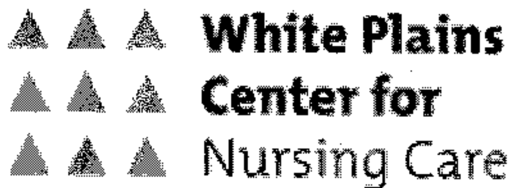

220 west post road White plains New York 10606
Tel: (914)-686-8880

APPLICATION FOR EMPLOYMENT

INSTRUCTIONS: Print clearly in black or blue ink. Answer all questions. Sign and date the form.

PERSONAL INFORMATION:

Full Name (include middle initial):____________________

Street Address:____________________

City, State, Zip Code:____________________

Home Phone Number:__________ Cell Phone Number:__________

Social Security No.:__________ Email Address:__________

EMERGENCY INFORMATION: Person to be contacted in case of emergency:

Name:__________ Relationship:__________

Street Address:____________________

City, State, Zip Code:____________________

Home Phone Number:__________ Cell Phone Number:__________

POSITION AVAILABILITY:

Position Applied For:____________________

Shift Preference:____________________

Rate of Pay Expected: $__________

Would you work: Full-Time: ____ Yes ____ No Part-Time: ____ Yes ____ No

Specify the days and hours if Part-Time:____

____

What date are you available to start work?____

Are you eligible to work in the United States? ____ Yes ____ No

If you are under age 18, do you have an employment/age certificate? Yes No

Have you been convicted of or pleaded no contest to a felony within the last five years? (Note: Conviction of a criminal offense will not necessarily preclude your employment)

____ Yes ____ No If yes, please explain: ____

____

____

EDUCATION:

Name of School	Address	Dates	Degree
High School			
____________	________________	____ to ____	______
Undergraduate			
____________	________________	____ to ____	______
____________	________________	____ to ____	______
Graduate			
____________	________________	____ to ____	______
____________	________________	____ to ____	______
Other / Trade			
____________	________________	____ to ____	______

Briefly state any special skills or qualifications you have which you feel are related to the position for which you are applying (including any Licenses, special training, awards, etc.):

____

____

____

<u>MILITARY SERVICE RECORD:</u>

Were you in the U.S. Armed Forces? ____ Yes ____ No

If yes, what branch?____

Dates of Duty: From ____________ to ______________

Rank at Discharge:____

List duties in the service including special training:______________________________

____

____

<u>EMPLOYMENT HISTORY:</u>

<u>Present or Most Recent Position</u>:

Name and Address of Employer:_____________________________________

Supervisor:________________________________ Phone:_______________

Supervisor's Email:____

Position Title:____

Dates of Employment - From: ______________ TO: ________________

Responsibilities:____

____

Salary:______________________

Reason for Leaving: ____

<u>Previous Position</u>:

Name and Address of Employer:_____________________________________

Supervisor:________________________________ Phone:_______________

Supervisor's Email:____

Position Title:____

Dates of Employment - From: ______________ TO: ________________

Responsibilities:____

____

Salary:______________________

Reason for Leaving: ____

Previous Position:
Name and Address of Employer:______________________________

Supervisor:______________________ Phone:______________________

Supervisor's Email:______________________________

Position Title:______________________________

Dates of Employment - From: ______________ TO: ______________

Responsibilities:______________________________

____

Salary:______________

Reason for Leaving: ______________________________

May we contact the employers listed above? ____ Yes ____ No

If not, indicate which ones you do not wish us to contact?______________________________

____

List any volunteer or community service positions (work) which you feel are related to the position you are applying for:______________________________

____

____

____

REFERENCES: Name/Title Address Phone:

1. ______________________________
2. ______________________________
3. ______________________________

This facility does not discriminate in hiring or in any other decision on the basis of race, color, sex, citizenship, national origin, and ancestry or on the basis of age or physical or mental disability unrelated to the ability to perform the required work. No question on this application is intended to secure information to be used for such discrimination.

I voluntarily give this facility the right to make a thorough investigation of my past employment and activities, agree to cooperate in such investigations and release from all liability and responsibility all persons, companies or corporations supplying such information. I consent to take a physical examination and such future physical examinations as may be required by this

facility at such times and places as the facility shall designate. I understand that an offer of employment may be contingent on passing the physical examination which relates to the essential duties I would be required to perform.

I understand that my employment is at will and that either party is free to terminate my employment relationship at any time without cause I also understand that my employment may be terminated for any misstatement or omission of fact appearing on this application form.

If employed, I will be required to complete an employment verification form I Dash nine and within three days show satisfactory evidence of identity and eligibility for employment.

I certify that information contained in this application is true and complete. I understand that false information may be grounds for not hiring me or for immediate termination of employment at any point in the future if I am hired. I authorize the verification of any or all information listed above.

Signature: ______________________________ Date__________________

White Plains Center for Nursing Care

Employer Reference Check Form

Date: ________________ Name of Applicant: ______________________________

Job Title Considered for: ____

Organization Contacted: ____________________________ Phone No.: ___________

Person Contacted: ____________________________ Title: __________________

Note: if prior employer is unwilling to provide answers, please confirm last question regarding eligibility for rehire.

	YES	NO
This applicant gave your name as a former employer. Applicant states that they were employed from ______________ to ______________ and that their position was ________________________ Can you verify this?		
Were you the applicant's immediate supervisor? If NO, please give your working relationship: ______________________________		
Was the applicant's work performance satisfactory?		
Did the applicant's absentee record (other than legitimate family/medical leave) affect his\her performance or the productivity of the team/organization?		
Did the employee ever receive disciplinary action? If yes, note: ______________________________		
Are you aware of any information that might negatively affect this individual's suitability for employment in a position caring for children or vulnerable seniors? ______________________________		
Would you rehire this person? ______________________________		

Individual completing form: ______________________________________

Title: ____

White Plains
Center for
Nursing Care

Employer Reference Check Form

Date: ________________ Name of Applicant: ________________________________

Job Title Considered for: ____

Organization Contacted: ______________________________ Phone No.: __________

Person Contacted: ____________________________ Title: ____________________

Note: if prior employer is unwilling to provide answers, please confirm last question regarding eligibility for rehire.

	YES	NO
This applicant gave your name as a former employer. Applicant states that they were employed from ______________ to ______________ and that their position was ______________________ Can you verify this?		
Were you the applicant's immediate supervisor? If NO, please give your working relationship: ________________________________		
Was the applicant's work performance satisfactory?		
Did the applicant's absentee record (other than legitimate family/medical leave) affect his\her performance or the productivity of the team/organization?		
Did the employee ever receive disciplinary action? If yes, note: ________________________________		
Are you aware of any information that might negatively affect this individual's suitability for employment in a position caring for children or vulnerable seniors? ________________________________		
Would you rehire this person? ________________________________		

Individual completing form: ________________________________

Title: ____

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 [illegible]

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

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

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

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

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

☐ 1. A citizen of the United States

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

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

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

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

1. Alien Registration Number/USCIS Number: ____________

OR

2. Form I-94 Admission Number: ____________

OR

3. Foreign Passport Number: ____________

Country of Issuance: ____________

QR Code - Section 1
Do Not Write In This Space

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

Preparer and/or Translator Certification (check one):

☐ [illegible] ☐ [illegible]

[illegible]

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

[illegible]

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

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		Additional Information		QR Code - Sections 2 & 3 Do Not Write In This Space
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

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

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:
   a. Foreign passport; and
   b. Form I-94 or Form I-94A that has the following:
   (1) The same name as the passport; and
   (2) An endorsement of the alien's nonimmigrant status as long as that period of endorsement has not yet expired and the proposed employment is not in conflict with any restrictions or limitations identified on the form.
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

LIST B
Documents that Establish Identity

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

AND

LIST C
Documents that Establish Employment Authorization

1. A Social Security Account Number card, unless the card includes one of the following restrictions:
   (1) NOT VALID FOR EMPLOYMENT
   (2) VALID FOR WORK ONLY WITH INS AUTHORIZATION
   (3) VALID FOR WORK ONLY WITH DHS AUTHORIZATION
2. 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.

DOH CHRC 102 (1/07)

NYS Department of Health

ACKNOWLEDGEMENT AND CONSENT FORM FOR FINGERPRINTING AND DISCLOSURE OF CRIMINAL HISTORY RECORD INFORMATION

THIS FORM IS TO BE RETAINED BY THE AGENCY- DO NOT FORWARD TO THE DOH CHRC UNIT.

chrc@health.state.ny.us

The purpose of this form is to obtain consent from the subject individual for fingerprints and criminal history record information pursuant to Article 28-E of the Public Health Law and Section 845-b of the Executive Law.

SECTION 1 – SUBJECT INDIVIDUAL INFORMATION

LAST Name	FIRST Name	M.I.	
Date of Birth (mm/dd/yyyy)	Mother's Maiden Name	Alias: AKA	

Mailing Address (street)	City	State	Zip

SECTION 2 - ATTESTATION

1. I have applied to an agency to provide direct care or supervision to residents or patients. I understand that as part of the application process, the Public Health Law (PHL) Article 28-E requires that the New York State Department of Health perform a criminal history check on me with the New York State Division of Criminal Justice Services (DCJS) and the Federal Bureau of Investigation (FBI).

2. I acknowledge and consent to having my fingerprints taken for the purpose of a criminal history record check by the DCJS and the FBI.

3. I have been advised that DOH is authorized by law to receive the results of the criminal history record check from DCJS and the FBI for the purpose of developing a criminal history record summary to be provided to the agency to which I applied for a position to provide direct care or supervision to residents or patients. I have been advised that the criminal history record summary will indicate whether I have a criminal history, as maintained by DCJS or the FBI, including convictions of a crime (felony or misdemeanor) or criminal charges which do not reflect a disposition. I have been advised that by law, DOH is authorized and may be required to provide the results of the criminal history record check through a criminal history record summary to the agency. The criminal history record summary prepared by DOH and sent to the agency will contain the results of the criminal history record check performed by DCJS. I have been advised that the information shall be confidential pursuant to applicable federal and state laws, rules and regulations and shall only be disclosed to persons authorized by law.

4. I hereby consent to DOH sharing with any DCJS agency to which I applied for a position to provide direct care or supervision, any criminal history record check information provided to DOH by the FBI, including the specific crime(s) for which I was convicted or charged, the date of the arrest for such charge, and/or date of conviction, and the jurisdiction in which the arrest or conviction took place.

5. I have been informed of the procedures and my rights to obtain, review and seek correction of my criminal history information pursuant to regulations and procedures established by the DCJS and the FBI.

6. I understand that I have the right to withdraw my application for employment, without prejudice, any time before employment is offered or declined, regardless of whether an agency, DOH or I have reviewed my criminal history information.

7. I certify to the best of my knowledge and belief that I (check as appropriate):

   ☐ **Have** ☐ **Have not been convicted of a crime in New York State or any other jurisdiction**

   ☐ **Do** ☐ **Do not have a final finding of patient or resident abuse**

   If you have checked either "Have" and/or "Do", please provide a brief explanation. (Optional)

   ____

8. My current mailing or home address is indicated in Section 1 of this form.

9. I have read this form and hereby consent to the request by the agency to use my fingerprints to obtain my criminal history record, if any, from the DCJS and the FBI. I hereby consent to the redisclosure of any convictions or open charges on my criminal history record, received by DOH from DCJS, to the requesting agency. I declare and affirm that the information I have provided on this consent form is true, complete and accurate and that the fingerprints to be submitted are my own (not applicable for Expedited Review submitted pursuant to CHRC Form 104).

Applicant Signature: ______________________________ Date: ______________

Signature of Parent or Legal Guardian______________________________ Date: ______________
(if subject individual is under 18 years of age)

SECTION 3 – AGENCY AUTHORIZED PERSON INFORMATION

Agency Name:	PFI/Operating License Number:
Print Name of Authorized Person:	Title:
Signature of Authorized Person:	Date:

NYS Department of Health

CHRC Unit
P. O. Box 2607
Albany, NY 12220-0607
Phone: 518.402.5549
Fax: 518.474.7477
www.nyhealth.gov/chrc
chrc@health.state.ny.us

REQUEST FOR CRIMINAL HISTORY RECORD CHECK
PAGE 1
INSTRUCTIONS

CRIMINAL HISTORY RECORD CHECK (CHRC) PROGRAM

For Department use only
Leave blank

This form is to be used to request a criminal history record check (CHRC) for a subject individual from the DOH CHRC Unit.

For purposes of this form, the term **"Agency"** means residential health care facility, certified home health agency, licensed home care services agency or long term home health care programs that are authorized by law to request a check of criminal history record information pursuant to Article 28-E of the Public Health Law and Section 845-b of the Executive Law.

"Authorized Person" is the individual that is allowed to request, on behalf of the Agency, fingerprints and criminal history record checks.

"Subject individual" is an "employee" as defined by Public Health Law Section 2899(3).

INSTRUCTIONS:

1. This form is to be completed by the Authorized Person, who will sign and date where indicated in Section 3.
2. Please obtain subject individual information and complete all sections on page 2 of this form prior to or at the time of fingerprinting. This information will be used to conduct both a Federal and State criminal history record check pursuant to State law.
3. If subject individual is employed by a staffing organization with an Agency work location, the Agency is responsible for completing this form and the staffing agency may complete Section 4 if that staffing agency fingerprints the subject individual.
4. Subject individual is required to present two (2) forms of identification (ID) when fingerprinted. One must be a government-issued ID with subject individual's signature. At least one of the two forms of ID must contain a current photograph. Acceptable forms of government-issued IDs are: valid driver's license or Department of Motor Vehicles (DMV) ID, valid passport, valid military identification or valid school identification document. The type of government-issued ID presented is recorded in Section 2 of this form. Refer to the Employment Eligibility Verification Form I-9 for examples of other forms of identification. The second ID must be produced but not recorded in Section 2 of this form.
5. If subject applicant is fingerprinted by other than the Authorized Person, provide this instructional page to that individual for assistance in completing Section 4 of this form.
6. Authorized Person is to ensure that all fields in all sections must be completed for accurate and timely submissions.
7. Authorized Person will forward Page 2 of this Form to the DOH CHRC Unit at the address indicated above.

FIELD DESCRIPTIONS:

SEX FIELD

M – Male
F – Female

RACE FIELD

A – Chinese, Japanese, Filipino, Korean, Polynesian, Indian, Indonesian, Asian Indian, Samoan or any other Pacific Islander
B – African black racial groups
I – American Indian, Eskimo, or Alaskan native
U – Of indeterminable race
W – Caucasian, Mexican, Puerto Rican, Cuban, Central/South American or other Spanish origin

BIRTH COUNTRY/PLACE FIELD

Enter **United States of America** for those of American birth
Enter Country of Birth for those not of American birth

HEIGHT FIELD

To be completed as a three (3) character value. If reported in feet and inches, the first (leftmost) digit is used to show feet with the two rightmost digits are used to show the inches between 00 and 11. If reported in inches, the leftmost character is "N" followed by two digits. If height in unknown, 000 is entered.

The allowable range is 400 to 711. Heights shorter than 4 ft. will be recorded as 400 and taller than 7 ft. 11 in. will be recorded as 711.

WEIGHT FIELD

In this field, the subject applicant's weight in pounds is entered (000-499). If weight is unknown, 000 is entered.
All weight in excess of 499 pounds will be recorded as 499 lbs.

HAIR FIELD – COLOR CODES

BAL – Bald
BLK – Black
BLN – Blonde or Strawberry
BLU – Blue
BRO – Brown
GRN – Green
GRY – Gray or Partially Gray
ONG – Orange
PNK – Pink
PLE – Purple
RED – Red or Auburn
SDY – Sandy
WHI – White
XXX – Unknown

EYE FIELD – COLOR CODES

BLK – Black
BLU – Blue
BRO – Brown
GRY – Gray
GRN – Green
HAZ – Hazel
MAR – Maroon
MUL – Multicolored
PNK – Pink
XXX – Unknown

51289

DOH CHRC 103 (9/06) - Page 2

NYS Department of Health | **CRIMINAL HISTORY RECORD CHECK**

Resubmission ○

Type or print all information - USE CAPITAL LETTERS.
Inaccurate, incomplete or illegible information will delay processing.

DOH use only. Leave blank

SECTION 1 - SUBJECT INDIVIDUAL INFORMATION

Social Security Number* ___ - __ - ____ Date of Birth mm/dd/yyyy __ / __ / ____

LAST Name FIRST Name M.I.

Maiden Name Alias (AKA)

Street Nmbr Street Name Apt #

City St Zip Home Phone ___ - ___ - ____

Sex Birth Country/Place Cell Phone ___ - ___ - ____

Race Height (ft-inch) _ - __ Weight (lbs) Hair Eyes

SECTION 2 - SUBJECT INDIVIDUAL IDENTIFICATION

Please Select the Type of **PICTURE IDENTIFICATION** (select one):

○ Drivers License/ DMV ID ○ Passport ○ Miltary ○ School ○ Other Identify:

Issuing State/Country/Armed Force/School: ID Number ID Expire Date mm/dd/yy __ / __ / __

SECTION 3 - AGENCY IDENTIFICATION

○ Nursing Home ○ CHHA ○ LTHHCP PFI# ○ LHCSA LICENSE #

Full name of Agency where applicant will be working Telephone number with area code ___ - ___ - ____

Authorized Person LAST Name FIRST Name

Agency's Street Nmbr Street Name

City State Zip

Authorized Party's e-mail:

The subject individual, whose identification I have confirmed, will provide direct care or supervision to individuals receiving care and/or services and is a subject individual concerning whom a criminal history record check is required by law (Article 28-E of the Public Health Law and Section 845-B of the Executive Law). I understand that the results of the criminal history record check will be used solely for purposes authorized by law and I will abide by the confidentiality requirements set forth in law. Informed consent (DOH CHRC Form 102) has been given by the subject individual and is on file.

Signature of Agency Authorized Person: Date: __ / __ / __ (MM DD YY)

SECTION 4 - FINGERPRINTING METHOD/IDENTIFICATION

Fingerprint Method:
○ Ink & Roll
○ Live Scan

Name & Address of Location where fingerprint services were performed

City State Zip

Identification verified before fingerprinting: (refer to Instruction #4)
○ Yes
○ No

The subject individual, whose identification I have confirmed, appeared before me for fingerprinting. I secured his/her fingerprints via the method indicated.

Signature:

First Name:

Last Name:

Title:

Date Fingerprinted __ / __ / ____ (MM DD YYYY)

51289

*The Authorized Person shall inform the subject individual that disclosure of the Social Security Number (SSN) is voluntary and not mandatory and that it will be used to assist DOH-CHRC Unit in performing criminal history record checks.

WHITE PLAINS CENTER FOR NURSING CARE

220 WEST POST ROAD

WHITE PLAINS, NEW YORL 10606

EMPLOYEE HEALTH EXAMINATION RECORD

NAME:______________________ MSWD:__________ DATE OF BIRTH:__________

NOTIFY INCASE OF EMERGENCY - NAME:______________ RELATIOSHIP:______________

ADDRESS: ______________ CITY__________ STATE________ ZIP________

APPLICANT: - Have you had any of the following ? (PLEASE CHECK BOX)

	YES	NO		YES	NO
Operations			*Fainting Spells*		
Fractures			*Epilepsy*		
Head Injury			*Mental Disease*		
Back Injury			*Jaundice*		
Other Injury			*Rheumatisim*		
Chronic Back Pain			*Asthma*		
Tuberculosis			*Sinus Trouble*		
Heart Trouble			*Skin Disease*		
Stomach Trouble			*Hernia*		

I have read the above and Declare that I have had no Injury, Illness or Ailment other than as specifically herein noted
Any falsification or misrepresentation will be sufficent grounds for my release from employment.

SIGNATURE: ______________________
APPLICANT

*Ears -*______________________

*Eyes -*______________________

*Teeth-*______________________

*Nose and Throat-*______________________

*Skin-*______________________

*Skars-*______________________

*Heart-*______________________

*lungs-*______________________

*Abdomen--*______________________ *MMR -* ________

*Hernia-*______________________ *X-ray -* ________

*Extremities-*______________________ *PPD -* ________

*Menstrual History-*______________________ *Weight -* ________

*Blood Pressure-*______________________ *Height -* ________

T. *P.* *R.*

LABORATORY: *RBC*________ *WBC*________ *HBG*________ *WASSERMAN*________

*U.A.*______________________ *Stool*________

*DATE:*______________ *EXAMINING PHYSICIAN NAME:*______________________

REVISED-9-2020mvr

INFLUENZA VACCINE CONSENT and EDUCATION DOCUMENTATION FORM

It is the Policy of **WHITE PLAINS CENTER FOR NURSING CARE,** *to offer the Influenza Vaccine to all eligible Residents during Influenza Season and that the risks and benefits are explained to the Residents or the Residents legal representative prior to administration of the vaccine. The resident or Residents legal representative has the right to refuse the vaccine. This vaccine will be administered annually while residing in the Facility.*

THE DISEASE - *Influenza (***flu***) is a highly contagious respiratory illness. Symptoms occur suddenly (***i.e., Fever, Chills, Headache, Sore Throat, Dry Cough and Muscle Aches***). The illness usually lasts* **5 to 7 days.** *In the US, more than 200,000 people are hospitalized from Flu complications and 36,000 die annually.* ***Getting a Flu Shot is the best thing you can do to avoid getting the Flu and helps prevent outbreaks of Flu in the Facility.***

WHO SHOULD GET VACCINATED – *All Residents living in Skilled Nursing Facilities and especially those with Chronic Medical Conditions* (**i.e., Heart, Lung, Kidney Disease and Diabetes, etc.**)

FLU VACCINE FACTS –

1. *Flu Vaccine is a killed, Inactive Vaccine, (***You, Can't Get the Flu, From the Flu Shot***).*
2. *Each Year a Flu Vaccine is made of* ***(3 Viruses' Strains)*** *that are Circulating Worldwide.*
3. *The benefits for older people are to shorten the length of time that you are sick. If you do get the Flu and to reduce the chance of a serious respiratory illness that may require hospitalization.*

WHO SHOULD NOT GET VACCINATED –

1. *RESIDENTS with a history of allergy to the Flu Vaccine, or eggs.*
2. *RESIDENTS with Fever > 101 F or who is being treated for an active infection.*
3. *RESIDENTS with history of Guillain-Barre Syndrome.*

POSSIBLE VACCINE REACTIONS -

1. *The Vaccine is safe. Most people experience no side effects.*
2. *You may have mild symptom: Soreness, Redness, and Swelling at the Vaccine cite and fever. This lasts less than 48 hours.*
3. *In 1976, the Swine Flu Vaccine was associated with Guillain-Barre Syndrome (***GBS***). Since then, the Flu Vaccines have not been clearly linked to (***GBS***).* ***Current risk 1-2 per million***
4. *As with Vaccine, there is a small risk of serious problem, even death. Symptoms of severe allergic reaction include Hives, Difficulty Breathing and Shock. Epinephrine is a Medicine that will be administered to treat these rare symptoms.*

PLEASE CHECK ALL THAT APPLY:

___- I have read the above information about the **Influenza Vaccine** and I have had the opportunity to ask questions. I understand the benefits and risks of the vaccination.

___- **Yes, I agree** to receive the Influenza Vaccine

___ - **NO, I REFUSE THE VACCINE**

___- I have already had the Influenza Vaccine this season, MONTH_________YEAR_________

RESIDENTS NAME: LAST ______________________FIRST______________________

RESIDENT SIGNATURE: OR LEGAL REPRESENTATIVE: ______________________DATE:__________

2021-2022 EMPLOYEE INFLUENZA ACCEPTANCE/DECLINATION FORM/VACCINATION RECORD

EMPLOYEE'S NAME: ________________________________ DEPT: __________

I have been advised that I should receive the Influenza vaccine. I have read the Center for Disease Control and Prevention Vaccine Information Statement explaining the vaccine and the disease it prevents. I have had the opportunity to discuss the statement and have my questions answered by a healthcare provider. I understand the following:

- The purpose of the need for the recommended vaccine
- The risks and benefits of the recommended vaccine
- My employer, the CDC Advisory Committee on Immunization Practices, and the New York State Department of Health have strongly recommended that the vaccine be given to all persons who have been screened and determined to be candidates for the vaccine
- I understand that I cannot get the flu from the influenza vaccine
- I understand that during the Influenza Season I will be required to wear a mask in resident care areas (as per facility policy) if I do not receive the Influenza Vaccine
- I understand that I will not be able to work at the facility if I fail to follow facility policy

( ) I wish to receive the Influenza Vaccine

( ) I decline to receive the Influenza Vaccine

( ) Medical Contraindication cannot receive (Submitted written documentation)

( ) I have received the Influenza Vaccine and submitted written documentation of the name and address of the individual who ordered and or administered the vaccine. (SEE ATTACHED)

Signature: ____________________________________ **Date:** _________

FACILITY INFLUENZA VACCINATION RECORD

Name: ____________ **Distributor of Vaccine:** _______________ **Lot #** __________

Expiration Date: ___________ **Dosage: 0.5ml** **Site:** __________

Date of Vaccination: ______________ **Administered by:** ___________ **Title:** _____

WHITE PLAINS CENTER FOR NURSING CARE

EMPLOYEE VACCINATION PERMISSION SLIP

INFLUENZA VACCINE :

PRINT

EMPLOYEE LAST NAME:____________________ **FIRST NAME:**__________________

DEPARTMENT:__________________________

☐ - **ACCEPT** ☐ - **I DECLINE** ☐ - **I HAVE ALREADY RECEIVED FLU VACCINE**
(WRIITEN DOCUMENTATION REQUIRED)

EMPLOYEE SIGNATURE:________________________________ **DATE:**___________

DATE GIVEN:	LOT #	SITE:	EXP. DATE:	GIVEN BY:	COMMENT:

PNEUMOCOCCAL VACCINE :

☐ - **ACCEPT** ☐ - **I DECLINE** ☐ - **I HAVE ALREADY RECEIVED, PNEUMOCOCCAL VACCINE**
(WRIITEN DOCUMENTATION REQUIRED)

EMPLOYEE SIGNATURE:________________________________ **DATE:**___________

DATE GIVEN:	LOT #	SITE:	EXP. DATE:	GIVEN BY:	COMMENT:

I have read the Centers for Disease Control and Preventive's (CDC) vaccine information statement (s) explaining the vaccine(s) and the disease(s) they prevent. I have the opportunity to discuss the statements and have my questions answered by a Health Care Provider. I understand the following:

* The purposeof the Vaccine(S)
* The risk and benefit(S) of the Vaccine(s)
* My Employer, the CDC Avisory Committee on Immunization Prastices and the New York State Department of Healthhave strongly recommended that the Vaccine(s) be given to all persons who have been screened and determined to be a candidate for the Vaccine(s).
* I understand I cannot get Flu from the Influenza Vaccine.

I know that failure to follow the recommendations about vaccination may endanger my heallth and the health of others I may come in contact with should I become infected. I can still receive either Vaccine should I change my mind.

I acknowledge that I have read this document in its entirely and fully understand it.

REVISED 10-2020ypl

White Plains Center for Nursing Care

Screening Checklist for Hepatitis B Vaccine

For Employees: The following questions will help us determine if the Hepatitis Vaccine may be given to you. If you answer "yes" to any question, it does not necessarily mean you should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please ask the DNS/ADNS to explain it.

EMPLOYEE NAME: ____________________ **DEPARTMENT:** _________

DATE: ____________________

Have you had the Hepatitis B Vaccination? ____NO ____YES ____DON'T KNOW

If yes, did you complete the 3 dose vaccination series? ____NO ____YES ____DON'T KNOW
Date Completed: ________

Do you have test results that indicate you are immune to Hepatitis B? ____NO ____YES

Do you have a medical contraindication for any vaccinations? ____NO ____YES

Have you read the vaccination information sheet on Hepatitis B vaccine? ____NO ____YES

Based upon the information received I understand that due to my occupational exposure to blood or other potentially infectious materials I may be at risk of acquiring hepatitis B virus (HBV) infection. I have been given the opportunity to be vaccinated with hepatitis B vaccine, at no charge to myself.

_____I wish to receive the hepatitis B vaccine (SEE HEPATITIS B VACCINE SHEET)

_____ I decline hepatitis B vaccination at this time. (SEE HBV DECLINATION SHEET)

EMPLOYEE SIGNATURE: ______________________ **DATE:** _______

INFECTION CONTROL PREVENTIONIST: ______________________

COMMENTS:

____

____

____

White Plains Center for Nursing Care

HBV VACCINE DECLINATION FORM

"I understand that due to my occupational exposure to blood or other potentially infectious material, I may be at risk of acquiring hepatitis B virus (HBV) infection. I have been given the opportunity to be vaccinated with hepatitis B vaccine, at no charge to myself. However, I decline hepatitis B vaccination at this time. I understand that by declining this vaccine, I continue to be at risk of acquiring hepatitis B, a serious disease.

If, in the future, I continue to have occupational exposure to blood or other potentially infectious materials and I want to be vaccinated with hepatitis B vaccine, I can receive the vaccination series at no charge to me."

____________________________ ________________

Employee signature Date

____

Employee printed name

Comments: ____

White Plains
Center for
Nursing Care

Tuberculosis Screen

Name:________________________ Dept.________________________ PPD HX: __________

1. Do you (or) have you had any of the following problems:

	No	Yes
Diabetes	☐	☐
Blood/ Lymph disease Such as leukemia or Hodgkin's	☐	☐

2. Do you take corticosteroids (prednisone, cortisone):
   No ☐ Yes ☐ If yes, then please explain:______________________________
   ____
   ____
   ____
   ____

3. Are you taking any immunosuppressive drugs (azathioprine, cyclosporine, muromonab)?
   No ☐ Yes ☐ If yes, then please explain:______________________________
   ____
   ____
   ____
   ____

4. Do you have any of the following symptoms:

	No	Yes		No	Yes
Fever	☐	☐	Tiredness	☐	☐
Weakness	☐	☐	Loss of Appetite	☐	☐
Night Sweats	☐	☐	Unexplained weight loss	☐	☐
Swelling in Neck/ armpits/ groins	☐	☐	Cough with Sputum	☐	☐
			Bloody Sputum	☐	☐

   No ☐ Yes ☐ If yes, then please explain:______________________________
   ____
   ____
   ____
   ____

Date:______________________________
Employee:__________________________

White Plains
Center for
Nursing Care

Latex Allergy Questionnaire

Name:______________________________ Dept.________________________ Title: __________________

Only Fill Out The Column That Applies To You

Category A
(May indicate Latex Sensitivity)

	Yes	No
1. Do you suffer from:		
Seasonal Hay Fever	☐	☐
Eczema	☐	☐
Autoimmune Disease	☐	☐
Chronic Asthma	☐	☐
2. Do you have any food allergies	☐	☐
3. Do you have "on the Job" exposure to latex?	☐	☐
4. Were you born with problems involving your spinal cord?	☐	☐
5. Do you catheterize yourself to urinate?	☐	☐
6. Are you allergic to any of the following items?		
Kiwi fruit	☐	☐
Avocados	☐	☐
Guacamole	☐	☐
Bananas	☐	☐
Chestnuts	☐	☐

Category B
(Significant indicators for Latex Allergy)

	Yes	No
1. Have you ever been told by a doctor that you are allergic to latex?	☐	☐
2. Have you ever experienced allergic symptoms after contact with latex or rubber?	☐	☐

If yes, do the symptoms include any of the following? (check all that apply?)

____ Hives
____ Itching
____ Difficulty breathing
____ Watery eyes

3. Have you ever had allergic Symptoms while

_____ Blowing up balloon(s)
_____ During dental examinations
_____ On contact with diaphragms/ condoms
_____ During vaginal or rectal exam
_____ While wearing rubber gloves

	Yes	No
4. Have you ever had a strong allergic reaction (anaphylaxis) or other unexplained reaction during or following a medical procedure?	☐	☐

Form **W-4**

Department of the Treasury
Internal Revenue Service

Employee's Withholding Certificate

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

OMB No. 1545-0074

2022

Step 1: Enter Personal Information	(a) First name and middle initial	Last name	(b) Social security number
	Address		► **Does your name match the name on your social security card?** If not, to ensure you get credit for your earnings, contact SSA at 800-772-1213 or go to *www.ssa.gov*.
	City or town, state, and ZIP code		

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

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

Step 2: Multiple Jobs or Spouse Works

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

Do **only one** of the following.

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

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

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

TIP: To be accurate, submit a 2022 Form W-4 for all other jobs. If you (or your spouse) have self-employment income, including as an independent contractor, use the estimator.

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

Step 3: Claim Dependents

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

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

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

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

Step 4 (optional): Other Adjustments

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

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

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

Step 5: Sign Here

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

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

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

General Instructions

Section references are to the Internal Revenue Code.

Future Developments

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

Purpose of Form

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

Exemption from withholding. You may claim exemption from withholding for 2022 if you meet both of the following conditions: you had no federal income tax liability in 2021 **and** you expect to have no federal income tax liability in 2022. You had no federal income tax liability in 2021 if (1) your total tax on line 24 on your 2021 Form 1040 or 1040-SR is zero (or less than the sum of lines 27a, 28, 29, and 30), 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 2022 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 15, 2023.

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

Step 4 (optional).

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

Step 4(b). Enter in this step the amount from the Deductions Worksheet, line 5, if you expect to claim deductions other than the basic standard deduction on your 2022 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 2022 itemized deductions (from Schedule A (Form 1040)). Such deductions may include qualifying home mortgage interest, charitable contributions, state and local taxes (up to $10,000), and medical expenses in excess of 7.5% of your income . . . . **1** $ ______

2 Enter:
- $25,900 if you're married filing jointly or qualifying widow(er)
- $19,400 if you're head of household
- $12,950 if you're single or married filing separately

. . . . **2** $ ______

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

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

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

Privacy Act and Paperwork Reduction Act Notice. We ask for the information on this form to carry out the Internal Revenue laws of the United States. Internal Revenue Code sections 3402(f)(2) and 6109 and their regulations require you to provide this information; your employer uses it to determine your federal income tax withholding. Failure to provide a properly completed form will result in your being treated as a single person with no other entries on the form; providing fraudulent information may subject you to penalties. Routine uses of this information include giving it to the Department of Justice for civil and criminal litigation; to cities, states, the District of Columbia, and U.S. commonwealths and 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	$110	$850	$860	$1,020	$1,020	$1,020	$1,020	$1,020	$1,020	$1,770	$1,870
$10,000 - 19,999	110	1,110	1,860	2,060	2,220	2,220	2,220	2,220	2,220	2,970	3,970	4,070
$20,000 - 29,999	850	1,860	2,800	3,000	3,160	3,160	3,160	3,160	3,910	4,910	5,910	6,010
$30,000 - 39,999	860	2,060	3,000	3,200	3,360	3,360	3,360	4,110	5,110	6,110	7,110	7,210
$40,000 - 49,999	1,020	2,220	3,160	3,360	3,520	3,520	4,270	5,270	6,270	7,270	8,270	8,370
$50,000 - 59,999	1,020	2,220	3,160	3,360	3,520	4,270	5,270	6,270	7,270	8,270	9,270	9,370
$60,000 - 69,999	1,020	2,220	3,160	3,360	4,270	5,270	6,270	7,270	8,270	9,270	10,270	10,370
$70,000 - 79,999	1,020	2,220	3,160	4,110	5,270	6,270	7,270	8,270	9,270	10,270	11,270	11,370
$80,000 - 99,999	1,020	2,820	4,760	5,960	7,120	8,120	9,120	10,120	11,120	12,120	13,150	13,450
$100,000 - 149,999	1,870	4,070	6,010	7,210	8,370	9,370	10,510	11,710	12,910	14,110	15,310	15,600
$150,000 - 239,999	2,040	4,440	6,580	7,980	9,340	10,540	11,740	12,940	14,140	15,340	16,540	16,830
$240,000 - 259,999	2,040	4,440	6,580	7,980	9,340	10,540	11,740	12,940	14,140	15,340	16,540	17,590
$260,000 - 279,999	2,040	4,440	6,580	7,980	9,340	10,540	11,740	12,940	14,140	16,100	18,100	19,190
$280,000 - 299,999	2,040	4,440	6,580	7,980	9,340	10,540	11,740	13,700	15,700	17,700	19,700	20,790
$300,000 - 319,999	2,040	4,440	6,580	7,980	9,340	11,300	13,300	15,300	17,300	19,300	21,300	22,390
$320,000 - 364,999	2,100	5,300	8,240	10,440	12,600	14,600	16,600	18,600	20,600	22,600	24,870	26,260
$365,000 - 524,999	2,970	6,470	9,710	12,210	14,670	16,970	19,270	21,570	23,870	26,170	28,470	29,870
$525,000 and over	3,140	6,840	10,280	12,980	15,640	18,140	20,640	23,140	25,640	28,140	30,640	32,240

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	$400	$930	$1,020	$1,020	$1,250	$1,870	$1,870	$1,870	$1,870	$1,970	$2,040	$2,040
$10,000 - 19,999	930	1,570	1,660	1,890	2,890	3,510	3,510	3,510	3,610	3,810	3,880	3,880
$20,000 - 29,999	1,020	1,660	1,990	2,990	3,990	4,610	4,610	4,710	4,910	5,110	5,180	5,180
$30,000 - 39,999	1,020	1,890	2,990	3,990	4,990	5,610	5,710	5,910	6,110	6,310	6,380	6,380
$40,000 - 59,999	1,870	3,510	4,610	5,610	6,680	7,500	7,700	7,900	8,100	8,300	8,370	8,370
$60,000 - 79,999	1,870	3,510	4,680	5,880	7,080	7,900	8,100	8,300	8,500	8,700	8,970	9,770
$80,000 - 99,999	1,940	3,780	5,080	6,280	7,480	8,300	8,500	8,700	9,100	10,100	10,970	11,770
$100,000 - 124,999	2,040	3,880	5,180	6,380	7,580	8,400	9,140	10,140	11,140	12,140	13,040	14,140
$125,000 - 149,999	2,040	3,880	5,180	6,520	8,520	10,140	11,140	12,140	13,320	14,620	15,790	16,890
$150,000 - 174,999	2,040	4,420	6,520	8,520	10,520	12,170	13,470	14,770	16,070	17,370	18,540	19,640
$175,000 - 199,999	2,720	5,360	7,460	9,630	11,930	13,860	15,160	16,460	17,760	19,060	20,230	21,330
$200,000 - 249,999	2,970	5,920	8,310	10,610	12,910	14,840	16,140	17,440	18,740	20,040	21,210	22,310
$250,000 - 399,999	2,970	5,920	8,310	10,610	12,910	14,840	16,140	17,440	18,740	20,040	21,210	22,310
$400,000 - 449,999	2,970	5,920	8,310	10,610	12,910	14,840	16,140	17,440	18,740	20,040	21,210	22,470
$450,000 and over	3,140	6,290	8,880	11,380	13,880	16,010	17,510	19,010	20,510	22,010	23,380	24,680

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	$760	$910	$1,020	$1,020	$1,020	$1,190	$1,870	$1,870	$1,870	$2,040	$2,040
$10,000 - 19,999	760	1,820	2,110	2,220	2,220	2,390	3,390	4,070	4,070	4,240	4,440	4,440
$20,000 - 29,999	910	2,110	2,400	2,510	2,680	3,680	4,680	5,360	5,530	5,730	5,930	5,930
$30,000 - 39,999	1,020	2,220	2,510	2,790	3,790	4,790	5,790	6,640	6,840	7,040	7,240	7,240
$40,000 - 59,999	1,020	2,240	3,530	4,640	5,640	6,780	7,980	8,860	9,060	9,260	9,460	9,460
$60,000 - 79,999	1,870	4,070	5,360	6,610	7,810	9,010	10,210	11,090	11,290	11,490	11,690	12,170
$80,000 - 99,999	1,870	4,210	5,700	7,010	8,210	9,410	10,610	11,490	11,690	12,380	13,370	14,170
$100,000 - 124,999	2,040	4,440	5,930	7,240	8,440	9,640	10,860	12,540	13,540	14,540	15,540	16,480
$125,000 - 149,999	2,040	4,440	5,930	7,240	8,860	10,860	12,860	14,540	15,540	16,830	18,130	19,230
$150,000 - 174,999	2,040	4,460	6,750	8,860	10,860	12,860	15,000	16,980	18,280	19,580	20,880	21,980
$175,000 - 199,999	2,720	5,920	8,210	10,320	12,600	14,900	17,200	19,180	20,480	21,780	23,080	24,180
$200,000 - 449,999	2,970	6,470	9,060	11,480	13,780	16,080	18,380	20,360	21,660	22,960	24,250	25,360
$450,000 and over	3,140	6,840	9,630	12,250	14,750	17,250	19,750	21,930	23,430	24,930	26,420	27,730

WHITE PLAINS CENTER FOR NURSING
DIRECT DEPOSIT FORM

Employee Name	Social Security Number

I authorize you and the financial institutions listed below to deposit my pay automatically to the indicated accounts and to make adjusting entries as may be required.

Bank/Credit Union	State	Amount	Routing #	Account Number	
					Chk Sav
					Chk Sav
					Chk Sav
					Chk Sav

Please attach voided check for the Direct Deposit bank account as verification for each request

Please check one:

- ○ First Time Direct Deposit
- ○ Additional Account
- ○ Change
- ○ Other

Deposits are normally available two banking days after payroll is processed. It is my responsibility to verify Deposits on a pay period basis before writing checks against these funds. This authorization can take up to three pay periods to activate. I understand that neither my employer nor ADP is responsible for bank errors or fees. I may elect to cancel this direct deposit at any time.

Signature	Date