foreign persons, including certain distributions, allocations of income, or transfers of sales proceeds, may be subject to withholding under chapter 3 or chapter 4 of the Code (sections 1441–1474). Under those rules, if a Form W-9 or other certification of non-foreign status has not been received, a withholding agent, transferee, or partnership (payor) generally applies presumption rules that may require the payor to withhold applicable tax from the recipient, owner, transferor, or partner (payee). See Pub. 515, Withholding of Tax on Nonresident Aliens and Foreign Entities.

The following persons must provide Form W-9 to the payor for purposes of establishing its non-foreign status.

• In the case of a disregarded entity with a U.S. owner, the U.S. owner of the disregarded entity and not the disregarded entity.

• In the case of a grantor trust with a U.S. grantor or other U.S. owner, generally, the U.S. grantor or other U.S. owner of the grantor trust and not the grantor trust.

• In the case of a U.S. trust (other than a grantor trust), the U.S. trust and not the beneficiaries of the trust.

See Pub. 515 for more information on providing a Form W-9 or a certification of non-foreign status to avoid withholding.

Foreign person. If you are a foreign person or the U.S. branch of a foreign bank that has elected to be treated as a U.S. person (under Regulations section 1.1441-1(b)(2)(iv) or other applicable section for chapter 3 or 4 purposes), do not use Form W-9. Instead, use the appropriate Form W-8 or Form 8233 (see Pub. 515). If you are a qualified foreign pension fund under Regulations section 1.897(l)-1(d), or a partnership that is wholly owned by qualified foreign pension funds, that is treated as a non-foreign person for purposes of section 1445 withholding, do not use Form W-9. Instead, use Form W-8EXP (or other certification of non-foreign status).

Nonresident alien who becomes a resident alien. Generally, only a nonresident alien individual may use the terms of a tax treaty to reduce or eliminate U.S. tax on certain types of income. However, most tax treaties contain a provision known as a saving clause. Exceptions specified in the saving clause may permit an exemption from tax to continue for certain types of income even after the payee has otherwise become a U.S. resident alien for tax purposes.

If you are a U.S. resident alien who is relying on an exception contained in the saving clause of a tax treaty to claim an exemption from U.S. tax on certain types of income, you must attach a statement to Form W-9 that specifies the following five items.

1. The treaty country. Generally, this must be the same treaty under which you claimed exemption from tax as a nonresident alien.

2. The treaty article addressing the income.

3. The article number (or location) in the tax treaty that contains the saving clause and its exceptions.

4. The type and amount of income that qualifies for the exemption from tax.

5. Sufficient facts to justify the exemption from tax under the terms of the treaty article.

Example. Article 20 of the U.S.-China income tax treaty allows an exemption from tax for scholarship income received by a Chinese student temporarily present in the United States. Under U.S. law, this student will become a resident alien for tax purposes if their stay in the United States exceeds 5 calendar years. However, paragraph 2 of the first Protocol to the U.S.-China treaty (dated April 30, 1984) allows the provisions of Article 20 to continue to apply even after the Chinese student becomes a resident alien of the United States. A Chinese student who qualifies for this exception (under paragraph 2 of the first Protocol) and is relying on this exception to claim an exemption from tax on their scholarship or fellowship income would attach to Form W-9 a statement that includes the information described above to support that exemption.

If you are a nonresident alien or a foreign entity, give the requester the appropriate completed Form W-8 or Form 8233.

Backup Withholding

What is backup withholding? Persons making certain payments to you must under certain conditions withhold and pay to the IRS 24% of such payments. This is called "backup withholding." Payments that may be subject to backup withholding include, but are not limited to, interest, tax-exempt interest, dividends, broker and barter exchange transactions, rents, royalties, nonemployee pay, payments made in settlement of payment card and third-party network transactions, and certain payments from fishing boat operators. Real estate transactions are not subject to backup withholding.

You will not be subject to backup withholding on payments you receive if you give the requester your correct TIN, make the proper certifications, and report all your taxable interest and dividends on your tax return.

Payments you receive will be subject to backup withholding if:

1. You do not furnish your TIN to the requester;

2. You do not certify your TIN when required (see the instructions for Part II for details);

3. The IRS tells the requester that you furnished an incorrect TIN;

4. The IRS tells you that you are subject to backup withholding because you did not report all your interest and dividends on your tax return (for reportable interest and dividends only); or

5. You do not certify to the requester that you are not subject to backup withholding, as described in item 4 under "*By signing the filled-out form*" above (for reportable interest and dividend accounts opened after 1983 only).

Certain payees and payments are exempt from backup withholding. See *Exempt payee code*, later, and the separate Instructions for the Requester of Form W-9 for more information.

See also *Establishing U.S. status for purposes of chapter 3 and chapter 4 withholding*, earlier.

What Is FATCA Reporting?

The Foreign Account Tax Compliance Act (FATCA) requires a participating foreign financial institution to report all U.S. account holders that are specified U.S. persons. Certain payees are exempt from FATCA reporting. See *Exemption from FATCA reporting code*, later, and the Instructions for the Requester of Form W-9 for more information.

Updating Your Information

You must provide updated information to any person to whom you claimed to be an exempt payee if you are no longer an exempt payee and anticipate receiving reportable payments in the future from this person. For example, you may need to provide updated information if you are a C corporation that elects to be an S corporation, or if you are no longer tax exempt. In addition, you must furnish a new Form W-9 if the name or TIN changes for the account, for example, if the grantor of a grantor trust dies.

Penalties

Failure to furnish TIN. If you fail to furnish your correct TIN to a requester, you are subject to a penalty of $50 for each such failure unless your failure is due to reasonable cause and not to willful neglect.

Civil penalty for false information with respect to withholding. If you make a false statement with no reasonable basis that results in no backup withholding, you are subject to a $500 penalty.

Criminal penalty for falsifying information. Willfully falsifying certifications or affirmations may subject you to criminal penalties including fines and/or imprisonment.

Misuse of TINs. If the requester discloses or uses TINs in violation of federal law, the requester may be subject to civil and criminal penalties.

Specific Instructions

Line 1

You must enter one of the following on this line; **do not** leave this line blank. The name should match the name on your tax return.

If this Form W-9 is for a joint account (other than an account maintained by a foreign financial institution (FFI)), list first, and then circle, the name of the person or entity whose number you entered in Part I of Form W-9. If you are providing Form W-9 to an FFI to document a joint account, each holder of the account that is a U.S. person must provide a Form W-9.

• **Individual.** Generally, enter the name shown on your tax return. If you have changed your last name without informing the Social Security Administration (SSA) of the name change, enter your first name, the last name as shown on your social security card, and your new last name.

Note for ITIN applicant: Enter your individual name as it was entered on your Form W-7 application, line 1a. This should also be the same as the name you entered on the Form 1040 you filed with your application.

• **Sole proprietor.** Enter your individual name as shown on your Form 1040 on line 1. Enter your business, trade, or "doing business as" (DBA) name on line 2.

• **Partnership, C corporation, S corporation, or LLC, other than a disregarded entity.** Enter the entity's name as shown on the entity's tax return on line 1 and any business, trade, or DBA name on line 2.

• **Other entities.** Enter your name as shown on required U.S. federal tax documents on line 1. This name should match the name shown on the charter or other legal document creating the entity. Enter any business, trade, or DBA name on line 2.

• **Disregarded entity.** In general, a business entity that has a single owner, including an LLC, and is not a corporation, is disregarded as an entity separate from its owner (a disregarded entity). See Regulations section 301.7701-2(c)(2). A disregarded entity should check the appropriate box for the tax classification of its owner. Enter the owner's name on line 1. The name of the owner entered on line 1 should never be a disregarded entity. The name on line 1 should be the name shown on the income tax return on which the income should be reported. For example, if a foreign LLC that is treated as a disregarded entity for U.S. federal tax purposes has a single owner that is a U.S. person, the U.S. owner's name is required to be provided on line 1. If the direct owner of the entity is also a disregarded entity, enter the first owner that is not disregarded for federal tax purposes. Enter the disregarded entity's name on line 2. If the owner of the disregarded entity is a foreign person, the owner must complete an appropriate Form W-8 instead of a Form W-9. This is the case even if the foreign person has a U.S. TIN.

Line 2

If you have a business name, trade name, DBA name, or disregarded entity name, enter it on line 2.

Line 3a

Check the appropriate box on line 3a for the U.S. federal tax classification of the person whose name is entered on line 1. Check only one box on line 3a.

IF the entity/individual on line 1 is a(n) . . .	THEN check the box for . . .
• Corporation	Corporation.
• Individual or • Sole proprietorship	Individual/sole proprietor.
• LLC classified as a partnership for U.S. federal tax purposes or • LLC that has filed Form 8832 or 2553 electing to be taxed as a corporation	Limited liability company and enter the appropriate tax classification: P = Partnership, C = C corporation, or S = S corporation.
• Partnership	Partnership.
• Trust/estate	Trust/estate.

Line 3b

Check this box if you are a partnership (including an LLC classified as a partnership for U.S. federal tax purposes), trust, or estate that has any foreign partners, owners, or beneficiaries, and you are providing this form to a partnership, trust, or estate, in which you have an ownership interest. You must check the box on line 3b if you receive a Form W-8 (or documentary evidence) from any partner, owner, or beneficiary establishing foreign status or if you receive a Form W-9 from any partner, owner, or beneficiary that has checked the box on line 3b.

Note: A partnership that provides a Form W-9 and checks box 3b may be required to complete Schedules K-2 and K-3 (Form 1065). For more information, see the Partnership Instructions for Schedules K-2 and K-3 (Form 1065).

If you are required to complete line 3b but fail to do so, you may not receive the information necessary to file a correct information return with the IRS or furnish a correct payee statement to your partners or beneficiaries. See, for example, sections 6698, 6722, and 6724 for penalties that may apply.

Line 4 Exemptions

If you are exempt from backup withholding and/or FATCA reporting, enter in the appropriate space on line 4 any code(s) that may apply to you.

Exempt payee code.

• Generally, individuals (including sole proprietors) are not exempt from backup withholding.

• Except as provided below, corporations are exempt from backup withholding for certain payments, including interest and dividends.

• Corporations are not exempt from backup withholding for payments made in settlement of payment card or third-party network transactions.

• Corporations are not exempt from backup withholding with respect to attorneys' fees or gross proceeds paid to attorneys, and corporations that provide medical or health care services are not exempt with respect to payments reportable on Form 1099-MISC.

The following codes identify payees that are exempt from backup withholding. Enter the appropriate code in the space on line 4.

1—An organization exempt from tax under section 501(a), any IRA, or a custodial account under section 403(b)(7) if the account satisfies the requirements of section 401(f)(2).

2—The United States or any of its agencies or instrumentalities.

3—A state, the District of Columbia, a U.S. commonwealth or territory, or any of their political subdivisions or instrumentalities.

4—A foreign government or any of its political subdivisions, agencies, or instrumentalities.

5—A corporation.

6—A dealer in securities or commodities required to register in the United States, the District of Columbia, or a U.S. commonwealth or territory.

7—A futures commission merchant registered with the Commodity Futures Trading Commission.

8—A real estate investment trust.

9—An entity registered at all times during the tax year under the Investment Company Act of 1940.

10—A common trust fund operated by a bank under section 584(a).

11—A financial institution as defined under section 581.

12—A middleman known in the investment community as a nominee or custodian.

13—A trust exempt from tax under section 664 or described in section 4947.

The following chart shows types of payments that may be exempt from backup withholding. The chart applies to the exempt payees listed above, 1 through 13.

IF the payment is for . . .	THEN the payment is exempt for . . .
• Interest and dividend payments	All exempt payees except for 7.
• Broker transactions	Exempt payees 1 through 4 and 6 through 11 and all C corporations. S corporations must not enter an exempt payee code because they are exempt only for sales of noncovered securities acquired prior to 2012.
• Barter exchange transactions and patronage dividends	Exempt payees 1 through 4.
• Payments over $600 required to be reported and direct sales over $5,000[1]	Generally, exempt payees 1 through 5.[2]
• Payments made in settlement of payment card or third-party network transactions	Exempt payees 1 through 4.

[1] See Form 1099-MISC, Miscellaneous Information, and its instructions.

[2] However, the following payments made to a corporation and reportable on Form 1099-MISC are not exempt from backup withholding: medical and health care payments, attorneys' fees, gross proceeds paid to an attorney reportable under section 6045(f), and payments for services paid by a federal executive agency.

Exemption from FATCA reporting code. The following codes identify payees that are exempt from reporting under FATCA. These codes apply to persons submitting this form for accounts maintained outside of the United States by certain foreign financial institutions. Therefore, if you are only submitting this form for an account you hold in the United States, you may leave this field blank. Consult with the person requesting this form if you are uncertain if the financial institution is subject to these requirements. A requester may indicate that a code is not required by providing you with a Form W-9 with "Not Applicable" (or any similar indication) entered on the line for a FATCA exemption code.

A—An organization exempt from tax under section 501(a) or any individual retirement plan as defined in section 7701(a)(37).

B—The United States or any of its agencies or instrumentalities.

C—A state, the District of Columbia, a U.S. commonwealth or territory, or any of their political subdivisions or instrumentalities.

D—A corporation the stock of which is regularly traded on one or more established securities markets, as described in Regulations section 1.1472-1(c)(1)(i).

E—A corporation that is a member of the same expanded affiliated group as a corporation described in Regulations section 1.1472-1(c)(1)(i).

F—A dealer in securities, commodities, or derivative financial instruments (including notional principal contracts, futures, forwards, and options) that is registered as such under the laws of the United States or any state.

G—A real estate investment trust.

H—A regulated investment company as defined in section 851 or an entity registered at all times during the tax year under the Investment Company Act of 1940.

I—A common trust fund as defined in section 584(a).

J—A bank as defined in section 581.

K—A broker.

L—A trust exempt from tax under section 664 or described in section 4947(a)(1).

M—A tax-exempt trust under a section 403(b) plan or section 457(g) plan.

Note: You may wish to consult with the financial institution requesting this form to determine whether the FATCA code and/or exempt payee code should be completed.

Line 5

Enter your address (number, street, and apartment or suite number). This is where the requester of this Form W-9 will mail your information returns. If this address differs from the one the requester already has on file, enter "NEW" at the top. If a new address is provided, there is still a chance the old address will be used until the payor changes your address in their records.

Line 6

Enter your city, state, and ZIP code.

Part I. Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. If you are a resident alien and you do not have, and are not eligible to get, an SSN, your TIN is your IRS ITIN. Enter it in the entry space for the Social security number. If you do not have an ITIN, see *How to get a TIN* below.

If you are a sole proprietor and you have an EIN, you may enter either your SSN or EIN.

If you are a single-member LLC that is disregarded as an entity separate from its owner, enter the owner's SSN (or EIN, if the owner has one). If the LLC is classified as a corporation or partnership, enter the entity's EIN.

Note: See *What Name and Number To Give the Requester*, later, for further clarification of name and TIN combinations.

How to get a TIN. If you do not have a TIN, apply for one immediately. To apply for an SSN, get Form SS-5, Application for a Social Security Card, from your local SSA office or get this form online at *www.SSA.gov*. You may also get this form by calling 800-772-1213. Use Form W-7, Application for IRS Individual Taxpayer Identification Number, to apply for an ITIN, or Form SS-4, Application for Employer Identification Number, to apply for an EIN. You can apply for an EIN online by accessing the IRS website at *www.irs.gov/EIN*. Go to *www.irs.gov/Forms* to view, download, or print Form W-7 and/or Form SS-4. Or, you can go to *www.irs.gov/OrderForms* to place an order and have Form W-7 and/or Form SS-4 mailed to you within 15 business days.

If you are asked to complete Form W-9 but do not have a TIN, apply for a TIN and enter "Applied For" in the space for the TIN, sign and date the form, and give it to the requester. For interest and dividend payments, and certain payments made with respect to readily tradable instruments, you will generally have 60 days to get a TIN and give it to the requester before you are subject to backup withholding on payments. The 60-day rule does not apply to other types of payments. You will be subject to backup withholding on all such payments until you provide your TIN to the requester.

Note: Entering "Applied For" means that you have already applied for a TIN or that you intend to apply for one soon. See also *Establishing U.S. status for purposes of chapter 3 and chapter 4 withholding*, earlier, for when you may instead be subject to withholding under chapter 3 or 4 of the Code.

Caution: A disregarded U.S. entity that has a foreign owner must use the appropriate Form W-8.

Part II. Certification

To establish to the withholding agent that you are a U.S. person, or resident alien, sign Form W-9. You may be requested to sign by the withholding agent even if item 1, 4, or 5 below indicates otherwise.

For a joint account, only the person whose TIN is shown in Part I should sign (when required). In the case of a disregarded entity, the person identified on line 1 must sign. Exempt payees, see *Exempt payee code*, earlier.

Signature requirements. Complete the certification as indicated in items 1 through 5 below.

1. Interest, dividend, and barter exchange accounts opened before 1984 and broker accounts considered active during 1983. You must give your correct TIN, but you do not have to sign the certification.

2. Interest, dividend, broker, and barter exchange accounts opened after 1983 and broker accounts considered inactive during 1983. You must sign the certification or backup withholding will apply. If you are subject to backup withholding and you are merely providing your correct TIN to the requester, you must cross out item 2 in the certification before signing the form.

3. Real estate transactions. You must sign the certification. You may cross out item 2 of the certification.

4. Other payments. You must give your correct TIN, but you do not have to sign the certification unless you have been notified that you have previously given an incorrect TIN. "Other payments" include payments made in the course of the requester's trade or business for rents, royalties, goods (other than bills for merchandise), medical and health care services (including payments to corporations), payments to a nonemployee for services, payments made in settlement of payment card and third-party network transactions, payments to certain fishing boat crew members and fishermen, and gross proceeds paid to attorneys (including payments to corporations).

5. Mortgage interest paid by you, acquisition or abandonment of secured property, cancellation of debt, qualified tuition program payments (under section 529), ABLE accounts (under section 529A), IRA, Coverdell ESA, Archer MSA or HSA contributions or distributions, and pension distributions. You must give your correct TIN, but you do not have to sign the certification.

What Name and Number To Give the Requester

For this type of account:	Give name and SSN of:
1. Individual	The individual
2. Two or more individuals (joint account) other than an account maintained by an FFI	The actual owner of the account or, if combined funds, the first individual on the account[1]
3. Two or more U.S. persons (joint account maintained by an FFI)	Each holder of the account
4. Custodial account of a minor (Uniform Gift to Minors Act)	The minor[2]
5. a. The usual revocable savings trust (grantor is also trustee)	The grantor-trustee[1]
b. So-called trust account that is not a legal or valid trust under state law	The actual owner[1]
6. Sole proprietorship or disregarded entity owned by an individual	The owner[3]
7. Grantor trust filing under Optional Filing Method 1 (see Regulations section 1.671-4(b)(2)(i)(A))**	The grantor*
8. Disregarded entity not owned by an individual	The owner
9. A valid trust, estate, or pension trust	Legal entity[4]
10. Corporation or LLC electing corporate status on Form 8832 or Form 2553	The corporation
11. Association, club, religious, charitable, educational, or other tax-exempt organization	The organization
12. Partnership or multi-member LLC	The partnership
13. A broker or registered nominee	The broker or nominee
14. Account with the Department of Agriculture in the name of a public entity (such as a state or local government, school district, or prison) that receives agricultural program payments	The public entity
15. Grantor trust filing Form 1041 or under the Optional Filing Method 2, requiring Form 1099 (see Regulations section 1.671-4(b)(2)(i)(B))**	The trust

[1] List first and circle the name of the person whose number you furnish. If only one person on a joint account has an SSN, that person's number must be furnished.

[2] Circle the minor's name and furnish the minor's SSN.

[3] You must show your individual name on line 1, and enter your business or DBA name, if any, on line 2. You may use either your SSN or EIN (if you have one), but the IRS encourages you to use your SSN.

[4] List first and circle the name of the trust, estate, or pension trust. (Do not furnish the TIN of the personal representative or trustee unless the legal entity itself is not designated in the account title.)

* **Note:** The grantor must also provide a Form W-9 to the trustee of the trust.

** For more information on optional filing methods for grantor trusts, see the Instructions for Form 1041.

Note: If no name is circled when more than one name is listed, the number will be considered to be that of the first name listed.

Secure Your Tax Records From Identity Theft

Identity theft occurs when someone uses your personal information, such as your name, SSN, or other identifying information, without your permission to commit fraud or other crimes. An identity thief may use your SSN to get a job or may file a tax return using your SSN to receive a refund.

To reduce your risk:

- Protect your SSN,
- Ensure your employer is protecting your SSN, and
- Be careful when choosing a tax return preparer.

If your tax records are affected by identity theft and you receive a notice from the IRS, respond right away to the name and phone number printed on the IRS notice or letter.

If your tax records are not currently affected by identity theft but you think you are at risk due to a lost or stolen purse or wallet, questionable credit card activity, or a questionable credit report, contact the IRS Identity Theft Hotline at 800-908-4490 or submit Form 14039.

For more information, see Pub. 5027, Identity Theft Information for Taxpayers.

Victims of identity theft who are experiencing economic harm or a systemic problem, or are seeking help in resolving tax problems that have not been resolved through normal channels, may be eligible for Taxpayer Advocate Service (TAS) assistance. You can reach TAS by calling the TAS toll-free case intake line at 877-777-4778 or TTY/TDD 800-829-4059.

Protect yourself from suspicious emails or phishing schemes. Phishing is the creation and use of email and websites designed to mimic legitimate business emails and websites. The most common act is sending an email to a user falsely claiming to be an established legitimate enterprise in an attempt to scam the user into surrendering private information that will be used for identity theft.

The IRS does not initiate contacts with taxpayers via emails. Also, the IRS does not request personal detailed information through email or ask taxpayers for the PIN numbers, passwords, or similar secret access information for their credit card, bank, or other financial accounts.

If you receive an unsolicited email claiming to be from the IRS, forward this message to *phishing@irs.gov*. You may also report misuse of the IRS name, logo, or other IRS property to the Treasury Inspector General for Tax Administration (TIGTA) at 800-366-4484. You can forward suspicious emails to the Federal Trade Commission at *spam@uce.gov* or report them at *www.ftc.gov/complaint*. You can contact the FTC at *www.ftc.gov/idtheft* or 877-IDTHEFT (877-438-4338). If you have been the victim of identity theft, see *www.IdentityTheft.gov* and Pub. 5027.

Go to *www.irs.gov/IdentityTheft* to learn more about identity theft and how to reduce your risk.

Privacy Act Notice

Section 6109 of the Internal Revenue Code requires you to provide your correct TIN to persons (including federal agencies) who are required to file information returns with the IRS to report interest, dividends, or certain other income paid to you; mortgage interest you paid; the acquisition or abandonment of secured property; the cancellation of debt; or contributions you made to an IRA, Archer MSA, or HSA. The person collecting this form uses the information on the form to file information returns with the IRS, reporting the above information. Routine uses of this information include giving it to the Department of Justice for civil and criminal litigation and to cities, states, the District of Columbia, and U.S. commonwealths and territories for use in administering their laws. The information may also be disclosed to other countries under a treaty, to federal and state agencies to enforce civil and criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism. You must provide your TIN whether or not you are required to file a tax return. Under section 3406, payors must generally withhold a percentage of taxable interest, dividends, and certain other payments to a payee who does not give a TIN to the payor. Certain penalties may also apply for providing false or fraudulent information.

Employment Eligibility Verification

Department of Homeland Security

U.S. Citizenship and Immigration Services

USCIS Form I-9

OMB No.1615-0047

Expires 05/31/2027

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

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

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

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

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

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

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

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

- ☐ 1. A citizen of the United States
- ☐ 2. A noncitizen national of the United States (See Instructions.)
- ☐ 3. A lawful permanent resident (Enter USCIS or A-Number.) _____
- ☐ 4. An alien authorized to work until (exp. date, if any) _____

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

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

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

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

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

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

Additional Information

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

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

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

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

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

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

LISTS OF ACCEPTABLE DOCUMENTS

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

LIST A Documents that Establish Both Identity and Employment Authorization	OR	LIST B Documents that Establish Identity	AND	LIST C Documents that Establish Employment Authorization
1. U.S. Passport or U.S. Passport Card		**1.** Driver's license or ID card issued by a State or outlying possession of the United States provided it contains a photograph or information such as name, date of birth, sex, 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, sex, height, eye color, and address		
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		**2.** Certification of report of birth issued by the Department of State (Forms DS-1350, FS-545, FS-240)
4. Employment Authorization Document that contains a photograph (Form I-766)		**4.** Voter's registration card		**3.** Original or certified copy of birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal
5. For an individual temporarily authorized to work for a specific employer because of his or her status or parole: **a.** Foreign passport; and **b.** Form I-94 or Form I-94A that has the following: **(1)** The same name as the passport; and **(2)** An endorsement of the individual's status or parole as long as that period of endorsement has not yet expired and the proposed employment is not in conflict with any restrictions or limitations identified on the form.		**5.** U.S. Military card or draft record		**4.** Native American tribal document
		6. Military dependent's ID card		**5.** U.S. Citizen ID Card (Form I-197)
		7. U.S. Coast Guard Merchant Mariner Card		**6.** Identification Card for Use of Resident Citizen in the United States (Form I-179)
		8. Native American tribal document		**7.** Employment authorization document issued by the Department of Homeland Security For examples, see **Section 7** and **Section 13** of the M-274 on **uscis.gov/i-9-central**. The Form I-766, Employment Authorization Document, is a List A, **Item Number 4.** document, not a List C document.
		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		

Acceptable Receipts

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

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

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

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

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

USCIS
Form I-9
Supplement A
OMB No. 1615-0047
Expires 05/31/2027

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

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

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

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

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

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

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

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

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

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

Supplement B,
Reverification and Rehire (formerly Section 3)

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

USCIS
Form I-9
Supplement B
OMB No. 1615-0047
Expires 05/31/2027

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

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

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

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

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

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

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

Additional Information (Initial and date each notation.)

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

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

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

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

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

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

Additional Information (Initial and date each notation.)

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

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

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

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

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

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

Additional Information (Initial and date each notation.)

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