

NEW WAE HIRE PACKET CHECKLIST (rev 1/17)

Name: _____ Job Title: _____
Office/Section: _____ Hire Date: _____

SECTION 1: NEW HIRE FORMS AND DOCUMENTS (to be completed by new hire)

Upon notification of a satisfactory drug test result and an effective date of hire, please complete Section 1 of this checklist, and present it (along with the required documents) to your supervisor on your first day of work.

A. When reporting for your first day of work, you are **REQUIRED** to present the following documents:

- ☐ Form I-9 Documents to prove citizenship and work authorization (if not presented at time of job offer);
- ☐ Social Security Card
- ☐ Valid Driver's License or State-issued ID
- ☐ Voided Check for Direct Deposit to Checking Account
- ☐ Copy of DD-214 (if you are a veteran)
- ☐ Selective Service Registration Card (males age 18-25)
- ☐ Form Affordable Health Care Act (ACA) "Options for Health Care Coverage" and ACA Acknowledgement.
- ☐ Health Insurance Acknowledge Form

B. The following forms should be completed prior to your first day of work:

- ☐ Personal Data Form
- ☐ L-4 State Withholding Exemption Certificate
- ☐ W-4 Federal Withholding Allowance Certificate
- ☐ Direct Deposit Enrollment Authorization – Main Bank (if your direct deposit will be sent to a savings account rather than a checking account, your bank **MUST** complete the form)
- ☐ Direct Deposit Enrollment Authorization – Secondary Bank (if applicable)
- ☐ Authorization and Driving History Form
- ☐ Employee Identification Badge/Access Card Enrollment Form

SECTION 2: CONDITIONS OF EMPLOYMENT (to be completed by supervisor)

This section must be completed by the supervisor to ensure that the new hire has met all of the conditions of his/her employment before proceeding to Section 3. If any of the answers below are "No," the supervisor must check with HR to determine the appropriate course of action.

A. The following conditions of this new hire's employment have been met, to include:

- | | | |
|--|------------------------------|-----------------------------|
| • Conditional Offer of Employment is completed, approved,
And discussed with employee | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| • Drug Testing results have been obtained from HR and
Employee notified | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| • Reference Checks have been completed by supervisor | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| • Criminal Background Check completed by HR (if necessary) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

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SECTION 3: FORMS/DOCUMENT REVIEW (to be completed by supervisor)

This section should be completed by the supervisor to ensure that the employee has completed his/her new hire paperwork appropriately.

The forms and documents as listed in Section 1 above have been reviewed for ☐ Yes ☐ No completeness, and any areas of deficiency or omission have been corrected.

SECTION 4: INTRODUCTION (to be completed by supervisor with employee)

*This section must be completed by the supervisor as an introduction to OLG/DCRT, as well as overall State employment. This introduction must be provided to **ALL employees**, regardless of Appointment Type.*

A. The following introductory materials have been provided to and/or completed with the new employee, to include:

- ☐ Appointment Affidavit (SF-13)
- ☐ Employee Work Schedule Form
- ☐ Louisiana Employees Online (LEO) System – Instruction Brochure (Handout)

ORIENTATION ACKNOWLEDGEMENT:

I, _____, have been informed of all the items listed on this New Hire Orientation Checklist and have been afforded an opportunity to ask questions. If I have any further questions for which my supervisor was unable to provide guidance, I understand that I am to contact the Human Resources Division at (225) 342-0880.

Employee's Signature

Date

Supervisor's Signature

Date

**** PLEASE RETURN COMPLETED CHECKLIST TO THE HUMAN RESOURCES DIVISION WITH ALL REQUIRED FORMS/DOCUMENTS WITHIN TWO (2) DAYS OF HIRE. ****

PERSONAL DATA FORM

*Revised
03/2025*

Employee's Name: _____
(Print full name as it appears on your Social Security Card)

Social Security Number: _____ **Date of Birth:** _____

Gender: _____Male _____Female

Check all that apply:

Race/Ethnicity: _____American Indian or Alaska Native _____Asian _____Black or African American
_____Hispanic or Latino _____Middle Eastern or North African _____White
_____Native Hawaiian or Pacific Islander

Check one:

Marital Status: _____Single _____Married _____Divorced _____Not Married

Section 1. R.S. 44:11 is hereby amended and reenacted to read as follow:

Confidential nature of certain personnel records notwithstanding anything contained in this Chapter or any other law to the contrary, the following items in the personnel records of a public employee of any public body shall be confidential:

1. The home telephone number of the public employee where such employee has choose to have a private or unlisted home telephone number because of the nature of his occupation with such body.
2. The home telephone number of the public employee where such employee has requested that the number be confidential.
3. The home address of the public employee where such employee has requested that the address be confidential.

____YES ____NO I want my home address to be regarded as confidential in accordance with R.S. 44:11.

HOME ADDRESS:

MAILING ADDRESS:

Telephone Number: _____

Cell Phone (Optional) _____

RESIDENCE PARISH: _____

EMERGENCY CONTACT:

NAME

PHONE

EMPLOYEE NAME (PRINTED)

EMPLOYEE SIGNATURE & DATE

DCRT HUMAN RESOURCES POLICIES ACKNOWLEDGEMENT FORM

Name: _____ Job Title: _____

Office/Section: _____ Hire Date: _____

NOTE:

- New employees **must** read the DCRT/ Human Resources policies during the OnBoarding process.
- Active employees, please refer to Channel Z for the DCRT/Human Resources policies:
Channel Z/Employee Information/Human Resources/Policies

SECTION 1: HUMAN RESOURCES POLICY

DCRT/HR policies to be initialed after reading: Please initial each box below to acknowledge that you have read and understand each of the DCRT HR Policies.

PPM# 3	Violence-Free Workplace	PPM#19	Work Hours/Schedule
PPM#4	Sexual Harassment	PPM#30	Recoupment of Overpayments
PPM#5	Workplace Harassment/Discrimination	PPM#39	Accident/Incident Investigations
PPM#6	Firearms Policy	PPM#42	Attendance/Leave
PPM#8	Ethics/Dual Employment	PPM#49	Employee Conduct
PPM#9	Outside Employment	PPM#52	Bloodborne Pathogens
PPM#11	Substance Abuse/Drug-Free Workplace	PPM#57	Training Policy and Requirement
PPM#14	Transitional Return to Work		

SECTION 2: GENERAL SAFETY RULES

☐ By initialing this box, I acknowledge have read the DCRT General Safety Program, Rules & Safety Responsibilities on Channel Z. **Channel Z/E-Forms/HR Forms Webpage/Safety/General Safety Rules**
<https://www.crt.state.la.us/channelz/hrforms.asp#Safety>

SECTION 3: SIGN AND SEND TO HUMAN RESOURCES

Once objectives above are completed, read and sign the acknowledgement below. New employees, return form to HR in the New Hire Documentation Packet. Active employees scan entire document and email to HRfrontdesk@crt.la.gov.

DCRT HR POLICIES & GENERAL SAFETY RULES ACKNOWLEDGEMENT:

I, _____, have been informed of all the policies within DCRT and have been afforded an opportunity to ask questions. Further, I have read and understand the General Safety Rules, and understand how to obtain a copy of any or all of these policies/rules. If I have any further questions for which my supervisor was unable to provide guidance, I understand that I am to contact the Human Resources Division at (225) 342-0880.

Employee's Signature

Date

Supervisor's Signature

Date

Department of Culture, Recreation and Tourism
POLICY PROHIBITING SEXUAL HARASSMENT

ACKNOWLEDGEMENT AND CERTIFICATION

My signature hereon acknowledges that I have read PPM #4 Sexual Harassment Policy on **Channel Z/Employee Information/Human Resource/Policies**:

- 1) I received a copy of OLG/DCRT's Policy Prohibiting Sexual Harassment;
- 2) I read this Policy;
- 3) I understand the content of this Policy;
- 4) I agree to abide by the terms and provisions of this Policy;
- 5) I understand that compliance with this Policy is a condition of employment; and
- 6) I understand that disciplinary action, including the possibility of dismissal, will be imposed on those who violate the terms and provisions of this Policy.
- 7) I understand that I may be personally liable and responsible for reimbursing the State of Louisiana for all or a portion of any judgment or settlement if a determination is made that I have engages in sexually inappropriate workplace behavior.

EMPLOYEE SIGNATURE

DATE

EMPLOYEE NAME (PRINT)

SUPERVISOR CERTIFICATION

My signature hereon acknowledges that:

- 1) I personally discussed in detail OLG/DCRT's Policy Prohibiting Sexual Harassment with the employee identified above;
- 2) I answered this employee's questions regarding this Policy;
- 3) I confirmed this employee's completion of the online training on sexual harassment provided through CPTP; and
- 4) I informed the employee of the consequences of violating this Policy.

SUPERVISOR SIGNATURE

DATE

SUPERVISOR NAME (PRINT)

**Office of the Lieutenant Governor
Department of Culture, Recreation and Tourism**

NOTICE OF PERSONAL LIABILITY

SEXUAL HARASSMENT

Louisiana law requires government agencies to develop and implement policies and related training to prevent sexual harassment in the workplace. The prohibitions and requirements within these policies apply to all public servants -- employees, appointees and elected officials.

Louisiana's taxpayers have been financially burdened by judgments and settlements arising from claims of workplace sexual harassment. To reduce this impact, La. R.S. 42:351, enacted in the 2019 Regular Session (Act No. 43), declares that consideration be given to requiring that a public servant, determined to have engaged in sexually inappropriate behavior, personally reimburse all or a portion of any judgment or settlement resulting from such behavior. La. R.S. 42:353 sets forth the process and factors to be considered in making this determination, and authorizes the Attorney General to file suit against a public servant to enforce the state's right to reimbursement and indemnification.

Notice of this potential personal liability is disseminated, along with our policy prohibiting sexual harassment, to every newly hired public servant. This notice also is disseminated, on an annual basis, to the employees of this agency and every public servant in the executive branch of state government. Reference to this potential personal liability also is included in the annual CPTP training on sexual harassment available through LEO.

ACKNOWLEDGEMENT:

I, _____, have been informed of the notice of liability regarding sexual harassment and have been afforded an opportunity to ask questions. If I have any further questions for which my supervisor was unable to provide guidance, I understand that I am to contact the Human Resources Division at (225) 342-0880.

Employee's Signature

Date

**STATE OF LOUISIANA
LAGOV ERP-HUMAN CAPITAL MANAGEMENT
DIRECT DEPOSIT ENROLLMENT AUTHORIZATION
MAIN BANK (PRIMARY ACCOUNT)**



EMPLOYEE SSN	DEPARTMENT/OFFICE OR AGENCY
ACTION TYPE (✓ one) <input type="checkbox"/> NEW <input type="checkbox"/> CHANGE <input type="checkbox"/> TERMINATE THIS OPTION	

**PRIMARY ACCOUNT INFORMATION
(Main Bank)**

DEPOSIT AMOUNT TO THIS ACCOUNT WILL BE EQUAL TO NET PAY LESS ANY DEPOSITS TO SECONDARY ACCOUNTS.

FINANCIAL INSTITUTION NAME	FINANCIAL INSTITUTION ROUTING (ABA) NUMBER <i>(Bank Key)</i>	
BANK ACCOUNT NUMBER	ACCOUNT NAME * (Ex: Mr. and Mrs. John Doe, John or Jane Doe, John Doe)	
ACCOUNT TYPE (✓ one) (Bank Control Key) <input type="checkbox"/> **CHECKING (provide voided check or account verification) <input type="checkbox"/> **SAVINGS (obtain account # & ABA # from financial institution)	**Account verification or completion of enrollment form by financial institution will assure the accuracy of account data: Signature from institution: _____	
	Effective Date	_____ PAYDAY
	Phone number:	

(Print full name)

I _____ authorize and request the State of Louisiana to direct my net pay check to the account at the financial institution I designated above.

It is my responsibility to notify my Employee Administration Office, as appropriate, should any changes occur to account specified. Considering all above conditions are met, this authorization remains in full effect until a written, signed notification to terminate, or another signed form (OSUP/F12A) indicating termination of this option is received from me and the State of Louisiana has had reasonable opportunity to act on the termination. However, I understand and acknowledge that I am responsible for any account information indicated on this form as well as any account information that I add or any changes that I make to my accounts through Louisiana Employees Online (LEO).

For direct deposits that are affected by the International ACH Transaction (IAT) rules check one:

- ☐ I affirm that the entire amount of the payroll direct deposits sent to my account at the financial institution designated above **will not** subsequently be forwarded to a foreign financial institution.
- ☐ I affirm that the entire amount of the payroll direct deposits sent to my account at the financial institution designated above **will** subsequently be forwarded to a foreign financial institution.

Signature

Date

Phone number where you can be reached
between 8:00 am and 4:30 pm

***Deposits can only be made to accounts that belong to you. Exceptions: Deposits can be made to the accounts of dependents or a parent/guardian when the employee is a dependent of the parent/guardian.**

****Agency requirements may vary. Contact your Employee Administration office if you have any questions.**

TO BE COMPLETED BY EMPLOYEE ADMINISTRATION OFFICE:

MAIN BANK	FINANCIAL INSTITUTION ROUTING (ABA) NO. (If not provided above)	
PERSONNEL AREA NUMBER	PERSONNEL NUMBER	EFT VALIDITY DATE

☐ **CHECK HERE IF SECONDARY ACCOUNT FORMS ARE ATTACHED**

**STATE OF LOUISIANA
LAGOV ERP-HUMAN CAPITAL MANAGEMENT
DIRECT DEPOSIT ENROLLMENT AUTHORIZATION
OTHER BANK (SECONDARY ACCOUNT)**



EMPLOYEE SSN	DEPARTMENT/OFFICE OR AGENCY
ACTION TYPE (✓ one) <div style="display: flex; justify-content: space-between;"> <div> <input type="checkbox"/> NEW <input type="checkbox"/> CHANGE </div> <div> <input type="checkbox"/> TERMINATE THIS OPTION <input type="checkbox"/> ADD ADDITIONAL SECONDARY ACCOUNT </div> </div>	

SECONDARY ACCOUNT INFORMATION

(Other Bank)

**DEPOSIT AMOUNT TO THIS ACCOUNT WILL BE EQUAL TO
THE DOLLAR AMOUNT SPECIFIED BELOW OR THE PERCENTAGE OF NET PAY SPECIFIED BELOW.**

FINANCIAL INSTITUTION NAME	FINANCIAL INSTITUTION ROUTING (ABA) NUMBER <i>(Bank Key)</i>					
BANK ACCOUNT NUMBER	ACCOUNT NAME * (Ex: Mr. and Mrs. John Doe, John or Jane Doe, John Doe)					
ACCOUNT TYPE (✓ one) <i>(Bank Control Key)</i> <input type="checkbox"/> **CHECKING (provide voided check or account verification) <input type="checkbox"/> **SAVINGS (obtain account # & ABA # from financial institution)	**Account verification or completion of enrollment form by financial institution will assure the accuracy of account data: Signature from Institution: _____ <table style="width: 100%;"> <tr> <td style="width: 50%;">Effective Date</td> <td style="width: 50%;">PAYDAY</td> </tr> <tr> <td colspan="2">Phone Number: _____</td> </tr> </table>		Effective Date	PAYDAY	Phone Number: _____	
Effective Date	PAYDAY					
Phone Number: _____						
PERCENT OF NET TO THIS ACCOUNT <i>(Print full name)</i>	OR	FIXED DOLLAR AMOUNT TO THIS ACCOUNT				

I _____ authorize and request the State of Louisiana to direct the percent of my net pay check or the dollar amount specified to the account at the financial institution I designated above.

It is my responsibility to notify my Employee Administration Office, as appropriate, should any changes occur to account specified. Considering all above conditions are met, this authorization remains in full effect until a written, signed notification to terminate, or another signed form (OSUP/F12B) indicating termination of this option is received from me and the State of Louisiana has had reasonable opportunity to act on the termination. However, I understand and acknowledge that I am responsible for any account information indicated on this form as well as any account information that I add or any changes that I make to my accounts through Louisiana Employees Online (LEO).

For direct deposits that are affected by the International ACH Transaction (IAT) rules check one:

- ☐ I affirm that the entire amount of the payroll direct deposits sent to my account at the financial institution designated above **will not** subsequently be forwarded to a foreign financial institution.
- ☐ I affirm that the entire amount of the payroll direct deposits sent to my account at the financial institution designated above **will** subsequently be forwarded to a foreign financial institution.

Signature

Date

Phone number where you can be reached
between 8:00 am and 4:30 pm

***Deposits can only be made to accounts that belong to you. Exceptions: Deposits can be made to the accounts of dependents or a parent/guardian when the employee is a dependent of the parent/guardian.**

****Agency requirements may vary. Contact your Employee Administration office if you have any questions.**

TO BE COMPLETED BY EMPLOYEE ADMINISTRATION OFFICE:

OTHER BANK	FINANCIAL INSTITUTION ROUTING (ABA) NO. (If not provided above)	
PERSONNEL AREA NUMBER	PERSONNEL NUMBER	EFT VALIDITY DATE

☐ **CHECK HERE IF ADDITIONAL ACCOUNT FORMS ARE ATTACHED**



LOUISIANA
DEPARTMENT of REVENUE

Employee's Withholding Certificate (L-4)

This form must be filed with your employer.

For Questions:

Phone: (855) 307-3893

Send an email by visiting www.revenue.louisiana.gov/Contact/ContactUs.

Purpose: Complete Form L-4 so that your employer can withhold the correct amount of state income tax from your salary.

Instructions: Employees who are subject to state withholding must provide their expected tax return filing status in Block A.

- Employees must file a new certificate within 10 days if the number of their deductions decreases, except if the change is the result of the death of a spouse.
- Employees may file a new certificate any time the number of their deductions increases.
- Line 7 should be used to increase or decrease the tax withheld for each pay period. Decreases should be indicated as a negative amount.

Penalties will be imposed for willfully supplying false information or willfully failing to supply information that would reduce the withholding amount.

This form must be filed with your employer. If an employee fails to complete this withholding certificate, the employer must withhold Louisiana income tax from the employee's wages without any standard deduction.

Note to Employer: Keep this certificate with your records.

Block A

- Enter "0" to claim no standard deduction and check the appropriate box under number 3 below. You may enter "0" if you are married, and have a working spouse or more than one job to avoid having too little tax withheld.
- Enter "1" to claim a standard deduction if your filing status is single or married filing separate and check the appropriate box under number 3 below if you did not claim this deduction in connection with other employment or if your spouse has not claimed a deduction.
- Enter "2" to claim a standard deduction if your filing status is married filing jointly, head of household, or qualifying surviving spouse and check the appropriate box under number 3 below.

A.

 Cut here and give the bottom portion of certificate to your employer. Keep the top portion for your records.

Form **L-4**
Louisiana
Department of
Revenue

Employee's Withholding Certificate

1. First name and middle initial		Last name	
2. Social security number	3. Select one: <input type="checkbox"/> No deduction <input type="checkbox"/> Single or married filing separately <input type="checkbox"/> Married filing jointly, qualifying surviving spouse, or head of household		
4. Home address (number and street or rural route)			
5. City		State	ZIP
6. Total number of deductions claimed in Block A			6.
7. Adjustments. Enter any increase or decrease in the amount of tax to be withheld each pay period. Decreases should be indicated as a negative amount and cannot result in an amount less than zero to be withheld each pay period.			7.
I declare under the penalties imposed for filing false reports that the number of deductions claimed on this certificate do not exceed the number to which I am entitled.			
Employee's signature			Date

The following is to be completed by employer.

8. Employer's name and address	9. Employer's state withholding account number
--------------------------------	--

Employee's Withholding Certificate

OMB No. 1545-0074

Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay.**Give Form W-4 to your employer.****Your withholding is subject to review by the IRS.****2026****Step 1:**
Enter
Personal
Information

(a) First name and middle initial	Last name	(b) Social security number
Address		Does your name match the name on your social security card? If not, to ensure you get credit for your earnings, contact SSA at 800-772-1213 or go to www.ssa.gov .
City or town, state, and ZIP code		
(c) <input type="checkbox"/> Single or Married filing separately <input type="checkbox"/> Married filing jointly or Qualifying surviving spouse <input type="checkbox"/> Head of household (Check only if you're unmarried and pay more than half the costs of keeping up a home for yourself and a qualifying individual.)		
Caution: To claim certain credits or deductions on your tax return, you (and/or your spouse if married filing jointly) are required to have a social security number valid for employment. See page 2 for more information.		

TIP: Consider using the estimator at www.irs.gov/W4App to determine the most accurate withholding for the rest of the year if you: are completing this form after the beginning of the year; expect to work only part of the year; or have changes during the year in your marital status, number of jobs for you (and/or your spouse if married filing jointly), dependents, other income (not from jobs), deductions, or credits. Have your most recent pay stub(s) from this year available when using the estimator. At the beginning of next year, use the estimator again to recheck your withholding.

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, and when to use the estimator at www.irs.gov/W4App.

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 the most accurate withholding for this step (and Steps 3–4). If you or your spouse have self-employment income, use this option; **or**
- (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 Step 2(b) if pay at the lower paying job is more than half of the pay at the higher paying job. Otherwise, Step 2(b) is more accurate ☐

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):

(a) Multiply the number of qualifying children under age 17 by \$2,200 **3(a)** \$

(b) Multiply the number of other dependents by \$500 **3(b)** \$

Add the amounts from Steps 3(a) and 3(b), plus the amount for other credits. Enter the total here **3** \$

Step 4:
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.** Use the Deductions Worksheet on page 4 to determine the amount of deductions you may claim, which will reduce your withholding. (If you skip this line, your withholding will be based on the standard deduction.) Enter the result here **4(b)** \$

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

Exempt from
withholding

I claim exemption from withholding for 2026, and I certify that I meet **both** of the conditions for exemption for 2026. See *Exemption from withholding* on page 2. I understand I will need to submit a new Form W-4 for 2027 ☐

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 unless otherwise noted.

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 2026 if you meet both of the following conditions: you had no federal income tax liability in 2025 **and** you expect to have no federal income tax liability in 2026. You had no federal income tax liability in 2025 if (1) your total tax on line 24 on your 2025 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 2026 tax return. To claim exemption from withholding, certify that you meet both of the conditions by checking the box in the *Exempt from withholding* section. Then, complete Steps 1(a), 1(b), and 5. Do not complete any other steps. You will need to submit a new Form W-4 by February 16, 2027.

Your privacy. Steps 2(c) and 4(a) ask for information regarding income you received from sources other than the job associated with this Form W-4. If you have concerns with providing the information asked for in Step 2(c), you may choose Step 2(b) as an alternative; if you have concerns with providing the information asked for in Step 4(a), you may enter an additional amount you want withheld per pay period in Step 4(c) as an alternative.

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

1. Are submitting this form after the beginning of the year;
2. Expect to work only part of the year;
3. Have changes during the year in your marital status, number of jobs for you (and/or your spouse if married filing jointly), or number of dependents, or changes in your deductions or credits;
4. Receive dividends, capital gains, social security, bonuses, or business income, or are subject to the Additional Medicare Tax or Net Investment Income Tax; or
5. Prefer the most accurate withholding for multiple job situations.

TIP: Have your most recent pay stub(s) from this year available when using the estimator to account for federal income tax that has already been withheld this year. At the beginning of next year, use the estimator again to recheck your withholding.

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. Submit a separate Form W-4 for each job.

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

Instead, 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 accurate for jobs with similar pay; otherwise, more tax than necessary may be withheld, and this extra amount of tax withheld 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 (and/or your spouse if married filing jointly) must have the required social security number to claim certain credits. 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.

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 15, if you expect to claim deductions other than the basic standard deduction on your 2026 tax return and want to reduce your withholding to account for these deductions. This includes both itemized deductions and other deductions such as for qualified tips, overtime compensation, and passenger vehicle loan interest; student loan interest; IRAs; and seniors. You (and/or your spouse if married filing jointly) must have the required social security number to claim certain deductions. For additional eligibility requirements, see Pub. 501.

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 when you file your tax return.

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; 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 5. 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 5 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 5 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 (plus any other additional amount you want withheld) **4** \$ _____

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

See the Instructions for Schedule 1-A (Form 1040) for more information about whether you qualify for the deductions on lines 1a, 1b, 1c, 3a, and 3b.

1	Deductions for qualified tips, overtime compensation, and passenger vehicle loan interest.	
a	Qualified tips. If your total income is less than \$150,000 (\$300,000 if married filing jointly), enter an estimate of your qualified tips up to \$25,000	1a \$ _____
b	Qualified overtime compensation. If your total income is less than \$150,000 (\$300,000 if married filing jointly), enter an estimate of your qualified overtime compensation up to \$12,500 (\$25,000 if married filing jointly) of the "and-a-half" portion of time-and-a-half compensation	1b \$ _____
c	Qualified passenger vehicle loan interest. If your total income is less than \$100,000 (\$200,000 if married filing jointly), enter an estimate of your qualified passenger vehicle loan interest up to \$10,000	1c \$ _____
2	Add lines 1a, 1b, and 1c. Enter the result here	2 \$ _____
3	Seniors age 65 or older. If your total income is less than \$75,000 (\$150,000 if married filing jointly):	
a	Enter \$6,000 if you are age 65 or older before the end of the year	3a \$ _____
b	Enter \$6,000 if your spouse is age 65 or older before the end of the year and has a social security number valid for employment	3b \$ _____
4	Add lines 3a and 3b. Enter the result here	4 \$ _____
5	Enter an estimate of your student loan interest, deductible IRA contributions, educator expenses, alimony paid, and certain other adjustments from Schedule 1 (Form 1040), Part II. See Pub. 505 for more information	5 \$ _____
6	Itemized deductions. Enter an estimate of your 2026 itemized deductions from Schedule A (Form 1040). Such deductions may include qualifying:	
a	Medical and dental expenses. Enter expenses in excess of 7.5% (0.075) of your total income	6a \$ _____
b	State and local taxes. If your total income is less than \$505,000 (\$252,500 if married filing separately), enter state and local taxes paid up to \$40,400 (\$20,200 if married filing separately)	6b \$ _____
c	Home mortgage interest. If your home acquisition debt is less than \$750,000 (\$375,000 if married filing separately), enter your home mortgage interest expense (including mortgage insurance premiums)	6c \$ _____
d	Gifts to charities. Enter contributions in excess of 0.5% (0.005) of your total income	6d \$ _____
e	Other itemized deductions. Enter the amount for other itemized deductions	6e \$ _____
7	Add lines 6a, 6b, 6c, 6d, and 6e. Enter the result here	7 \$ _____
8	Limitation on itemized deductions.	
a	Enter your total income	8a \$ _____
b	Subtract line 4 from line 8a. If line 4 is greater than line 8a, enter -0- here and on line 10. Skip line 9	8b \$ _____
9	Enter: $\left\{ \begin{array}{l} \bullet \$768,700 \text{ if you're married filing jointly or a qualifying surviving spouse} \\ \bullet \$640,600 \text{ if you're single or head of household} \\ \bullet \$384,350 \text{ if you're married filing separately} \end{array} \right\}$	9 \$ _____
10	If line 9 is greater than line 8b, enter the amount from line 7. Otherwise, multiply line 7 by 94% (0.94) and enter the result here	10 \$ _____
11	Standard deduction.	
Enter:	$\left\{ \begin{array}{l} \bullet \$32,200 \text{ if you're married filing jointly or a qualifying surviving spouse} \\ \bullet \$24,150 \text{ if you're head of household} \\ \bullet \$16,100 \text{ if you're single or married filing separately} \end{array} \right\}$	11 \$ _____
12	Cash gifts to charities. If you take the standard deduction, enter cash contributions up to \$1,000 (\$2,000 if married filing jointly)	12 \$ _____
13	Add lines 11 and 12. Enter the result here	13 \$ _____
14	If line 10 is greater than line 13, subtract line 11 from line 10 and enter the result here. If line 13 is greater than line 10, enter the amount from line 12	14 \$ _____
15	Add lines 2, 4, 5, and 14. Enter the result here and in Step 4(b) of Form W-4	15 \$ _____

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	\$480	\$850	\$850	\$1,020	\$1,020	\$1,020	\$1,020	\$1,020	\$1,020	\$1,020
\$10,000 - 19,999	0	480	1,480	1,850	2,050	2,220	2,220	2,220	2,220	2,220	2,220	2,620
\$20,000 - 29,999	480	1,480	2,480	3,050	3,250	3,420	3,420	3,420	3,420	3,420	3,820	4,820
\$30,000 - 39,999	850	1,850	3,050	3,620	3,820	3,990	3,990	3,990	3,990	4,390	5,390	6,390
\$40,000 - 49,999	850	2,050	3,250	3,820	4,020	4,190	4,190	4,190	4,590	5,590	6,590	7,590
\$50,000 - 59,999	1,020	2,220	3,420	3,990	4,190	4,360	4,360	4,760	5,760	6,760	7,760	8,760
\$60,000 - 69,999	1,020	2,220	3,420	3,990	4,190	4,360	4,760	5,760	6,760	7,760	8,760	9,760
\$70,000 - 79,999	1,020	2,220	3,420	3,990	4,190	4,760	5,760	6,760	7,760	8,760	9,760	10,760
\$80,000 - 99,999	1,020	2,220	3,420	4,240	5,440	6,610	7,610	8,610	9,610	10,610	11,610	12,610
\$100,000 - 149,999	1,870	4,070	6,270	7,840	9,040	10,210	11,210	12,210	13,210	14,210	15,360	16,560
\$150,000 - 239,999	1,870	4,100	6,500	8,270	9,670	11,040	12,240	13,440	14,640	15,840	17,040	18,240
\$240,000 - 319,999	2,040	4,440	6,840	8,610	10,010	11,380	12,580	13,780	14,980	16,180	17,380	18,580
\$320,000 - 364,999	2,040	4,440	6,840	8,610	10,010	11,380	12,580	13,860	15,860	17,860	19,860	21,860
\$365,000 - 524,999	2,720	5,920	9,390	12,260	14,760	17,230	19,530	21,830	24,130	26,430	28,730	31,030
\$525,000 and over	3,140	6,840	10,540	13,610	16,310	18,980	21,480	23,980	26,480	28,980	31,480	33,990

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	\$90	\$850	\$1,020	\$1,020	\$1,020	\$1,070	\$1,870	\$1,870	\$1,870	\$1,870	\$1,870	\$1,970
\$10,000 - 19,999	850	1,780	1,980	1,980	2,030	3,030	3,830	3,830	3,830	3,830	3,930	4,130
\$20,000 - 29,999	1,020	1,980	2,180	2,230	3,230	4,230	5,030	5,030	5,030	5,130	5,330	5,530
\$30,000 - 39,999	1,020	1,980	2,230	3,230	4,230	5,230	6,030	6,030	6,130	6,330	6,530	6,730
\$40,000 - 59,999	1,020	2,880	4,080	5,080	6,080	7,080	7,950	8,150	8,350	8,550	8,750	8,950
\$60,000 - 79,999	1,870	3,830	5,030	6,030	7,100	8,300	9,300	9,500	9,700	9,900	10,100	10,300
\$80,000 - 99,999	1,870	3,830	5,100	6,300	7,500	8,700	9,700	9,900	10,100	10,300	10,500	10,700
\$100,000 - 124,999	2,030	4,190	5,590	6,790	7,990	9,190	10,190	10,390	10,590	10,940	11,940	12,940
\$125,000 - 149,999	2,040	4,200	5,600	6,800	8,000	9,200	10,200	10,950	11,950	12,950	13,950	14,950
\$150,000 - 174,999	2,040	4,200	5,600	6,800	8,150	10,150	11,950	12,950	13,950	14,950	16,170	17,470
\$175,000 - 199,999	2,040	4,200	6,150	8,150	10,150	12,150	13,950	15,020	16,320	17,620	18,920	20,220
\$200,000 - 249,999	2,720	5,680	7,880	10,140	12,440	14,740	16,840	18,140	19,440	20,740	22,040	23,340
\$250,000 - 449,999	2,970	6,230	8,730	11,030	13,330	15,630	17,730	19,030	20,330	21,630	22,930	24,240
\$450,000 and over	3,140	6,600	9,300	11,800	14,300	16,800	19,100	20,600	22,100	23,600	25,100	26,610

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	\$280	\$850	\$950	\$1,020	\$1,020	\$1,020	\$1,020	\$1,560	\$1,870	\$1,870	\$1,870
\$10,000 - 19,999	280	1,280	1,950	2,150	2,220	2,220	2,220	2,760	3,760	4,070	4,070	4,210
\$20,000 - 29,999	850	1,950	2,720	2,920	2,980	2,980	3,520	4,520	5,520	5,830	5,980	6,180
\$30,000 - 39,999	950	2,150	2,920	3,120	3,180	3,720	4,720	5,720	6,720	7,180	7,380	7,580
\$40,000 - 59,999	1,020	2,220	2,980	3,570	4,640	5,640	6,640	7,750	8,950	9,460	9,660	9,860
\$60,000 - 79,999	1,020	2,610	4,370	5,570	6,640	7,750	8,950	10,150	11,350	11,860	12,060	12,260
\$80,000 - 99,999	1,870	4,070	5,830	7,150	8,410	9,610	10,810	12,010	13,210	13,720	13,920	14,120
\$100,000 - 124,999	1,870	4,270	6,230	7,630	8,900	10,100	11,300	12,500	13,700	14,210	14,720	15,720
\$125,000 - 149,999	2,040	4,440	6,400	7,800	9,070	10,270	11,470	12,670	14,580	15,890	16,890	17,890
\$150,000 - 174,999	2,040	4,440	6,400	7,800	9,070	10,580	12,580	14,580	16,580	17,890	18,890	20,170
\$175,000 - 199,999	2,040	4,440	6,400	8,510	10,580	12,580	14,580	16,580	18,710	20,320	21,620	22,920
\$200,000 - 249,999	2,720	5,920	8,680	10,900	13,270	15,570	17,870	20,170	22,470	24,080	25,380	26,680
\$250,000 - 449,999	2,970	6,470	9,540	12,040	14,410	16,710	19,010	21,310	23,610	25,220	26,520	27,820
\$450,000 and over	3,140	6,840	10,110	12,810	15,380	17,880	20,380	22,880	25,380	27,190	28,690	30,190



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 <div></div>		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.):				
		<input type="checkbox"/> 1. A citizen of the United States				
		<input type="checkbox"/> 2. A noncitizen national of the United States (See Instructions.)				
		<input type="checkbox"/> 3. A lawful permanent resident (Enter USCIS or A-Number.)				
		<input type="checkbox"/> 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)		Additional Information			
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					
Document Title 3 (if any)					
Issuing Authority		<input type="checkbox"/> Check here if you used an alternative procedure authorized by DHS to examine documents.			
Document Number (if any)					
Expiration Date (if any)					
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		LIST B	LIST C
Documents that Establish Both Identity and Employment Authorization	OR	Documents that Establish Identity	AND 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	
Acceptable Receipts May be presented in lieu of a document listed above for a temporary period. For receipt validity dates, see the M-274.			
<ul style="list-style-type: none">• 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 .
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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.
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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.)			<input type="checkbox"/> 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.)			<input type="checkbox"/> 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.)			<input type="checkbox"/> Check here if you used an alternative procedure authorized by DHS to examine documents.

Office of the Lieutenant Governor (OLG)
Department of Culture, Recreation and Tourism (DCRT)

WORK SCHEDULE FORM

The following work schedule and work hours are requested for:

Employee Name: _____
Personnel #: _____
Job Title: _____
Department/Section: _____
Requested Effective Date: _____ (Must be beginning of a pay period)

OPTION 1: Traditional Full-time Work Schedule

☐ Five (5) eight (8) hour workdays, Monday through Friday
Daily work schedule: _____ A.M. to _____ P.M.
Lunch (check one): ☐ 30 minutes ☐ 1 hour

OPTION 2: Flexible Full-time Work Schedule

☐ Four (4) ten (10) hour workdays
Daily work schedule: _____ A.M. to _____ P.M.
Scheduled workday off (any day Monday – Friday): (Select one)
Lunch (check one): ☐ 30 minutes ☐ 1 hour

☐ Four (9) hour workdays plus one (1) four (4) hour workday
Daily work schedule: _____ A.M. to _____ P.M.
Four-hour workday (any day Monday – Friday): (Select one)
Lunch (check one): ☐ 30 minutes ☐ 1 hour

☐ Four (4) nine (9) hour workdays in one week of the pay period and four (4) nine (9) hour workdays plus one (1) eight (8) hour day in the other week of the pay period **(Available to Exempt employees only.)**
Nine (9) hour workday schedule:: _____ A.M. to _____ P.M.
Eight (8) hour workday schedule:: _____ A.M. to _____ P.M.
Scheduled workday off (any day Monday – Friday): (Select one)
Lunch (check one): ☐ 30 minutes ☐ 1 hour

OPTION 3: Positive Time Entry (24/7)

☐ No pre-determined work schedule as provided for by Option 1 or 2 above. This option is usually reserved for part-time wage and student employees to allow for scheduling fluctuations. If a regularly-recurring work schedule is assigned, please indicate below:

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday

I have read and understand PPM #19, Work Hours and Work Schedules Policy. I understand that if business needs change, I may be required to change my work schedule accordingly upon immediate notice. Furthermore, if I choose a flexible work schedule, I may be compensated differently from others while traveling and when holidays fall within the workweek. I agree to these terms and conditions.

Employee's signature

Date

Supervisor's signature

Date

APPOINTMENT AFFIDAVITS

IMPORTANT: Please read the following appointment affidavits. Before swearing to these affidavits, make sure you understand the fully. It is the responsibility of the employing agency to determine any change in employment status since the applicant filed the original pre-employment application.

APPOINTEE		AGENCY /DIVISION	
PRESENT STREET ADDRESS		PLACE OF EMPLOYMENT	
CITY/ STATE/ZIP		DATE OF BIRTH	
A. SINCE YOU FILED THE APPLICATION RESULTING IN YOUR APPOINTMENT, HAVE YOU BEEN INDICTED OR CONVICTED OF ANY LAW VIOLATION (excludes minor traffic violations)? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE DETAILS:			
DATE	LOCATION	CHARGE	
DISPOSITION			
B. SINCE YOU FILED THE APPLICATION RESULTING IN YOUR APPOINTMENT, HAVE YOU RESIGNED OR BEEN DISCHARGED AS A RESULT OF MISCONDUCT? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE DETAILS:			
C. DO YOU NOW HOLD OR ARE YOU A CANDIDATE FOR AN ELECTIVE PUBLIC OFFICE? <input type="checkbox"/> YES <input type="checkbox"/> NO			
D. AS REQUIRED BY LOUISIANA REVISED STATUE 42:52			
Do you solemnly swear (or affirm) to support the Constitution and laws of the United States and Constitution and laws of this State, and faithfully and impartially discharge and perform all of the duties incumbent upon you as a State employee according to the best of your ability and understanding? <input type="checkbox"/> YES <input type="checkbox"/> NO			
DATE	SIGNATURE OF APPOINTEE	SOCIAL SECURITY NO. - -	

STATE OF LOUISIANA
DRIVER AUTHORIZATION FORM

TO BE COMPLETED ANNUALLY, UPON CHANGE OF STATE OF ISSUANCE, CLASS OF LICENSE, AND/OR DRIVING
RESTRICTION CHANGE

Agency: _____
Employee Name: _____ Employee Number: _____
Immediate Supervisor: _____ Driver Training Course (MM/DD/YY): _____
Drivers License Number: _____ State of Issuance: _____

AGENCY HEAD OR DESIGNEE AUTHORIZATION

By executing this document, I have reviewed the Official Driving Record and Driver Training Course dates and have confirmed the information to be current and in accordance with the ORM Loss Prevention requirements.

My signature authorizes the aforementioned employee to drive the following on state business as required (check all that apply):

_____ **STATE VEHICLE**
_____ **RENTAL VEHICLE**
_____ **PERSONAL VEHICLE**

AGENCY HEAD
(or designated individual)

DATE OF AUTHORIZATION

EMPLOYEE ACKNOWLEDGEMENT/AUTHORIZATION

This is to certify that, as a condition of and if authorized to drive my personal vehicle on state business, I have and will maintain at least the minimum liability coverage as required by *LA. R.S. 32:900 (B) (2)*.

I understand that the use of my vehicle on state business requires prior written authorization from my supervisor or agency head.

Further, by signing this document, I agree to notify my agency in writing should any of the following change on my license: Drivers License No., State of Issuance, Class of License or Driving Restrictions.

I authorize my agency to obtain access to my Official Driving Record (ODR) as necessary to comply with the State's Loss Prevention Program.

My signature on this document shall remain in effect until revoked by the agency or until a new form is executed.

EMPLOYEE SIGNATURE

DATE

ANNUAL SUPPLEMENTAL SIGNATURE PAGE

EMPLOYEE NAME: _____

DRIVERS LICENSE NUMBER: _____

DEPARTMENT/AGENCY: _____

AGENCY HEAD OR DESIGNEE STATEMENT

By executing this document, I have reviewed the following and have confirmed the information to be current and in accordance with the ORM Loss Prevention requirements:

Official Driving Record Drivers Training Course

Further, my signature allows the aforementioned employee to drive a state vehicle, rental vehicle or personal vehicle on state business.

Agency Head
(or designated individual)

Date of Authorization

Agency Head
(or designated individual)

Date of Authorization

Agency Head
(or designated individual)

Date of Authorization

Agency Head
(or designated individual)

Date of Authorization

Agency Head
(or designated individual)

Date of Authorization

Agency Head
(or designated individual)

Date of Authorization

Agency Head
(or designated individual)

Date of Authorization

(DUPLICATE SUPPLEMENTAL SIGNATURE PAGE AS NEEDED)

07/01/2011

DA 2054

Supp.-1

HEALTH INSURANCE ACKNOWLEDGEMENT FORM

My signature below acknowledges I understand I am a Part-time employee working less than 30 hours, therefore, I am not eligible for insurance coverage.

Employee Signature

Date

Printed Name

Agency Name

Employee's Name: _____ Division/Section: _____

Do you have military service time? _____

If yes - Dates of Service From: _____ To: _____

Are you currently retired from any system? If so, which one?

Social Security	Employee Signature	Date
------------------------	---------------------------	-------------

OFFICE USE ONLY:

Leave Balances

Sick: _____

Annual: _____

FMLA: _____

Adjusted Leave Service Date: _____

Adjusted Service Date: _____

Verified By _____

**LOUISIANA WORKERS' COMPENSATION SECOND INJURY BOARD
POST-HIRE/CONDITIONAL JOB OFFER KNOWLEDGE QUESTIONNAIRE**

EMPLOYEE: The intent of this questionnaire is to provide your employer with knowledge about any pre-existing medical condition or disability which may entitle your employer to reimbursement from the Louisiana Workers' Compensation Second Injury Board in the event you suffer an on-the-job injury.¹ This reimbursement in no way affects the benefits owed to you by your employer or its insurance company under the Louisiana Workers' Compensation Act. La. R.S. 23:1021-1361. However, your failure to answer truthfully and/or correctly to any of the question on this questionnaire may result in a forfeiture of your workers' compensation benefits.

In order for your employer to be considered for reimbursement from the Second Injury Board, it has to show that it knowingly hired or retained you with a pre-existing medical condition or disability. To establish its knowledge, your employer is requesting that this questionnaire be completed.

INSTRUCTIONS: Please answer ALL questions completely. If a response requires an explanation, please provide a brief description on the Explanation Page. If you have any questions or need help in answering the questions on this form, please ask for assistance from the Employer Representative signing this form.

NOTE: Since this questionnaire contains medical information, you can request that the form be kept CONFIDENTIAL and not made part of your personnel file. Please let your employer know that you want the completed questionnaire placed in a sealed folder for confidentiality purposes.

EMPLOYEE WARNING

FAILURE TO ANSWER TRUTHFULLY AND/OR CORRECTLY TO ANY OF THE QUESTIONS ON THIS FORM MAY RESULT IN A FORFEITURE OF YOUR WORKERS' COMPENSATION BENEFITS UNDER La. R.S. 23:1208.1.

Employee Signature: _____ Date: _____

Employer Representative Signature: _____ Date: _____

Employer Name: _____

Employee Name: _____

Date of Birth (mm/dd/yyyy): _____ Male: ☐ Female: ☐

Soc. Sec. # (last 4 digits only): _____

Home Address: _____

Telephone Number: (____) _____

¹ Under La. R.S. 23:1371(A), the purpose of the Second Injury Board is to encourage the employment, re-employment, or retention of employees who have a permanent partial disability.

Disease and Other Medical Conditions you currently have or have ever had.

For all conditions that you check yes, write a brief explanation on the Explanation Page.

[Please check the appropriate box next to each. Every illness/injury requires a Yes (Y) or No (N) answer.]

Y N	Y N	Y N	Y N
<input type="checkbox"/> <input type="checkbox"/> Diabetes	<input type="checkbox"/> <input type="checkbox"/> Cerebral Palsy	<input type="checkbox"/> <input type="checkbox"/> Arthritis	<input type="checkbox"/> <input type="checkbox"/> Heart Disease/Heart Attack
<input type="checkbox"/> <input type="checkbox"/> Silicosis	<input type="checkbox"/> <input type="checkbox"/> Tuberculosis	<input type="checkbox"/> <input type="checkbox"/> Parkinson's	<input type="checkbox"/> <input type="checkbox"/> Congestive Heart Failure
<input type="checkbox"/> <input type="checkbox"/> Varicose Veins	<input type="checkbox"/> <input type="checkbox"/> Multiple Sclerosis	<input type="checkbox"/> <input type="checkbox"/> Brain Damage	<input type="checkbox"/> <input type="checkbox"/> Vision Loss, one or both eyes
<input type="checkbox"/> <input type="checkbox"/> Asbestosis	<input type="checkbox"/> <input type="checkbox"/> Post Traumatic Stress	<input type="checkbox"/> <input type="checkbox"/> Asthma	<input type="checkbox"/> <input type="checkbox"/> Disability from Polio
<input type="checkbox"/> <input type="checkbox"/> Hyperinsulinism	<input type="checkbox"/> <input type="checkbox"/> Osteomyelitis	<input type="checkbox"/> <input type="checkbox"/> Dementia	<input type="checkbox"/> <input type="checkbox"/> Psychoneurotic Disability
<input type="checkbox"/> <input type="checkbox"/> Alzheimer's	<input type="checkbox"/> <input type="checkbox"/> Nervous Disorder	<input type="checkbox"/> <input type="checkbox"/> Thrombophlebitis	<input type="checkbox"/> <input type="checkbox"/> Ruptured or Herniated Disc
<input type="checkbox"/> <input type="checkbox"/> Emphysema	<input type="checkbox"/> <input type="checkbox"/> Muscular Dystrophy	<input type="checkbox"/> <input type="checkbox"/> Arteriosclerosis	<input type="checkbox"/> <input type="checkbox"/> Ankylosis or Joint Stiffening
<input type="checkbox"/> <input type="checkbox"/> Hearing Loss	<input type="checkbox"/> <input type="checkbox"/> Migraine Headaches	<input type="checkbox"/> <input type="checkbox"/> Hodgkin's	<input type="checkbox"/> <input type="checkbox"/> High/Low Blood Pressure
<input type="checkbox"/> <input type="checkbox"/> COPD	<input type="checkbox"/> <input type="checkbox"/> Mental Retardation	<input type="checkbox"/> <input type="checkbox"/> Cancer	<input type="checkbox"/> <input type="checkbox"/> Carpal Tunnel Syndrome
<input type="checkbox"/> <input type="checkbox"/> Hypertension	<input type="checkbox"/> <input type="checkbox"/> Kidney Disorder	<input type="checkbox"/> <input type="checkbox"/> Double Vision	<input type="checkbox"/> <input type="checkbox"/> Compressed Air Sequelae
<input type="checkbox"/> <input type="checkbox"/> Head Injury	<input type="checkbox"/> <input type="checkbox"/> Loss of Use of Limb	<input type="checkbox"/> <input type="checkbox"/> Mental Disorders	<input type="checkbox"/> <input type="checkbox"/> Disease of the Lung
<input type="checkbox"/> <input type="checkbox"/> Epilepsy	<input type="checkbox"/> <input type="checkbox"/> Seizure Disorder	<input type="checkbox"/> <input type="checkbox"/> Hemophilia	<input type="checkbox"/> <input type="checkbox"/> Coronary Artery Disease
<input type="checkbox"/> <input type="checkbox"/> Stroke	<input type="checkbox"/> <input type="checkbox"/> Sickle Cell Disease	<input type="checkbox"/> <input type="checkbox"/> Bleeding Disorder	<input type="checkbox"/> <input type="checkbox"/> Heavy Metal Poisoning

Surgical Treatment [Please check the appropriate box. Each illness/injury requires a Yes (Y) or No (N) answer.] For each Yes (Y) answer, please complete the information corresponding to the surgery on the right. Additional information can be provided on the Explanation Page, if necessary.

Y N

<input type="checkbox"/> <input type="checkbox"/> Spinal Disc Surgery	Year (approximate if unsure) _____
<input type="checkbox"/> <input type="checkbox"/> Spinal Fusion Surgery	Year (approximate if unsure) _____
<input type="checkbox"/> <input type="checkbox"/> Amputated Foot	Left <input type="checkbox"/> Right <input type="checkbox"/> Year (approx. if unsure) _____
<input type="checkbox"/> <input type="checkbox"/> Amputated Leg	Left <input type="checkbox"/> Right <input type="checkbox"/> Year (approx. if unsure) _____
<input type="checkbox"/> <input type="checkbox"/> Amputated Arm	Left <input type="checkbox"/> Right <input type="checkbox"/> Year (approx. if unsure) _____
<input type="checkbox"/> <input type="checkbox"/> Amputated Hand	Left <input type="checkbox"/> Right <input type="checkbox"/> Year (approx. if unsure) _____
<input type="checkbox"/> <input type="checkbox"/> Knee Replacement	Left <input type="checkbox"/> Right <input type="checkbox"/> Year (approx. if unsure) _____
<input type="checkbox"/> <input type="checkbox"/> Hip Replacement	Left <input type="checkbox"/> Right <input type="checkbox"/> Year (approx. if unsure) _____
<input type="checkbox"/> <input type="checkbox"/> Other Joint Replacement	Joint _____ Year _____
<input type="checkbox"/> <input type="checkbox"/> Other Surgical Procedure	Procedure _____ Year _____
<input type="checkbox"/> <input type="checkbox"/> Other Surgical Procedure	Procedure _____ Year _____
<input type="checkbox"/> <input type="checkbox"/> Other Surgical Procedure	Procedure _____ Year _____
<input type="checkbox"/> <input type="checkbox"/> Other Surgical Procedure	Procedure _____ Year _____

Employee Signature: _____ Date: _____

Employer Representative: _____ Date: _____

PAGE ____ OF ____

EXPLANATION PAGE

Please use the space below to explain the illnesses and/or conditions that you checked a Yes (Y) **or** any other medical conditions that may not be listed on this form. Ask your employer for additional copies of this page if needed.

CONDITION: _____ Year Diagnosed (approx): _____

Are you still treating for this condition? Yes ☐ No ☐

Are you taking medication for this condition? Yes ☐ No ☐

Do you have any permanent restrictions for this condition? Yes ☐ No ☐

Brief Explanation: _____

CONDITION: _____ Year Diagnosed (approx): _____

Are you still treating for this condition? Yes ☐ No ☐

Are you taking medication for this condition? Yes ☐ No ☐

Do you have any permanent restrictions for this condition? Yes ☐ No ☐

Brief Explanation: _____

CONDITION: _____ Year Diagnosed (approx): _____

Are you still treating for this condition? Yes ☐ No ☐

Are you taking medication for this condition? Yes ☐ No ☐

Do you have any permanent restrictions for this condition? Yes ☐ No ☐

Brief Explanation: _____

CONDITION: _____ Year Diagnosed (approx): _____

Are you still treating for this condition? Yes ☐ No ☐

Are you taking medication for this condition? Yes ☐ No ☐

Do you have any permanent restrictions for this condition? Yes ☐ No ☐

Brief Explanation: _____

Employee Signature: _____ Date: _____

Employer Representative: _____ Date: _____

Please answer the following questions.

1. Has any doctor ever restricted your activities? Yes ☐ No ☐

If "Yes," please list the restrictions: _____

Were the restrictions: Permanent _____ Temporary _____

Are your activities currently restricted? Yes ☐ No ☐

What is the medical condition for which you have restrictions? _____

2. Are you presently treating with a doctor, chiropractor, psychiatrist, psychologist or other health-care provider? Yes ☐ No ☐

Please list the medical condition being treated: _____

Doctor's Name: _____ Specialty: _____

Doctor's Address: _____

3. If you are currently taking prescription medication other than those listed on the Explanation Page, please complete the requested information below.

Medication: _____ Prescribing Doctor: _____

Medication: _____ Prescribing Doctor: _____

4. Have you ever had an on the job accident? Yes ☐ No ☐

If you answered "YES," please provide the date for each injury and the nature of the injury:

How long were you on compensation? _____

Name of Employer: _____

5. Has a doctor recommended a surgical procedure, which has not been completed prior to this date, including but not limited to knee, hip or shoulder replacement? Yes ☐ No ☐

If you answered YES, please provide:

Recommended surgery: _____

Approximate date of recommendation: _____

Doctor's Name: _____ Specialty: _____

Doctor's Address: _____

Employee Signature: _____ Date: _____

Employer Representative: _____ Date: _____

EMPLOYEE WARNING

FAILURE TO ANSWER TRUTHFULLY AND/OR CORRECTLY TO ANY OF THE QUESTIONS ON THIS FORM MAY RESULT IN A FORFEITURE OF ANY AND ALL WORKERS COMPENSATION BENEFITS UNDER La. R.S. 23:1208.1.

I have completed this form honestly and to the best of my knowledge. I understand that providing false information or omitting pertinent information could result in loss of my workers compensation benefits should I become injured on the job.

Employee Signature: _____ Date: _____

Employee Printed Name: _____

EMPLOYER WARNING

PURSUANT TO La. R.S. 23:1208 OF THE LOUISIANA WORKERS' COMPENSATION ACT, IT SHALL BE UNLAWFUL FOR A PERSON, FOR THE PURPOSE OF OBTAINING OR DEFEATING ANY BENEFIT PAYMENT UNDER THE PROVISIONS OF THIS CHAPTER, EITHER FOR HIMSELF OR FOR ANY OTHER PERSON, TO WILLFULLY MAKE A FALSE STATEMENT OR REPRESENTATION. PENALTIES FOR VIOLATIONS INCLUDE IMPRISONMENT, FINES, AND/OR THE FORFEITURE OF BENEFITS.

You must certify the following:

1. That I am an authorized representative of the employer designated to obtain and review the information provided by the employee on this questionnaire;
2. That I have provided the employee with as many copies of the Explanation Page as needed and have confirmed the number of and labeled the pages of this questionnaire;
3. That I have provided assistance to the employee (if requested) in responding to the questions on this questionnaire;
4. That the information sought by this authorization is made on an applicant for employment only after a conditional job offer has been made and accepted, or on a current employee; and
5. That the information obtained in the authorization will **NOT** be used to discriminate in any manner against the individual who is the subject of this authorization on any basis, in violation of the Americans with Disabilities Act of 1990, 42 U.S.C. §12101, *et seq.*, or any other state or federal law;
6. That if requested, a photocopy of this fully completed and signed form will be provided to the employee.

Employer Representative Signature: _____ Date: _____

Employer Representative Printed Name: _____

Title: _____



BILLY NUNGESSER
LIEUTENANT GOVERNOR

State of Louisiana
OFFICE OF THE LIEUTENANT GOVERNOR
DEPARTMENT OF CULTURE, RECREATION & TOURISM
OFFICE OF MANAGEMENT AND FINANCE

RICHARD H. HARTLEY
DEPUTY SECRETARY

NANCY WATKINS
UNDERSECRETARY

PARENTAL CONSENT FOR EMPLOYEE DRUG TESTING

My minor child, _____, has been offered employment by the Office of the Lieutenant Governor (OLG) or the Department of Culture, Recreation, and Tourism (DCRT). I fully understand that as an employee of the OLG/DCRT, my child will be subject to the OLG/DCRT's Substance Abuse and Drug-Free Workplace Policy. I have been provided a copy of this policy, and I hereby acknowledge that I have thoroughly read and understand its terms and provisions.

My signature hereon serves as parental consent:

- a) For my child to undergo pre-employment drug/alcohol testing and to submit a urine sample for that purpose;
- b) For my child to be drug/alcohol tested in accordance with the terms of the OLG/DCRT's policy and as permitted by law;
- c) For the OLG/DCRT to submit my child's urine sample for testing for drugs/alcohol prohibited by its policy; and
- d) For the OLG/DCRT to obtain the results of my child's drug/alcohol test from a certified laboratory for use in accordance with the OLG/DCRT's policy.

SIGNATURE: _____

DATE: _____

Revised 5/13/16



State of Louisiana

OFFICE OF THE LIEUTENANT GOVERNOR
DEPARTMENT OF CULTURE, RECREATION & TOURISM

Education Verification Form

Name _____ Date _____

Address _____

E-mail Address _____

Home Phone # _____ Mobile Phone # _____

Please list your **Highest Level** of education below:

EDUCATION	Name and location of school	Degree Received	Subjects studied/Major	Start Date	Graduation Date
High School					
College or University					
Trade, Business or Correspondence School					

Please read carefully before signing.

I attest with my signature below that I have given OLG/DCRT true and complete information on this application. No requested information has been concealed. If any information I have provided is untrue, or if I have concealed material information, I understand that this may constitute cause for the denial of employment or immediate dismissal.

Date _____ Signature _____

Office of the Lieutenant Governor (OLG)
Department of Culture, Recreation, & Tourism (DCRT)

RELATIVES DISCLOSURE FORM

In order to minimize complications associated with the employment of relatives, all applicants for employment are required to disclose family relationships to existing OLG/DCRT employees. This disclosure is necessary to preclude a violation of the Code of Governmental Ethics (R.S. 42:1119) and avoid a supervisor-subordinate relationship between immediate family members and relatives which creates a conflict of interest or the appearance of impropriety. For a full review of the ethics code regarding nepotism, please visit ethics.la.gov.

Definition of Immediate Family Members:

Your Children; Your Spouse; Your Parents; Your Brothers and Sisters, including Half-siblings; Your Children's Spouses; Your Spouse's Parents; and The Spouses of your Brothers, Sisters, and Half-siblings.

_____ To the best of my knowledge, I am not related to anyone employed by OLG/DCRT.

_____ To the best of my knowledge, I am related to the following current employee(s) of OLG/DCRT.

<u>NAME</u>	<u>RELATIONSHIP</u>	<u>DIVISION /SECTION</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

I CERTIFY that the foregoing disclosure is true and correct to the best of my knowledge, information and belief, and understand that any knowing or intentional failure to disclose a family relationship existing upon my employment with OLG/DCRT or occurring during my employment with OLG/DCRT may result in disciplinary action, including the possibility of termination.

Signature

Date

Print Name



State of Louisiana

Employment Application

civilservice.la.gov

Position applying for: (Please print and attach supplemental questions included in the posting for which you are applying)

*Job Title: _____ Job#: _____

*Agency: _____ *Location: _____

NOTE: Any Supplemental Questions accompanying this job posting must be printed, answered, and submitted with this application or your application will be considered incomplete.

Contact Information

*Name _____
First Middle Initial Last

*Mailing Address _____
Street City State Zip Code

*Email Address _____

*Home Phone _____ Alternative Phone _____

*Social Security Number (Full # Required) _____

*By which method would you prefer to be notified about application status, testing dates and examination results?
(Note: if you select 'E-mail,' you may still continue to receive paper notices from certain employers, depending on their preference.)

Please check one of the following options: _____ E-mail _____ Mail

Other Personal Information

*Do you possess a valid Driver's License? (Please check one)

_____ Yes, I possess a valid Driver's License. _____ No, I do not possess a valid Driver's License.

If Yes, Please provide the State and number _____

*Class: _____ 1 _____ 2 _____ 3 _____ 4 _____ A _____ A CDL
_____ B _____ B CDL _____ C _____ C CDL _____ CM _____ D
_____ E _____ E (Learner) _____ F _____ M1 _____ M2
_____ Motorcycle _____ R _____ None

I consent to the release of information concerning my capacity and/or all aspects of prior job performance by employers, educational institutions, law enforcement agencies, and other individuals and agencies to duly accredited investigators, human resources staff, and other authorized employees of the state government for the purpose of determining my eligibility and suitability for employment.

I certify that all statements made on this application and any attached papers are true and complete to the best of my knowledge. I understand that the information on this application may be subject to investigation and verification and that any misrepresentation or material omission may cause my application to be rejected, my name to be removed from the eligible register and/or subject me to dismissal from state service.

I have read the statements above carefully before signing this application:

Signature of Applicant _____ **Date** _____

* Required field

Additional Information

*Can you, after employment, submit proof of your legal right to work in the United States? (Please check one)

_____ Yes

_____ No

*Please check the types of employment you will accept: _____ Permanent _____ Temporary

Certificates and Licenses

Type	License Number	Issued By	Date Issued	Date Expires

Additional Skills _____

*Are you currently at least 18 years old? _____ Yes _____ No

The State of Louisiana requests the information below so we may comply with federal Equal Employment Opportunity law requirements. The information is strictly voluntary and in no way influences employment prospects.

Gender: _____ Male _____ Female _____ Decline to state

Ethnicity: _____ Hispanic or Latino _____ Non-Hispanic or Non-Latino _____ Decline to state

Race: _____ White/Caucasian _____ Asian _____ American Indian/Alaskan Native
_____ Black or African American _____ Native Hawaiian or other Pacific Islander
_____ 2 or more races _____ Decline to state

Date of Birth (Month/Day/Year): _____/_____/_____

How did you find out about this job? _____ Civil Service website _____ Paper announcement at agency
_____ Newspaper ad _____ Flier _____ Career Fair _____ Word of mouth _____ Other

Please select all that apply to you:

_____ I am a certified Vocational Rehabilitation Client. (Rule 22.8(a))

_____ I have a 3.5 GPA or higher for my baccalaureate degree. (Rule 22.8(c))

_____ I am an active duty member of the armed forces, or a veteran of the armed forces who has served at least 90 days of active service for purposes other than training and who has been honorably discharged from active duty within the previous 12 months. (Rule 22.8(d))

_____ I am eligible for Non-competitive Re-employment. (Rule 23.13)

_____ I am a current permanent classified state employee in a job which requires the same Civil Service test as this vacancy, and I have been in this job for at least the last six months.

_____ None of the above.

*Are you an *Army Pays* participant? _____ Yes _____ No

To enable us to fully evaluate any military experience claimed, please list in the space provided below each rank and grade you have held (e.g., include E, O or W grade) and the date that each was attained. If you do not have any military experience, enter N/A. _____

* Are you claiming Veteran's Preference points on this application? _____ Yes _____ No

If claiming Veteran's Preference points, were you honorably discharged or discharged under honorable conditions from the Armed Forces of the United States? _____ Yes _____ No _____ Does not apply

Are you an honorably discharged veteran who served either in peace or in war and who has one or more disabilities recognized as service-connected by the Veteran's Administration? _____ Yes _____ No

** Required field*

During which period did you serve? (check all that apply)

- ☐ In the wartime period April 6, 1917 through November 11, 1918
☐ In the wartime period September 16, 1940 through July 25, 1947
☐ In the wartime period June 27, 1950 through January 31, 1955
☐ In the wartime period July 1, 1958 through May 7, 1975
☐ In a peacetime campaign or expedition for which campaign badges are authorized
☐ Post 09/11/01 for 90 days or more and for purposes other than training
☐ Does not apply/None of the above

Please select all that apply:

- ☐ I am the spouse of a veteran whose physical condition precludes his or her appointment to a civil service job in his or her usual line of work.
☐ I am the unmarried widow of a deceased veteran who served in a war period as defined in the question above, or in a peacetime campaign or expedition.
☐ I am the un-remarried widowed parent of any person who died in active wartime or peacetime service or who suffered total and permanent disability in active wartime or peacetime service.
☐ I am the divorced or separated parent of any person who died in wartime or peacetime service or who became totally and permanently disabled in wartime or peacetime service.
☐ None of the above

*Are you currently holding or running for an elective public office? ☐ Yes ☐ No

*Have you ever been fired from a job or resigned to avoid dismissal? ☐ Yes ☐ No

If "Yes", please explain below. A "Yes" answer will not necessarily bar you from state employment

*If you are a male from the ages 18 through 25, please answer the following question "Yes" or "No". If you are not a male in this group, select "Does not apply". Are you registered with the Selective Service System?

☐ Yes ☐ No ☐ Does not apply

In which parishes are you available for employment?

<input type="checkbox"/> Acadia	<input type="checkbox"/> Allen	<input type="checkbox"/> Ascension
<input type="checkbox"/> Assumption	<input type="checkbox"/> Avoyelles	<input type="checkbox"/> Beauregard
<input type="checkbox"/> Bienville	<input type="checkbox"/> Bossier	<input type="checkbox"/> Caddo
<input type="checkbox"/> Calcasieu	<input type="checkbox"/> Caldwell	<input type="checkbox"/> Cameron
<input type="checkbox"/> Catahoula	<input type="checkbox"/> Claiborne	<input type="checkbox"/> Concordia
<input type="checkbox"/> DeSoto	<input type="checkbox"/> E. Baton Rouge	<input type="checkbox"/> E. Carroll
<input type="checkbox"/> E. Feliciana	<input type="checkbox"/> Evangeline	<input type="checkbox"/> Franklin
<input type="checkbox"/> Grant	<input type="checkbox"/> Iberia	<input type="checkbox"/> Iberville
<input type="checkbox"/> Jackson	<input type="checkbox"/> Jefferson	<input type="checkbox"/> Jeff Davis
<input type="checkbox"/> Lafayette	<input type="checkbox"/> Lafourche	<input type="checkbox"/> LaSalle
<input type="checkbox"/> Lincoln	<input type="checkbox"/> Livingston	<input type="checkbox"/> Madison
<input type="checkbox"/> Morehouse	<input type="checkbox"/> Natchitoches	<input type="checkbox"/> Orleans
<input type="checkbox"/> Ouachita	<input type="checkbox"/> Plaquemines	<input type="checkbox"/> Pointe Coupee
<input type="checkbox"/> Rapides	<input type="checkbox"/> Red River	<input type="checkbox"/> Richland
<input type="checkbox"/> Sabine	<input type="checkbox"/> St. Bernard	<input type="checkbox"/> St. Charles
<input type="checkbox"/> St. Helena	<input type="checkbox"/> St. James	<input type="checkbox"/> St. John
<input type="checkbox"/> St. Landry	<input type="checkbox"/> St. Martin	<input type="checkbox"/> St. Mary
<input type="checkbox"/> St. Tammany	<input type="checkbox"/> Tangipahoa	<input type="checkbox"/> Tensas
<input type="checkbox"/> Terrebonne	<input type="checkbox"/> Union	<input type="checkbox"/> Vermillion
<input type="checkbox"/> Vernon	<input type="checkbox"/> Washington	<input type="checkbox"/> Webster
<input type="checkbox"/> W. Baton Rouge	<input type="checkbox"/> W. Carroll	<input type="checkbox"/> W. Feliciana
<input type="checkbox"/> Winn		

Education

*High School Name _____ Location _____

Have you received a high school diploma or equivalency certificate? _____ Yes _____ No

Give the name and address of the school, major course of study, and degree achieved:

Undergraduate University _____

Graduate School _____

College Major _____

Area of Study _____

Degree Attained _____

Degree Attained _____

Year _____

Year _____

Undergraduate Semester Hours Completed	Undergraduate Quarter Hours Completed	Graduate Semester Hours Completed	Graduate Quarter Hours Completed

Work History

Describe your work experience, beginning with your current or most recent job. Include military service, volunteer work, self-employment, and part-time employment.

1. Name of Present or Last

Employer _____

Job Title _____

Address _____

Phone _____ Supervisor _____

From (Month/Year) _____ / _____ To _____ / _____ Hours Per Week _____

Salary _____ Number of Employees Supervised _____

May we contact this employer? _____ Yes _____ No

Job Duties (give details)

Reason For Leaving _____

2. Your Next Most Recent

Employer _____

Job Title _____

Address _____

Phone _____ Supervisor _____

From (Month/Year) _____ / _____ To _____ / _____ Hours Per Week _____

Salary _____ Number of Employees Supervised _____

May we contact this employer? _____ Yes _____ No

Job Duties (give details)

Reason For Leaving

3. Your Next Most Recent

Employer

Job Title

Address

Phone

Supervisor

From (Month/Year) / To / Hours Per Week

Salary Number of Employees Supervised

May we contact this employer? Yes No

Job Duties (give details)

Reason For Leaving

4. Your Next Most Recent

Employer

Job Title

Address

Phone

Supervisor

From (Month/Year) / To / Hours Per Week

Salary Number of Employees Supervised

May we contact this employer? Yes No

Job Duties (give details)

Reason For Leaving

5. Your Next Most Recent

Employer

Job Title

Address

Phone

Supervisor

From (Month/Year) / To / Hours Per Week

Salary Number of Employees Supervised

May we contact this employer? Yes No

Job Duties (give details)

Reason For Leaving



EMPLOYEE PAY STATEMENT QUICK REFERENCE

[Click here for PRINTABLE VERSION](#)

Best printed in DUPLEX

To View Current Pay Statement:

1. Access **LEO**
From the **Louisiana.gov** page, locate Online Services and click **LEO: Louisiana State Employees Online** **or** use this address: <https://leo.doa.louisiana.gov/>
2. Log into LEO
 - **Personnel Number** field enter 8 character P id. Must enter a “p” and all necessary preceding zeros (ex: P00123456). Tab to the **Password** field, enter your password and press enter. Need help? Click and view the **Log On Assistance** quick reference.
 - Enter your **Password**. If you can’t remember your password, reset it by clicking on the **Forgot password? Locked?** and follow “on screen” instructions.

3. Click **\$** [View/Print Pay Statement](#) option under the **Shortcuts** area of the Announcement page or click **My Info** tab and select **Pay Statement**.
4. Select the period you wish to display (use Pay Date or Period Begin and End dates to identify statement desired) from the choices on the left. Click **MORE** to load additional period dates.

01/06/2017	2,728.83	USD
12/19/2016 - 01/01/2017		
More		

To Print Pay Statement:



Click . A printer selection box may appear. Select the correct printer and click the **PRINT** button.

To Save Pay Statement:



Click the download icon, select where you want to store it, name your file, and then click **Save** . You may want to include the pay date as part of the file name (e.g., Pay12072007).

Office of the State Americans with Disabilities Act Coordinator (OSADAC)
VOLUNTARY SELF-IDENTIFICATION OF DISABILITY FORM

Employee Name: _____ Personnel #: _____

Why are you being asked to complete this form?

As an executive branch state agency, the Office of Lieutenant Governor/Department of Culture, Recreation & Tourism is required by La. R.S. 46:2597 to establish annual strategies and goals related to employment of individuals with disabilities. In order to effectively measure and report our progress to this end, La. R.S. 46:2597 requires us to ask employees if they have a disability or have ever had a disability. Because a person may become disabled at any time, we ask all of our employees to update their information at least every five (5) years.

Identifying yourself as an individual with a disability is **voluntary**, and we hope that you will choose to do so (if applicable). Your answer will be maintained confidentially and will not be seen by hiring officials or anyone else involved in making personnel decisions. Completing the form will not negatively impact you in any way. For more information about this form or the Americans with Disabilities Act, visit the Office of the State Americans with Disabilities Act (ADA) Coordinator's website at <https://www.doa.la.gov/office-of-state-ada-coordinator/>.

How do you know if you have a disability?

You are considered to have a disability if you have a physical or mental impairment that substantially limits a major life activity, or if you have a history or record of such an impairment. Disabilities include, but are not limited, to:

- Autism
- Autoimmune disorder, for example, lupus, fibromyalgia, rheumatoid arthritis, or HIV/AIDS
- Blind or low vision
- Cancer
- Cardiovascular or heart disease
- Celiac disease
- Cerebral palsy
- Deaf or hard of hearing
- Depression or anxiety
- Diabetes
- Epilepsy
- Gastrointestinal disorders, for example, Crohn's disease, or irritable bowel syndrome
- Intellectual disability
- Missing limbs or partially missing limbs
- Nervous system condition, for example, migraine headaches, Parkinson's disease or Multiple Sclerosis (MS)
- Psychiatric condition, for example, bipolar disorder, schizophrenia, Post Traumatic Stress Disorder (PTSD) or major depression

Please check ONE of the boxes below:

☐ **YES**, I have a disability ☐ **NO**, I do not have a disability ☐ I do not wish to answer

You are encouraged to carefully review our agency's policy specific to the Americans with Disabilities Act and/or Disability Rights, and to request workplace accommodations as may be needed for your disability.

Employee Signature: _____

Date: _____