

EMPLOYEE EMERGENCY CONTACT INFORMATION

Date Last Updated: _____

Personal Information	
First Name	
Middle Name	
Last Name	
Nickname	
Gender	
Place of Birth (country / region)	
Home Address	
District / County	
Home Phone	
Cell Phone	
Email Address	
Birthday (MM/DD/YYYY)	
Government ID or SSN	
Driver's License Number or State ID Number	
Medical Information	
Doctor's Name	
Address	
Phone Number	
Blood Type	
Medical Conditions	
Allergies	
Current Medications	
Emergency Information	
Emergency Contact's Name	
Relationship	
Address	
Phone Number(s)	



DIRECT DEPOSIT AUTHORIZATION

BSM Wall Systems, Inc prefers to pay by the direct deposit system.

The direct deposit authorization form needs to be completed and returned to the Payroll Department ***prior to your first day on the job.*** Please note if you do not have an account, you will need to acquire one on your own. You must provide a VOIDED CHECK. **Note: a deposit slip is not acceptable!**

You must list a valid email address in order to receive your pay stubs.

Paper checks will not be delivered to your jobsite! They are available for pick-up on your scheduled pay day at the main office located at 616 N Rogers Rd., Olathe, KS 66062. If they are not picked up by 5:00PM on pay day, they will be mailed the next business day.

I (We) hereby authorize BSM Wall Systems, Inc. (“Company”) to electronically credit my (our) account (and, if necessary, to electronically debit my (our) account to correct erroneous credits) as follows:

Bank Name:		Checking <input type="checkbox"/>	Savings <input type="checkbox"/>
Name on Account:			
Routing # (9 Digits):			
Account #:			

I, (We) understand that this authorization will remain in full force and effect until I (we) no longer work for the company OR I (we) have provided the company with an update form and another voided check for a different account and/or new banking institution. I (we) understand that BSM Wall Systems, Inc. requires at least 10business days prior notice in order to cancel this authorization.

Printed Name(s) _____

Email Address _____

Signature(s) _____



DIRECT DEPOSIT AUTHORIZATION

BSM Wall Systems, Inc prefiere pagar por el sistema de depósito directo.

El formulario de autorización de depósito directo debe completarse y devolverse al Departamento de Nómina antes de su primer día en el trabajo. Tenga en cuenta que si no tiene una cuenta, tendrá que adquirir una por su cuenta. Debe proporcionar un CHECK VOIDED.

Nota: ¡un resguardo de depósito no es aceptable!

Debe enumerar una dirección de correo electrónico válida para recibir sus talones de pago. ¡Los cheques en papel no se entregarán en su sitio de trabajo! Están disponibles para su recogida en su día de pago programado en la oficina principal ubicada en 616 N Rogers Rd., Olathe, KS 66062. Si no son recogidos antes de las 5:00PM el día de pago, se enviarán por correo el siguiente día hábil.

Yo (Nosotros) autorizo a BSM Wall Systems, Inc. ("Empresa") a acreditar electrónicamente mi (nuestra) cuenta (y, si es necesario, a debitar electrónicamente mi (nuestra) cuenta para corregir créditos erróneos) de la siguiente manera:

Nombre del banco:	Checking <input type="checkbox"/> Savings <input type="checkbox"/>
Nombre en la cuenta:	
Enrutamiento # (9 Digitos):	
Cuenta #:	

Yo, (Nosotros) entendemos que esta autorización permanecerá en pleno vigor y efecto hasta que yo (nosotros) ya no trabaje para el empresa O yo (nosotros) hemos proporcionado a la empresa un formulario de actualización y otro cheque anulado para un cuenta y/o nueva institución bancaria. Yo (entendemos) que BSM Wall Systems, Inc. requiere al menos 10 días hábiles de antelación para cancelar esta autorización.

Nombre(s) impreso(s): _____

Dirección de correo electrónico: _____

Firma(s): _____



June 10, 2016

Dear BSM Wall Systems, Inc. Employee:

On March 7, 2016, the IRS issued guidance to enable taxpayers, including BSM Wall Systems, Inc., the opportunity to determine if any of the company's new hires meet certain qualifications. If it is determined the company hired qualifying individuals, the company would receive a one time tax credit. As part of the process to determine if Safe Haven would qualify, we respectfully request you complete the attached IRS Form 8850, Pre-Screening Notice and Certification Request for the Work Opportunity Credit, and U.S. Department of Labor Form 9061, Individual Characteristics Form, to help verify if we qualifying for the hiring credit.

Let me state how you complete the two attached forms will have no bearing on your employment status with the company. The IRS has implemented the Work Opportunity Tax Credit program to encourage employers to hire individuals that may be a disabled Veteran, Veteran receiving SNAP, a qualified ex-felon, qualified food stamp recipient, qualified Supplemental Security Income recipient, or a Temporary Assistance to Need Families (TANF). The company is simply wanting to participate in a program offered by IRS to earn tax credits.

Upon completion of each of the forms, please return the signed forms to Tori in Payroll. Internal Revenue Code Section 51(d)(13) permits a prospective employer to request the applicant to complete this form and give it to the prospective employer. The information will be used by the employer to complete the employer's federal tax return. As aforementioned above, your responses to the questions on these two forms will not affect your employment status. We appreciate your assistance to help determine if the company may qualify for tax credits. If you have any questions, please contact Mr. Stephen Jasper at 913-764-4446.

Sincerely,

Brandon Becker President Builder's Stone



Green and Red Keys

BSM Wall Systems ("Company") requires its employees to record their time using a green and red key system. These keys require a \$25.00 deposit which will be returned to the employee once the employee returns the keys to the Company. If keys are not returned, Employee acknowledges that he or she forfeits the return of the deposit. By signing this acknowledgment, the undersigned Employee is authorizing the Company to withdraw \$25.00 from the Employee's first paycheck for the convenience of the Employee. If Employee does not wish the \$25.00 to be withdrawn from his or her first paycheck, Employee must submit the \$25.00 deposit via cash or check when turning in this paperwork to Company.

Employee will be responsible for any lost keys or any replacement keys.

Time Keeping

Accurately recording time worked is the responsibility of every non-exempt employee. Federal and State laws require the company to keep an accurate record of time worked in order to calculate employee pay and benefits. Altering, falsifying, working "off the clock," tampering with time records, or recording time on another employee's time record may result in disciplinary action, up to and including termination of employment.

If an employee fails to bring his or her time keeping keys to work, he or she will not be allowed to work and, accordingly, will not be compensated for the day. At management's discretion, the employee may, on the employee's own time, be allowed time to retrieve his or her time keeping keys and return to the job site, clock in, and begin work.

There will be no manual time in/time out sheets that will be accepted. Employees who forget their time keeping keys must immediately tell their supervisor and are prohibited from performing any work. Again, *off the clock work is strictly prohibited.*

Supervisor Authorization

No overtime will be worked unless first authorized by the employee's supervisor. If a non-exempt employee works unauthorized overtime, he or she will receive all overtime pay for the hours worked, but will be subject to discipline under the Company's progressive discipline policy for violating this provision of the Company's overtime policy.

Safe Harbor Policy

Review Your Paystub – The Company makes every effort to ensure its employees are paid correctly. Occasionally, however, inadvertent mistakes can happen. When mistakes do happen and are called to the Company's attention, the Company promptly makes any correction that is necessary. An employee should review his or her pay stubs when he or she receives it to make sure it is correct. If an employee believes a mistake has occurred or if the employee has any question, the employee should use the reporting procedure outlined below.

To Report Violations of This Policy, Communicate Concerns, or Obtain More Information - If an employee has questions about deductions from his or her pay, please contact the Human Resources Department immediately. If an employee believes wages have been subject to any improper deductions or his or her pay does not accurately reflect all hours worked, the employee should report his or her concerns to a supervisor immediately. If a supervisor is unavailable or if the employee believes it would be inappropriate to contact that person (or if the employee has not received a prompt and fully acceptable reply within three business days), the employee should immediately contact the Human Resources Department.

Every report will be fully investigated and corrective action will be taken - In addition, the company will not allow any form of retaliation against individuals who report alleged violations of this policy or who cooperate in the company's investigation of such reports. Retaliation is unacceptable. Any form of retaliation in violation of this policy will result in disciplinary action, up to and including termination.

* * * * *

I, _____, acknowledge that I have received, reviewed, and understand the above time keeping policy. I further acknowledge that it is my responsibility to report all time worked and that I am prohibited from working off the clock. I further acknowledge that I would like the \$25.00 deposit to be paid as follows (check the one that applies):

____ Deduction from my first paycheck

____ Manual payment by myself (payment is included with this form)

Signature

Date

* * * * * FOR

COMPANY USE:

Employee paid \$25.00 manually – Date received payment _____

Supervisor Name (Print)

Supervisor Signature

Notices

Notice of Special Enrollment Rights

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage you may be able to enroll yourself and your dependents in this plan **if** you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage). In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

Notice of Patient Protections

Your plan generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. For children, you can designate a pediatrician as the primary care provider. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the Human Resources Department.

You do not need prior authorization from your plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the Human Resources Department.

Women's Health and Cancer Rights Act

Do you know that your plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema? Call your plan administrator for more information.

Newborns' and Mothers' Health Protection Act

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than eight hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay in excess of 48 hours (or 96 hours).

Hf PAA Privacy

Your employer is required by law to take reasonable steps to ensure the privacy and inform you about the uses of your protected health information (PHI). The use and disclosure of PHI is regulated by the federal law known as HIPAA (the Health Insurance Portability and Accountability Act). A more complete description of your privacy rights and protections is available to you on request. Contact the Human Resources Department with any questions or to request a copy of the full HIPAA privacy notice.



Builder's Stone & Masonry- Medical Benefit Enrollment Form

Name:	Date:
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Coverage	EE Only	EE+SP	EE+CH	FAM	No Change	Waive
Plan Year Effective 8/1/2020						
Medical: Blue Cross Blue Shield of KC <input checked="" type="checkbox"/> \$5,000 Blue Select Plus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dental: Delta Dental <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vision: Surency <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Only fill this out this section if you wish to enroll dependents on the benefit plans:

Spouse Name:		<input type="checkbox"/> Male <input type="checkbox"/> Female	Social Security #:		Date of Birth:	
Child Name:		<input type="checkbox"/> Male <input type="checkbox"/> Female	Social Security #:		Date of Birth:	
Child Name:		<input type="checkbox"/> Male <input type="checkbox"/> Female	Social Security #:		Date of Birth:	
Child Name		<input type="checkbox"/> Male <input type="checkbox"/> Female	Social Security #:		Date of Birth:	

Employee Signature: _____ Date: _____

If you are declining medical coverage for yourself or your dependents (including your spouse) because of other group coverage, you or your dependents may in the future be able to enroll in this plan, provided that you request enrollment within 31 days after your other group coverage ends. In addition, you may be able to enroll yourself and your dependent(s), provided you request enrollment within 31 days after a marriage, birth, adoption or placement for adoption. If you decline coverage for yourself or your dependents while Medicaid coverage or coverage under a state children's health insurance program (CHIP) is in effect, you and your dependents may be able to enroll in this plan if you or your dependents lose eligibility for that coverage, provided you request enrollment within 60 days after that coverage ends. If you are declining medical and/or dental coverage for any other reason, or if you fail to complete this form, you may be limited to enrolling only during the annual enrollment period. If you or your dependents become eligible for a state premium assistance subsidy from Medicaid or CHIP with respect to this plan, you and your dependents may be eligible to enroll in this plan, provided you request enrollment within 60 after such eligibility is determined. I understand that if at any time it is determined by Blue KC or USABLE Life that a person listed on this application did not meet the Contract's or Policy's definition of dependent, Blue KC and/or USABLE Life has the right to terminate or rescind coverage for that person or for all ineligible persons under the application, and to recover any benefit payments made for such ineligible person or persons. **Furthermore, I understand that if I intentionally or fraudulently misrepresented a material fact on the application, made a material misrepresentation of a material fact about any person contained herein, or committed fraud in the process of obtaining the coverage outlined on this application, Blue KC and/or USABLE Life have the right to terminate or rescind coverage for that person or for all persons under the application; however, no statement I make voids my coverage unless my statements are material to the risk assumed and contained in my written application.** After my coverage has been in force for two (2) years from the effective date, no statement except fraudulent statements I make voids my medical, life, or dental coverage or reduces my benefits. I understand that my medical records will be maintained with strict confidentiality by Blue KC and USABLE Life in accordance with applicable federal and state laws.



BUILDER'S
STONE & MASONRY

2020 HOURLY BENEFITS PLAN

Medical

BCBS of KC

	HSA \$5,000	
Network	Blue Select Plus Network	Out-of-Network
Deductible		
Individual	\$5,000	\$5,000
Family	\$10,000	\$10,000
Coinsurance	10%	40%
Out-of-Pocket Maximum		
Individual	\$6,450	\$32,250
Family	\$12,900	\$64,500
Physician Visits		
Primary	Deductible + 10%	Deductible + 40%
Routine Preventive	Covered	Deductible + 40%
Specialist	Deductible + 10%	Deductible + 40%
Hospital Services		
Inpatient Hospitalization	Deductible + 10%	Deductible + 40%
Physician Services	Deductible + 10%	Deductible + 40%
Outpatient Surgery	Deductible + 10%	Deductible + 40%
Outpatient Diagnostics	Deductible + 10%	Deductible + 40%
Urgent Care	Deductible + 10%	Deductible + 40%
Emergency Room	Deductible + 10%	
Retail Prescription Benefits		
Tier 1	Deductible + 10%	Deductible + 50%
Tier 2		
Tier 3		
Tier 4		

Dental

Delta Dental of Kansas

Benefits

Type I - Preventive Services:	100%
Type II - Basic Services:	90%
Type III - Major Services:	60%
Type IV - Orthodontia Services:	50%: \$1,000 Lifetime Max.
Calendar Year Deductible	\$50 / \$150
Maximum Benefit per Person	\$1,500

2020 Plan Enhancements

- Increased Annual Maximum Benefit from \$1,000 to \$1,500
- Unlimited Cleanings
- Right Start 4 Kids - Kids 12 and under receive 100% coverage with no deductible for all services covered under the plan when at an in-network dentist

Vision

Surency

Benefits

Comprehensive Eye Exam	\$10 Copay
Standard Lenses (Per Pair) Single Vision Bifocal Trifocal Lenticular	\$25 Copay
Contact Lenses (Per Pair) Medically Necessary Elective	\$0 \$130 Retail Allowance / 15% Off Balance Over \$130
Frames - Standard	Retail Allowance \$130
Service Frequency Exam Lenses Frames	12 Months 12 Months 24 Months

Human Resources Contact

Jeff Thurlow
CFO
913-764-4446
jeff.thurlow@buildersstonekc.com

Disclaimer: The benefits outlined in this document are intended for summary purposes only and are not intended to be a complete explanation of all plan provisions. Please refer to the actual plan document or plan certificate for detailed provisions of the plan.

Rates

	HSA \$5,000
Network	Blue Select Plus
Medical Monthly Rates	
Employee Only	\$244.51
Employee + Spouse	\$579.15
Employee + Child(ren)	\$518.61
Employee + Family	\$822.90

Dental Monthly Rates	
Employee Only	\$29.78
Employee + Spouse	\$58.91
Employee + Child(ren)	\$75.65
Employee + Family	\$116.41

Vision Monthly Rates	
Employee Only	\$5.90
Employee + Spouse	\$12.38
Employee + Child(ren)	\$10.62
Employee + Family	\$19.86

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You do not need prior authorization from your plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the Human Resources Department.

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HIPAA Privacy

Your employer is required by law to take reasonable steps to ensure the privacy and inform you about the uses of your protected health information (PHI). The use and disclosure of PHI is regulated by the federal law known as HIPAA (the Health Insurance Portability and Accountability Act). A more complete description of your privacy rights and protections is available to you on request. Contact the Human Resources Department with any questions or to request a copy of the full HIPAA privacy notice.

Builder's Stone and Masonry, Inc. Health Insurance Agreement

I, the undersigned, acknowledge that I have accepted health insurance through Builder's Stone and Masonry, Inc. The first payment will be deducted from the paycheck prior to the insurance effective date. I understand that my insurance will continue with a monthly deduction and in order to cancel I must sign a form to waive the insurance and it has to be received by Tori Lofthouse.

Employee Signature _____

Date _____



EMPLOYEE ACKNOWLEDGMENT FORM OF SAFE PRACTICES

I _____ (print), hereby acknowledge that I have received, read, and understand the "Safe Practices" of BSM Wall Systems. Additionally, I confirm, and I have viewed safety video and understand, and I agree to conform to all Company practices, rules, and regulations relating to safe work performance. I understand that my failure to follow these safety procedures will result in disciplinary action up to and including discharge. I further understand that:

It is my responsibility to report all unsafe conditions or violations of Safe Practices to my supervisor or other management personnel to minimize the potential of injury to my fellow workers and myself.

(Signature of Employee)

Date

BSM Wall Systems SAFE PRACTICES

The purpose of the Code of Safe Practices is to assist you in making safety a regular part of your work habits. This is a minimum guide to help identify your responsibility for safety. Your supervisor is obligated to hold you responsible for your safety by enforcing these rules and by providing you a safe place to work.

- I will immediately report to my supervisor all accidents or near misses, and injuries, no matter how slight, that occur on the job.
- I will cooperate with and assist in the investigation of accidents to identify the causes and to prevent recurrence.
- I will promptly report to my supervisor all unsafe acts, practices or conditions that I observe.
- I will become familiar with and observe safe work procedures during the course of my work activities. I will keep my work areas clean and orderly at all times.
- I will not engage in any horseplay and avoid distracting others.
- I will obey all safety rules and follow published work instructions.
- I will wear personal protective equipment when working in hazardous areas, and/or as required by my supervisor.
- I will inspect all equipment prior to use and report any unsafe conditions to my immediate supervisor.
- I will submit any suggestions for accident prevention which may assist in improved working conditions or work practices to my immediate superior.
- I will smoke in authorized locations only.
- I will not have in my possession, use, or introduce any kind of intoxicating liquor or illegal drugs on any property or work area or facility, or I will accept possible discharge for these illegal actions.
- I will not come to work under the influence of intoxicating liquor or illegal drugs and realize that I will not be allowed to start work and may be immediately discharged for this action.

I HAVE READ AND UNDERSTAND THE ABOVE ITEMS AND REALIZE THAT FAILURE TO FOLLOW THESE RULES MAY BE GROUNDS FOR DISMISSAL.

Safety video Questionnaire

1. What is the reason for high visibility safety vest or shirt?
 - a. keeps you cool on hot days
 - b. makes you visible to your surroundings
 - c. prevents sun burns
 - d. all the above
2. If you are involved in an accident or incident will you need to take a drug screen?
 - a. True
 - b. False
3. When do you report an injury to your supervisor?
 - a. The next day
 - b. only if you are in pain
 - c. immediately after it occurs
 - d. when your work shift is over
4. At what feet do you need fall protection?
 - a. 6 feet
 - b. 8 feet
 - c. 4 feet
 - d. 10 feet
5. When should you inspect your personal fall arrest system?
 - a. once a month
 - b. weekly
 - c. after your work shift
 - d. before every use
6. What should you do when power tool ground pin is missing from the plug?
 - a. go ahead and connect it
 - b. look for an adapter
 - c. put out of service
 - d. all of the above
7. When inspecting a fire extinguisher, you need to check if it is?
 - a. charged
 - b. expired
 - c. cleaned
 - d. none of the above
8. Poor housekeeping is the number one reason for slips, trips, and falls?
 - a. True
 - b. False

- 9.** What is the minimum PPE that should be worn at a jobsite?
- a. safety vest and boots
 - b. Safety glasses
 - c. safety glasses, safety vest, and hard hat
 - d. safety glasses, safety vest, hard hat, and safety boots
- 10.** Are toe boards needed on working platforms?
- a. True
 - b. False
- 11.** 1/3 of work-related injuries are?
- a. heat stress
 - b. lacerations
 - c. illness
 - d. falls
- 12.** When lifting, you should keep the load/material as close too your body as possible and lift with your legs?
- a. true
 - b. false



1. Control No. (For Agency use only)	APPLICANT INFORMATION (See instructions on reverse)	2. Date Received (For Agency Use only)
EMPLOYER INFORMATION		
3. Employer Name	4. Employer Address and Telephone	5. Employer Federal ID Number (EIN)
APPLICANT INFORMATION		
6. Applicant Name (Last, First, MI)	7. Social Security Number	8. Have you worked for this employer before? Yes ____ No ____ If YES, enter last date of employment: _____
APPLICANT CHARACTERISTICS FOR WOTC TARGET GROUP CERTIFICATION		
9. Employment Start Date	10. Starting Wage	11. Position
12. Are you at least age 16, but under age 40? Yes ____ No ____ If YES, enter your <i>date of birth</i> _____		
13. Are you a Veteran of the U.S. Armed Forces? Yes ____ No ____ If NO, go to Box 14. If YES, are you a member of a family that received Supplemental Nutrition Assistance Program (SNAP) benefits (Food Stamps) for at least 3 months during the 15 months before you were hired? Yes ____ No ____ If YES, enter name of <i>primary recipient</i> _____ and <i>city and state</i> where benefits were received _____. OR, are you a veteran entitled to compensation for a service-connected disability? Yes ____ No ____ If YES, were you discharged or released from active duty within a year before you were hired? Yes ____ No ____ OR, were you unemployed for a combined period of at least 6 months (whether or not consecutive) during the year before you were hired? Yes ____ No ____		
14. Are you a member of a family that received Supplemental Nutrition Assistance Program (SNAP) (formerly Food Stamps) benefits for the 6 months before you were hired? Yes ____ No ____ OR, received SNAP benefits for at least a 3-month period within the last 5 months But you are no longer receiving them? Yes ____ No ____ If YES to either question, enter name of <i>primary recipient</i> _____ and <i>city</i> _____ And <i>state</i> where benefits were received _____.		
15. Were you referred to an employer by a Vocational Rehabilitation Agency approved by a State? Yes ____ No ____ OR, by an Employment Network under the Ticket to Work Program? Yes ____ No ____ OR, by the Department of Veterans Affairs? Yes ____ No ____		
16. Are you a member of a family that received TANF assistance for at least the last 18 months		

before you were hired? Yes___ No___ OR , are you a member of a family that received TANF benefits for any 18 months beginning after August 5, 1997, and the earliest 18-month period beginning after August 5, 1997, ended within 2 years before you were hired? Yes___ No___ OR , did your family stop being eligible for TANF assistance within 2 years before you were hired because a Federal or state law limited the maximum time those payments could be made? Yes___ No___ If NO , are you a member of a family that received TANF assistance for any 9 months during the 18-month period before you were hired? Yes___ No___ If YES, to any question , enter name of <i>primary recipient</i> _____ and the <i>city and state</i> where benefits were received _____	
17. Were you convicted of a felony or released from prison after a felony conviction during the year before you were hired? Yes___ No___ If YES , enter <i>date of conviction</i> _____ and <i>date of release</i> _____. Was this a Federal _____ or a State conviction _____ ? (Check one)	
18. Do you live in an Empowerment Zone or Rural Renewal County (RRC)? Yes___ No___	
19. Do you live in an Empowerment Zone and are at least age 16, but not yet 18, on your hiring date? Yes___ No___	
20. Did you receive Supplemental Security Income (SSI) benefits for any month ending within 60 days before you were hired? Yes___ No___	
21. Are you a veteran unemployed for a combined period of at least 6 months (whether or not consecutive) during the year before you were hired? Yes___ No___	
22. Are you a veteran unemployed for a combined period of at least 4 weeks but less than 6 months (whether or not consecutive) during the year before you were hired? Yes___ No___	
23. Are you an individual who is or was in a period of unemployment that is at least 27 consecutive weeks and for all or part of that period you received unemployment compensation? Yes___ No___ If YES , what state did you receive unemployment compensation in? _____ <div style="text-align: right;">(Enter state where UI compensation was received)</div>	
24. Sources used to document eligibility: (Employers/Consultants: List all documentation provided or forthcoming. For SWA Staff: List all documentation used in determining target group eligibility and enter your initials and date when the determination was made.)	
I certify that this information is true and correct to the best of my knowledge. I understand that the information above may be subject to verification.	
25(a). Signature: (See instructions in Box 25.(b) for who signs this signature block)	25.(b) Indicate with a ✓ mark who signed this form: <input type="checkbox"/> Employer, <input type="checkbox"/> Consultant, <input type="checkbox"/> SWA, <input type="checkbox"/> Participating Agency, <input type="checkbox"/> Applicant, or <input type="checkbox"/> Parent/Guardian (if applicant is a minor)
26. Date:	

ETA Form 9061 (Rev. November 2016)

INSTRUCTIONS FOR COMPLETING THE INDIVIDUAL CHARACTERISTICS FORM (ICF), ETA 9061. This form is used together with IRS Form 8850 to help state workforce agencies (SWAs) determine eligibility for the Work Opportunity Tax Credit (WOTC) Program. The form may be completed, on behalf of the applicant, by: 1) the employer or employer representative, the SWA, a participating agency, or 2) the applicant directly (if a minor, the parent or guardian must sign the form) and signed (Box 25a.) by the individual completing the form. This form is required to be used, without modification, by all employers (or their representatives) seeking WOTC certification.

Boxes 3-5. **Employer Information.** Enter the name, address including ZIP code, telephone number, and employer Federal ID number (EIN) of the employer requesting the certification for the WOTC. Do not enter information pertaining to the employer's representative, if any.

Boxes 6-11. **Applicant Information.** Enter the applicant's name and social security number as they appear on the applicant's social security card. In Box 8, indicate whether the applicant previously worked for the employer, and if Yes, enter the last date or approximate last date of employment. This information will help the "48-hour" reviewer to, early in the verification process, eliminate requests for former employees and to issue denials to these type of requests, or certifications in the case of "qualifying rehires" during valid "breaks in employment" (see pages III-12 and III-13, Nov. 2002, Third Ed., ETA Handbook 408) during the first year of employment.

Boxes 12-23. **Applicant Characteristics.** Read questions carefully, answer each question, and provide additional information where requested.

The Protecting Americans from Tax Hikes Act of 2015 retroactively reauthorized current target groups for a 5-year period, January 1, 2015 through December 31, 2019, and extended the Empowerment Zones designations for a two-year period, January 1, 2015 through December 31, 2016. The Act introduced a new target group, Qualified Long-term Unemployment Recipient (LTUR), for new hires that begin to work for an employer on or after January 1, 2016 – December 31, 2019, see Box 23. For guidance see IRS Relief Period in TEGL No. TEGL 25-15 and IRS Notice 2016-22 and 2016-40.

Box 24 **Sources to Document Eligibility.** The applicant or employer is requested to provide documentary evidence to substantiate the **YES answers** in Boxes 12 - 23. List or describe the documentary evidence that is attached to the ICF or that will be provided to the SWA. Indicate in parentheses next to each document listed whether it is attached (A) or forthcoming (F). Some examples of acceptable documentation are provided below. A letter from the agency that administers a program may be furnished specifically addressing the question to which the applicant answered YES. For example, if an applicant answers YES to either question in Box 14 and enters the name of the primary recipient and the city and state in which the benefits were received, the applicant could provide a letter from the appropriate SNAP (formerly Food Stamp) agency stating to whom SNAP benefits were paid, the months for which they were paid, and the names of the individuals included on the grant for each month. SWAs use this box to list the sources used to verify target group eligibility, followed with their initials and the date the determination was completed.

Description of Examples of Documentary Evidence and Collateral Contacts. Employers/Consultants: You may check with your SWA to find out what other sources you can use to prove target group eligibility. (You are encouraged to provide copies of documentation or names of collateral contacts for each question for which you answered **YES**.)

QUESTION 12

- Birth Certificate or Copy of Hospital Record
- Driver's License
- School I.D. Card¹
- Work Permit¹
- Federal/State/Local Gov't I.D.¹

QUESTION 13

- DD-214 or Discharge Papers
- Reserve Unit Contacts
- Letter of Separation or other agency documents issued only by the Department of Veterans Affairs (DVA) on DVA Letterhead certifying the Veteran has a service-connected disability and signed by the individual who verified this information.

QUESTIONS 14 & 16

- TANF/SNAP (Food Stamp) Benefit History or Case Number Identifier
- Signed statement from Authorized Individual with a specific description of the months benefits that were received

QUESTION 15

- Vocational Rehabilitation Agency Contact
- Veterans Administration for Disabled Veterans
- Signed letter of separation or related document from authorized Individual on DVA letter head or agency stamp with specific description of months benefits were received.
- **For SWAs:** To determine *Ticket Holder* (TH) eligibility, Fax page 1 of Form 8850 to MAXIMUS at: 703-683-1051 to verify if applicant: 1) is a TH, and 2) has an Individual Work Plan from an Employment Network.

QUESTION 17

- Parole Officer's Name or Statement
- Correction Institution Records
- Court Records Extracts

QUESTION 18 & 19

- To determine if a Designated Community Resident lives in a RRC, visit the site: www.usps.com. **Click on Find Zip Code; Enter & Submit Address/Zip Code; Click on Mailing Industry Information; Download and Print the Information**, then compare the county of the address to the list in the January 2012 Instructions to IRS 8850.
- To determine if the DCR or a Summer Youth lives in an Empowerment Zone, use the Empowerment Zones (EZ) Locator Address Lookup tool available on the WOTC site: <https://www.doleta.gov/business/incentives/opptax/resources>.

QUESTION 20

- SSI Record or Authorization
- SSI Contact
- Evidence of SSI Benefits

QUESTIONS 21, 22

- Unemployment Insurance (UI) Claims Records
- UI Wage Records

QUESTION 23

- UI Wage Records
- UI Claims Records
- Self-Attestation Form, ETA Form 9175

QUESTION 24

- **Employers/Representatives:** List All sources used and provided to the SWA to document target group eligibility. **SWA Staff:** List all documentation used to determine/verify eligibility in the target group requested by the employer/rep., to reach the final determination.

Notes:

1. Where a Federal/State/Local Gov't., School I.D. Card, or Work Permit does not contain age or birth date, another valid document must be obtained to verify an individual's age.
2. ESPL No. 05-98, dated 3/18/98, officially rescinded the authority to use Form I-9 as proof of age and residence. **Therefore, the I-9 is no longer a valid piece of documentary evidence.**

Box 25.(a) **Signature.** The person who completes the form signs the signature block.

Box 25(b) **Signature Options.** (a) Employer or Authorized Representative, (b) SWA staff, (c) Participating Agency staff, or (d) Applicant (If applicant is a minor, the parent or guardian must sign).

Box 26. **Date.** Enter the month, day and year when the form was completed.

Persons are not required to respond to this collection of information unless it displays a currently valid OMB Control Number. Respondent's obligation to reply to these questions is required to obtain and retain benefits per law 104-188. Public reporting burden for this collection of information is estimated to average 20 minutes per response including the time for reading instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing burden to the U.S. Department of Labor, Employment and Training Administration, Division of National Programs, Tools, and Technical Assistance, 200 Constitution Ave., NW, Room C-4510, Washington, D.C. 20210 (Paperwork Reduction Project Control No. 1205-0371).

.....✂
(Cut along dotted line and keep in your files)

TO: THE JOB APPLICANT OR EMPLOYEE,

Privacy Act Statement: *The Internal Revenue Code of 1986, Section 51, as amended and its enacting legislation, P.L. 104-188, specify that the State Workforce Agencies are the "designated" agencies responsible for administering the WOTC certification procedures of this program. The information you have provided completing this form will be disclosed by your employer to the State Workforce Agency. Provision of this information is voluntary. However, the information is required for your employer to receive the federal tax credit. IF THE INFORMATION YOU PROVIDE IS ABOUT A MEMBER OF YOUR FAMILY, YOU SHOULD PROVIDE HIM/HER A COPY OF THIS NOTICE.*



**Individual Characteristics Form (ICF)
Work Opportunity Tax Credit**

U.S. Department of Labor
Employment and Training Administration

SPANISH VERSION

OMB Control No. 1205-0371
Fecha de Expiración: 31 de Enero de 2020

1. Numero de Control (Para uso de la Agencia solamente)

Información del Solicitante

(Esta forma en Español **NO** es la oficial. Úsela solo para familiarizarse con las preguntas. Luego conteste, firme, y feche la forma en Ingles)

2. Fecha en que la información fue recibida.

INFORMACION DEL PATRONO

3. Nombre del Patrono

4. Dirección y Teléfono del Patrono

5. Numero Federal ID (EIN) (Patrono)

INFORMACION DEL SOLICITANTE

6. Nombre del Solicitante (Apellido, Primer, Inicial)

7. Numero Seguro Social:

8. Ha trabajado para este patrono antes?
Si ____ No ____

Si contesta "Si" provea la fecha de su ultimo empleo:

(Fecha)

REQUISITOS QUE HACEN AL SOLICITANTE ELEGIBLE PARA CERTIFICACION BAJO WOTC

9. Fecha en que comenzó a trabajar

10. Salario:

11. Posición/Título:

12. Tiene Ud., por lo menos 16 años, pero es menor de 40?

Si ____ No ____

Si contesta SI, provea su *fecha de nacimiento*: _____

13. Es Ud. un Veterano de las Fuerzas Armadas de los Estados Unidos de América (USA)?

Si ____ No ____

Si contesta NO, llene el encasillado 14.

Si contesta SI, es Ud. miembro de una familia que recibió beneficios de "Pan y Trabajo" (Aplica a Puerto Rico solamente o que recibió Cupones para Alimentos (Programa Suplementario de Asistencia Nutricional (SNAP) (o sea, Food Stamps) por lo menos por 3 mese durante los 15 meses antes de ser empleado?

Si ____ No ____

Si contesta SI, provea nombre del *beneficiario principal* _____ y el nombre de la ciudad/estado donde recibió los beneficios _____,

O, es Ud. un Veterano con derecho a beneficios por *Incapacidad Física* relacionados con su *servicio militar*?

Si ____ No ____

Si contesta SI, fue Ud. dado de baja del servicio activo militar un año antes de ser empleado?

Si ____ No ____

O, estuvo Ud. desempleado por un periodo de por lo menos 6 meses durante el año antes de ser empleado?

Si ____ No ____

14. Es Ud. miembro de una familia que recibió beneficios bajo el *Programa Pan y Trabajo* (en P.R.) o beneficios bajo el Programa Suplementario de Asistencia Nutricional (SNAP) Cupones de Alimento (o sea Food Stamps) durante los 6 meses antes de ser empleado?

Si ____ No ____

O, recibió beneficios bajo el programan SNAP (Cupones de Alimentos) por un periodo de 3 meses durante los 5 meses antes de ser empleado pero ya no recibe estos beneficios?

Si ____ No ____

Si contesta SI, a **cualquiera de las preguntas**, provea el nombre del

beneficiario principal _____ y la ciudad/estado donde los beneficios fueron recibidos _____.

Ciudad/Estado

Individual Characteristics Form (ICF)
Work Opportunity Tax Credit
(Continuacion)

U.S. Department of Labor
Employment and Training Administration

SPANISH VERSION

15. Fue Ud. referido a un patrono por una Agencia de Rehabilitación Vocacional Estatal? Si___ No ___
O, por un "Employment Network" bajo el programa "Ticket to Work" del Seguro Social? Si___ No ___
O, por el Departamento de Asuntos del Veterano? Si___ No ___

16. Es Ud., miembro de una familia que recibió asistencia TANF por lo menos en los últimos 18 meses antes de ser empleado? Si ___ No ___
O, es Ud. miembro de una familia que recibió asistencia TANF por cualquier periodo de 18 meses comenzando estos beneficios después del 5 de agosto de 1997, y el ultimo periodo de 18 meses que comenzó después del 5 de agosto de 1997, termino 2 años antes de Ud. ser empleado? Si ___ No ___
O, su familia no cualificó para asistencia TANF durante 2 años antes de ser empleado pero una ley Federal o estatal limito el período máximo para Ud. recibir esos pagos? Si ___ No ___
Si contesta No, es Ud., miembro de una familia que recibió asistencia TANF por 9 meses durante los 18 meses antes de ser empleado? Si ___ No ___
Si contesta Si, provea el nombre del *beneficiario principal* _____
Nombre
y el nombre de la ciudad/estado donde los beneficios fueron recibidos _____.
Ciudad/Estado

17. Fue Ud. convicto por un delito o violación a la ley y puesto en libertad después de la encarcelación durante el año antes de Ud. ser empleado? Si___ No ___
Si contesta SI, provea la *fecha de apresamiento (o encarcelación)* _____ y la fecha de excarcelación (o *cundo fue puesto en libertad*) _____.
Indique con un (✓) si esta fue una convicción Federal ____ o Estatal ____.

18. Vive Ud. en un "Rural Renewal County (RRC) o en un Empowerment Zone?" Si ___ No ___

19. Recibió Ud. beneficios de "Supplemental Security Income (SSI)" por cualquier mes y los beneficios terminaron 60 días antes de ser empleado? Si ___ No ___

20. Es Ud., un Veterano y ha estado desempleado por un período combinado de 6 meses (consecutivos o no) durante el año inmediatamente antes de ser empleado? Si___ No___

21. Es Ud., un Veterano y ha estado desempleado por un periodo combinado de, por lo menos, 4 semanas pero menos de 6 meses durante el año inmediatamente antes de ser empleado? Si___ No___

22. Ha estado Ud. desempleado por un periodo de no menos de 27 semanas consecutivas y durante o parte de este tiempo ha recibido Ud. beneficios por desempleo? Si___ No___
Si contesta SI, en qué estado recibió los beneficios por desempleo en? _____
(estado)

23. Evidencia para documentar elegibilidad: (**Patronos:** Favor de indicar con su nombre en este encasillado los documentos que envió con esta forma o los que enviara luego. **SWAs:** Indiquen con su nombre, los documentos que usaron para determinar si el empleado es elegible o no. El agente oficial que completo esta determinación deberá escribir sus iniciales y fecha en que dicha determinación se llevó a cabo.)

Patrono o Veterano:

Someta documentación necesaria para corroborar su elegibilidad como *Veterano Desempleado* durante el periodo requerido (Vea ejemplos de documentos/cartas en las Instrucciones de la versión oficial en Ingles de ETA Form 9061).

Preguntas 20, 21 y 22 (Ejemplos de documentación).

✓ Completar, fechar y firmar "Self-Attestation Form," ETA Form 9175, OMB Exp. Date: MM/DD/YY

Certifico que esta información es verídica y correcta y entiendo que dicha información esta sujeta a verificación.

24.(a). Firma: (Vea instrucciones en el encasillado 23(b) para saber quien firma este encasillado)	24.(b) Indique con un ✓ quien firmo la forma: <input type="checkbox"/> Patrono, <input type="checkbox"/> Representante, <input type="checkbox"/> SWA, <input type="checkbox"/> Agencia Participante, <input type="checkbox"/> Solicitante, o <input type="checkbox"/> Padre/Guardián (si el solicitante es menor de edad)	25. Fecha:
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Pre-Screening Notice and Certification Request for the Work Opportunity Credit

OMB No. 1545-1500

► Information about Form 8850 and its separate instructions is at www.irs.gov/form8850.

Job applicant: Fill in the lines below and check any boxes that apply. Complete only this side.

Your name _____ Social security number ► _____

Street address where you live _____

City or town, state, and ZIP code _____

County _____ Telephone number _____

If you are under age 40, enter your date of birth (month, day, year) _____

- 1 ☐ Check here if you received a conditional certification from the state workforce agency (SWA) or a participating local agency for the work opportunity credit.
- 2 ☐ Check here if **any** of the following statements apply to you.
- I am a member of a family that has received assistance from Temporary Assistance for Needy Families (TANF) for any 9 months during the past 18 months.
 - I am a veteran and a member of a family that received Supplemental Nutrition Assistance Program (SNAP) benefits (food stamps) for at least a 3-month period during the past 15 months.
 - I was referred here by a rehabilitation agency approved by the state, an employment network under the Ticket to Work program, or the Department of Veterans Affairs.
 - I am at least age 18 but **not** age 40 or older and I am a member of a family that:
 - a. Received SNAP benefits (food stamps) for the past 6 months; **or**
 - b. Received SNAP benefits (food stamps) for at least 3 of the past 5 months, **but** is no longer eligible to receive them.
 - During the past year, I was convicted of a felony or released from prison for a felony.
 - I received supplemental security income (SSI) benefits for any month ending during the past 60 days.
 - I am a veteran and I was unemployed for a period or periods totaling at least 4 weeks but less than 6 months during the past year.
- 3 ☐ Check here if you are a veteran and you were unemployed for a period or periods totaling at least 6 months during the past year.
- 4 ☐ Check here if you are a veteran entitled to compensation for a service-connected disability and you were discharged or released from active duty in the U.S. Armed Forces during the past year.
- 5 ☐ Check here if you are a veteran entitled to compensation for a service-connected disability and you were unemployed for a period or periods totaling at least 6 months during the past year.
- 6 ☐ Check here if you are a member of a family that:
- Received TANF payments for at least the past 18 months; **or**
 - Received TANF payments for any 18 months beginning after August 5, 1997, **and** the earliest 18-month period beginning after August 5, 1997, ended during the past 2 years; **or**
 - Stopped being eligible for TANF payments during the past 2 years because federal or state law limited the maximum time those payments could be made.
- 7 ☐ Check here if you are in a period of unemployment that is at least 27 consecutive weeks and for all or part of that period you received unemployment compensation.

Signature—All Applicants Must Sign

Under penalties of perjury, I declare that I gave the above information to the employer on or before the day I was offered a job, and it is, to the best of my knowledge, true, correct, and complete.

Job applicant's signature ►

Date

For Employer's Use Only

Employer's name _____ Telephone no. _____ EIN ► _____

Street address _____

City or town, state, and ZIP code _____

Person to contact, if different from above _____ Telephone no. _____

Street address _____

City or town, state, and ZIP code _____

If, based on the individual's age and home address, he or she is a member of group 4 or 6 (as described under *Members of Targeted Groups* in the separate instructions), enter that group number (4 or 6) ► _____

Date applicant:

Gave information _____	Was offered job _____	Was hired _____	Started job _____
---------------------------	--------------------------	--------------------	----------------------

Under penalties of perjury, I declare that the applicant provided the information on this form on or before the day a job was offered to the applicant and that the information I have furnished is, to the best of my knowledge, true, correct, and complete. Based on the information the job applicant furnished on page 1, I believe the individual is a member of a targeted group. I hereby request a certification that the individual is a member of a targeted group.

Employer's signature ►**Title****Date**

Privacy Act and Paperwork Reduction Act Notice

Section references are to the Internal Revenue Code.

Section 51(d)(13) permits a prospective employer to request the applicant to complete this form and give it to the prospective employer. The information will be used by the employer to complete the employer's federal tax return. Completion of this form is voluntary and may assist members of targeted groups in securing employment. Routine uses of this form include giving it to the state workforce agency (SWA), which will contact appropriate sources to confirm that the applicant is a member of a targeted group. This form may also be given to the Internal Revenue Service for administration of the Internal Revenue laws, to the Department of Justice for civil and

criminal litigation, to the Department of Labor for oversight of the certifications performed by the SWA, and to cities, states, and the District of Columbia for use in administering their tax laws. We may also disclose this information to other countries under a tax treaty, to federal and state agencies to enforce federal nontax criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism.

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

The time needed to complete and file this form will vary depending on individual circumstances. The estimated average time is:

Recordkeeping . . . 6 hr., 27 min.

**Learning about the law
or the form** 24 min.

**Preparing and sending this form
to the SWA** 31 min.

If you have comments concerning the accuracy of these time estimates or suggestions for making this form simpler, we would be happy to hear from you. You can send us comments from www.irs.gov/formspubs. Click on "More Information" and then on "Give us feedback." Or you can send your comments to:

Internal Revenue Service
Tax Forms and Publications
1111 Constitution Ave. NW, IR-6526
Washington, DC 20224

Do not send this form to this address. Instead, see *When and Where To File* in the separate instructions.



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):

<input type="checkbox"/> 1. A citizen of the United States	
<input type="checkbox"/> 2. A noncitizen national of the United States <i>(See instructions)</i>	
<input type="checkbox"/> 3. A lawful permanent resident (Alien Registration Number/USCIS Number): _____	
<input type="checkbox"/> 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. <i>(See instructions)</i>	
<p><i>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.</i></p> <p>1. Alien Registration Number/USCIS Number: _____ OR 2. Form I-94 Admission Number: _____ OR 3. Foreign Passport Number: _____ Country of Issuance: _____</p>	<p>QR Code - Section 1 Do Not Write In This Space</p>

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



Employer Completes Next Page





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

Section 2. Employer or Authorized Representative Review and Verification

(Employers or their authorized representative must complete and sign Section 2 within 3 business days of the employee's first day of employment. You must physically examine one document from List A OR a combination of one document from List B and one document from List C as listed on the "Lists of Acceptable Documents.")

Employee Info from Section 1	Last Name (Family Name)	First Name (Given Name)	M.I.	Citizenship/Immigration Status
List A Identity and Employment Authorization	OR	List B Identity	AND	List C Employment Authorization
Document Title		Document Title		Document Title
Issuing Authority		Issuing Authority		Issuing Authority
Document Number		Document Number		Document Number
Expiration Date (if any) (mm/dd/yyyy)		Expiration Date (if any) (mm/dd/yyyy)		Expiration Date (if any) (mm/dd/yyyy)
Document Title		<div>Additional Information</div> <div>QR Code - Sections 2 & 3 Do Not Write In This Space</div>		
Issuing Authority				
Document Number				
Expiration Date (if any) (mm/dd/yyyy)				
Document Title				
Issuing Authority				
Document Number				
Expiration Date (if any) (mm/dd/yyyy)				
Document Title				
Issuing Authority				
Document Number				
Expiration Date (if any) (mm/dd/yyyy)				

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

The employee's first day of employment (mm/dd/yyyy): _____ (See instructions for exemptions)

Signature of Employer or Authorized Representative		Today's Date (mm/dd/yyyy)		Title of Employer or Authorized Representative	
Last Name of Employer or Authorized Representative		First Name of Employer or Authorized Representative		Employer's Business or Organization Name	
Employer's Business or Organization Address (Street Number and Name)			City or Town		State ZIP Code

Section 3. Reverification and Rehires (To be completed and signed by employer or authorized representative.)

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

C. If the employee's previous grant of employment authorization has expired, provide the information for the document or receipt that establishes continuing employment authorization in the space provided below.

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

I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented document(s), the document(s) I have examined appear to be genuine and to relate to the individual.

Signature of Employer or Authorized Representative	Today's Date (mm/dd/yyyy)	Name of Employer or Authorized Representative
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LISTS OF ACCEPTABLE DOCUMENTS

All documents must be UNEXPIRED

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

LIST A Documents that Establish Both Identity and Employment Authorization	OR	LIST B Documents that Establish Identity	AND LIST C Documents that Establish Employment Authorization
<ol style="list-style-type: none"> 1. U.S. Passport or U.S. Passport Card 2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551) 3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa 4. Employment Authorization Document that contains a photograph (Form I-766) 5. For a nonimmigrant alien authorized to work for a specific employer because of his or her status: <ol style="list-style-type: none"> a. Foreign passport; and b. Form I-94 or Form I-94A that has the following: <ol style="list-style-type: none"> (1) The same name as the passport; and (2) An endorsement of the alien's nonimmigrant status as long as that period of endorsement has not yet expired and the proposed employment is not in conflict with any restrictions or limitations identified on the form. 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 		<ol style="list-style-type: none"> 1. Driver's license or ID card issued by a State or outlying possession of the United States provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address 2. ID card issued by federal, state or local government agencies or entities, provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address 3. School ID card with a photograph 4. Voter's registration card 5. U.S. Military card or draft record 6. Military dependent's ID card 7. U.S. Coast Guard Merchant Mariner Card 8. Native American tribal document 9. Driver's license issued by a Canadian government authority For persons under age 18 who are unable to present a document listed above: 10. School record or report card 11. Clinic, doctor, or hospital record 12. Day-care or nursery school record 	<ol style="list-style-type: none"> 1. A Social Security Account Number card, unless the card includes one of the following restrictions: <ol style="list-style-type: none"> (1) NOT VALID FOR EMPLOYMENT (2) VALID FOR WORK ONLY WITH INS AUTHORIZATION (3) VALID FOR WORK ONLY WITH DHS AUTHORIZATION 2. Certification of report of birth issued by the Department of State (Forms DS-1350, FS-545, FS-240) 3. Original or certified copy of birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal 4. Native American tribal document 5. U.S. Citizen ID Card (Form I-197) 6. Identification Card for Use of Resident Citizen in the United States (Form I-179) 7. Employment authorization document issued by the Department of Homeland Security

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

Refer to the instructions for more information about acceptable receipts.

Employee's Withholding Certificate

OMB No. 1545-0074

- ▶ **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.**

2020**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) <input type="checkbox"/> Single or Married filing separately <input type="checkbox"/> Married filing jointly (or Qualifying widow(er)) <input type="checkbox"/> 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 online estimator, 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 2020 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 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)
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General Instructions

Future Developments

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

Purpose of Form

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

Exemption from withholding. You may claim exemption from withholding for 2020 if you meet both of the following conditions: you had no federal income tax liability in 2019 **and** you expect to have no federal income tax liability in 2020. You had no federal income tax liability in 2019 if (1) your total tax on line 16 on your 2019 Form 1040 or 1040-SR is zero (or less than the sum of lines 18a, 18b, and 18c), or (2) you were not required to file a return because your income was below the filing threshold for your correct filing status. If you claim exemption, you will have no income tax withheld from your paycheck and may owe taxes and penalties when you file your 2020 tax return. To claim exemption from withholding, certify that you meet both of the conditions above by writing "Exempt" on Form W-4 in the space below Step 4(c). Then, complete Steps 1(a), 1(b), and 5. Do not complete any other steps. You will need to submit a new Form W-4 by February 16, 2021.

Your privacy. If you prefer to limit information provided in Steps 2 through 4, use the online estimator, which will also increase accuracy.

As an alternative to the estimator: if you have concerns with Step 2(c), you may choose Step 2(b); if you have concerns with Step 4(a), you may enter an additional amount you want withheld per pay period in Step 4(c). If this is the only job in your household, you may instead check the box in Step 2(c), which will increase your withholding and significantly reduce your paycheck (often by thousands of dollars over the year).

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

1. Expect to work only part of the year;
2. Have dividend or capital gain income, or are subject to additional taxes, such as the additional Medicare tax;
3. Have self-employment income (see below); or
4. Prefer the most accurate withholding for multiple job situations.

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

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

Specific Instructions

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

Step 2. Use this step if you (1) have more than one job at the same time, or (2) are married filing jointly and you and your spouse both work.

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

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



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

Step 3. Step 3 of Form W-4 provides instructions for determining the amount of the child tax credit and the credit for other dependents that you may be able to claim when you file your tax return. To qualify for the child tax credit, the child must be under age 17 as of December 31, must be your dependent who generally lives with you for more than half the year, and must have the required social security number. You may be able to claim a credit for other dependents for whom a child tax credit can't be claimed, such as an older child or a qualifying relative. For additional eligibility requirements for these credits, see Pub. 972, Child Tax Credit and Credit for Other Dependents. You can also include **other tax credits** in this step, such as education tax credits and the foreign tax credit. To do so, add an estimate of the amount for the year to your credits for dependents and enter the total amount in Step 3. Including these credits will increase your paycheck and reduce the amount of any refund you may receive when you file your tax return.

Step 4 (optional).

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

Step 4(b). Enter in this step the amount from the Deductions Worksheet, line 5, if you expect to claim deductions other than the basic standard deduction on your 2020 tax return and want to reduce your withholding to account for these deductions. This includes both itemized deductions and other deductions such as for student loan interest and IRAs.

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

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

If you choose the option in Step 2(b) on Form W-4, complete this worksheet (which calculates the total extra tax for all jobs) on **only ONE** Form W-4. Withholding will be most accurate if you complete the worksheet and enter the result on the Form W-4 for the highest paying job.

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

- 1 Two jobs.** If you have two jobs or you're married filing jointly and you and your spouse each have one job, find the amount from the appropriate table on page 4. Using the "Higher Paying Job" row and the "Lower Paying Job" column, find the value at the intersection of the two household salaries and enter that value on line 1. Then, **skip** to line 3 **1** \$ _____
- 2 Three jobs.** If you and/or your spouse have three jobs at the same time, complete lines 2a, 2b, and 2c below. Otherwise, skip to line 3.
 - a** Find the amount from the appropriate table on page 4 using the annual wages from the highest paying job in the "Higher Paying Job" row and the annual wages for your next highest paying job in the "Lower Paying Job" column. Find the value at the intersection of the two household salaries and enter that value on line 2a **2a** \$ _____
 - b** Add the annual wages of the two highest paying jobs from line 2a together and use the total as the wages in the "Higher Paying Job" row and use the annual wages for your third job in the "Lower Paying Job" column to find the amount from the appropriate table on page 4 and enter this amount on line 2b **2b** \$ _____
 - c** Add the amounts from lines 2a and 2b and enter the result on line 2c **2c** \$ _____
- 3** Enter the number of pay periods per year for the highest paying job. For example, if that job pays weekly, enter 52; if it pays every other week, enter 26; if it pays monthly, enter 12, etc. **3** _____
- 4 Divide** the annual amount on line 1 or line 2c by the number of pay periods on line 3. Enter this amount here and in **Step 4(c)** of Form W-4 for the highest paying job (along with any other additional amount you want withheld) **4** \$ _____

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

- 1** Enter an estimate of your 2020 itemized deductions (from Schedule A (Form 1040 or 1040-SR)). Such deductions may include qualifying home mortgage interest, charitable contributions, state and local taxes (up to \$10,000), and medical expenses in excess of 7.5% of your income **1** \$ _____
- 2** Enter: $\left\{ \begin{array}{l} \bullet \$24,800 \text{ if you're married filing jointly or qualifying widow(er)} \\ \bullet \$18,650 \text{ if you're head of household} \\ \bullet \$12,400 \text{ if you're single or married filing separately} \end{array} \right\}$ **2** \$ _____
- 3** If line 1 is greater than line 2, subtract line 2 from line 1. If line 2 is greater than line 1, enter "-0-" . . . **3** \$ _____
- 4** Enter an estimate of your student loan interest, deductible IRA contributions, and certain other adjustments (from Part II of Schedule 1 (Form 1040 or 1040-SR)). See Pub. 505 for more information . . . **4** \$ _____
- 5 Add** lines 3 and 4. Enter the result here and in **Step 4(b)** of Form W-4 **5** \$ _____

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

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

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

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

Married Filing Jointly or Qualifying Widow(er)

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	\$0 - 9,999	\$10,000 - 19,999	\$20,000 - 29,999	\$30,000 - 39,999	\$40,000 - 49,999	\$50,000 - 59,999	\$60,000 - 69,999	\$70,000 - 79,999	\$80,000 - 89,999	\$90,000 - 99,999	\$100,000 - 109,999	\$110,000 - 120,000
\$0 - 9,999	\$0	\$220	\$850	\$900	\$1,020	\$1,020	\$1,020	\$1,020	\$1,020	\$1,210	\$1,870	\$1,870
\$10,000 - 19,999	220	1,220	1,900	2,100	2,220	2,220	2,220	2,220	2,410	3,410	4,070	4,070
\$20,000 - 29,999	850	1,900	2,730	2,930	3,050	3,050	3,050	3,240	4,240	5,240	5,900	5,900
\$30,000 - 39,999	900	2,100	2,930	3,130	3,250	3,250	3,440	4,440	5,440	6,440	7,100	7,100
\$40,000 - 49,999	1,020	2,220	3,050	3,250	3,370	3,570	4,570	5,570	6,570	7,570	8,220	8,220
\$50,000 - 59,999	1,020	2,220	3,050	3,250	3,570	4,570	5,570	6,570	7,570	8,570	9,220	9,220
\$60,000 - 69,999	1,020	2,220	3,050	3,440	4,570	5,570	6,570	7,570	8,570	9,570	10,220	10,220
\$70,000 - 79,999	1,020	2,220	3,240	4,440	5,570	6,570	7,570	8,570	9,570	10,570	11,220	11,240
\$80,000 - 99,999	1,060	3,260	5,090	6,290	7,420	8,420	9,420	10,420	11,420	12,420	13,260	13,460
\$100,000 - 149,999	1,870	4,070	5,900	7,100	8,220	9,320	10,520	11,720	12,920	14,120	14,980	15,180
\$150,000 - 239,999	2,040	4,440	6,470	7,870	9,190	10,390	11,590	12,790	13,990	15,190	16,050	16,250
\$240,000 - 259,999	2,040	4,440	6,470	7,870	9,190	10,390	11,590	12,790	13,990	15,520	17,170	18,170
\$260,000 - 279,999	2,040	4,440	6,470	7,870	9,190	10,390	11,590	13,120	15,120	17,120	18,770	19,770
\$280,000 - 299,999	2,040	4,440	6,470	7,870	9,190	10,720	12,720	14,720	16,720	18,720	20,370	21,370
\$300,000 - 319,999	2,040	4,440	6,470	8,200	10,320	12,320	14,320	16,320	18,320	20,320	21,970	22,970
\$320,000 - 364,999	2,720	5,920	8,750	10,950	13,070	15,070	17,070	19,070	21,290	23,590	25,540	26,840
\$365,000 - 524,999	2,970	6,470	9,600	12,100	14,530	16,830	19,130	21,430	23,730	26,030	27,980	29,280
\$525,000 and over	3,140	6,840	10,170	12,870	15,500	18,000	20,500	23,000	25,500	28,000	30,150	31,650

Single or Married Filing Separately

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	\$0 - 9,999	\$10,000 - 19,999	\$20,000 - 29,999	\$30,000 - 39,999	\$40,000 - 49,999	\$50,000 - 59,999	\$60,000 - 69,999	\$70,000 - 79,999	\$80,000 - 89,999	\$90,000 - 99,999	\$100,000 - 109,999	\$110,000 - 120,000
\$0 - 9,999	\$460	\$940	\$1,020	\$1,020	\$1,470	\$1,870	\$1,870	\$1,870	\$1,870	\$2,040	\$2,040	\$2,040
\$10,000 - 19,999	940	1,530	1,610	2,060	3,060	3,460	3,460	3,460	3,640	3,830	3,830	3,830
\$20,000 - 29,999	1,020	1,610	2,130	3,130	4,130	4,540	4,540	4,720	4,920	5,110	5,110	5,110
\$30,000 - 39,999	1,020	2,060	3,130	4,130	5,130	5,540	5,720	5,920	6,120	6,310	6,310	6,310
\$40,000 - 59,999	1,870	3,460	4,540	5,540	6,690	7,290	7,490	7,690	7,890	8,080	8,080	8,080
\$60,000 - 79,999	1,870	3,460	4,690	5,890	7,090	7,690	7,890	8,090	8,290	8,480	9,260	10,060
\$80,000 - 99,999	2,020	3,810	5,090	6,290	7,490	8,090	8,290	8,490	9,470	10,460	11,260	12,060
\$100,000 - 124,999	2,040	3,830	5,110	6,310	7,510	8,430	9,430	10,430	11,430	12,420	13,520	14,620
\$125,000 - 149,999	2,040	3,830	5,110	7,030	9,030	10,430	11,430	12,580	13,880	15,170	16,270	17,370
\$150,000 - 174,999	2,360	4,950	7,030	9,030	11,030	12,730	14,030	15,330	16,630	17,920	19,020	20,120
\$175,000 - 199,999	2,720	5,310	7,540	9,840	12,140	13,840	15,140	16,440	17,740	19,030	20,130	21,230
\$200,000 - 249,999	2,970	5,860	8,240	10,540	12,840	14,540	15,840	17,140	18,440	19,730	20,830	21,930
\$250,000 - 399,999	2,970	5,860	8,240	10,540	12,840	14,540	15,840	17,140	18,440	19,730	20,830	21,930
\$400,000 - 449,999	2,970	5,860	8,240	10,540	12,840	14,540	15,840	17,140	18,450	19,940	21,240	22,540
\$450,000 and over	3,140	6,230	8,810	11,310	13,810	15,710	17,210	18,710	20,210	21,700	23,000	24,300

Head of Household

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	\$0 - 9,999	\$10,000 - 19,999	\$20,000 - 29,999	\$30,000 - 39,999	\$40,000 - 49,999	\$50,000 - 59,999	\$60,000 - 69,999	\$70,000 - 79,999	\$80,000 - 89,999	\$90,000 - 99,999	\$100,000 - 109,999	\$110,000 - 120,000
\$0 - 9,999	\$0	\$830	\$930	\$1,020	\$1,020	\$1,020	\$1,480	\$1,870	\$1,870	\$1,930	\$2,040	\$2,040
\$10,000 - 19,999	830	1,920	2,130	2,220	2,220	2,680	3,680	4,070	4,130	4,330	4,440	4,440
\$20,000 - 29,999	930	2,130	2,350	2,430	2,900	3,900	4,900	5,340	5,540	5,740	5,850	5,850
\$30,000 - 39,999	1,020	2,220	2,430	2,980	3,980	4,980	6,040	6,630	6,830	7,030	7,140	7,140
\$40,000 - 59,999	1,020	2,530	3,750	4,830	5,860	7,060	8,260	8,850	9,050	9,250	9,360	9,360
\$60,000 - 79,999	1,870	4,070	5,310	6,600	7,800	9,000	10,200	10,780	10,980	11,180	11,580	12,380
\$80,000 - 99,999	1,900	4,300	5,710	7,000	8,200	9,400	10,600	11,180	11,670	12,670	13,580	14,380
\$100,000 - 124,999	2,040	4,440	5,850	7,140	8,340	9,540	11,360	12,750	13,750	14,750	15,770	16,870
\$125,000 - 149,999	2,040	4,440	5,850	7,360	9,360	11,360	13,360	14,750	16,010	17,310	18,520	19,620
\$150,000 - 174,999	2,040	5,060	7,280	9,360	11,360	13,480	15,780	17,460	18,760	20,060	21,270	22,370
\$175,000 - 199,999	2,720	5,920	8,130	10,480	12,780	15,080	17,380	19,070	20,370	21,670	22,880	23,980
\$200,000 - 249,999	2,970	6,470	8,990	11,370	13,670	15,970	18,270	19,960	21,260	22,560	23,770	24,870
\$250,000 - 349,999	2,970	6,470	8,990	11,370	13,670	15,970	18,270	19,960	21,260	22,560	23,770	24,870
\$350,000 - 449,999	2,970	6,470	8,990	11,370	13,670	15,970	18,270	19,960	21,260	22,560	23,900	25,200
\$450,000 and over	3,140	6,840	9,560	12,140	14,640	17,140	19,640	21,530	23,030	24,530	25,940	27,240

Hourly Employee Handbook 2020



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Mission Statement

At BSM Wall Systems, it is our mission to provide our customers with an excellent product by combining the highest quality of personnel, materials, and service while maintaining a profitable organization. We expect all employees to take part in taking care of our customers, so they feel that their business is important to us and appreciated by us.

General Policies and Procedures

Paychecks

You will receive a paycheck every Friday. We prefer that you sign up for the BSM Wall Systems' direct deposit program. Under direct deposit, your pay will automatically be deposited into your bank account at or around 12:01 on Friday morning. Your funds will be available for withdrawal at that time. You will receive documentation of your wages and withholdings but will not receive a paycheck. This saves time and money for both you and BSM Wall Systems.

Reimbursements

A need may arise where you purchase something for BSM Wall Systems purposes. Please save the receipt. If the purchase relates to a specific job, please put the job number on the receipt. If there is no job number, please put the name of the customer on the receipt. Take the receipt to the company's accountant for reimbursement. Reimbursement will be made the Friday following the approval of the receipt.

Purchasing Materials from BSM Wall Systems

There may come a time when you need to purchase something at BSM Wall Systems. All employees are entitled to a 20% discount from the retail price if payment is made in cash or check. Payment by credit card will result in a 10% discount. Please pay for the materials purchased at the time of the sale. Employees are not allowed to have purchases deducted from their paycheck.

Alcohol & Drugs

Drinking of alcoholic beverages during work hours or while in BSM Wall Systems vehicles or arriving at work after drinking alcohol is prohibited. Any violation of this policy will result in termination.

BSM Wall Systems also prohibits the use, sale, transfer, or possession of illegal drugs, or the misuse of legal drugs by employees. This policy also applies to the off-premises use of illegal drugs, or the off-premises misuse of legal drugs. All employees of BSM Wall Systems are required to submit to a drug test, as part of the investigation of the employment application. In addition, periodic tests may be ordered over the entire course of employment. Failure to submit to these tests will result in termination. A positive drug test will result in the following procedure:

1. A 30 day no-pay suspension or termination.
2. Employee must enroll in and complete a drug treatment/rehab program at the employee's expense.
3. Employee must return proof of completion of treatment/rehab program from the attending doctor.
4. Test negative to drug test. Random drug tests will be conducted over the remaining course of employment.
5. Positive follow-up test will result in termination.

Dress Code

Since our business is dramatically affected by the customer's impression of our company and each individual in it, a dress code is effective as follows:

1. All employees must always look neat and clean. Employees must always wear shirts. Employees must wear full length pants in the months between October and April. From May through September, installers and salesmen are allowed to wear shorts.
2. Beards and long hair, if worn, must be trimmed and kept clean. We are all representatives of BSM Wall Systems. Please look professional.
3. BSM Wall Systems will pay for half the cost of uniforms and BSM Wall Systems attire. All employees that have uniforms are required to wear them on a daily basis. You should have enough shirts and pants to be able to wear a clean set every day.
4. Employees that wear a cap to work must wear a BSM Wall Systems cap.

Absenteeism Policy

Notification to your supervisor of late arrival or no-show is required no later than 10 minutes prior to starting time. You are responsible for contacting your supervisor.

If an employee misses a day of work or is late without notice, that employee will be subject to discipline up to and including immediate termination.

Holidays

Closed on the following Holidays:

New Years Day
Memorial Day Fourth of July
Labor Day
Thanksgiving Day
Christmas Day

Holidays are given as unpaid days off.

Accrual and Payment of PTO

Accruals are based upon paid hours of up to 1500 hours per year, excluding overtime. Time in service with Builder's Stone and Masonry will determine the rate you accrue PTO. You will not accrue PTO on unpaid leaves of absence. You are eligible for the next level of accrual on the first day of the pay period of your employment anniversary according to the table below.

Years of Service	Annual PTO Accrual
Less Than 3 Years	0 Days
3 – 5 Years	3 Days (24 Hours)
More than 5 Years	7 Days (56 Hours)

Retirement Plan (401K)

A 401K plan is available on an employee contribution only basis. The plan is available during open enrollment twice a year after the employee has worked, on a full-time basis, for one full year. Details about the plan are available from the accounting office upon request.

Health Insurance

BSM Wall Systems will cover \$17.20 of employee's premium after a period of 90 days of full-time employment. If dependent coverage is needed, the employee will be responsible for paying 100% for their coverage. An application must be submitted to the insurance company prior to coverage for them to determine whether you qualify for

coverage. If you qualify for coverage and elect insurance coverage, we will deduct the charges from your pay. Refer to the healthcare plan document in effect for specific policy provisions and rates.

We understand that health care costs are rising. We make every effort we can to keep your insurance rates as low as possible.

Safety

All employees will be required to attend a safety orientation immediately after hiring. All employees must abide by the safety standards for each department of BSM Wall Systems. An example of some of those safety standards is listed below.

Required Safety Equipment:

1. Warehouse
 - a. Safety glasses must be worn at all times
 - i. The company will buy the 1st pair of glasses and the employee is required to buy replacement glasses
 - ii. Visitors are required to wear safety glasses while in the shop
 - iii. Safety glasses are required when operating the chop saw, punch press, and bench grinder
 - b. Hard hats are required in the yard at all times and on all job sites
 - c. Safety glasses are required when using any power tools
 - d. Earplugs are required when using any power tools

Phone Usage

Both the office phones and cell phones are for business use only. Any employee not abiding by this rule is subject to discipline. BSM Wall Systems encourages the safe use of cell phones. Even though some employees are provided with cell phones, talking on one of these devices while operating a vehicle or equipment is not allowed.

Electronic Access Policy

The use of electronic devices and systems are an important part of our day to day business activities and comes with an understanding of the obligation required of each individual employee to abide by the intended business use of each device.

BSM Wall Systems provides some, if not all, employees with electronic access, consisting of an e-mail system, a network connection, and Internet/Intranet access. These policies govern all use of the Company's network, Internet/Intranet access, and e-mail system at all Company locations and offices. This policy includes, but is not limited to, electronic mail, chat rooms, the Internet, news groups, electronic bulletin boards, the Company's Intranet, and all other Company electronic messaging systems.

Employee initials

Company initials

1. E-mail

BSM Wall Systems' e-mail system is designed to improve service to our customers, enhance internal communications, and reduce paperwork. Employees using the Company's e-mail system must adhere to the following policies and procedures:

- The Company's e-mail system, network, and Internet/Intranet access are intended for business-use only. Employees may access e-mail and the Internet for personal use only during non-working hours, and strictly in compliance with the terms of this policy.
- All information created, sent, or received via the Company's e-mail system, network, Internet, or Intranet, including all e-mail messages and electronic files and/or attachments, is the property of the Company. The Company reserves the right to access, read, review, monitor, and copy all messages and files on its computer system at any time and without notice. When deemed necessary, the Company reserves the right to disclose text or images to law enforcement agencies or other third parties without the employee's consent.
- Use extreme caution to ensure that the correct e-mail address is used for the intended recipient(s).
- Any message or file sent via e-mail must have the employee's name attached.
- Personal e-mail accounts are not permitted unless expressly authorized in advance by the Company's Chief Information Officer.
- Alternate Internet Service Provider connections to the Company's internal network are not permitted unless expressly authorized by the Company and are properly protected by a Company configured firewall and/or other appropriate security device(s) and/or software.
- Confidential information should not be sent via e-mail unless encrypted by Company approved encryption software and according to established Company procedure in affect at the time of transmittal. This includes the transmission of customer financial information, Social Security numbers, employee health records, or other confidential information.
- Employees must provide the System Administrator and/or Chief Information Officer with all passwords.
- Only authorized management personnel are permitted to access another person's e-mail without consent.
- Employees should exercise sound judgment when distributing messages. Client-related messages should be carefully guarded and protected. Employees must also abide by copyright laws, ethics rules, and other applicable laws.

- E-mail messages must always contain professional and appropriate language . Employees are prohibited from sending abusive, harassing, intimidating, threatening, and discriminatory or otherwise offensive messages via e-mail. Sending abusive, harassing, intimidating, threatening, discriminatory, or otherwise offensive messages via e-mail will result in disciplinary action up to and including termination.
- E-mail usage must conform to the Company's harassment and discrimination policies.
- Use of the Company's e-mail system to solicit for any purpose, personal or otherwise, without the consent of the Company is strictly prohibited.
- Chain messages and executable graphics and/or programs should be deleted. Any employee engaging in the transmission of inappropriate e-mails, as determined by management, will be subject to disciplinary action, up to and including termination.
- Employees should archive messages to prevent them from being deleted. All messages archived in the Company's computer system shall be deemed Company property, as is all information on the Company's systems. Employees are responsible for knowing the Company's e-mail retention policies.
- Misuse and/or abuse of electronic access, including but not limited to, personal use during working hours, copying or downloading copyrighted/licensed materials, visiting pornographic sites or sending abusive e-mail messages will result in disciplinary action, up to and including termination.

Violation of any of these policies will subject an employee to disciplinary action, up to and including termination.

2. Network and Internet

- Personal Responsibility: By accepting an account password, related information, and accessing the Company's Network or Internet system, an employee agrees to adhere to the Company policies regarding their use. You also agree to report any misuse or policy violation(s) to your supervisor and the Company's Chief Information Officer.
- Permitted Use and Term: Use of the Network and the Internet is a privilege, not a right. Use of Network and Internet access extends throughout an employee's term of employment, providing the employee does not violate BSM Wall Systems' policies regarding Network, Internet, or Intranet use.

- Availability and Access: BSM Wall Systems reserves the right to suspend access at any time, without notice, for technical reasons, possible policy violations, security, or other concerns.
- Content and Communications: The Company, at its sole discretion, will determine what materials, files, information, software, communications, and other content and/of activity will be permitted or prohibited.
- Privacy: Network and Internet access I provided as a tool for our organization's business. The Company reserves the right to monitor inspect, copy, review and store at any time, without prior notice, any and all usage of the Network and the Internet, as well as any and all materials, files, information, software, communications, and other content transmitted, received or stored in connection with this usage. All such information, content, files are the property of the Company. An employee should have no expectation of privacy regarding them. Network administrators may review files and intercept communications for any reason, including but not limited to maintaining system integrity and ensuring employees are using the system consistent with this Policy.
- Downloaded Sites: Files are not to be downloaded from the Internet without the prior authorization of management. Any files authorized for download from the Internet must be scanned with virus detection software before being opened. Employees are reminded that information obtained from the Internet is not always reliable and should be verified for accuracy before use.
- Confidential Information: Employees may have access to confidential information about the Company, other employees, and clients. With the approval of management, employees may use e-mail to communicate confidential information internally to those with a "need to know". Such e-mail must be marked "Confidential". For purposes of this Policy, confidential information includes, but is not limited to:
 - Procedures for computer access and passwords of the Company's clients and customers, program manuals, user manuals, or other documentation, run books, screen, file, or database layouts, systems flowcharts, and all documentation normally related to the design or implementation of any computer programs developed by the Company relating to computer programs or systems installed either for customers or for internal use;

- Lists of present clients and customers and the names of individuals at each client or customer location with whom the Company deals, the type of equipment or computer software they purchase or use, and information relating to those clients and customers which has been given to the Company by them or developed by the Company, relating to computer programs or systems installed;
- Lists of or information about personnel seeking employment with or who are employed by the Company.
- Prospect lists for actual or potential clients and customers of the Company and contact persons at such actual or potential clients and customers.
- Any other information relating to the Company's research, development, inventions, purchasing, engineering, marketing, merchandising, and selling.
- Prohibited Activities: Employees are prohibited from using the Company's e-mail system, network, or Internet/Intranet access for the following activities:
 - Downloading software without the prior written approval of the Company's Chief Information Officer.
 - Using software that is not licensed by the manufacturer of approved by the Company.
 - Sending, printing, or otherwise disseminating the Company's proprietary data, or any other information deemed confidential by the Company, to unauthorized persons.
 - Operating a business, soliciting money for personal gain or otherwise engaging in commercial activity outside the scope of employment.
 - Making offensive or harassing statements based on religion, national origin, veteran status, ancestry, disability, age, sex, sexual orientation, or any other protected class.
 - Sending or forwarding messages containing defamatory, obscene, offensive, or harassing statements. An employee should notify their supervisor and Human Resource manager immediately upon receiving such a message. This type of message should not be forwarded.
 - Sending or forwarding a message that discloses personal information without Company authorization. This shall also include accessing, transmitting, receiving, or seeking confidential information about clients or fellow employees without authorization.

- Sending ethnic, sexual-preference, or gender-related slurs and/or jokes via e-mail. “Jokes”, which often contain objectionable material, are easily misconstrued when communicated electronically.
- Sending or soliciting sexually oriented messages or images.
- Attempting to access or visit sites featuring pornography, terrorism, espionage, theft, or drugs.
- Gambling or engaging in any in any other criminal activity in violation of local, state, or federal law.
- Engaging in unethical activities or content.
- Participating in activities, including the preparation or dissemination of content, which could damage the Company’s professional image, reputation, and/or financial stability.
- Permitting or granting use of an e-mail or system account to another employee or persons outside the Company.
Permitting another person to use an account or password to access the Network or the Internet, including, but not limited to, someone whose access has been denied or terminated, is a violation of the policy.
- Using another employee’s password or impersonating another person while communicating or accessing the Network or Internet.
- Introducing a virus, harmful component, corrupted data, or the malicious tampering with any of the Company’s computer systems.
- Computer Equipment: The following policies are designed to reduce repair costs, maintain the integrity of our system, and protect the Company’s assets. Employees should adhere to the following:
 - Do not keep liquids or magnets on or near the computer.
 - Do not remove the computer from the building without written permission from the Chief Information Officer.
 - Do not transport disks back and forth between home and office. This will help minimize exposure to viruses.
 - Do not install computers or other peripheral devices to the Company’s system without the approval of the Chief Information Officer and involvement of the Information Technology provider.
- Compliance & Noncompliance: Though everyone is responsible for his/her own actions, management personnel are responsible for ensuring employee compliance with Company Policy.

Any employee aware of a policy violation should immediately report the violation to their supervisor, the Company’s Chief Information Officer, and the Human Resources Manager.

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BSM Wall Systems, Inc.

January 1, 2020 Edition

Employees who violate this policy and/or use the Company's e-mail system, network, Internet, or Intranet access for improper purposes will be subject to disciplinary action, up to and including termination.

3. Software Usage Policy

Software piracy is both a crime and a violation of the Company's Software Usage Policy.

Employees are to use software strictly in accordance with its license agreement. Unless otherwise provided in the license, the duplication of copyrighted software (except for backup and archival purposes by designated managerial personnel) is a violation of copyright law. In addition to being in violation of the law, unauthorized duplication of software is contrary to the Company's standards of employee conduct.

To ensure compliance with software license agreements and the Company's Software Usage Policy, employees must adhere to the following:

- Employees must use software in accordance with the manufacturer's license agreements and the Company's Software Usage Policy. The Company licenses the use of computer software from a variety of outside companies. The Company does not own the copyright to software licensed from other companies or individuals. Employees acknowledge they do not own software or its related documentation. Employees may not make additional copies of software, unless expressly authorized by the software publisher. The only exception will be a single copy, as authorized by designated managerial personnel, for backup or archival purposes.
- The Company does not condone and prohibits the unauthorized duplication of software. Employees illegally reproducing software will be subject to disciplinary action. In addition, employees illegally reproducing software may be subject to civil and criminal penalties including fines and imprisonment.

NOTE: Unauthorized reproduction of software is a federal offense under US and Canadian copyright laws. In the United States, violators may be subject to civil damages in amounts up to \$150,000 per title copied. Criminal penalties include fines as high as \$250,000 per software title copied, and imprisonment of up to 5 years.

- Any employee, who knowingly makes, acquires, or uses unauthorized copies of computer software on the Company's premises or equipment will be subject to disciplinary action, up to and including termination.
- Employees are not permitted to install their personal software onto the Company's computer system.

Employee initials

Company initials

- Employees are not permitted to copy software from the Company's computer system for installation on home or other computers without the permission of the Chief Information Officer and the involvement of the Information Technology provider.
- In cases that require an employee to use Company software at home, the Company will purchase required license. Any employee issued additional copy(s) of software for home use acknowledges that such additional copy(s) or licenses(s) purchased for home use are the property of the Company. Employees who are required to use software at home should consult with the Chief Information Officer and Systems Administrator to determine if appropriate licenses and safeguards exist for home use.
- Employees are prohibited from giving software or fonts to clients, customers, vendors, and other persons not in employ of the company. Under no circumstances will the Company use software from an unauthorized source, including, but not limited to, the Internet, home, friends and/or colleagues.
- Employees who suspect or become aware of software misuse are required to notify their supervisor, Chief Information Officer, and Human Resources Manager.
- All software used on Company owned computers will be purchased and installed through appropriate procedures. Consult the Chief Information Officer to request software purchases and installation.

Employees who violate this policy will be subject to disciplinary action, up to and including termination. Any employee aware of a software policy violation should immediately report the violation to their supervisor, the Company's Chief Information Officer, and the Human Resources Manager.

Anti-Harassment Policy

BSM Wall Systems reaffirms its long-standing policy of providing equal opportunity for all applicants and employees regardless of their race, color, religion, age, sex, national origin, disability, veteran status, or other protected category. This policy extends to recruiting, recruitment advertising, and/or other communications media, hiring, rates of pay and other compensation, benefits, overtime, job classifications and assignments, training, work conditions, promotions, transfers, demotions, layoffs or terminations, recalls, disciplinary and other employee treatment, and all other terms, conditions, or privileges of employment.

Harassment is conduct towards another person or group of persons which purposely or which may create offensive, intimidating, or hostile work environment. Harassment is also conduct which unreasonably interferes with an individual's work environment or work opportunity. Harassment is defined as behavior that is unwelcome,

is personally offensive, reducing morale, thereby interfering with the work productivity of the company.

Sexual and Other Unlawful Harassment

The Company is committed to providing a work environment that is free from all forms of discrimination and conduct that can be considered harassing, coercive, or disruptive, including sexual harassment, whether by employees, vendors, or guest. The Company will not tolerate any actions, words, jokes, or comments based on a person's gender, race, color, national origin, age, religion, disability, sexual orientation, or any other legally protected characteristic. We provide ongoing anti-harassment training to ensure you the opportunity to work in an environment free of sexual and other unlawful harassment.

Consistent with the policy, the Company prohibits any supervisor, employee, vendor, or client from making sexual advances of a verbal or physical nature toward another employee or applicant for employment. Sexual harassment is viewed as a form of employee conduct that undermines the integrity of the employment relationship. All employees must be allowed to work in an environment free from unsolicited and unwelcome sexual overtures.

Some examples of sexual harassment include but are not limited to:

- Unwelcome or unwanted sexual advances. This includes patting, pinching, brushing up against, hugging, cornering, kissing, fondling, or any other similar physical contact considered unacceptable by another individual.
- Requests or demands for sexual favors. This includes subtle or blatant expectations, pressures, or requests of any type of sexual favor accompanied by an implied or stated promise of preferential treatment or negative consequences concerning one's employment.
- Verbal abuse or kidding that is sex-oriented and considered unacceptable by another individual. This includes comments about an individual's body or appearance (where such comments go beyond more than mere compliment), off-color jokes that are clearly unwanted or considered offensive by others, or any other tasteless, sex-oriented comments, innuendoes or offensive actions.
- Any sexually oriented conduct that would unreasonably interfere with another's work performance. This includes extending unwanted sexual attention to someone, which reduces personal productivity. This would also include mutually permissive behavior between two individuals which would be offensive to a third party/
- Participation in fostering a work environment that is generally intimidating, hostile, or offensive because of unwelcome or unwanted sexually oriented conversation, suggestions, requests, demands, physical contacts, or attention.

Sexual harassment is a practice that demeans the individual being treated in such a manner. Consequently, BSM Wall Systems will not tolerate sexual harassment of its applicants or employees by anyone – supervisors, employees, vendors, or clients. Cooperation in preventing this type of conduct is essential. BSM Wall Systems will, as necessary, act in accordance with our policy to ensure that the Company meets its responsibilities to employees.

If you experience or witness sexual or other unlawful harassment in the workplace, report it immediately to your supervisor. If the supervisor is unavailable or you believe it would be inappropriate to discuss it with that person, you should immediately contact your Human Resources Department or any other member of management, including Brandon Becker. You can raise concerns and make reports without fear of reprisal or retaliation. Anyone found to be retaliating against an employee for making a complaint or participating in an investigation will be subject to discipline up to, and including, termination.

All allegations of sexual harassment will be quickly and discreetly investigated. To the extent possible, your confidentiality and that of any witnesses and the alleged harasser will be protected against unnecessary disclosure. When the investigation is completed, you will be informed of the outcome of the investigation. Any supervisor or manager who becomes aware of possible sexual or other unlawful harassment must immediately advise the Human Resources Department or any member of management so it can be investigated in a timely and confidential manner. Anyone engaging in sexual or other unlawful harassment will be subject to disciplinary action up to and including separation of employment.

Racial Harassment

Racial harassment is conduct which directs hostility towards another person (Or group of persons) on the basis of race, color, national origin, or ancestry and which has the purpose or effect of creating an intimidating or hostile work environment and/or work opportunities. All forms of racial harassment are prohibited.

We take our anti-harassment policy very seriously. The Company encourages all employees to report and address incidents of harassment internally to their immediate supervisor or Brandon Becker. All alleged behaviors will be evaluated and investigated. Acts of reprisal, interference, restraint, discrimination, intimidation or harassment against an individual (or group of individuals) for exercising their rights under this policy will be subjected to prompted disciplinary action up to and including termination of their employment.

If you have any suggestion or problem, feel free to follow the Company's open-door communication system by contacting Brandon Becker. Retaliation is strictly prohibited. Every employee is welcome to access this confidential system without fear of reprisal.

REASONABLE ACCOMMODATION POLICY

The Company is committed to making reasonable accommodations for the following unless doing so would create an undue hardship on the Company:

- Physical, mental, medical, or psychological impairments, or a history or record of such impairment.
- Religious needs.
- Pregnancy, childbirth, or condition related to pregnancy.
- Victims of domestic violence, sexual violence, or stalking.

Accommodation Request Process

The Company will make reasonable accommodation when it knows or becomes aware of a need for accommodation, but the Company cannot accommodate a need of which it has no knowledge. If you believe you need some type of accommodation, please notify Human Resources as soon as possible. You may be asked to provide medical information or submit to a medical examination by a physician to assist the Company in the accommodation process.

The Company will engage everyone requesting an accommodation in a cooperative dialogue to evaluate the request for accommodation(s). This cooperative dialogue will include a discussion of the individual's accommodation needs, potential accommodations and alternatives that may address those needs, and any difficulties the potential accommodations may pose for the Company.

Upon completion of the cooperative dialogue, the Company will provide the individual requesting the accommodation with a written final determination identifying any accommodation granted or denied.