ESMAR MANAGEMENT GROUP

302 S. Milliken Avenue, Suite E2, Ontario, CA 91761

Applicant Name_____

First Middle Last

Street Address_____ Apartment/Unit #_____

City_____ State_____ ZIP Code_____

Phone 1:_____ Phone 2:_____

Email:_____

Employment Positions

Position(s) Applying For_____

What Days And Hours are you Available for Work_____

Can you work weekends? **YES** ◯ **NO** ◯ Are you available to work overtime? **YES** ◯ **NO** ◯

Do you have any friends, relatives or acquaintances working for company? **YES** ◯ **NO** ◯

If yes, state name & relationship? _____

If hired, do you have your own transportation to/from work? **YES** ◯ **NO** ◯

If hired, would you be able to present proof of your eligibility to work in the United States? **YES** ◯ **NO** ◯

If hired, are you willing to submit to and pass a controlled substance test? **YES** ◯ **NO** ◯

Are you able to perform the essential functions or the job for which you are applying, either with/without reasonable accommodation? **YES** ◯ **NO** ◯

If No, describe the functions that cannot be performed:_____

(Note: Company complies with the ADA and consider reasonable accommodation measures that may be necessary for eligible applicants/employees to perform essential functions. It is possible that a hire may be tested on skill/agility and may be subject to a medical examination conducted by a medical professional.)

Education, Training and Experience

School Name:_____

School Address:_____

Number of Years Completed_____ Did you Graduate? **YES** ◯ **NO** ◯ Degree/Diploma Earned:_____

Work History

Employer Name:_____ PHONE:_____ Dates of Employment:_____

Job Duties:_____

Reason for Leaving:_____ Supervisor's Name:_____

Employer Name:_____ PHONE:_____ Dates of Employment:_____

Job Duties:_____

Reason for Leaving:_____ Supervisor's Name:_____

302 S. Milliken Avenue, Suite E2, Ontario, CA 91761

Work References:

Name:_____ Phone:_____ Email:_____

Name:_____ Phone:_____ Email:_____

Name:_____ Phone:_____ Email:_____

Disclaimer and Signature:

I certify that my answers are true and complete to the best of my knowledge.

If this application leads to employment, I understand that false or misleading information In my application or Interview may result In my release.

Signature:_____ **Date:**_____

302 S. Milliken Avenue, Suite E2, Ontario, CA 91761

Employment Agreement

FOR OFFICE USE ONLY

Client Name:_____ **Client ID:**_____

Client Address:_____

City:_____ State:_____ Zip Code:_____

Client Phone Number:_____ Alternate Number:_____

Start Date:_____ W/C Code:_____ Rates(s) Pay:_____

Rate(s) by:_____ Overtime Rate(s) of Pay:_____ Regular Pay Day:_____

APPLICANTS COMPLETE BELOW

Military Veteran: **YES** ◯ **NO** ◯ Allowances:_____

Applicants Name:_____ Social Security:_____

Applicant's Address:_____ City:_____ Sate:____ Zip:_____

Applicant's Phone Number:_____ Alternative Number:_____

In case of emergency, please notify:

Emergency Contact Name:_____ Relationship:_____

Emergency Contact Phone Number:_____

EEO-1 Report Information

The following information pertains to applicable federal EEO-1 Reports. Information received will not be used in any way to evaluate the employee.

Check One Below:

Male: ◯ Female: ◯

White: ◯ Black: ◯ Hispanic: ◯ Asian or Pacific Islander: ◯ American Indian: ◯

Native Hawaiian: ◯ Other: ◯ Two or More Races: ◯

Marital Status: Married: ◯ Married (withhold a higher single rate): ◯ Single: ◯

Employee Initial Here_____

302 S. Milliken Avenue, Suite E2, Ontario, CA 91761

Welcome to ESMAR Management Group (Here in after "ESMAR Management Group"). The Company for which Issues your paychecks, process your year end, W2 and to offer a variety of Employee benefits for your consideration. Under this agreement, you will be considered an employee of ESMAR Management Group. All information contained in the employment agreement is Important to your employment with ESMAR Management Group. All blanks must be completed, and you must sign the agreement, including the 19 and W4. A copy of your social security is requested for employment tax purposes.

Check on of the following:

Official or Manager ◯ Technician ◯ Craft Worker ◯ Professional ◯ Office (Clerical) ◯ Laborer ◯
Operatives ◯ Service Worker ◯

At-Will Employment:

I, the undersigned employee, in consideration of my hiring by ESMAR Management Group as an at-will employee of ESMAR Management Group's, acknowledge and agree to the following: I have been ESMAR Management Group hired as an at-will employee of ESMAR Management Group which is an employee staffing company and there is no contract of employment which exists between me and the client to which I have been assigned, Nor between ESMAR Management Group and me. I understand and agree that either ESMAR Management Group or I can terminate our employment relationship at any time, as I am an at-will employee. I also agree that I may be assigned to an affiliated ESMAR Management Group company and employed by such company at any time at the sole and complete discretion of ESMAR Management Group and without my consent or agreement. I also agree that while I am a staffed employee with ESMAR Management Group , if ESMAR Management Group does not receive payment from client for services which I perform as a staff employee, ESMAR Management Group will still pay me regular hourly rate of pay if I am a non-exempt employee and to pay my full salary if I am a exempt employee even if ESMAR Management Group is not paid by the client to which I am assigned. I have been informed and that I agree that if my assignment with ESMAR Management Group within seventy-two (72) hours for possible reassignment and that unemployment covered by state workers' compensation statutes, and to avoid circumventions of such statutes which might result from suits herby waive and forever release any rights I might have to make claims to bring suits against any clients or customers of ESMAR Management Group or against ESMAR Management Group for damages based upon injuries which are covered under such workers compensation statutes.

Client Company Paid Leave Policies and Other Benefits.

In the case of that Client Company maintains policy providing paid leave benefits such as vacation, sick leave, pto, or severance pay, client company is solely responsible for paying any accrued benefits under such policies during employment and at time of termination. ESMAR Management Group does not provide, and has no policy providing vacation and or other paid leave benefits. To the extent paid leave benefits are paid thru ESMAR Management Group payroll to employee, it is solely as a payroll service on behalf of client company. Similarly, to the extent client company provides other benefits pursuant to policies to which ESMAR Management Group is not a party, such as stock options, bonuses, profit sharing, retirement benefits, and so forth, client company is solely responsible for providing benefits prescribed by those policies.

Assignment.

If Client Company files any form of bankruptcy, employee will and hereby transfers to ESMAR Management Group all of his/her rights as a employee for the purposes of payment of wages and applicable payroll taxes. For this right, ESMAR Management Group will compensate Employee an additional five percent (5%) premium, on those amounts ESMAR Management Group receives from client as a result of the assignment of Employee's rights.

Employee Initial Here:_____

ESMAR MANAGEMENT GROUP

302 S. Milliken Avenue, Suite E2, Ontario, CA 91761

Policies and Benefits.

Employee agrees to abide by the policies of ESMAR Management Group including but not limited to policies contained in any applicable Employee handbook. Employee understands that eligibility and coverage for ESMAR Management Group benefits is controlled by the terms and conditions of the applicable Plan Documents.

Arbitration:

ESMAR Management Group promotes a voluntary system of alternative dispute resolution that utilities binding arbitration to resolve all disputes that may arise out of the employment context.

Medical Authorization

I hereby authorize the release of any and all medical, hospital vocational and psychological records and other information related to my Injury, illness or worker's compensation claim (hereinafter collectively referred to as "Medical Information") to ESMAR Management Group ; its employees, agents and authorized representatives. I hereby permit ESMAR Management Group to review and obtain copies of any and all Medical Information and to discuss pertinent Medical Information with professionals involved in my health care treatment. Thereby give ESMAR Management Group permission to release the Medical information to healthcare providers, third party administrators, federal or state court, Workers' Compensation Boards, employers Insurers and any other party who may be involved with my claim, treatment or vocational rehabilitation, or as required by law. Further pursuant to Title 42 Section 1395y, carriers are required to share claimants' Medical Information to enable the Centers for Medicare & Medicaid Services, formerly known as Healthcare Financing Administration (CMS) to determine eligibility for benefits. Thereby give ESMAR Management Group Workforce permission to discuss, disclose and release any Medical Information with or to CMS in connection with my claim. I hereby release ESMAR Management Group from any liability or loss due to the release of Medical information. I understand that all information released will be handled confidentially and in accordance with all applicable laws. I also understand that this authorization shall stay in effect until the closure of the claim file. I certify that this authorization has been made. voluntarily and that the Information given herein is accurate to the best of my knowledge. A photocopy of this authorization shall have the same validity as the original.

Accident/Injury Guidelines & Procedures

1. All Injuries must first be reported to your immediate supervisor, who will then report the incident to ESMAR Management Group Workers Compensation Department before authorization will be given for medical treatment. Exception; emergency situations or if the injury occurs after hours and/or on the weekends.
2. A drug screen Is required within 24 hours for all injuries. In accordance with state law, a positive result relieves ESMAR Management Group and Its Insurers from any responsibility for any medical expenses incurred in connection with your injury, Refusal to submit to a drug test will result in the same consequences as a positive drug test result. If an employee tests positive on a post-accident drug test, they will be discharged for violation of the company's substance abuse policy, and workers' compensation benefits and/or medical bills incurred by the employee will be denied.
3. The employee is required to inform the doctor or medical facility that light duty work is available. The Employee will be required to work light duty per the doctor's instructions,
4. Employees are required to forward all medical information associated with the workplace Injury/illness (doctor's work status report, medical records, etc.) within 24 hours
5. Employees are required to complete an Employee Accident/Injury report within 24 hours of the injury/illness.

Employee Initial Here:_____

ESMAR MANAGEMENT GROUP

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MPN (Medical Provider Network Confirmation

I have received the MPN (Medical Provider Network) I acknowledge that my employer has posted the provider listings for the MPN. I acknowledge that if I do not complete the enrollment forms and return it to my employer within 30 days, my employer will enroll me in the MPN. I acknowledge that this letter pertains to workers' compensation only. This is not a health plan. This applies only to work related injuries or work-related illnesses,

Substance Abuse Policy

Any employee on duly or on company property who possesses, sells, receives, or is determined to have measurable levels of any illegal drug, or sufficient alcohol to Impair performance in their blood or urine, will be subject to immediate discharge, and in appropriate situations, referred to law enforcement authorities. See your Employee Handbook regarding procedures applicable to prescriptive medications. Periodically, unannounced inspections will be made of persons entering or leaving company work sites by authorized company representatives. Entry onto company property is deemed to be consent to an Inspection of a person, locker, vehicle, or any other personal effects. ESMAR Management Group also reserves the right to require employee testing for illegal or controlled drugs or alcohol, based on reasonable suspicion and I as an employee specifically agree to post-accident drug testing in any situation where it is allowed by law.

Deductions

By initialing this page below and signing this employment agreement form I authorize deductions when applicable to be made out of my paycheck for tools, uniforms, health Insurance, errors in payroll, garnishments, overpayments, bank fees for stop payment of a lost or damaged check, and any other work-related deductions. I agree that if I should leave or be discharged from employment at the above client company ESMAR Management Group before the full amount is paid, any earning over minimum wage will be applied to my deduction loan. The amount deducted from my last paycheck may be greater than the amount shown for each paycheck in accordance with the applicable labor law.

Six Hour Meal Period Waiver Agreement

I, hereby agree, by mutual consent of the employer and employee, to waive my required meal period is when a work period of not more than six {6) hours will complete the day's work, as defined by the State of California Industrial Welfare Commission Order, Section 11(A)

Acknowledgement of Meal & Rest Periods Policy

This policy details the meal and rest period policy and process for Nonexempt employees in California, Pursuant to California law, employees who work more than five (5) hours will be provided with at least a full thirty (30) minute meal period. This meal period will begin no later than the fifth hour of work. Additionally, employees who work more than ten:(10) hours in a workday will be provided with a second thirty (30) minute meal period. This second meal period must be taken before the end of the tenth hour of work. Meal periods cannot be taken at the beginning or end of shifts.

Employees will be relieved of all of their duties during meal periods and may not work during this time. An employee's meal period shall not be considered "on duty" and will not be counted as time worked. Employees will be provided ten (10) minute paid rest periods to employees for every four (4) hours worked or major fraction thereof, unless the employee works less than three and a half hours in a day. Employees will be informed by a supervisor when to take their rest periods: Whenever practicable, employees should be able to take their rest breaks near the middle of each four-hour work period. Employees may not accumulate rest periods or use rest periods as a basis for starting work late, leaving their assigned shift early, or extending a meal period, Because rest breaks are paid, employees should not clock out for them. This meal and rest break policy applies at all times during your employment; including while placed on job assignment at any client company in California. I hereby certify that I fully understand this policy and process regarding meal and rest periods and will comply with these rules. If I miss or am unable to take a meal or rest period, I agree to notify my local branch office within twenty-four (24) hours so that my employer can investigate and take the appropriate corrective action.

Employee Initial Here:_____

302 S. Milliken Avenue, Suite E2, Ontario, CA 91761

Harassment Discrimination and Retaliation Prevention Policy.

Reporting Harassment or Discrimination. If you believe that you have been subjected to or witnessed any unlawful harassment, discrimination, or retaliation, you should immediately report such conduct to your supervisor. If you do not feel comfortable reporting harassment or discrimination to your supervisor, you should report the harassment and or discrimination to ESMAR Management Group Human Resources Employee. In addition, if an employee observes harassment or discrimination by another employee, supervisor, manager, or non-employee, the employee should immediately report the incident to Human Resources Department. Employees notification to ESMAR Management Group is essential to enforcing this policy. Employees may be assured that they will not be penalized in any way for reporting a harassment or discrimination problem. It is unlawful for employers to retaliate against employees who oppose practices prohibited by the California Fair Employment and Housing Act ("FEHA"), or who file complaints or otherwise participate in an investigation, proceeding, or hearing conducted by the California Department of Fair Employment and Housing ("FEHC"). Similarly, ESMAR Management Group prohibits employees from hindering its internal investigations or its Internal complaint procedure. All complaints of unlawful harassment or discrimination that are reported to management or to the Humans Resources Department will be investigated as promptly as possible through a fair and thorough investigation by an impartial qualified ESMAR Management Group Representative. ESMAR Management Group will conduct its investigation in a manner that provides all parties appropriate due process and reasonable conclusions that are based on the evidence collected, including by documenting and tracking its investigation. Corrective action will be taken where warranted and based on the documented evidence. Supervisors and/or managers who witness harassment, discrimination, or retaliation, or who receive reports of harassment, discrimination, or retaliation, must immediately report such conduct to Human Resources Department. Failure to do so for supervisors and/or managers may result in disciplinary action. Violations of this policy will subject an individual to disciplinary action, up to and including immediate termination. Additionally, under California law, employees may be held to be personally liable for harassing conduct that violates the FEHA. Retaliation Prohibited. ESMAR Management Group prohibits retaliation against those who report, oppose or participate in an investigation of alleged violations of this policy. Participating in an investigation of alleged wrongdoing in the workplace includes:

1. Filing a complaint with a federal or state enforcement or administrative agency.
2. Participating in or cooperating with a federal or state enforcement agency that is conducting an investigation of the company regarding alleged unlawful activity.
3. Testifying as a party, witness or accused regarding alleged unlawful activity.
4. Associating with another employee who is engaged in any of these activities,
5. Making or filing an internal complaint with the company regarding alleged unlawful activity.
6. Providing informal notice to the company regarding alleged unlawful activity

ESMAR Management Group strictly prohibits any adverse action or retaliation against an employee for participating in an investigation of alleged violation of this policy. If an employee feels that he or she is being retaliated against, the employee should immediately contact ESMAR Management Group Human Resources Employee. In addition, if an employee observes retaliation by another employee, supervisor, manager or nonemployee, he or she should immediately report the incident to the individuals above. Any employee determined to be responsible for violating this policy will be subject to appropriate disciplinary action, up to and Including termination. Moreover, any employee, supervisor or manager who condones or ignores potential violations of this policy will be subject to appropriate disciplinary action, up to and including termination.

Employee Initial Here:_____

ESMAR MANAGEMENT GROUP

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Please Check one of the item boxes next to the option in which you would like to designate below:

☐ **I want to enroll in the MPN** (Medical Provider Network) program for my medical care for any work-related injury or illness, I have received information about the HealthCare Organization offered by my employer and want to enroll in the MPN (Medical Provider Network) Program

☐ **I do NOT want to enroll in the MPN**. I want my personal physician, personal chiropractor, or personal acupuncturist to treat me for any related Injury or illness. My personal physician, personal chiropractor or personal acupuncturist is:

(write name and address of your personal physician, personal chiropractor, or personal acupuncturist)

Doctors Name: _____ Phone Number: _____

Address: _____

City: _____ State: _____ Zip Code: _____

☐ **I do not want to enroll in the MPN** or designate a personal physician, personal chiropractor, or personal acupuncturist to treat me for any work-related Injury or illness. I understand that my employer will enroll me in the MPN (Medical Provider Network) program for treatment of any work-related injury or illness

WORKER'S COMPENSATION INFORMATION:

Insurance Carrier: _____

Address: _____

Telephone Number: _____ Policy Number: _____

This Employment Agreement form is in compliance with labor LC2810.5

BY SIGNING BELOW, T ACKNOWLEDGE THE RECEIPT OF MY EMPLOYER INFORMATION, MY WAGE INFORMATION, A COPY OF THIS EMPLOYENT AGREEMENT, RECEIPT OF HARASSMENT, DISCRIMINATION AND RETALIATION PREVENTION POLICY, AND MY EMPLOYER'S WORKERS COMPENSATION INFORMATION. BY SIGNING BELOW, ALSO ACCEPT THE TERMS OF THIS EMPLOYMENT.AGREEMENT FORM, ACKNOWLEDGE THAT I UNDERSTAND AND AGREE TO COMPLY WITH THE HARASSMENT, DISCRIMINATION, AND RETALIATION PREVENTION POLICY, AND CONFIRM THAT ALL MY PERSONAL AND EMPLOYMENT INFORMATION IS ACCURATE AND CORRECT:

_____	_____
(PRINT NAME of Employee Representative)	**PRINT NAME of Employee**
_____	_____
(SIGNATURE of Employee Representative)	**(SIGNATURE of Employee)**
_____	_____
(Date provided to employee & Signed by Rep)	**(Date Received by Employee & Signed by Employee)**

Forward Your Completed Form to the Human Resource Department *Form: 08/01/2020*

ESMAR MANAGEMENT GROUP

302 S. Milliken Avenue, Suite E2, Ontario, CA 91761

CONSENT TO EMPLOYEE DRUG AND/OR ALCOHOL TESTING

I understand that submission to a Post-Injury Drug And/or Alcohol Screen is a condition of employment with this employer. I understand that should my testing results be confirmed positive or I refuse to test, I will be subject to the company's disciplinary action; including possible discharge, I understand that a tampered with or an adulterated specimen will be considered a refusal to test, resulting in possible discharge.

I hereby give my consent to release the results of my blood and/or urinalysis to the person(s) or department(s) or the specified agent of my employer; Including my employer's Workers' Compensation Insurance Company, for the purpose of determining the presence of alcohol and/or other drugs in my body for the duration of my employment.

I understand that if I am injured during the course and scope of my employment and I test positive for the presence of alcohol and/or drugs, I may forfeit my eligibility for medical and indemnity benefits. I also understand that a refusal to test, a tampered with or an adulterated specimen under this circumstance may also result in forfeiture of my eligibility for medical and indemnity benefits and immediate action. including possible discharge

By signing this form, I hereby release to the Company and/or Company's Medical Review Officer the results of the test(s) to which I have consented, I further authorize the Company to discuss the results with medical personnel / physician collecting the specimen, the testing facility, its directors, officers, agents, and employees responsible for administering the aforementioned test(s) or evaluating the results thereof and any of them herein. I also authorize the Company to discuss the results with its legal advisors and to use the test results as a defense to any legal action to which I am a party.

I further release any testing facility or any physicians who have tested me from any liability arising from a release of any and all results, written reports, medical records, and data concerning my test(s) to the appropriate Employer officials. I agree to have the results released to the Company and/or the Company's Medical Review officer.

Employee or Applicant Signature *(Parent or Guardian if Employee is a Minor)*	Print Name	Date

Employee or Applicant SS#	Witness	Date

OR

I hereby refuse to consent to submit testing for the presence of drugs and/or alcohol.

Employee or Applicant Signature *(Parent or Guardian if Employee is a Minor)*	Print Name	Date

Employee or Applicant SS#	Witness	Date

Forward Your Completed Form to the Human Resource Department

Form: 08/01/2020

302 S. Milliken Avenue, Suite E2, Ontario, CA 91761

AUTHORIZATION FOR AUTOMATIC PAYROLL DEPOSIT

Authorization for Direct Deposit - Employee Form This authorizes **ESMAR Management Group/ Diamond PEO** (the "Company") to send **credit** entries (and appropriate **debit** and adjustment entries), electronically or by any other commercially accepted method, to my (our) account(s) indicated below and to other accounts I (we) identify in the future (the "Account"). This authorizes the financial institution holding the Account to post all such entries.

Account #1 Type (check one): Checking ◯ Savings ◯

Employee Bank Name:_____ Employee SS#:_____

Bank Routing #:_____ Account #:_____

This authorization will be in effect until the Company receives a written termination notice from myself and has a reasonable opportunity to act on it.

Employee or Applicant Signature	Print Name	Date

IMPORTANT: This document must be signed by employees requesting automatic deposit of paychecks and retained on file by the employer. Employees must attach a voided check for each of their accounts to help verify their account numbers and bank routing numbers.

***IF FUNDS ARE DEPOSITED INTO YOUR ACCOUNT IN ERROR (OVERPAYMENT OR PAYMENT FOR HOURS NOT WORKED) YOU ARE RESPONSIBLE TO RETURN FUNDS TO A.R.C. / Diamond PEO WITHIN 24 HOURS. IF FUNDS ARE NOT RETURNED ESMAR Management Group/ Diamond PEO WILL PERSUE LEGAL ACTIONS.**

302 S. Milliken Avenue, Suite E2, Ontario, CA 91761

Form **W-4**

Department of the Treasury
Internal Revenue Service

Employee's Withholding Certificate

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

OMB No. 1545-0074

2020

Step 1: Enter Personal Information

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

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

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

Step 2: Multiple Jobs or Spouse Works

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

Do **only one** of the following.

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

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

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

TIP: To be accurate, submit a 2020 Form W-4 for all other jobs. If you (or your spouse) have self-employment income, including as an independent contractor, use the estimator.

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

Step 3: Claim Dependents

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

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

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

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

Step 4 (optional): Other Adjustments

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

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

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

Step 5: Sign Here

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

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

Employers Only

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

Employment Development Department
State of California

Clear Form

EMPLOYEE'S WITHHOLDING ALLOWANCE CERTIFICATE

Complete this form so that your employer can withhold the correct California state income tax from your paycheck.

Enter Personal Information	
First, Middle, Last Name	Social Security Number
Address City, State, and ZIP Code	Filing Status ○ SINGLE or MARRIED (with two or more incomes) ○ MARRIED (one income) ○ HEAD OF HOUSEHOLD

1. Total Number of Allowances you're claiming (Use Worksheet A for regular withholding allowances. Use other worksheets on the following pages as applicable, Worksheet A+B). _____

2. Additional amount, if any, you want withheld each pay period (if employer agrees), **(Worksheet B and C)** _____
   OR

Exemption from Withholding

3. I claim exemption from withholding for 2020, and I certify I meet both of the conditions for exemption. ☐ Write "Exempt" here
   OR

4. I certify under penalty of perjury that I am **not subject** to California withholding. I meet the conditions set forth under the Service Member Civil Relief Act, as amended by the Military Spouses Residency Relief Act and the Veterans Benefits and Transition Act of 2018. (Check box here) ☐

Under the penalties of perjury, I certify that the number of withholding allowances claimed on this certificate does not exceed the number to which I am entitled or, if claiming exemption from withholding, that I am entitled to claim the exempt status.

Employee's Signature _____ Date _____

Employer's Section: Employer's Name and Address	California Employer Payroll Tax Account Number

PURPOSE: This certificate, DE 4, is for **California Personal Income Tax (PIT) withholding** purposes only. The DE 4 is used to compute the amount of taxes to be withheld from your wages, by your employer, to accurately reflect your state tax withholding obligation.

Beginning January 1, 2020, *Employee's Withholding Allowance Certificate* (Form W-4) from the Internal Revenue Service (IRS) will be used for federal income tax withholding **only**. You must file the state form *Employee's Withholding Allowance Certificate* (DE 4) to determine the appropriate California Personal Income Tax (PIT) withholding.

If you do not provide your employer with a withholding certificate, the employer must use Single with Zero withholding allowance.

CHECK YOUR WITHHOLDING: After your DE 4 takes effect, compare the state income tax withheld with your estimated total annual tax. For state withholding, use the worksheets on this form.

EXEMPTION FROM WITHHOLDING: If you wish to claim exempt, complete the federal Form W-4 and the state DE 4. You may claim exempt from withholding California income tax if you meet both of the following conditions for exemption:

1. You did not owe any federal/state income tax last year, and
2. You do not expect to owe any federal/state income tax this year. The exemption is good for one year.

If you continue to qualify for the exempt filing status, a new DE 4 designating EXEMPT must be submitted by February 15 each year to continue your exemption. If you are not having federal/state income tax withheld this year but expect to have a tax liability next year, you are required to give your employer a new DE 4 by December 1.

Member Service Civil Relief Act: Under this act, as provided by the Military Spouses Residency Relief Act and the Veterans Benefits and Transition Act of 2018, you may be exempt from California income tax on your wages if

(i) your spouse is a member of the armed forces present in California in compliance with military orders;

(ii) you are present in California solely to be with your spouse; and

(iii) you maintain your domicile in another state.

If you claim exemption under **this** act, **check the box on Line 4**. You may be required to provide proof of exemption upon request.

Employment Eligibility Verification

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

USCIS
Form I-9
OMB No. 1615-0047
Expires 10/31/2022

►START HERE: Read instructions carefully before completing this form. The instructions must be available, either in paper or electronically, during completion of this form. Employers are liable for errors in the completion of this form.

ANTI-DISCRIMINATION NOTICE: It is illegal to discriminate against work-authorized individuals. Employers **CANNOT** specify which document(s) an employee may present to establish employment authorization and identity. The refusal to hire or continue to employ an individual because the documentation presented has a future expiration date may also constitute illegal discrimination.

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

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

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

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

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

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

- ☐ 1. A citizen of the United States
- ☐ 2. A noncitizen national of the United States *(See instructions)*
- ☐ 3. A lawful permanent resident (Alien Registration Number/USCIS Number): _____
- ☐ 4. An alien authorized to work until (expiration date, if applicable, mm/dd/yyyy): _____
  Some aliens may write "N/A" in the expiration date field. *(See instructions)*

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

1. Alien Registration Number/USCIS Number: _____

OR

2. Form I-94 Admission Number: _____

OR

3. Foreign Passport Number: _____

Country of Issuance: _____

QR Code - Section 1
Do Not Write In This Space

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

Preparer and/or Translator Certification (check one):

☐ I did not use a preparer or translator. ☐ A preparer(s) and/or translator(s) assisted the employee in completing Section 1.

(Fields below must be completed and signed when preparers and/or translators assist an employee in completing Section 1.)

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

Signature of Preparer or Translator	Today's Date *(mm/dd/yyyy)*

Last Name *(Family Name)*	First Name *(Given Name)*

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

STOP *Employer Completes Next Page* STOP

Form **8850**
(Rev. March 2016)
Department of the Treasury
Internal Revenue Service

Pre-Screening Notice and Certification Request for the Work Opportunity Credit

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

OMB No. 1545-1500

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

Your name _____ Social security number ► _____

Street address where you live _____

City or town, state, and ZIP code _____

County _____ Telephone number _____

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

1 ☐ Check here if you received a conditional certification from the state workforce agency (SWA) or a participating local agency for the work opportunity credit.

2 ☐ Check here if **any** of the following statements apply to you.

- I am a member of a family that has received assistance from Temporary Assistance for Needy Families (TANF) for any 9 months during the past 18 months.
- I am a veteran and a member of a family that received Supplemental Nutrition Assistance Program (SNAP) benefits (food stamps) for at least a 3-month period during the past 15 months.
- I was referred here by a rehabilitation agency approved by the state, an employment network under the Ticket to Work program, or the Department of Veterans Affairs.
- I am at least age 18 but **not** age 40 or older and I am a member of a family that:
  a. Received SNAP benefits (food stamps) for the past 6 months; **or**
  b. Received SNAP benefits (food stamps) for at least 3 of the past 5 months, **but** is no longer eligible to receive them.
- During the past year, I was convicted of a felony or released from prison for a felony.
- I received supplemental security income (SSI) benefits for any month ending during the past 60 days.
- I am a veteran and I was unemployed for a period or periods totaling at least 4 weeks but less than 6 months during the past year.

3 ☐ Check here if you are a veteran and you were unemployed for a period or periods totaling at least 6 months during the past year.

4 ☐ Check here if you are a veteran entitled to compensation for a service-connected disability and you were discharged or released from active duty in the U.S. Armed Forces during the past year.

5 ☐ Check here if you are a veteran entitled to compensation for a service-connected disability and you were unemployed for a period or periods totaling at least 6 months during the past year.

6 ☐ Check here if you are a member of a family that:

- Received TANF payments for at least the past 18 months; **or**
- Received TANF payments for any 18 months beginning after August 5, 1997, **and** the earliest 18-month period beginning after August 5, 1997, ended during the past 2 years; **or**
- Stopped being eligible for TANF payments during the past 2 years because federal or state law limited the maximum time those payments could be made.

7 ☐ Check here if you are in a period of unemployment that is at least 27 consecutive weeks and for all or part of that period you received unemployment compensation.

Signature—All Applicants Must Sign

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

Job applicant's signature ► **Date**