White Plains Center for Nursing Care

WHITE PLAINS CENTER FOR NURSING CARE
Tel. (914) 686-8880
Fax. (914) 948-7658
220 West Post Road, White Plains, NY 10606

APPLICATION FOR EMPLOYMENT

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?					
If you are under age 18, do you have an employment/age certificate?					
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	
Graduate			
		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.):

MILITARY SERVICE RECORD:

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:			

EMPLOYMENT HISTORY:

Present or Most Recent Position:

Name and Address of Employer					
Supervisor				Phone	
Supervisor's Email					
Position Title					
Dates of Employment:	From:		To:		
Responsibilities					
Salary		Reason for Leaving			

Previous Position (1):

Name and Address of Employer					
Supervisor				Phone	
Supervisor's Email					
Position Title					
Dates of Employment:	From:		To:		
Responsibilities					
Salary		Reason for Leaving			

Previous Position (2):

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?	

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		Phone #	
Address			

Name / Title		Phone #	
Address			

Name / Title		Phone #	
Address			

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	

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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:

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EMPLOYEE HEALTH EXAMINATION RECORD

NAME:	MSWD:	DATE OF BIRTH:
NOTIFY INCASE OF EMERGENCY - NAME:		RELATIONSHIP:
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 sufficient grounds for my release from employment.

Signature of 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:
UA:	Stool:
DATE:	EXAMINING PHYSICIAN NAME:

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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 35,000 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 (Le., 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:

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2023-2024 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 pet-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: 0.5m1		Site:		
Date of Vaccination:		Administered by:		Title:	

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WHITE PLAINS CENTER FOR NURSING CARE
EMPLOYEE VACCINATION PERMISSION SLIP

INFLUENZA VACCINE:

PRINT

EMPLOYEE LAST NAME:	FIRST NAME:
DEPARTMENT:	

☐ I 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:

☐ I ACCEPT ☐ I DECLINE

☐ I HAVE ALREADY RECEIVED, PNEUMOCOCCAL VACCINE (WRILTEN 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, L understand the following:

- The purpose of the Vaccine(S)
- The risk and benefit(S) of the Vaccine(s)
- My Employer, the CDC Advisory Committee on Immunization Practices and the New York State Department of Health have 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 health and the health of others I may come in contact with should I become infected. I can still receive either Vaccine should 1 change my mind.

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

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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 EINSLADNS to explain it.

EMPLOYEE NAME:	DEPARTMENT:
DATE:	

	No	Yes	Don't Know
Have you had the Hepatitis B Vaccination?	☐	☐	☐
If yes, did you complete the 3 dose vaccination series? Date completed: _____	☐	☐	☐
Do you have any treatment that indicate you are immune to Hepatitis B?	☐	☐	☐
Do you have a medical contraindication for any vaccinations?	☐	☐	☐
Have you react the vaccination information sheet on Hepatitis B vaccine?	☐	☐	☐

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:

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HBV VACCINE DECLINATION FORM

I understand that clue 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:

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TUBERCULOSIS SCREEN

Name:	Department:
PPD HX:	

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

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

2. Do you take corticosteroids (prednisone, cortisone): ☐ Yes ☐ No

If yes, then please explain:

3. Are you taking any immunosuppressive drugs (azathioprine, cyclosporine, muromonab)?

☐ Yes ☐ No

If yes, then please explain:

4. Do you have any of the following symptoms:

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

If yes, then please explain:

EMPLOYEE SIGNATURE:	DATE:

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LATEX ALLERGY QUESTIONNAIRE

Name:	Department:
Title:	

Only fill out the column that applies to you.

Category A May indicate Later Sensivity			Category B Significant indicators for Latext Allergy
1. Do you suffer form:	Yes	No	1. Have you ever been told by a doctor that you Etre allergic to latex? ☐ Yes ☐ No
Seasonal Heavy Fever	☐	☐	2. Have you ever experienced allergic symptoms after contact with latex or rubber? ☐ Yes ☐ No
Eczema	☐	☐	If yes, do the symptoms include any of the following? (check all that apply?)
Autoimmune Disease	☐	☐	☐ Hives ☐ Watery eyes
Chronic Asthma	☐	☐	☐ Itching ☐ Difficulty breathing
2. Do you have any food allergies?	☐	☐	3. Have you ever had allergic Symptoms while:
3. Do you have "on the Job" exposure to latex?	☐	☐	☐ Blowing up balloon(s)
4. Were you born with problems involving your spinal cord?	☐	☐	☐ During dental examinations
5. Do you catheterize yourself to urinate?	☐	☐	☐ On contact with diaphrams condoms
6. Are you allergic to any of the following items?	☐	☐	☐ During vaginal or rectal exam
Kiwi Fruit	☐	☐	☐ While wearing rubber gloves
Avocados	☐	☐	4. Have you ever had a strong allergic reaction (anaphylaxis) or other unexplained reaction during or following a medical procedure? ☐ Yes ☐ No
Guacamole	☐	☐	
Bananas	☐	☐	
Chestnut	☐	☐	

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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 Say
					Chk Say
					Chk Say
					Chk Say

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.

EMPLOYEE SIGNATURE:	DATE:

Employment Eligibility Verification

Department of Homeland Security

U.S. Citizenship and Immigration Services

USCIS Form I-9

OMB No.1615-0047

Expires 07/31/2026

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

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

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

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

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

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

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

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

- ☐ 1. A citizen of the United States
- ☐ 2. A noncitizen national of the United States (See Instructions.)
- ☐ 3. A lawful permanent resident (Enter USCIS or A-Number.)
- ☐ 4. A noncitizen (other than **Item Numbers 2.** and **3.** above) authorized to work until (exp. date, if any)

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

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

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

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

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

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

Additional Information

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

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

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

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

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

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

LISTS OF ACCEPTABLE DOCUMENTS

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

LIST A **Documents that Establish Both Identity and Employment Authorization**	OR	LIST B **Documents that Establish Identity**	AND	LIST C **Documents that Establish Employment Authorization**
1. U.S. Passport or U.S. Passport Card		**1.** Driver's license or ID card issued by a State or outlying possession of the United States provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		**1.** A Social Security Account Number card, unless the card includes one of the following restrictions: **(1)** NOT VALID FOR EMPLOYMENT **(2)** VALID FOR WORK ONLY WITH INS AUTHORIZATION **(3)** VALID FOR WORK ONLY WITH DHS AUTHORIZATION
2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551)		**2.** ID card issued by federal, state or local government agencies or entities, provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		**2.** Certification of report of birth issued by the Department of State (Forms DS-1350, FS-545, FS-240)
3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa		**3.** School ID card with a photograph		**3.** 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. Employment Authorization Document that contains a photograph (Form I-766)		**4.** Voter's registration card		**4.** Native American tribal document
5. For an individual temporarily authorized to work for a specific employer because of his or her status or parole: **a.** Foreign passport; and **b.** Form I-94 or Form I-94A that has the following: **(1)** The same name as the passport; and **(2)** An endorsement of the individual's status or parole as long as that period of endorsement has not yet expired and the proposed employment is not in conflict with any restrictions or limitations identified on the form.		**5.** U.S. Military card or draft record		**5.** U.S. Citizen ID Card (Form I-197)
		6. Military dependent's ID card		**6.** Identification Card for Use of Resident Citizen in the United States (Form I-179)
		7. U.S. Coast Guard Merchant Mariner Card		**7.** Employment authorization document issued by the Department of Homeland Security For examples, see **Section 7** and **Section 13** of the M-274 on **uscis.gov/i-9-central**. The Form I-766, Employment Authorization Document, is a List A, **Item Number 4.** document, not a List C document.
		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		
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				

Acceptable Receipts

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

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

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

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

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

USCIS Form I-9 Supplement A
OMB No. 1615-0047
Expires 07/31/2026

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

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

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

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

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

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

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

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

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

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

Supplement B,
Reverification and Rehire (formerly Section 3)

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

USCIS
Form I-9
Supplement B
OMB No. 1615-0047
Expires 07/31/2026

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

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

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

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

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

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

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

Additional Information (Initial and date each notation.)

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

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

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

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

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

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

Additional Information (Initial and date each notation.)

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

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

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

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

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

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

Additional Information (Initial and date each notation.)

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

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

2023

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 surviving spouse**
☐ **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, other details, 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) Reserved for future use.

(b) Use the Multiple Jobs Worksheet on page 3 and enter the result in Step 4(c) below; **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 generally more accurate than (b) if pay at the lower paying job is more than half of the pay at the higher paying job. Otherwise, (b) is more accurate . . . . . ☐

TIP: If you have self-employment income, see page 2.

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 Dependent and Other Credits

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 for qualifying children and other dependents. You may add to this the amount of any other credits. 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 2023 if you meet both of the following conditions: you had no federal income tax liability in 2022 **and** you expect to have no federal income tax liability in 2023. You had no federal income tax liability in 2022 if (1) your total tax on line 24 on your 2022 Form 1040 or 1040-SR is zero (or less than the sum of lines 27, 28, and 29), 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 2023 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, 2024.

Your privacy. 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).

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 income and self-employment taxes through withholding from your wages, you should enter the self-employment income on Step 4(a). Then compute your self-employment tax, divide that tax by the number of pay periods remaining in the year, and include that resulting amount per pay period on Step 4(c). You can also add half of the annual amount of self-employment tax to Step 4(b) as a deduction. To calculate self-employment tax, you generally multiply the self-employment income by 14.13% (this rate is a quick way to figure your self-employment tax and equals the sum of the 12.4% social security tax and the 2.9% Medicare tax multiplied by 0.9235). See Pub. 505 for more information, especially if the sum of self-employment income multiplied by 0.9235 and wages exceeds $160,200 for a given individual.

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.

If you (and your spouse) have a total of only two jobs, you may 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 2023 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. To be accurate, submit a new Form W-4 for all other jobs if you have not updated your withholding since 2019.

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.

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 2023 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:
- $27,700 if you're married filing jointly or a qualifying surviving spouse
- $20,800 if you're head of household
- $13,850 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 territories 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 Surviving Spouse

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	$0	$850	$850	$1,000	$1,020	$1,020	$1,020	$1,020	$1,020	$1,020	$1,870
$10,000 - 19,999	0	930	1,850	2,000	2,200	2,220	2,220	2,220	2,220	2,220	3,200	4,070
$20,000 - 29,999	850	1,850	2,920	3,120	3,320	3,340	3,340	3,340	3,340	4,320	5,320	6,190
$30,000 - 39,999	850	2,000	3,120	3,320	3,520	3,540	3,540	3,540	4,520	5,520	6,520	7,390
$40,000 - 49,999	1,000	2,200	3,320	3,520	3,720	3,740	3,740	4,720	5,720	6,720	7,720	8,590
$50,000 - 59,999	1,020	2,220	3,340	3,540	3,740	3,760	4,750	5,750	6,750	7,750	8,750	9,610
$60,000 - 69,999	1,020	2,220	3,340	3,540	3,740	4,750	5,750	6,750	7,750	8,750	9,750	10,610
$70,000 - 79,999	1,020	2,220	3,340	3,540	4,720	5,750	6,750	7,750	8,750	9,750	10,750	11,610
$80,000 - 99,999	1,020	2,220	4,170	5,370	6,570	7,600	8,600	9,600	10,600	11,600	12,600	13,460
$100,000 - 149,999	1,870	4,070	6,190	7,390	8,590	9,610	10,610	11,660	12,860	14,060	15,260	16,330
$150,000 - 239,999	2,040	4,440	6,760	8,160	9,560	10,780	11,980	13,180	14,380	15,580	16,780	17,850
$240,000 - 259,999	2,040	4,440	6,760	8,160	9,560	10,780	11,980	13,180	14,380	15,580	16,780	17,850
$260,000 - 279,999	2,040	4,440	6,760	8,160	9,560	10,780	11,980	13,180	14,380	15,580	16,780	18,140
$280,000 - 299,999	2,040	4,440	6,760	8,160	9,560	10,780	11,980	13,180	14,380	15,870	17,870	19,740
$300,000 - 319,999	2,040	4,440	6,760	8,160	9,560	10,780	11,980	13,470	15,470	17,470	19,470	21,340
$320,000 - 364,999	2,040	4,440	6,760	8,550	10,750	12,770	14,770	16,770	18,770	20,770	22,770	24,640
$365,000 - 524,999	2,970	6,470	9,890	12,390	14,890	17,220	19,520	21,820	24,120	26,420	28,720	30,880
$525,000 and over	3,140	6,840	10,460	13,160	15,860	18,390	20,890	23,390	25,890	28,390	30,890	33,250

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	$310	$890	$1,020	$1,020	$1,020	$1,860	$1,870	$1,870	$1,870	$1,870	$2,030	$2,040
$10,000 - 19,999	890	1,630	1,750	1,750	2,600	3,600	3,600	3,600	3,600	3,760	3,960	3,970
$20,000 - 29,999	1,020	1,750	1,880	2,720	3,720	4,720	4,730	4,730	4,890	5,090	5,290	5,300
$30,000 - 39,999	1,020	1,750	2,720	3,720	4,720	5,720	5,730	5,890	6,090	6,290	6,490	6,500
$40,000 - 59,999	1,710	3,450	4,570	5,570	6,570	7,700	7,910	8,110	8,310	8,510	8,710	8,720
$60,000 - 79,999	1,870	3,600	4,730	5,860	7,060	8,260	8,460	8,660	8,860	9,060	9,260	9,280
$80,000 - 99,999	1,870	3,730	5,060	6,260	7,460	8,660	8,860	9,060	9,260	9,460	10,430	11,240
$100,000 - 124,999	2,040	3,970	5,300	6,500	7,700	8,900	9,110	9,610	10,610	11,610	12,610	13,430
$125,000 - 149,999	2,040	3,970	5,300	6,500	7,700	9,610	10,610	11,610	12,610	13,610	14,900	16,020
$150,000 - 174,999	2,040	3,970	5,610	7,610	9,610	11,610	12,610	13,750	15,050	16,350	17,650	18,770
$175,000 - 199,999	2,720	5,450	7,580	9,580	11,580	13,870	15,180	16,480	17,780	19,080	20,380	21,490
$200,000 - 249,999	2,900	5,930	8,360	10,660	12,960	15,260	16,570	17,870	19,170	20,470	21,770	22,880
$250,000 - 399,999	2,970	6,010	8,440	10,740	13,040	15,340	16,640	17,940	19,240	20,540	21,840	22,960
$400,000 - 449,999	2,970	6,010	8,440	10,740	13,040	15,340	16,640	17,940	19,240	20,540	21,840	22,960
$450,000 and over	3,140	6,380	9,010	11,510	14,010	16,510	18,010	19,510	21,010	22,510	24,010	25,330

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	$620	$860	$1,020	$1,020	$1,020	$1,020	$1,650	$1,870	$1,870	$1,890	$2,040
$10,000 - 19,999	620	1,630	2,060	2,220	2,220	2,220	2,850	3,850	4,070	4,090	4,290	4,440
$20,000 - 29,999	860	2,060	2,490	2,650	2,650	3,280	4,280	5,280	5,520	5,720	5,920	6,070
$30,000 - 39,999	1,020	2,220	2,650	2,810	3,440	4,440	5,440	6,460	6,880	7,080	7,280	7,430
$40,000 - 59,999	1,020	2,220	3,130	4,290	5,290	6,290	7,480	8,680	9,100	9,300	9,500	9,650
$60,000 - 79,999	1,500	3,700	5,130	6,290	7,480	8,680	9,880	11,080	11,500	11,700	11,900	12,050
$80,000 - 99,999	1,870	4,070	5,690	7,050	8,250	9,450	10,650	11,850	12,260	12,460	12,870	13,820
$100,000 - 124,999	2,040	4,440	6,070	7,430	8,630	9,830	11,030	12,230	13,190	14,190	15,190	16,150
$125,000 - 149,999	2,040	4,440	6,070	7,430	8,630	9,980	11,980	13,980	15,190	16,190	17,270	18,530
$150,000 - 174,999	2,040	4,440	6,070	7,980	9,980	11,980	13,980	15,980	17,420	18,720	20,020	21,280
$175,000 - 199,999	2,190	5,390	7,820	9,980	11,980	14,060	16,360	18,660	20,170	21,470	22,770	24,030
$200,000 - 249,999	2,720	6,190	8,920	11,380	13,680	15,980	18,280	20,580	22,090	23,390	24,690	25,950
$250,000 - 449,999	2,970	6,470	9,200	11,660	13,960	16,260	18,560	20,860	22,380	23,680	24,980	26,230
$450,000 and over	3,140	6,840	9,770	12,430	14,930	17,430	19,930	22,430	24,150	25,650	27,150	28,600

NEW YORK STATE DEPARTMENT OF HEALTH

Criminal History Record Check

NEW YORK STATE | Department of Health

DOH CHRC form 102: Acknowledgement and Consent for Fingerprinting and Disclosure of Criminal History Record Information

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 | Middle Initial | Maiden Name

Date of Birth (mm/dd/yyyy) | Alias/AKA | Mother's Maiden Name

Mailing Address (street) | City | State | ZIP Code

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. In accordance with applicable laws, DOH will furnish appropriate summary information 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, including convictions of a crime (felony or misdemeanor) or criminal charges which do not reflect a disposition. 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. I have been informed that upon receiving notification from DCJS that there is a subsequent pending criminal action or proceeding or conviction, the DOH shall promptly notify an authorized person(s) of a provider of the additional allegation or new conviction.
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. If I believe an error has been made by DCJS for any New York State conviction/charge or the FBI for a non-New York State conviction/charge, I understand that I should notify DCJS and/or the FBI to report and request correction of this error to the addresses below.
	NYS Division of Criminal Justice Services Criminal History Bureau Record Review Unit-5th Floor 4 Tower Place, Albany, NY 12203 (518) 485-7675 — Federal Bureau of Investigation Criminal Justice Information Services (CJIS) Division 1000 Custer Hollow Road, Clarksburg, WV 26306 (304) 625-5590
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 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 re-disclosure of any convictions or open charges on my criminal history record, received by DOH from DCJS, to the requesting agency in accordance with applicable laws. 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.

Applicant Signature: | Date: ☐☐/☐☐/☐☐☐☐

Name and Signature of Parent or Legal Guardian: (if subject individual is under 18 years of age) | Date: ☐☐/☐☐/☐☐☐☐

SECTION 3 – AGENCY AUTHORIZED PERSON INFORMATION

Agency Name: | Operating License Number (PFI):

Print Name of Authorized Person: | Title:

Signature of Authorized Person: | Date: ☐☐/☐☐/☐☐☐☐

This form is to be retained by the agency. Do not forward to the DOH CHRC

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

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 / Y Y Y Y)

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.