Alliance Staffing

NC Alliance of Public Health Agencies

New Employee Checklist:

Paperwork to complete and turn in:

- ❑ Employment Application
  - ❑ On-line application **OR**
  - ❑ Paper application
- ❑ I-9 Form (full instructions can be found here: https://www.uscis.gov/sites/default/files/files/form/i-9.pdf)
- ❑ I-9 verifying documents (ex: passport, drivers license, SS card, etc.)
- ❑ Employee Immunization Record
- ❑ Hepatitis B Waiver Form
- ❑ W-4 Form
- ❑ NC-4 EZ Form (long form available upon request)
- ❑ Direct Deposit
- ❑ New Hire Form (Confidentiality Agreement, Work History Release, Emergency Contact and OSHA Instructions)
- ❑ OSHA certificates once you have completed the OSHA training
- ❑ Driver History form (follow instructions and complete only if driving is a requirement of this job)

We must have all documents listed above completed and returned promptly! Omitting paperwork may delay your first paycheck!

Payroll Information to keep:

- Payroll letter
- Payroll Calendar
- Timesheets

Employment Eligibility Verification

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

USCIS
Form I-9
OMB No. 1615-0047
Expires 08/31/2019

►**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

Section 2. Employer or Authorized Representative Review and Verification

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

Employee Info from Section 1	Last Name *(Family Name)*	First Name *(Given Name)*	M.I.	Citizenship/Immigration Status

List A Identity and Employment Authorization	OR	List B Identity	AND	List C Employment Authorization
Document Title		Document Title		Document Title
Issuing Authority		Issuing Authority		Issuing Authority
Document Number		Document Number		Document Number
Expiration Date *(if any)(mm/dd/yyyy)*		Expiration Date *(if any)(mm/dd/yyyy)*		Expiration Date *(if any)(mm/dd/yyyy)*
Document Title				
Issuing Authority				
Document Number				
Expiration Date *(if any)(mm/dd/yyyy)*				
Document Title				
Issuing Authority				
Document Number				
Expiration Date *(if any)(mm/dd/yyyy)*				

Additional Information

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

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

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

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

Last Name of Employer or Authorized Representative	First Name of Employer or Authorized Representative	Employer's Business or Organization Name

Employer's Business or Organization Address (Street Number and Name)	City or Town	State	ZIP Code

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

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

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

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

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

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

LISTS OF ACCEPTABLE DOCUMENTS
All documents must be UNEXPIRED

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

LIST A Documents that Establish Both Identity and Employment Authorization	OR	LIST B Documents that Establish Identity	AND	LIST C Documents that Establish Employment Authorization
1. U.S. Passport or U.S. Passport Card		**1.** Driver's license or ID card issued by a State or outlying possession of the United States provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		**1.** A Social Security Account Number card, unless the card includes one of the following restrictions: (1) NOT VALID FOR EMPLOYMENT (2) VALID FOR WORK ONLY WITH INS AUTHORIZATION (3) VALID FOR WORK ONLY WITH DHS AUTHORIZATION
2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551)		**2.** ID card issued by federal, state or local government agencies or entities, provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		**2.** Certification of Birth Abroad issued by the Department of State (Form FS-545)
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.** Certification of Report of Birth issued by the Department of State (Form DS-1350)
4. Employment Authorization Document that contains a photograph (Form I-766)		**4.** Voter's registration card		**4.** Original or certified copy of birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal
5. For a nonimmigrant alien authorized to work for a specific employer because of his or her status: **a.** Foreign passport; and **b.** Form I-94 or Form I-94A that has the following: (1) The same name as the passport; and (2) An endorsement of the alien's nonimmigrant status as long as that period of endorsement has not yet expired and the proposed employment is not in conflict with any restrictions or limitations identified on the form.		**5.** U.S. Military card or draft record		**5.** Native American tribal document
		6. Military dependent's ID card		**6.** U.S. Citizen ID Card (Form I-197)
		7. U.S. Coast Guard Merchant Mariner Card		**7.** Identification Card for Use of Resident Citizen in the United States (Form I-179)
		8. Native American tribal document		**8.** Employment authorization document issued by the Department of Homeland Security
		9. Driver's license issued by a Canadian government authority		
		For persons under age 18 who are unable to present a document listed above:		
6. Passport from the Federated States of Micronesia (FSM) or the Republic of the Marshall Islands (RMI) with Form I-94 or Form I-94A indicating nonimmigrant admission under the Compact of Free Association Between the United States and the FSM or RMI		**10.** School record or report card		
		11. Clinic, doctor, or hospital record		
		12. Day-care or nursery school record		

Examples of many of these documents appear in Part 8 of the Handbook for Employers (M-274).

Refer to the instructions for more information about acceptable receipts.

NORTH CAROLINA ALLIANCE OF PUBLIC HEALTH AGENCIES, INC.
EMPLOYEE IMMUNIZATION RECORD & HEPATITIS B WAIVER FORM

The Alliance follows the CDC Immunization Guidelines for all of our employees.
Please complete the form or submit copies of your immunization records from your health care provider.

Employee:_____ Date:_____
County_____ Position:_____

Hepatitis B Series: Yes _____ Dates: _____ _____ _____

No _____ Declination Form Signed? Yes _____ No _____

MMR / MR: (Measles, Mumps, Rubella)

One of the following is required:

1. Titer indicating immunity
   Date: _____
2. Birth during or after 1957 and documentation of 2 doses of vaccine
   Dates: _____ _____
3. Birth prior to 1957 and 1 dose of vaccine
   Date: _____

[For healthcare personnel (HCP) born in 1957 or later without serologic evidence of immunity or prior vaccination, give 2 doses of MMR, 4 weeks apart. For HCP born prior to 1957or later can be considered immune to measles, mumps, or rubella only if they have documentation of (a) physician-diagnosed measles or mumps disease.]

Varicella:

One of the following required:

1. Titer indicating immunity
   Date: _____
2. Documentation of 2 doses of vaccine
   Dates _____ _____

It is recommended that all HCP be immune to varicella. Evidence of immunity in HCP includes documentation of 2 doses of varicella vaccine given at least 28 days apart.

[Highly Recommended, not required unless required by work site-Tetanus/Influenza/TB

Tetanus:

1. One dose of Tdap vaccine at least 5 years after last Tetanus booster
   Date Received: _____ Date Due: _____

2. Tetanus (Td) booster every 10 years
   Last Dose: _____ Date Due: _____

Influenza

Annual influenza vaccine is highly recommended by Alliance (must be obtained if required by employee's work site,) _____Yes _____No Date:_____

TB Skin test:

1. Two-step test if no skin test in the past year.
   Date of test #1: _____ Date of test #2: _____
2. Please provide documentation of test in the past year, only one required.
   [If documentation in the past year, only one test is required.]
   Date of last skin test: _____ Date of test #2_____

If you do not have these immunizations, you will need to get them unless your worksite follows different guidelines or due to a documented medical condition. NCAPHA will pay for missing immunizations.

NORTH CAROLINA ALLIANCE OF PUBLIC HEALTH AGENCIES, INC.

HEPATITIS B VACCINATION WAIVER FORM

I understand that due to my occupational exposure to blood or other potentially infectious material, I am at risk of acquiring HBV (Hepatitis B Virus) infection.

I have read the Hepatitis B Information Sheet and have had an opportunity to ask questions and understand the risks and benefits of the HBV vaccine.

I have been given the opportunity to be vaccinated at no charge to myself.

Having been so informed,

_____ I request the HBV vaccine.

_____ I decline to take the HBV vaccine at this time.

_____ I have already had the HBV vaccine.

I understand that due to my occupational exposure to blood or other potentially infectious material I may be at risk of acquiring hepatitis B (HBV) infection. I have been given the opportunity to be vaccinated with the hepatitis B vaccine, at no charge to me. However, I decline hepatitis B vaccine at this time. I understand that by declining this vaccine, I continue to be at risk of acquiring hepatitis B, a serious disease. If in the future I continue to have occupational exposure to blood or other potentially infectious materials and I want to be vaccinated with hepatitis B vaccine, I can receive the vaccination series at no charge to me.

_____ _____

Employee's signature Date

Form W-4 (2017)

Purpose. Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay. Consider completing a new Form W-4 each year and when your personal or financial situation changes.

Exemption from withholding. If you are exempt, complete **only** lines 1, 2, 3, 4, and 7 and sign the form to validate it. Your exemption for 2017 expires February 15, 2018. See Pub. 505, Tax Withholding and Estimated Tax.

Note: If another person can claim you as a dependent on his or her tax return, you can't claim exemption from withholding if your total income exceeds $1,050 and includes more than $350 of unearned income (for example, interest and dividends).

Exceptions. An employee may be able to claim exemption from withholding even if the employee is a dependent, if the employee:

- Is age 65 or older,
- Is blind, or
- Will claim adjustments to income; tax credits; or itemized deductions, on his or her tax return.

The exceptions don't apply to supplemental wages greater than $1,000,000.

Basic instructions. If you aren't exempt, complete the **Personal Allowances Worksheet** below. The worksheets on page 2 further adjust your withholding allowances based on itemized deductions, certain credits, adjustments to income, or two-earners/multiple jobs situations.

Complete all worksheets that apply. However, you may claim fewer (or zero) allowances. For regular wages, withholding must be based on allowances you claimed and may not be a flat amount or percentage of wages.

Head of household. Generally, you can claim head of household filing status on your tax return only if you are unmarried and pay more than 50% of the costs of keeping up a home for yourself and your dependent(s) or other qualifying individuals. See Pub. 501, Exemptions, Standard Deduction, and Filing Information, for information.

Tax credits. You can take projected tax credits into account in figuring your allowable number of withholding allowances. Credits for child or dependent care expenses and the child tax credit may be claimed using the **Personal Allowances Worksheet** below. See Pub. 505 for information on converting your other credits into withholding allowances.

Nonwage income. If you have a large amount of nonwage income, such as interest or dividends, consider making estimated tax payments using Form 1040-ES, Estimated Tax for Individuals. Otherwise, you may owe additional tax. If you have pension or annuity income, see Pub. 505 to find out if you should adjust your withholding on Form W-4 or W-4P.

Two earners or multiple jobs. If you have a working spouse or more than one job, figure the total number of allowances you are entitled to claim on all jobs using worksheets from only one Form W-4. Your withholding usually will be most accurate when all allowances are claimed on the Form W-4 for the highest paying job and zero allowances are claimed on the others. See Pub. 505 for details.

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

Check your withholding. After your Form W-4 takes effect, use Pub. 505 to see how the amount you are having withheld compares to your projected total tax for 2017. See Pub. 505, especially if your earnings exceed $130,000 (Single) or $180,000 (Married).

Future developments. Information about any future developments affecting Form W-4 (such as legislation enacted after we release it) will be posted at *www.irs.gov/w4*.

Personal Allowances Worksheet (Keep for your records.)

A	Enter "1" for **yourself** if no one else can claim you as a dependent	**A** _____
B	Enter "1" if: • You're single and have only one job; or • You're married, have only one job, and your spouse doesn't work; or • Your wages from a second job or your spouse's wages (or the total of both) are $1,500 or less. . . .	**B** _____
C	Enter "1" for your **spouse.** But, you may choose to enter "-0-" if you are married and have either a working spouse or more than one job. (Entering "-0-" may help you avoid having too little tax withheld.)	**C** _____
D	Enter number of **dependents** (other than your spouse or yourself) you will claim on your tax return	**D** _____
E	Enter "1" if you will file as **head of household** on your tax return (see conditions under **Head of household** above) . .	**E** _____
F	Enter "1" if you have at least $2,000 of **child or dependent care expenses** for which you plan to claim a credit . . . (**Note:** Do **not** include child support payments. See Pub. 503, Child and Dependent Care Expenses, for details.)	**F** _____
G	**Child Tax Credit** (including additional child tax credit). See Pub. 972, Child Tax Credit, for more information. • If your total income will be less than $70,000 ($100,000 if married), enter "2" for each eligible child; then **less** "1" if you have two to four eligible children or **less** "2" if you have five or more eligible children. • If your total income will be between $70,000 and $84,000 ($100,000 and $119,000 if married), enter "1" for each eligible child.	**G** _____
H	Add lines A through G and enter total here. (**Note:** This may be different from the number of exemptions you claim on your tax return.) ►	**H** _____

For accuracy, complete all worksheets that apply.

- If you plan to **itemize** or **claim adjustments to income** and want to reduce your withholding, see the **Deductions and Adjustments Worksheet** on page 2.
- If you are **single and have more than one job** or are **married and you and your spouse both work** and the combined earnings from all jobs exceed $50,000 ($20,000 if married), see the **Two-Earners/Multiple Jobs Worksheet** on page 2 to avoid having too little tax withheld.
- If **neither** of the above situations applies, **stop here** and enter the number from line H on line 5 of Form W-4 below.

---------- **Separate here and give Form W-4 to your employer. Keep the top part for your records.** ----------

Form **W-4**
Department of the Treasury
Internal Revenue Service

Employee's Withholding Allowance Certificate

► **Whether you are entitled to claim a certain number of allowances or exemption from withholding is subject to review by the IRS. Your employer may be required to send a copy of this form to the IRS.**

OMB No. 1545-0074

2017

1	Your first name and middle initial	Last name	**2** **Your social security number**
	Home address (number and street or rural route)	**3** ☐ Single ☐ Married ☐ Married, but withhold at higher Single rate. **Note:** If married, but legally separated, or spouse is a nonresident alien, check the "Single" box.	
	City or town, state, and ZIP code	**4** **If your last name differs from that shown on your social security card, check here. You must call 1-800-772-1213 for a replacement card.** ► ☐	

5	Total number of allowances you are claiming (from line **H** above **or** from the applicable worksheet on page 2)	**5**	
6	Additional amount, if any, you want withheld from each paycheck	**6**	$
7	I claim exemption from withholding for 2017, and I certify that I meet **both** of the following conditions for exemption. • Last year I had a right to a refund of **all** federal income tax withheld because I had **no** tax liability, **and** • This year I expect a refund of **all** federal income tax withheld because I expect to have **no** tax liability. If you meet both conditions, write "Exempt" here . . . . . ►	**7**	

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

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

8	Employer's name and address (Employer: Complete lines 8 and 10 only if sending to the IRS.)	**9** Office code (optional)	**10** Employer identification number (EIN)

Deductions and Adjustments Worksheet

Note: Use this worksheet *only* if you plan to itemize deductions or claim certain credits or adjustments to income.

1	Enter an estimate of your 2017 itemized deductions. These include qualifying home mortgage interest, charitable contributions, state and local taxes, medical expenses in excess of 10% of your income, and miscellaneous deductions. For 2017, you may have to reduce your itemized deductions if your income is over $313,800 and you're married filing jointly or you're a qualifying widow(er); $287,650 if you're head of household; $261,500 if you're single, not head of household and not a qualifying widow(er); or $156,900 if you're married filing separately. See Pub. 505 for details	1	$
2	Enter: { $12,700 if married filing jointly or qualifying widow(er); $9,350 if head of household; $6,350 if single or married filing separately }	2	$
3	**Subtract** line 2 from line 1. If zero or less, enter "-0-"	3	$
4	Enter an estimate of your 2017 adjustments to income and any additional standard deduction (see Pub. 505)	4	$
5	**Add** lines 3 and 4 and enter the total. (Include any amount for credits from the *Converting Credits to Withholding Allowances for 2017 Form W-4* worksheet in Pub. 505.)	5	$
6	Enter an estimate of your 2017 nonwage income (such as dividends or interest)	6	$
7	**Subtract** line 6 from line 5. If zero or less, enter "-0-"	7	$
8	**Divide** the amount on line 7 by $4,050 and enter the result here. Drop any fraction	8	
9	Enter the number from the **Personal Allowances Worksheet,** line H, page 1	9	
10	**Add** lines 8 and 9 and enter the total here. If you plan to use the **Two-Earners/Multiple Jobs Worksheet,** also enter this total on line 1 below. Otherwise, **stop here** and enter this total on Form W-4, line 5, page 1	10	

Two-Earners/Multiple Jobs Worksheet (See *Two earners or multiple jobs* on page 1.)

Note: Use this worksheet *only* if the instructions under line H on page 1 direct you here.

1	Enter the number from line H, page 1 (or from line 10 above if you used the **Deductions and Adjustments Worksheet**)	1	
2	Find the number in **Table 1** below that applies to the **LOWEST** paying job and enter it here. **However,** if you are married filing jointly and wages from the highest paying job are $65,000 or less, do not enter more than "3"	2	
3	If line 1 is **more than or equal to** line 2, subtract line 2 from line 1. Enter the result here (if zero, enter "-0-") and on Form W-4, line 5, page 1. **Do not** use the rest of this worksheet	3	

Note: If line 1 is **less than** line 2, enter "-0-" on Form W-4, line 5, page 1. Complete lines 4 through 9 below to figure the additional withholding amount necessary to avoid a year-end tax bill.

4	Enter the number from line 2 of this worksheet	4	
5	Enter the number from line 1 of this worksheet	5	
6	**Subtract** line 5 from line 4	6	
7	Find the amount in **Table 2** below that applies to the **HIGHEST** paying job and enter it here	7	$
8	**Multiply** line 7 by line 6 and enter the result here. This is the additional annual withholding needed	8	$
9	Divide line 8 by the number of pay periods remaining in 2017. For example, divide by 25 if you are paid every two weeks and you complete this form on a date in January when there are 25 pay periods remaining in 2017. Enter the result here and on Form W-4, line 6, page 1. This is the additional amount to be withheld from each paycheck	9	$

Table 1

Married Filing Jointly		All Others	
If wages from **LOWEST** paying job are—	Enter on line 2 above	If wages from **LOWEST** paying job are—	Enter on line 2 above
$0 - $7,000	0	$0 - $8,000	0
7,001 - 14,000	1	8,001 - 16,000	1
14,001 - 22,000	2	16,001 - 26,000	2
22,001 - 27,000	3	26,001 - 34,000	3
27,001 - 35,000	4	34,001 - 44,000	4
35,001 - 44,000	5	44,001 - 70,000	5
44,001 - 55,000	6	70,001 - 85,000	6
55,001 - 65,000	7	85,001 - 110,000	7
65,001 - 75,000	8	110,001 - 125,000	8
75,001 - 80,000	9	125,001 - 140,000	9
80,001 - 95,000	10	140,001 and over	10
95,001 - 115,000	11		
115,001 - 130,000	12		
130,001 - 140,000	13		
140,001 - 150,000	14		
150,001 and over	15		

Table 2

Married Filing Jointly		All Others	
If wages from **HIGHEST** paying job are—	Enter on line 7 above	If wages from **HIGHEST** paying job are—	Enter on line 7 above
$0 - $75,000	$610	$0 - $38,000	$610
75,001 - 135,000	1,010	38,001 - 85,000	1,010
135,001 - 205,000	1,130	85,001 - 185,000	1,130
205,001 - 360,000	1,340	185,001 - 400,000	1,340
360,001 - 405,000	1,420	400,001 and over	1,600
405,001 and over	1,600		

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 who claims no withholding allowances; providing fraudulent information may subject you to penalties. Routine uses of this information include giving it to the Department of Justice for civil and criminal litigation; to cities, states, the District of Columbia, and U.S. commonwealths and possessions for use in administering their tax laws; and to the Department of Health and Human Services for use in the National Directory of New Hires. We may also disclose this information to other countries under a tax treaty, to federal and state agencies to enforce federal nontax criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism.

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

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

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

NC-4 EZ
Web
10-13

Employee's Withholding Allowance Certificate

North Carolina Department of Revenue

Social Security Number _____ – _____ – _____

Marital Status

____ Single ____ Head of Household ____ Married or Qualifying Widow(er)

First Name *(USE CAPITAL LETTERS FOR YOUR NAME AND ADDRESS)* M.I. Last Name

_____ ____ _____

Address County *(Enter first five letters)*

_____ _____

City State Zip Code *(5 Digit)* Country *(If not U.S.)*

_____ _____ _____ _____

⚠ **Important: You must complete a new Form NC-4 EZ or NC-4 for tax year 2014. As a result of recent law changes, how you determine the number of allowances for tax year 2014 will differ from previous years. Most taxpayers will not be entitled to as many allowances, and as a result, more taxpayers should claim zero (0) allowances. Additionally, you are no longer allowed to claim a N.C. withholding exemption for yourself, your spouse, your children, or any other qualifying dependents.**

FORM NC-4EZ: Please use this form if you:

- Plan to claim the N.C. standard deduction
- Plan to claim no tax credits or only the credit for children
- Prefer not to complete the extended Form NC-4
- Qualify to claim exempt status *(See line 3 or 4 below)*

You may complete Form NC-4, if you plan to claim N.C. itemized deductions, federal adjustments to income, or N.C. deductions.

If you do not plan to claim the credit for children, enter zero (0) on line 1. If you plan to claim the credit for children, use the table below for your filing status, amount of income, and number of children under age 17 to determine the number of allowances to enter on line 1. For married taxpayers, only 1 spouse may claim the allowance for the credit for each child.

Single & Married Filing Separately

Income	# of Children under age 17									
	1	2	3	4	5	6	7	8	9	10
	# of Allowances									
0-20,000	0	1	2	3	4	5	6	6	7	8
20,001-50,000	0	1	2	2	3	4	4	5	6	6

Married Filing Jointly & Qualifying Widow(er)

Income	# of Children under age 17									
	1	2	3	4	5	6	7	8	9	10
	# of Allowances									
0-40,000	0	1	2	3	4	5	6	6	7	8
40,001-100,000	0	1	2	2	3	4	4	5	6	6

Head of Household

Income	# of Children under age 17									
	1	2	3	4	5	6	7	8	9	10
	# of Allowances									
0-32,000	0	1	2	3	4	5	6	6	7	8
32,001-80,000	0	1	2	2	3	4	4	5	6	6

1. **Total number of allowances you are claiming for 2014** *(Enter zero (0), or the number of allowances from the table above)* _____

2. **Additional amount, if any, withheld from each pay period** *(Enter whole dollars)* _____.00

3. **I certify that I am exempt from North Carolina withholding because I meet both of the following conditions:**
   - Last year I was entitled to a refund of all State income tax withheld because I had no tax liability; and
   - For tax year 2014, I expect a refund of all State income tax withheld because I expect to have no tax liability

   Check Here ☐

4. **I certify that I am exempt from North Carolina withholding because I meet the requirements of the Military Spouses Residency Relief Act and I am legally domiciled in the state of** *(Enter state of domicile)* _____ Check Here ☐

   If line 3 or line 4 above applies to you, enter the effective year 20____

5. **I certify that I no longer meet the requirements for exemption on line 3** ☐ **or line 4** ☐ *(Check applicable box)*

   Therefore, I revoke my exemption and request that my employer withhold North Carolina income tax based on the number of allowances entered on line 1 and any amount entered on line 2. Check Here ☐

CAUTION: If you furnish an employer with an Employee's Withholding Allowance Certificate that contains information which has no reasonable basis and results in a lesser amount of tax being withheld than would have been withheld had you furnished reasonable information, you are subject to a penalty of 50% of the amount not properly withheld.

Employee's Signature _____ **Date** _____

I certify, under penalties provided by law, that I am entitled to the number of withholding allowances claimed on line 1 above, or if claiming exemption from withholding, that I am entitled to claim the exempt status on line 3 or 4, whichever applies.

Direct Deposit Authorization Form

NC Alliance of Public Health Agencies is pleased to offer direct deposit of employee pay checks to a bank and account of your choice. To arrange for direct deposit:

_____ Complete the employee portion of this form

_____ CHECKING ACCOUT: Attach a voided personal check

_____ SAVINGS ACCOUNT: have your bank complete account and routing numbers

_____ Return the complete form to the Payroll Department.

ATTENTION: Your first check will be mailed so make sure that you have given us your correct mailing address when you applied!!!!
Your direct deposit should begin within two pay periods after we receive your completed form.

****NOTIFY PAYROLL IMMEDIATELY IF YOU CLOSE OR CHANGE BANK ACCOUNTS****

TO BE COMPLETED BY EMPLOYEE:

_____ New Enrollment _____ Cancel Enrollment

I hereby authorize NC Alliance of Public Health Agencies to initiate credit and to initiate, if necessary, debit entries and adjustments for any credit entries in error to my account indicated below and the depository name below, hereinafter called depository, to credit and/or debit the same as such:

NAME: _____

ACCOUNT TYPE: _____ **Checking** (attach voided check)

_____ **Savings** (HAVE BANK COMPLETE – DO NOT USE DEPOSIT SLIP INFO)

BANK NAME: _____

ACCOUNT #: _____

ROUTING #: _____

Employee Signature: _____ Date: _____

NC Alliance of Public Health Agencies (NCAPHA)
3000 Industrial Dr., Ste. 140
Raleigh, NC 27609
(919) 828-6202
Fax: (919) 828-6203
jbrassington@ncapha.org

NORTH CAROLINA ALLIANCE OF PUBLIC HEALTH AGENCIES. - CONFIDENTIALITY

I understand as an employee of the Alliance and as a patient care provider, I must use discretion when discussing any patient information. Patients and any patient information is discussed on a need to know basis, to only those health care providers involved in that particular case. I will not acknowledge or reveal the names of the clients/patients seen by me to anyone other than those directly involved in the case, reviewers, in response to legal summons or as directed by agency management. As a Staffing Pool employee, I will read, sign, and adhere to the Confidentiality Policy of the agency(s) with which I am working.

I further understand that all medical record information must be safe guarded, that I may copy designated parts of the chart to aid me in caring for patients, however, it is my responsibility to ensure that these materials are safe guarded as well. I understand that I am not to leave any patient materials unprotected and that once a patient has been discharged or is no longer in my care, I am responsible for the safe destruction of that patient's information in my position.

I understand that failure to comply with this policy could result in termination of my employment and legal action.

I have read this policy and understand its content. *[My signature below indicates my acceptance of this policy.]*

WORK HISTORY AUTHORIZATION PERMISSION RELEASE

I grant NCAPHA my permission from my signature below to request and receive information regarding my previous employment records. (Photocopies of this authorization are valid.)

This is to certify that I have read, understand and agree to all of the above information.

_____ _____

Employee Signature Date

EMERGENCY CONTACT: In case of an emergency, please contact the following person:

Name:_____

Relationship:_____ Telephone Number:_____

OSHA TRAINING: NCAPHA employees are required to complete 3 online courses through our vendor, Pure Safety. You will be emailed training instructions to facilitate the training process. To get started:

Access website: http://www.puresafety.com
Click on Login button at the upper right corner.
Enter the following information:
Company Name: ncapha
User Name: e**mployee's first name.employee's last name**
Password: ncapha11

Courses:
1. Bloodborne Pathogens
2. Hazard Communications
3. Workplace Violence Prevention

For technical questions contact: PureSafety @888-202-3018

Complete only if the position you are applying for requires on-the job driving.

DRIVER HISTORY FORM

Name (Print):_____

Home Address:_____

City:_____ State: _____ Zip: _____

1. Do you have a valid Driver's License? Yes _____ No _____

2. In what State are you a Licensed Driver?_____

3. If you have held a license in any other state during the past 5 years, please provide the following information:

Dates	State
From _____ to _____	_____
From _____ to _____	_____
From _____ to _____	_____

4. Have you been convicted of driving while impaired or under the influence of alcohol and/or drugs within the past three years? Yes ( ) No ( ) If Yes, give explanation(s) and date(s):
_____
_____
_____

5. Have you refused to submit to a Blood Alcohol Content (BAC) test within the past three years? Yes ( ) No ( ) If Yes, give explanation(s) and date(s): .
_____
_____
_____

6. Have you been convicted of reckless driving, or leaving the scene of an accident, or committing a felony involving a vehicle within the past three years? Yes ( ) No ( ) If Yes, give explanation(s) and date(s):
_____
_____
_____

7. Have you had your operator's license suspended, revoked or administratively restricted within the past three years? Yes ( ) No ( ) If Yes, give explanation(s) and date(s):
_____
_____
_____

8. Have you been convicted or found at fault for any non-fatal accident involving a motor vehicle during the past three years? Yes ( ) No( ) If Yes, list the date(s):
_____
_____
_____

9. Have you been convicted or found at fault for any fatal accidents involving a motor vehicle during the past three years? Yes ( ) No ( ) If Yes, list the date(s):
_____
_____
_____

10. Have you been convicted of any other moving vehicle violations during the past three years? Yes ( ) No ( ) If Yes, list type(s) and date(s):
_____
_____
_____

I certify that the answers provided to the questions on this form are true to the best of my knowledge.

I authorize NCAPHA or its designated representative(s) to obtain information regarding my driving record in any state at any time while I am employed by (or seeking employment with) the company.

I understand that any misstatement of the facts on this form may be grounds for termination of employment.

In the event that my MVR indicates that I am a "High Risk Driver" as defined in the glossary of the Fleet Safety Program, I understand that I may be subject to dismissal.

_____ _____
Driver's signature Date

_____ _____Male _____ Female _____
Social Security Number Date of Birth

_____ _____ _____
Driver's License Number Expiration Date State

Important Note: Attach photocopy of both sides of driver's license

NORTH CAROLINA ALLIANCE OF PUBLIC HEALTH AGENCIES, INC.

FLEET SAFETY CHECK SHEET

[Complete only if the position you are applying for requires on-the job driving.]

_____ Current N C Drivers License
Expiration Date _____

_____ Documentation of Current Insurance
Expiration Date _____

_____ Vehicle Safety Inspection
Expiration Date _____

_____ The employee has been informed that they are required to notify the supervisor/Alliance if they have any illness, injury, physical condition or use medication that may impair or affect their ability to safely drive a "Motor Vehicle," or if their license is revoked, or they have had administrative restrictions imposed.

_____ Agrees to comply with requirement that all drivers must wear seat belts.

I certify that I have had the Fleet Safety Policy reviewed with me and will follow all state, federal, and local laws involving the use of my vehicle. I further acknowledge that any actions taken by me in the use of my vehicle which are considered unsafe/dangerous may result in termination of my employment.

Important Note: Please submit copy of current vehicle insurance

NC Alliance of Public Health Agencies, Inc.
222 N. Person St, Suite 208
Raleigh, NC 27601
919-828-6204
919-828-6203 (fax)
bhughes@ncapha.org

Dear Alliance Employee,

Congratulations and welcome to the North Carolina Alliance of Public Health Agencies.

The Alliance payroll calendar and timesheets are included for you below. Some employees will be given timesheets customized for their specific position. If that is the case then please use the customized timesheet. Our pay periods run from the 1st day of the month through the 15th and the 16th through the last day of the month. Time worked should be recorded on the timesheet in .25 intervals (ex. 5 hours, 15 min = 5.25). Please refer to the payroll calendar for timesheet deadlines.

Also, please note that the timesheets contain a request for patient contact information. This is for those employees such as Dentists, Home Health Nurses, Social Workers, etc. who have direct patient contact. Please use the last column to record the total number of patient contacts and then summarize totals at the bottom. If you do not have direct patient contact, then please leave these lines blank.

Time sheets received after the due date will be held and paid with the next check cycle.

Please have the Agency **supervisor sign your time sheet** and either:

Fax it to (919) 828-6203

OR

Scan and email it to timesheet@ncapha.org

If you haven't already, please submit a **voided check** for set up of direct deposit as soon as possible and allow up to one month for direct deposit to become active. **Your first and possibly second check will be mailed!** Once direct deposit begins entry will be made to your account by the 10th and 25th of the month.

Please contact me with any payroll related questions or concerns at (919) 828-6204.

Sincerely,

Becky Hughes
Finance Director

NC Alliance of Public Health Agencies, Inc.

Alliance Staffing

2017 Payroll Calendar

Pay Period	Timesheets Must Be Received on the Date Listed Below	Pay Date
December 16 - 31	January 3, 2017	January 10, 2017
January 1 - 15	January 17, 2017	January 25, 2017
January 16 - 31	February 1, 2017	February 10, 2017
February 1 - 15	February 16, 2017	February 24, 2017
February 16 - 28	March 1, 2017	March 10, 2017
March 1 - 15	March 16, 2017	March 24, 2017
March 16 - 31	April 3, 2017	April 10, 2017
April 1 - 15	April 17, 2017	April 25, 2017
April 16 - 30	May 1, 2017	May 10, 2017
May 1 - 15	May 16, 2017	May 25, 2017
May 16 - 31	June 1, 2017	June 9, 2017
June 1 - 15	June 16, 2017	June 23, 2017
June 16 - 30	July 3, 2017	July 10, 2017
July 1 - 15	July 17, 2017	July 25, 2017
July 16 - 31	August 1, 2017	August 10, 2017
August 1 - 15	August 16, 2017	August 25, 2017
August 16 - 31	September 1, 2017	September 8, 2017
September 1 - 15	September 18, 2017	September 25, 2017
September 16 - 30	October 2, 2017	October 10, 2017
October 1 - 15	October 16, 2017	October 25, 2017
October 16 - 31	November 1, 2017	November 9, 2017
November 1 - 15	November 16, 2017	November 22, 2017
November 16 - 30	December 1, 2017	December 8, 2017
December 1 - 15	December 18, 2017	December 22, 2017
December 16 - 31	January 2, 2018	January 10, 2018

North Carolina Alliance of Public Health Agencies, Inc.
Timesheet

FAX TO BECKY HUGHES 919-828-6203
Or scan and email to: timesheet@ncapha.org

Print Name:_____ Title: _____

Month & Year: _____ County: _____

Date	Hours	Home Health Visits	Home Health Resumption Visits	Home Health Admission Visits	On - Call	Other:	Mileage	Paid Time Off	Number of Patient Contacts:
1									
2									
3									
4									
5									
6									
7									
8									
9									
10									
11									
12									
13									
14									
15									
TOTAL									

Employee's Signature: _____

Approved By: _____

*****Please remember to have your supervisor sign here!!!!!**

*****Also please remember to total your hours, visits, mileage, etc.**

Total Patient Contacts: _____

Total Home Health Care Visits: _____

Total Dental Patient Contacts: _____

North Carolina Alliance of Public Health Agencies, Inc.
Timesheet

FAX TO BECKY HUGHES 919-828-6203
Or scan and email to: timesheet@ncapha.org

Print Name:_____ Title: _____

Month & Year: _____ County: _____

Date	Hours	Home Health Visits	Home Health Resumption Visits	Home Health Admission Visits	On - Call	Other:	Mileage	Paid Time Off	Number of Patient Contacts:
16									
17									
18									
19									
20									
21									
22									
23									
24									
25									
26									
27									
28									
29									
30									
31									
TOTAL									

Employee's Signature: _____

Approved By: _____

*****Please remember to have your supervisor sign here!!!!!**

*****Also please remember to total your hours, visits, mileage, etc.**

Total Patient Contacts: _____

Total Home Health Care Visits: _____

Total Dental Patient Contacts: _____