America's First Choice
Nursing Staffing LLP
4205 W 86th Street. Suite L.
Indianapolis.
46268. IN

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Office: +1 (317) 744 9603
Cell: +1 (317) 998 3878

JOB DESCRIPTION

CHARGE NURSE

NAME:________________________________ TITLE:___________________

SUMMARY OF POSITION FUNCTIONS

As a member of the interdisciplinary team, the Charge Nurse assumes planning, responsibility, and accountability for resident care of a designated unit for the shift and in accordance with Federal and State regulations and company/facility policies, procedures and care plans.

ESSENTIAL POSITION FUNCTIONS

- Monitors delivery of care and services throughout shift to ensure needs are met, tasks are completed, including complete and accurate resident documentation, and that work of direct care staff is of acceptable quality and quantity, while complying with the resident rights.

- Coordinates patient care and non-patient care by assigning nursing assignments for each unit employee which outlines residents to be cared for and other duties to be executed during the shift. Charge Nurse takes into consideration that residents' needs are matched with the skills of individuals staff members, while maintaining consistency to the extent practicable.

- Makes rounds on the unit with off going nurse at the beginning of the shift and with oncoming nurse at the end of the shift. Monitors regulatory compliance, and to determine or rotate staff assignments and make adjustments according to qualified staff availability and resident needs.

- Outlines care plan goals and approaches to direct care staff so that plan is consistently implemented on all shifts by all caregivers. Seeks input from QMA and nurse aides about resident condition, functional abilities, preferences, and alternative approaches to care.

- Assists staff by identifying learning needs while taking opportunities to teach on the unit. Keeps unit personnel informed of new trends in resident care, policies, and procedures. Instructs staff on use of equipment. Supervises special needs of nursing assistant trainee and provides performance assessments.

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- Coaches and monitors staff performance and intervenes whenever necessary, takes disciplinary actions to staff, when needed, in fair and consistent manner in conjunction with federal and state laws and company policies procedures. May suspend employees when appropriate and in best interest of the safety and welfare of the residents and staff, to conduct internal investigations while seeking facility management guidance.

- Monitors restorative measures provided by staff in daily care of residents (i.e range of motion, self-help skills, positioning and body mechanics and gives recommendation to therapists.

- Assists in training staff in compliance with OSHA mandate on workplace safety including hazard communication, blood borne pathogens, and infection control procedures. In case of work place exposure, coordinates immediate first aid, ensure proper documentation and refers employee for post-exposure treatment.

- Ensure correct number of staff on duty, schedules lunch and rest breaks, approves or denies requests to leave early. Approves requests for time off in conjunction with DON.

- Performs duties as assigned in facility Fire and Disaster Plan that may include taking charge of evacuation, drills, and transportation of residents.

- Receives, investigates and responds to employee problems and complaints.

- Complies with the facility's privacy practices and procedures related to residents and employee records and all state/federal laws as outlined by HIPAA.

Administrative

- Completes weekly and monthly summaries reflective of patient's status specifically addressing problems identified on the patient care plan. Initiates and updates patient care plans as needed with appropriate problems, resident-oriented goals and approaches based on resident needs.

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- Gives and listens to verbal shift report making special note of significant changes in condition, admissions, transfers, discharges, unnecessary use of any drug, incidents, unexplained injuries, medications errors, loss of resident property, evidences of resident of family dissatisfaction or case of resident abuse and reports as necessary to the DON and interdisciplinary team.

- Monitors positive or negative staff behavior, staffing needs, equipment and supply needs, and opportunities to revise policies or procedures and improve quality.

- Completes required documentation of care and services delivered during shift including subjective findings, objectives symptoms, interventions, and resident responses to interventions. Completes required documentation of special circumstances including accidents / incident reports in compliance with state and federal laws and regulations.

- Ensures delivery of compassionate quality care evidenced by adequate services and staff coverage on unit, appropriateness of staff, cleanliness, absence of pressure wounds, and apparent maintenance of optimal physical, mental, and psychosocial function.

- Assists with preparation for long-term care survey and attends survey training, interacts with state surveyors as instructed or needed.

- Updates daily census, completes admission/ discharge documentation, ensures documentation of vital and neurological signs and weights, and notifies physician of significant weight loss/gain.

- Oversees facility operations in the absence of DON, Supervisor or otherwise directed.

- Supports the facility quality improvement which may include weekly/monthly action team meetings. Communicates action team recommendations, outcomes, and changes to unit staff and other shifts not present at the meeting.

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<u>Clinical</u>

- Makes rounds with physicians, schedules lab, x-ray, and appointments as ordered, reviews lab test results, and notifies physician of the same in a timely manner.

- Provide direct patient care, administers medications and specialized treatments and diet as prescribed to residents on unit according to physician orders and incompliance with facility policies and procedures.

- Performs physical assessment of new admissions and current residents as indicated. Completes assigned sections of residence assessment per facility protocols.

- Helps implement care plans to assist each resident to attain or maintain highest practicable physical, mental, and psychosocial well-being. Modifies approaches in plans of care to accommodate resident needs and preferences to manage risk factors for functional decline and to improve functional abilities. Coordinates care and delivery of services will all disciplines.

- Respects rights of residents regarding freedom of choice, consent for care and services, refusal of treatment and implementation of advance directives if any. Promptly consults with DON if unsure of proper course of action that respects resident's rights, complies with facility policies and procedures and provides consistency with federal and state laws and regulations.

- Immediately informs the residents, consults with physician, and notifies the designated family member and/or legal representative when there is an accident involving an injury which has potential for physician intervention; a significant change in the resident's physical, mental or psychosocial status; a need to alter treatment significantly or a decision to transfer or discharge from the facility or change of room of the resident.

- Uses good judgment to prepare, administer and immediately document medications and treatments as ordered by physicians. Authorizes administration of P.N.R. medications and treatments by a Q.M.A. when necessary. Maintains awareness of prominent medication interactions and side effects, monitors resident for occurrences of such and notifies physician as needed. Orders medication in timely manner to endure continuity of administration.

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- Keeps medication rooms and carts locked when unattended and is responsible for the security of the keys and correct reconciliation of controlled substances during shift. Counts all drugs on individual Control Drug Records with on-coming charge persons at change of shifts. Keeps medication room and cart clean and organized. Ensures proper storage of drugs and biological items.

- Informs residents in advance about care and treatment and any changes to the care plan.

- Attends in-service education programs and applies to job tasks.

NON-ESSENTAIL POSITION FUNCTIONS

- Other duties assigned by DON.

SUPERVISORY RESPONSIBILITIES

- Directly supervises C.N.A and Q.M.A employees on the unit. Carries out supervisory responsibilities in accordance with the organization's policies and applicable laws. Responsibilities include training employees; planning, assigning, and directing work; appraising performance; rewarding and disciplining employees; addressing complaints and resolving problems

SPECIAL REQUIREMENTS

- Must be able to work different shifts.

EDUCATION & QUALIFICATION

- To perform this position successfully, an individual must be able to perform each essential duty satisfactorily. Reasonable accommodations may be made to enable each individual with disabilities to perform the essential functions.

- Graduate of an accredited school of nursing.

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- Experience in providing direct care to residents in long-term care, acute care, restorative or geriatric nursing setting preferred.

- Prior experience as a Charge Nurse or similar supervisory experience an advantage.

KNOWLEDGE, SKILLS, ABILITIES

- Knowledge of federal/states regulations.

- Ability to interpret and apply knowledge of regulations and policy to direct care staff to ensure compliance while maintaining consistence and fairness.

- Ability to coordinate numerous activities at any given time and make sound judgments and judicious decisions quickly, often under pressure.

- Ability to read, analyze, and interpret general business periodicals, professional journals, technical procedures, or government regulations. Ability to write reports, business correspondence, and procedure manuals. Ability to effectively present information and respond to questions from group of managers, clients, staff, and the general public.

- Ability to add and subtract two digit numbers and to multiply and divide with 10's and 100's. Ability to perform these operations using units of American money and weight measurements, volume, and distance.

- Ability to define problems, collect data, establish data, establish facts, and draw valid conclusions. Ability to interpret an extensive variety of technical instructions in mathematical or diagram form and deal with several abstract and concrete variables.

CERTIFICATES, LICENSES, REGISTRATION

- Current active Indiana Registered Nurse or Licensed Practical Nurse.
- Current CPR Certification

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PHYSICAL DEMANDS

The physical demands described here are representative of those that must be met by an employee to successfully the essential functions of this job. Reasonable accommodations may be made to enable individuals with disabilities to perform essential functions.

	YES	NO
Lifting/Carrying		
1-10 lbs.		
11-25 lbs.		
26-50 lbs.		
Pushing/Pulling		
20-50 lbs.		
Over 50 lbs		
Climbing/Balancing		
Stooping/Bending		
Standing/Sitting		
Walking		
Travel		

WORK ENVIRONMENT DEMANDS

The work environment characteristics described here are representative of some an employee may encounter while performing the essential functions of this position. Reasonable accommodations may be made to enable individuals with disabilities to perform essential functions. Able to perform duties within the scenario below:

	YES	NO
Cold		
Hot		
Humid		
Wet		
Dry		
Dust		
Noise		
Odors		
Chemical Exposures		
Infections		

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I have read the above Job description and I am able to perform the above essential physical and work environment demands and agree to perform accordingly.

_____________________________ _______________________

Employee Signature **Date**

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NURSING COMPETENCY TEST

NAME:____

TITLE:____

1. **Carbidopal/Levodopa (Sinemet) is found in what therapeutic class?**
   Antibiotic
   Antiparkinson
   NSAID

2. **Digoxin (Lanoxin) is found in what therapeutic class?**
   Opiod
   Antipsychotic
   Antiarrhythmic

3. **Docusate Sodium (Colace) belongs in what following what therapeutic class?**
   Stool softener
   Stimulant
   Benzodiazepine

4. **Enalapril Maleate (Vasotec) is used in what therapeutic class?**
   Analgesic
   Antihypertensive
   Antiacid

5. **Furosemide is used as a?**
   Stool softener
   Antidepressant
   Diuretic

6. **Metoprolol (Lopresor) is treatment for?**
   Antidiarrheal
   Anticonvulsant
   Antihypertensive

7. **Mirtazapine (Remeron) is in what class**
   Antidepressant
   Diuretic
   GI Agent

8. **Pantoprazole Sodium (Protonin) is what agent?**
   Loop Diuretic
   Antihistames
   GI Agent

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9. **1 kg IS equivalent to how many Lbs?**________________________________

10. **1tsp = mL?**

____

11. **1 tbs = in mL?**

____

12. **1 oz = in mL?**

____

13. **1Liter = ____ cc**

____

14. **List medication rights below**

    1. **Right:**____
    2. **Right:**____
    3. **Right:**____
    4. **Right:**____
    5. **Right:**____

15. **NPO stands for?**

____

16. **CAD stand for?**

____

17. **BUE stand for?**

____

18. **RUQ stand for?**

____

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19. **PERLA stand for?**

____

20. **CVA stand for?**

____

21. **VS stand for?**

____

22. **WNL stand for?**

____

23. **GI stand for?**

____

24. **D5W stand for?**

____

25. **HS stand for?**

____

26. **PRN stand for?**

____

27. **P.O. stand for?**

____

28. **TID stand for?**

____

29. **500ml D5W + 2 GM Lidocaine. Give 2mg/min. What is the rate of flow of the IV in ml/hr?**

15 mL/hr

30 mL/hr

25 mL/hr

12 mL/hr

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30. **Administer 250ml D5W + 25,000 U Heparin IV at 500 U/HR. Calculate how many CC/HR?***

    5 cc/hr

    20 cc/hr

    10 cc/hr

    15 cc/hr

31. **Administer Tylenol 500 mg P.O. On hand is 0.25 gm tablets. How many tabs will you give?**

    3 tabs

    1 tabs

    2 tabs

    $^{1}/_{2}$ tab (one half)

32. **Robitussin 480 mg via G-Tube. Available Robitussin 160mg/5cc. How much do you administer?**

    7 cc

    2 cc

    10 cc

    15 cc

33. **30cc is equal to how many fluid oz?**

    A. 1 oz
    B. 2 oz
    C. 3 oz

34. **2 Milligrams is equivalent to how many grams?**

    A. 0.002 gm
    B. 0.02 gm
    C. 0.2 gm

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35. **Patient weight is 60kg. You are to administer Lasix 0.15mg per kg intravenously. How much drug do you administer?**

A. 4 mg
B. 9 mg
C. 29 mg

36. **Doctor's order. Administer 1,200 ml 0.45 ns AT 100 ML/HR. How long will it take to complete the therapy?**

10 hrs

8 hrs

12 hrs

3 hrs

37. **Doctor's order. Administer 5mg Compazine IM q 3-4hr PRN for nausea. Available is 10 mg/2ml. how many ml will the patient receive?**

10 mL
4 mL
5 mL
1 mL

NAME:______________________________ **Date:**________________

SIGNATURE__________________________

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NURSING SKILLS CHECKLIST

Check the column number that best describes your experience.
1) Experienced **2) Some Experience** **3) No Experience**

WOUND AND SKIN PROBLEMS

Skills (check appropriate box)

	1	2	3
Dressing changes			
Assessment of Integumentary System			
Care of Patient with			
Burns			
Wound care			
Open Draining Sores			
Decubitis Ulcers			
Legg Ulcers			
Irrigation of wounds			
Wound Debridement			
Patient Teaching of Wound Care			
Universal Safety Precautions			

ADMINISTRATION OF MEDICATIONS

Skills (check appropriate box)

	1	2	3
Intradermal			
Ear Drops			
Eye Drops			
Topical			
Oral			
IM			
SQ			
IV			
IVP			

RESPIRATORY SYSTEM

Skills (check appropriate box)

	1	2	3
TB			
COPD			
Asthma			
Pleurisy			
Emphysema			
Lung cancer			
Pneumonia			
Pulmonary Emboli			
Identify rales/rhonchi/ Wheezes			
	1	2	3
Chest Physiotherapy			
Incentive Spirometry			
Nasotracheal Suctioning			
Oxygen Delivery Devices			
Ultrasonic Nebulizer			
IPPB			
Care of Patient With			
Tracheostomy			
Chest Tubes			
Ventilator			
Collection of Sputum Specimens			
Administration of Oxygen			
Nasal Cannula			
Face Masks			
Administration of bronchodilators			
IV			
Aerosols			
Oral			
Use of Ambu Bag			
Inserting Oral Airways			

GENITOURINARY PROBLEMS

Skills (check appropriate box)

	1	2	3
Assessment of Renal System			
Assessment of Genitourinary System			
Care of Patient			
Cancer of female reproductive system			
Cancer of prostate			
Cancer of kidneys			
Renal failure			
Cancer of bladder			
Peritoneal dialysis			
Hemodialysis			
Urinary Diversion (i.e ileal conduit			
Insertion of Foley Catheter			
Male			
Female			
	1	2	3
Bladder Irrigations			
Continuous			
Intermittent			
Care of Nephrostomy Tube			
Collection of Urine Specimens			
Interpretation of homo urinalysis			
A-V Fistula/Shunt care			
Administration Diuretics & Patient Teaching			
Oral			
IV			
Blood Glucose Monitoring, Testing, Patient Teaching			
Bladder Training & Teaching			

GASTROINTESTINAL PROBLEMS

Skills (check appropriate box)

	1	2	3
Assessment of GI System			
Inflammatory Bowel Disease			
Malabsorption Syndrome			
Cancer of Colon			
Cancer of Esophagus			
Cancer of the Rectum			
Fistulas & Shunts			
Colostomy, Ileostomy Jejunostomy, gastrostomy			
Dehiscence			
Cirrhosis			
Liver failure			
Liver transplant			
Insertion & maintenance of Nasogastric tubes (Salem Pump, Levine)			
Administration of tube feeding			
	1	2	3
NG Lavage			
NV gavage			

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Gastoinstinal tube (cantor, etc)			
Tube irrigations			
Bowel Preparations & Cleaning Enemas			
Removal of Fecal impaction			
Bowel training & teaching			
Administration of medication via nasogastric tube			
Wound care & dressing changes			

OTHOPEDIC PROBLEMS

Skills (check appropriate box)

	1	2	3
Assessment of Vascular Systems			
Circulation Checks			
Care of Patient with			
Total knee replacement			
Total hip replacement			
Total joint replacement			
Rheumatic/arthritic disease			
Amputation of an extremity			
Cast care			
Traction			
Skin			
Skeletal			
Range of motion Exercises			
Use of assisting device (Canes, Walkers, Wheelchairs, etc)			
Care of prosthetic/Orthopedic Devices/patient Teaching			

HOME IV THERAPY

Skills (check appropriate box)

	1	2	3
Starting Peripheral IVs			
Over the needle plastic Cannulas			
Steel needles (Scalp vein, wing tipped)			
Heparin locks			
Maintain & Discontinuing IV therapy			
	1	2	3
Care/Maintenance of Central Venous			

Catheters			
Hickman catheter			
Quinton catheter			
Boviac catheter			
Groshong catheter			
IV dressing site changes			
Implantable venous access devices			
IV Infusion Controllers/Pumps			
Volumetric controllers/pumps			
Nonvolumetric controllers/pumps			
Prepare and mix IV			
Calculate & regulate IVs			

IV ADMINISTRATION

Skills (check appropriate box)

	1	2	3
Antibiotics			
Antineoplastic (chemotherapy)			
Lipids			
TPN			
Blood & Blood products			
Heparin flushes			
Pain control medication via continuous infusions (narcotics)			
IV Push Medications			

NEUROGICAL PROBLEMS

Skills (check appropriate box)

	1	2	3
Assessment of levels of consciousness			
Assess sensory-motor functions extremities			
Assess cranial nerves			
Seizure precautions			
Traction			
Cervical			
Lumbar			
Care of patients with			
Seizures			
Spinal cord injury			
CVA			
Drug overdose			
Neuromuscular disease (MS, parkison's, myasthenia gravis			
	1	2	3
Administration of Anticonvulsants			

Oral			
IV			
Administration of steroids			
Oral			
IV			
Stryker frames			

SPECIAL PATIENT CONSIDERATIONS

Skills (check appropriate box)

	1	2	3
Patient with terminal illness			
Patient with AIDS			
Anaphylactic shock			
Cardiac arrest			
Respiratory arrest			
Pain management			
Cardiopulmonary resuscitation			
Documentation of			
Medicare 485/486 forms			
Other			
Other			
Diabetes teaching & care			
Skin, foot & nail care			
Insulin administration & teaching			
Post cataract care			
Assessment of home environment			
Care of patients with Alzheimer's or other forms of dementia			

CARDIOVASCULAR SYSTEM

Skills (check appropriate box)

	1	2	3
Chest tightness/ pain			
Hypertension/hypotension			
Acute MI			
Syncope			
Arrhythmias			
Other/Arteriosclerosis			
Temporary external pacemaker			
Internal pacemaker			
Pulse checks			
Taking EKG Rhythm strips			
	1	2	3
Administration of Antihypertensives			

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Oral			
IV			
Patient teaching			

COLLECTION OF SPECIMENS

Skills (check appropriate box)

	1	2	3
Sputum			
Stool			
Urine			
Venipuncture of lab work			

EMPLOYEE NAME:

EMPLYEE SIGNATURE:

DATE:

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Abuse Training Test

1. Name 5 types of abuse:

   A. Physical B. Sexual C. Financial D. Chemical E. Neglect

   F. All of the above

2. Provide 3 examples of physical abuse:

   A. Hitting B. Kicking C. Slapping D. Shaking hands

3. Provide an example of psychological abuse:

   A. Harassment B. Insults C. Both A & B

4. Provide an example of financial exploitation:

   A. Forgery B. Theft of money C. Misuse of money D. All of the above

5. Provide 2examples of neglect:

   A. Denying food B. Denying medication C. Giving Resident a shower

6. What can you do to ensure you treat residents with respect?

   A. Listen to their needs B. Be empathetic C. Acknowledge the resident

   D. All of the above

7. If you witness abuse, what do you do first?

   A. Make sure resident is safe B. Confront person abusing the resident

8. If you witness abuse, who do you report it to?

   A. Executive Director B. Immediate Supervisor C. Both A & B

9. If you witness abuse, when do you report it?

   A. Immediately B. At the end of shift

10. If you continue to have concerns, who else can you report the abuse to?

    A. Follow up with Executive Director B. Call the hotline C. Both A & B

Print Name: ____

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ALCOHOL AND DRUG ABUSE POLICY

The purpose of this policy is to ensure to maintain a safe, and productive work environment for all employees by preventing accidents or other dangerous incidents that may result from drug or alcohol use. This policy pertains to all AFC employees. The possession use or sale of alcohol or drugs at place of work is strictly prohibited.

Employees are prohibited from reporting to workplace under the influence of alcohol or drugs. An employee taking prescription medication is required to present to AFC a valid prescription from the prescribing physician. To be considered for employment, applicants will be subject to drug screen.

Employee agrees to be tested for the presence of controlled substances including but not limited marijuana, cocaine, opiates, amphetamines, phencyclidine (PCP), alcohol] etc.

In case of reasonable suspicion that an employee is under the influence of drug or alcohol, the employee will be subject to random drug screen.

Any employee who refuses to submit to the test will no longer be considered eligible for employment.

Employees found to be in violation of this policy by either directly possessing or using alcohol or drugs, as described above, or through a verified positive drug test or by court conviction, will be subject to immediate termination from employment.

By signing below the employee agrees to the above requirements and conditions.

____

Employee's Signature **Date**

____

Employee's Name Printed

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ATTENDANCE POLICY

AFC being a temporary staffing agency, offers the employee the autonomy to choose shifts that best fits them. Therefore, it is the employee responsibility to make sure that the shifts they pick up they can work or arrange for other AFC staff to cover for them.

Call off should be at least 2hrs prior to the beginning of the scheduled shift. Phone calls are the only acceptable means of call off. Text messages are not acceptable way of calling off.
1st cancellation of scheduled shift within **30 days**, the employee receives a verbal warning.
2nd call off in 30 days; the employee will be excluded from receiving available shift hours for the next 30 days.

Employee are required to at least work one **8hr** shift in **60 Days** to remain active with AFC.

It is the facilities expectation that our employee is on time and stay until relived by the next shift, unless otherwise approved. Any shift changes must be communicated to AFC regardless of any arrangements with the facility. This helps AFC keep track and ensure you are paid the right way and in timely manner.

EMPLOYEE IS RESPONSIBLE FOR CLOCKING IN AND OUT, SIGNING AGENCY VERIFACTION LOG WHERE REQUIRED BY FACILITIES. EMPLOYEE UNDERSTAND THAT FAILURE TO DO SO WILL DELAY THEIR PAY FOR AFFECTED SHIFTS UNTIL THE EMPLOYEE GET IT FIXED WITH FACILITY HR OR SCHEDULER. EMPLOYEE UNDERSTAND TO CHECK DAILY IF THERE IS ANY DISCREPANCY ON TIMECLOCK AND NOTIFY FACILITY HR OR SCHEDULER IMMEDIATELY.

AFC understands some situations are emergency and unavoidable e.g., death, sickness, car breakdown e.t.c. In such cases the employee has 24hs to present proof of such situations e.g. doctors note, receipts to AFC. By signing below, you agree to above policy.

Name: ……….

Signature: ………..

Date: ………

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EMPLOYEE DIRECT DEPOSIT FORM

Personal Information

1. First Name ________________ Middle initial ___Last Name______________________
2. Street Address ____
3. City _______________________________State _______Zip Code ___________
4. Rate of Pay ______________________
5. Social Security Number _______-_____-______
6. Date of Hire ______/ _____/ _______
7. Date of Birth ______/ _____/ _______
8. Email: _____________________________________

Direct Deposit – Bank Information

Bank Name __________________________________

Routing # ____________________________________

Account # ____________________________________ Savings☐ ☐ Checking

Dollar Amount or % of Pay _______________________

Bank Name #2 ________________________________

Routing # ____________________________________

Account # ____________________________________ Savings☐ ☐ Checking

Dollar Amount or % of pay _______________________

America's First Choice
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Indianapolis.
46268. IN

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Office: +1 (317) 744 9603
Cell: +1 (317) 998 3878

CONFIDENTIALITY AND PRIVACY AGREEMENT

I________________________________AFC Staffing employee hereby acknowledge and agree that:-

- During the time I am working at any facility, I can only disclose information I gain while on assignment to authorized parties only.
- I will not disclose or disseminate any facility information, facility procedures or way of operation that I may come into contact with, and agree not to remove any documentation for other use other than my assignment.
- I have been presented with Hippa Right and responsibility, read and understood it and all questions answered to my satisfaction. I agree to abide by Hippa and follow any privacy and confidentiality policies provided to me during my assignment.
- I agree not to use, disclose, reveal or disseminate any health information that come into my possession during my assignment, unless authorized and in accordance with Hippa requirements.
- I understand that even after my employment with AFC Staffing has ended, I will be responsible for any damage that may result in violation to the terms on this agreement.

Name:____

Signature:_____________________________________

Date:____

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COVID-19 VACCINE DECLINATION FORM

Employee Information:

First Name: ______________________ **Last name:**________________________

Date:___________________

I...AFC staffing employee,
Employee Name

I acknowledge that I have read, or had explained to me, the Coronavirus Disease (COVID-19) General In formation handout and the Emergency Use Authorization (EUA) Fact Sheet regarding the COVID-19 vaccine.

I have had the opportunity to ask questions, which have been answered to my satisfaction.

I understand that if I decline the vaccine, I may change my mind and request to be vaccinated at a later date, with the understanding that the vaccination will be based on the availability of the COVID-19 vaccine at that time.

I wish to decline the COVID-19 vaccination. I certify that I am at least 18 yrs of age. I acknowledge that in making this decision I have had a chance to ask questions and that such questions were answered to my satisfaction.

Date:___________________ **Employee Signature:**_____________________

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6 Hour Dementia Training – Quiz

1. **What is person-centered care?**

   ____

2. **Besides physiological need, what are the basic needs every person has, regardless of disease and condition?**
   (Select all that may apply)

   Identity

   Esteem

   Love and Belonging

   Safety & Security

   Physiological

   All of the above

3. **When can you create a meaningful moment with a resident?**

   ____

4. **Give two examples of how to make a quality connection**

   Doing WITH not FOR

   Offering successful choices

   All of the above

5. **Is there a cure for Alzheimer's?**

   Yes No

6. **What is happening to the brain throughout dementia?**

   A. The brain is dying – Brain failure B. Nothing is happening to the brain

7. **What does the frontal lobe, (filter), control?**

   A. Control impulses B. Control movement

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8. How much of the brain is left by the end of the disease?

A. Approximately $^1/_3$ B. Approximately $^3/_4$

9. In the early stages of dementia, people will miss out of every __________ words.

A. Four B. Two C. None

10. List 3 symptoms of dementia:

A. Memory loss
B. Confusion/Orientation to Time & Place
C. Problems with Reasoning /Judgment /Problem solving
D. All of the above

11. Name an example of something that may present some of the same symptoms and look like dementia until treated

A. Depression
B. Urinary tract infection
C. All of the above

12. While much of formal language is lost, what is retained that allows us to still connect with a resident?

A. Music
B. Rhythm
C. Automatic social chat
D. Forbidden language
E. All of the above

13. List 5 communication tips:
A. Approach from the front
B. Enter their reality
C. Don't r corrector or argue
D. Use visual cues
E. Pay attention to non-verbal communication
F. All of the above

14. What do you do and say when a resident says something that doesn't quite make sense?
A. Repeat the question
B. Do nothing

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15. What "bossy" words should care companions avoid when talking to a resident?

A. NO
B. DON'T
C. STOP
D. All of the above

16. List the 3 steps (in order) for the Greet Before You Treat approach"

A. See
B. Talk
C. Touch
D. All of the above

17. What are the benefits of the hand under hand position? Select all that apply.

A. Feels friendly
B. Relieves stress
C. Connects and protects
D. All of the above

18. What can occur if we attempt a task without this approach?

A. Behaviors B. Resident is happy

19. Why?

A. Resident may feel threatened B. Resident maybe startled C. Both A & B

20. Behaviors are a form of:

A. Communication B. Nothing

21. What might someone's behavior be communicating?

A. Unmet needs e.g hungry B. Nothing

List 3 common behaviors:

A. Repetition
B. Refusal
C. Defensiveness
D. All of the above

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22. Are behaviors the resident's fault?

Yes No

23. Does our action have the potential to cause a resident to have a behavior?

Yes No

24. Can a resident with dementia always tell you when they are in pain?

Yes No

Name:____

Title:____

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AFC DISASTER PREPAREDNESS TEST

1. What does the acronym RACE stand for?

   R: _____________A: _______________C: _______________ E: ____________

2. What type of extinguisher can be used on any type of fire?

   …………………………………………………………………

3. In the event the Executive Director is unable to serve as disaster response coordinator, what direction do you follow?

   ………………………………………………………………………………..……..

4. What is the difference between a Tornado watch and Tornado warning?

   ………………………………………………………………………………………

   ………………………………………………………………………………………

Signature

Print Name: Date:

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EMPLOYEE INFORMED CONSENT FOR IMMUNIZATION WITH HEPATITIS B VACCINE

Each year 300,000 people in the United States develop infection due to Hepatitis B virus. This is the result of exposure to infected body fluids, such as blood. Health care employees can be exposed to this virus in their every day working environment. A vaccine is available to prevent Hepatitis B infection in people exposed to this virus. This vaccine will not prevent hepatitis caused by other agents such as hepatitis A virus, non-A, non-B hepatitis viruses, etc.

Hepatitis B infection of the liver may be a very mild illness or a life threatening one. Of the approximately 300,000 new cases of Hepatitis B virus infections occurring annually in the United States: 26% will develop jaundice and 74% will remain sub-clinic: (non-specific symptoms such as fatigue, muscle and joint pains, loss of appetite); 5.2% will become hospitalized; % will die of acute Hepatitis; 2% will die of cirrhosis, and% will die of hepatocellular carcinoma. Six to ten percent of those who are infected annually (amounting to 18,000 to 30,000 people per year) will become chronic carries of the disease.

Hepatitis B vaccine is a non-infectious sub-unit viral vaccine derived from Hepatitis B surface antigens produced in yeast cells. It is usually delivered in three doses via intra-muscular injection. The first dose of 1.0 ml is followed by booster doses at one and six months. Eighty-five to ninety-six percent of the individuals receiving the complete series of vaccinations are protected from Hepatitis B infections to which they may be subsequently exposed. The long-term duration of this protection against illness and subsequent carriage of the virus, and the need for further boosters is not known at the present time.

A review of medical literature about the side effects of the vaccine has been made. As with any vaccine, there is a possibility that broad public use of the vaccine may reveal rare adverse reactions which were not observed during the clinical trial. The most common adverse reactions from Hepatitis B vaccine is local soreness at the injection site, which subsides within 48 hours. Vaccinated people may experience low grade fever, fatigue, headache, nausea, vomiting, dizziness, and muscular or joint pain. There reactions are short – lived. Disorders of the nervous system, such as abnormal sensations like burning, prickling and shooting pains in the arms and legs, as well as paralysis as in the Guillian-Barre Syndrome, have been rarely reported following the administration of several commonly used vaccines including Hepatitis B vaccine. At this point in time, there is no known cause and effect relationship between these nervous system disorders and the administration of Hepatitis B vaccine.

More detail about the disease and the vaccine including further explanation of this consent form is available from staff development or the infection control nurse. Questions regarding pregnancy and the vaccine should be discussed with your obstetrician.

Name:____________________________Date:____________Department____________________________

I desire to participate in the Hepatitis B Vaccination Program and agree to be screened for Hepatitis B Antibody.

I do not desire to participate in the Hepatitis B Vaccination Program.

______________________ _________ ______________________ ______

Signature Social Security Number

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INFLUENZA VACCINE CONSENT OR DECLINATION

AFC Staffing has provided me information regarding the risks and benefits of the *Influenza* vaccines. I have been given the Centers for Disease Control Vaccine Information Statements, which have allowed me to be educated as to these risks and benefits. I have been given the opportunity to ask questions and discuss any concerns that I may have. I am making an informed decision regarding the influenza vaccine.

I_______________________________________, AFC Staffing Employee, do hereby
Employee name

☐ Consent
or
☐ Decline

to receive the influenza vaccine. I understand that if I request the vaccine at a later date, a will be administered based on availability.

Signature: _____________________________ Date:____________________

PHYSICAL

If you are unable to see your provider and need pre-employment physical you can visit:

PIKE MEDICAL CONSULTANTS

Telephone: 377 9566 288

Address: 7911 N Michigan Rd. Indianapolis, IN 46268

NO APPOINTEMENT NEED.

HOURS	
SATURDAY	9 A.M – 3 P.M
SUNDAY	9 A.M – 3 P.M
MONDAY	8:00 A.M – 8:00 P.M
TUESDAY	8:00 A.M – 8:00 P.M
WEDNESDAY	8:00 A.M – 8:00 P.M
THURSADAY	8:00 A.M – 8:00 P.M
FRIDAY	8:00 A.M – 8:00 P.M

NB: Pike Consultants charges out of pocket cost for physical (around $50), they accept most insurances.

Any physical paperwork is acceptable, it has to be current and signed by a doctor or NP with date and their ID Number

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POLICY ON ELECTRONIC COMMUNICATIONS

STATEMENT OF POLICY

All the buildings have the internet to assist with your job. It is the responsibility of each user to ensure this technology is used for proper business purposes in a manner that is: (1) Responsible, professional, and legal (2) Does not compromise the confidentiality of resident information (3) Does not compromise the security computer resources of any building.

OWNERSHIP

All computer resources provided to users are assets and owned by that building. All data, information, programs, electronic mail, graphic works, literary works, documentation, and other material created, received, sent or stored using any computers, whether or not designated as private or confidential, are assets of, and owned by the building you're working in and not the individual user.

SYSTEM SECURITY

It is the responsibility of every user to protect the computer resources of the building you're assigned to from unauthorized access, modification, destruction, or disclosure. Users must immediately report any suspected security threat to any computer.

Users should pay attention to the following:

Unattended terminals: Programs must be closed when the employee is not in attendance at the computer terminal.

Passwords: Individual passwords are confidential and may not be shared

External Network Connections: Only authorized personnel may establish internet or other external network connections.

Computer Configuration Changes: No one can make any changes to computer systems.

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NO PRIVACY

Users do not have any personal privacy right to any matter created, received, sent, or stored on the company's computers. Inconsequential whether the matter is designated as private or confidential.

The building reserves the right to monitor its computer resources, read, and copy all files or data contained on any computer. It includes, and not limited to email, messages, and personal file directories. Monitoring may be done without prior notice.

The building reserves the right to access computer resources. This is to assure compliance with statutory requirements as well as internal policies supporting internal investigations. It also assists with the management of information systems.

PROHIBITED USES

It is the responsibility of each user to use the computer resources in a manner consistent with the building policies. Users shall not use computer resources in any way that:

- Violates any law, statute, regulation, or ordinance
- Violates any policy or procedure of the company
- Jeopardizes the security of any computer resource
- Jeopardizes the tax-exempt status of the company
- Violates the legal rights of any person or entity
- Gives the impression a user is representing, giving opinions, making statements or commitments on behalf of the facility unless authorized to do so.
- Results in the transmission of obscene, pornographic, discriminatory, harassing, defamatory, political, or partisan campaign material.
- Interferes with the use facility computer resources or another person or entity.
- Involves personal financing gain or gambling
- Is inconsistent with norms of professional and business conduct

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RESPONSIBLE USE OF INTERNET

The internet is for work-related purposes only. Unauthorized use includes, but is not limited to: (1) posting, viewing, downloading, or otherwise transmitting or receiving offensive, defamatory, pornographic, or sexually explicit material (2) Gambling (3) Engaging in computer "hacking", or other related activities (4) Shopping, playing games, surfing/not working (5) Attempting to disable or compromise the security of information on any computer.

A user should never provide confidential, proprietary, or restricted information about AFC staffing or any building you're assigned to. It includes its employees, residents, vendors, or donors without prior written consent. The building reserves the right to monitor internet usage at its discretion in the ordinary course of business.

Violations of this policy, as with all policies of the AFC staffing may result in discipline, up to and including termination of employment.

Please read the statement below and sign designating your understanding and agreement with the policy on Electronic Communications.

I, ____ agree to follow this policy. I understand the building I am assigned to need to know and monitor the internet sites I access while I am at work under their company.

Signature : __________________________________ Date : __________________________

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Pre-Employment Physical Form

(To be completed by Physician)

Employee Name: ____Date:____________________________

Social Security Number: ____

Position you are applying for: ……………………………………………………….

EMPLOYEE RELEASE: I authorize the release of the information contained on this form to be provided to AFC Staffing in accordance with maintaining required medical employment record. I understand that this health profile required in order that I may be considered for assignment with AFC Staffing. I also authorize AFC Staffing to release this information relevant to my employment to AFC clients.

Signature ………………………………………… Date …………………………………………………

Cleared. May work without limitations or any restrictions.

May work with the following limitations/ restrictions.
Please explain:
………
………

Not cleared. Unable to meet physical requirements of this position
Please explain:
………
………

Physician Certification of Fitness for Duty

I certify that the above named person is free from symptoms indicating the presence of an infectious disease and the determination of the above fitness to work been based on information provided by the employee.

…………………………………	…………………………………	………………
Physician Name	**License #**	**Date**

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EMPLOYEE TUBERCULOSIS SCREENING

Name:_______________________________________ **Date:**__________________

Social Security Number: ____

EMPLOYEE RELEASE: I authorize the release of the information contained on this form to be provided to AFC Staffing in accordance with maintaining required medical employment record. I understand that this health profile required in order that I may be considered for assignment with AFC Staffing.

Signature:___________________________ **Date:**___________________________

Tuberculosis Screening

Date______________By__________________Title____________________

Site ____

Lot#__________________Exp ___________________

Mfg. by: _____________________________________

Signature: ___________________________________

Results read at 48 - 72 hours

Read Date:___________________________________

Read by____________________________Title_____

Induration_____________(MM) Positive Negative

Signature____________________________________

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UNIVERSAL PRECAUTIONS QUIZ

NAME:________________________________ TITLE:______________________

1. **"Standard precautions" are infection control practices that are designed to protect heathcare workers from: (Select all that apply)**
   a. Contact with clients' blood and body fluids.
   b. Contact with potentially infected surfaces
   c. Becoming infected with diseases
   d. All the above

2. **The key steps for standard precautions include: (Select all that apply)**
   a. Using gloves.
   b. Wearing an apron, mask, and eye protectors as trained.
   c. Frequent hand washing
   d. Proper handling and disposal of possibly infected linens and wastes.
   e. Proper handling and disposal of sharps (such as needles or diabetes sticks).
   f. All of the above.

3. **Which is the single most important infection control activity?**
   a. Hand washing
   b. Using gloves
   c. using gown

4. **When should healthcare workers wash their hands.**

____
____
____

5. **When should healthcare workers use gloves.**

____
____
____

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UNIVERSAL PRECAUTIONS QUIZ

NAME:_______________________________ **TITLE:_____________________**

6. **You should consider all blood, or any substance containing visible blood, to be potentially infectious.**
   True
   False

7. **Personal protective equipment works by putting a physical barrier between you and potentially infectious materials.**
   True
   False

8. **It's not necessary to wash your hands after handling potentially contaminated substances if you are wearing gloves.**
   True
   False

9. **Dealing with everyday cuts and scrapes doesn't require any particular precautions.**
   True
   False

10. **Does people with blood borne viruses always show signs and symptoms?**
    True
    False

11. **Your skin is a natural, protective barrier against exposure.**
    True
    False

12. **There is a vaccine or cure for Human Immunodeficiency Virus (HIV)?**
    True
    False

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UNIVERSAL PRECAUTIONS QUIZ

NAME:________________________________ **TITLE:______________________**

13. **A Blood test is the best way to confirm infection by a bloodborne pathogen**
    True
    False

14. **HBV, HCV, HIV are among the greatest pathogens putting healthcare workers at risk.**

    True

    False

15. **Hepatitis C virus can live outside the body for upto 4 days**
    True
    False

Employment Eligibility Verification

Department of Homeland Security

U.S. Citizenship and Immigration Services

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

	List A	Additional Information
Document Title 2 (if any)		
Issuing Authority		
Document Number (if any)		
Expiration Date (if any)		
Document Title 3 (if any)		
Issuing Authority		
Document Number (if any)		
Expiration Date (if any)		Check here if you used an alternative procedure authorized by DHS to examine documents.

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

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

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

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

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

LISTS OF ACCEPTABLE DOCUMENTS

All documents containing an expiration date must be unexpired.
* Documents extended by the issuing authority are considered unexpired.
Employees may present one selection from List A or a
combination of one selection from List B and one selection from List C.

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

LIST A **Documents that Establish Both Identity and Employment Authorization**	OR	LIST B **Documents that Establish Identity**	AND	LIST C **Documents that Establish Employment Authorization**
1. U.S. Passport or U.S. Passport Card **2.** Permanent Resident Card or Alien Registration Receipt Card (Form I-551) **3.** Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa **4.** Employment Authorization Document that contains a photograph (Form I-766) **5.** For 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. **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		**1.** Driver's license or ID card issued by a State or outlying possession of the United States provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address **2.** ID card issued by federal, state or local government agencies or entities, provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address **3.** School ID card with a photograph **4.** Voter's registration card **5.** U.S. Military card or draft record **6.** Military dependent's ID card **7.** U.S. Coast Guard Merchant Mariner Card **8.** Native American tribal document **9.** Driver's license issued by a Canadian government authority **For persons under age 18 who are unable to present a document listed above:** **10.** School record or report card **11.** Clinic, doctor, or hospital record **12.** Day-care or nursery school record		**1.** A Social Security Account Number card, unless the card includes one of the following restrictions: **(1)** NOT VALID FOR EMPLOYMENT **(2)** VALID FOR WORK ONLY WITH INS AUTHORIZATION **(3)** VALID FOR WORK ONLY WITH DHS AUTHORIZATION **2.** Certification of report of birth issued by the Department of State (Forms DS-1350, FS-545, FS-240) **3.** Original or certified copy of birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal **4.** Native American tribal document **5.** U.S. Citizen ID Card (Form I-197) **6.** Identification Card for Use of Resident Citizen in the United States (Form I-179) **7.** Employment authorization document issued by the Department of Homeland Security 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.

Acceptable Receipts

May be presented in lieu of a document listed above for a temporary period.

For receipt validity dates, see the M-274.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Supplement B, Reverification and Rehire (formerly Section 3)

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

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

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

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

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

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

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

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

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

Additional Information (Initial and date each notation.)

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

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

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

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

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

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

Additional Information (Initial and date each notation.)

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

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

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

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

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

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

Additional Information (Initial and date each notation.)

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

Form **W-4**

Department of the Treasury
Internal Revenue Service

Employee's Withholding Certificate

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

OMB No. 1545-0074

2024

Step 1: Enter Personal Information

(a) First name and middle initial | Last name | (b) Social security number

Address

City or town, state, and ZIP code

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*.

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

Complete Steps 2–4 ONLY if they apply to you; otherwise, skip to Step 5. See page 2 for more information on each step, who can claim exemption from withholding, 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 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 (b) if pay at the lower paying job is more than half of the pay at the higher paying job. Otherwise, (b) is more accurate . . . . ☐

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

Step 3: Claim Dependent and Other Credits

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

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

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

Add the amounts above for qualifying children and other dependents. You may add to this the amount of any other credits. Enter the total here . . . . **3** $

Step 4 (optional): Other Adjustments

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

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

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

Step 5: Sign Here

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

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

Employers Only

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

General Instructions

Section references are to the Internal Revenue Code.

Future Developments

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

Purpose of Form

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

Exemption from withholding. You may claim exemption from withholding for 2024 if you meet both of the following conditions: you had no federal income tax liability in 2023 **and** you expect to have no federal income tax liability in 2024. You had no federal income tax liability in 2023 if (1) your total tax on line 24 on your 2023 Form 1040 or 1040-SR is zero (or less than the sum of lines 27, 28, and 29), or (2) you were not required to file a return because your income was below the filing threshold for your correct filing status. If you claim exemption, you will have no income tax withheld from your paycheck and may owe taxes and penalties when you file your 2024 tax return. To claim exemption from withholding, certify that you meet both of the conditions above by writing "Exempt" on Form W-4 in the space below Step 4(c). Then, complete Steps 1(a), 1(b), and 5. Do not complete any other steps. You will need to submit a new Form W-4 by February 15, 2025.

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. Expect to work only part of the year;

2. Receive dividends, capital gains, social security, bonuses, or business income, or are subject to the Additional Medicare Tax or Net Investment Income Tax; or

3. Prefer the most accurate withholding for multiple job situations.

Self-employment. Generally, you will owe both income and self-employment taxes on any self-employment income you receive separate from the wages you receive as an employee. If you want to pay these taxes through withholding from your wages, use the estimator at *www.irs.gov/W4App* to figure the amount to have withheld.

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

Specific Instructions

Step 1(c). Check your anticipated filing status. This will determine the standard deduction and tax rates used to compute your withholding.

Step 2. Use this step if you (1) have more than one job at the same time, or (2) are married filing jointly and you and your spouse both work.

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

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 will be larger the greater the difference in pay is between the two jobs.

Multiple jobs. *Complete Steps 3 through 4(b) on only one Form W-4. Withholding will be most accurate if you do this on the Form W-4 for the highest paying job.*

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

Step 4 (optional).

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

Step 4(b). Enter in this step the amount from the Deductions Worksheet, line 5, if you expect to claim deductions other than the basic standard deduction on your 2024 tax return and want to reduce your withholding to account for these deductions. This includes both itemized deductions and other deductions such as for student loan interest and IRAs.

Step 4(c). Enter in this step any additional tax you want withheld from your pay **each pay period**, including any amounts from the Multiple Jobs Worksheet, line 4. Entering an amount here will reduce your paycheck and will either increase your refund or reduce any amount of tax that you owe.

Step 2(b)—Multiple Jobs Worksheet *(Keep for your records.)*

If you choose the option in Step 2(b) on Form W-4, complete this worksheet (which calculates the total extra tax for all jobs) on **only ONE** Form W-4. Withholding will be most accurate if you complete the worksheet and enter the result on the Form W-4 for the highest paying job. To be accurate, submit a new Form W-4 for all other jobs if you have not updated your withholding since 2019.

Note: If more than one job has annual wages of more than $120,000 or there are more than three jobs, see Pub. 505 for additional tables; or, you can use the online withholding estimator at *www.irs.gov/W4App*.

1 **Two jobs.** If you have two jobs or you're married filing jointly and you and your spouse each have one job, find the amount from the appropriate table on page 4. Using the "Higher Paying Job" row and the "Lower Paying Job" column, find the value at the intersection of the two household salaries and enter that value on line 1. Then, **skip** to line 3 . . . . **1** $ ________

2 **Three jobs.** If you and/or your spouse have three jobs at the same time, complete lines 2a, 2b, and 2c below. Otherwise, skip to line 3.

a Find the amount from the appropriate table on page 4 using the annual wages from the highest paying job in the "Higher Paying Job" row and the annual wages for your next highest paying job in the "Lower Paying Job" column. Find the value at the intersection of the two household salaries and enter that value on line 2a . . . . **2a** $ ________

b Add the annual wages of the two highest paying jobs from line 2a together and use the total as the wages in the "Higher Paying Job" row and use the annual wages for your third job in the "Lower Paying Job" column to find the amount from the appropriate table on page 4 and enter this amount on line 2b . . . . **2b** $ ________

c Add the amounts from lines 2a and 2b and enter the result on line 2c . . . . **2c** $ ________

3 Enter the number of pay periods per year for the highest paying job. For example, if that job pays weekly, enter 52; if it pays every other week, enter 26; if it pays monthly, enter 12, etc. . . . . . . **3** ________

4 **Divide** the annual amount on line 1 or line 2c by the number of pay periods on line 3. Enter this amount here and in **Step 4(c)** of Form W-4 for the highest paying job (along with any other additional amount you want withheld) . . . . **4** $ ________

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

1 Enter an estimate of your 2024 itemized deductions (from Schedule A (Form 1040)). Such deductions may include qualifying home mortgage interest, charitable contributions, state and local taxes (up to $10,000), and medical expenses in excess of 7.5% of your income . . . . **1** $ ________

2 Enter:
- $29,200 if you're married filing jointly or a qualifying surviving spouse
- $21,900 if you're head of household
- $14,600 if you're single or married filing separately

. . . . . . **2** $ ________

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

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

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

Privacy Act and Paperwork Reduction Act Notice. We ask for the information on this form to carry out the Internal Revenue laws of the United States. Internal Revenue Code sections 3402(f)(2) and 6109 and their regulations require you to provide this information; your employer uses it to determine your federal income tax withholding. Failure to provide a properly completed form will result in your being treated as a single person with no other entries on the form; providing fraudulent information may subject you to penalties. Routine uses of this information include giving it to the Department of Justice for civil and criminal litigation; to cities, states, the District of Columbia, and U.S. commonwealths and territories for use in administering their tax laws; and to the Department of Health and Human Services for use in the National Directory of New Hires. We may also disclose this information to other countries under a tax treaty, to federal and state agencies to enforce federal nontax criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism.

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

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

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

Married Filing Jointly or Qualifying Surviving Spouse

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	$0 - 9,999	$10,000 - 19,999	$20,000 - 29,999	$30,000 - 39,999	$40,000 - 49,999	$50,000 - 59,999	$60,000 - 69,999	$70,000 - 79,999	$80,000 - 89,999	$90,000 - 99,999	$100,000 - 109,999	$110,000 - 120,000
$0 - 9,999	$0	$0	$780	$850	$940	$1,020	$1,020	$1,020	$1,020	$1,020	$1,020	$1,370
$10,000 - 19,999	0	780	1,780	1,940	2,140	2,220	2,220	2,220	2,220	2,220	2,570	3,570
$20,000 - 29,999	780	1,780	2,870	3,140	3,340	3,420	3,420	3,420	3,420	3,770	4,770	5,770
$30,000 - 39,999	850	1,940	3,140	3,410	3,610	3,690	3,690	3,690	4,040	5,040	6,040	7,040
$40,000 - 49,999	940	2,140	3,340	3,610	3,810	3,890	3,890	4,240	5,240	6,240	7,240	8,240
$50,000 - 59,999	1,020	2,220	3,420	3,690	3,890	3,970	4,320	5,320	6,320	7,320	8,320	9,320
$60,000 - 69,999	1,020	2,220	3,420	3,690	3,890	4,320	5,320	6,320	7,320	8,320	9,320	10,320
$70,000 - 79,999	1,020	2,220	3,420	3,690	4,240	5,320	6,320	7,320	8,320	9,320	10,320	11,320
$80,000 - 99,999	1,020	2,220	3,620	4,890	6,090	7,170	8,170	9,170	10,170	11,170	12,170	13,170
$100,000 - 149,999	1,870	4,070	6,270	7,540	8,740	9,820	10,820	11,820	12,830	14,030	15,230	16,430
$150,000 - 239,999	1,960	4,360	6,760	8,230	9,630	10,910	12,110	13,310	14,510	15,710	16,910	18,110
$240,000 - 259,999	2,040	4,440	6,840	8,310	9,710	10,990	12,190	13,390	14,590	15,790	16,990	18,190
$260,000 - 279,999	2,040	4,440	6,840	8,310	9,710	10,990	12,190	13,390	14,590	15,790	16,990	18,190
$280,000 - 299,999	2,040	4,440	6,840	8,310	9,710	10,990	12,190	13,390	14,590	15,790	16,990	18,380
$300,000 - 319,999	2,040	4,440	6,840	8,310	9,710	10,990	12,190	13,390	14,590	15,980	17,980	19,980
$320,000 - 364,999	2,040	4,440	6,840	8,310	9,710	11,280	13,280	15,280	17,280	19,280	21,280	23,280
$365,000 - 524,999	2,720	6,010	9,510	12,080	14,580	16,950	19,250	21,550	23,850	26,150	28,450	30,750
$525,000 and over	3,140	6,840	10,540	13,310	16,010	18,590	21,090	23,590	26,090	28,590	31,090	33,590

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	$240	$870	$1,020	$1,020	$1,020	$1,540	$1,870	$1,870	$1,870	$1,870	$1,910	$2,040
$10,000 - 19,999	870	1,680	1,830	1,830	2,350	3,350	3,680	3,680	3,680	3,720	3,920	4,050
$20,000 - 29,999	1,020	1,830	1,980	2,510	3,510	4,510	4,830	4,830	4,870	5,070	5,270	5,400
$30,000 - 39,999	1,020	1,830	2,510	3,510	4,510	5,510	5,830	5,870	6,070	6,270	6,470	6,600
$40,000 - 59,999	1,390	3,200	4,360	5,360	6,360	7,370	7,890	8,090	8,290	8,490	8,690	8,820
$60,000 - 79,999	1,870	3,680	4,830	5,840	7,040	8,240	8,770	8,970	9,170	9,370	9,570	9,700
$80,000 - 99,999	1,870	3,690	5,040	6,240	7,440	8,640	9,170	9,370	9,570	9,770	9,970	10,810
$100,000 - 124,999	2,040	4,050	5,400	6,600	7,800	9,000	9,530	9,730	10,180	11,180	12,180	13,120
$125,000 - 149,999	2,040	4,050	5,400	6,600	7,800	9,000	10,180	11,180	12,180	13,180	14,180	15,310
$150,000 - 174,999	2,040	4,050	5,400	6,860	8,860	10,860	12,180	13,180	14,230	15,530	16,830	18,060
$175,000 - 199,999	2,040	4,710	6,860	8,860	10,860	12,860	14,380	15,680	16,980	18,280	19,580	20,810
$200,000 - 249,999	2,720	5,610	8,060	10,360	12,660	14,960	16,590	17,890	19,190	20,490	21,790	23,020
$250,000 - 399,999	2,970	6,080	8,540	10,840	13,140	15,440	17,060	18,360	19,660	20,960	22,260	23,500
$400,000 - 449,999	2,970	6,080	8,540	10,840	13,140	15,440	17,060	18,360	19,660	20,960	22,260	23,500
$450,000 and over	3,140	6,450	9,110	11,610	14,110	16,610	18,430	19,930	21,430	22,930	24,430	25,870

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	$510	$850	$1,020	$1,020	$1,020	$1,020	$1,220	$1,870	$1,870	$1,870	$1,960
$10,000 - 19,999	510	1,510	2,020	2,220	2,220	2,220	2,420	3,420	4,070	4,070	4,160	4,360
$20,000 - 29,999	850	2,020	2,560	2,760	2,760	2,960	3,960	4,960	5,610	5,700	5,900	6,100
$30,000 - 39,999	1,020	2,220	2,760	2,960	3,160	4,160	5,160	6,160	6,900	7,100	7,300	7,500
$40,000 - 59,999	1,020	2,220	2,810	4,010	5,010	6,010	7,070	8,270	9,120	9,320	9,520	9,720
$60,000 - 79,999	1,070	3,270	4,810	6,010	7,070	8,270	9,470	10,670	11,520	11,720	11,920	12,120
$80,000 - 99,999	1,870	4,070	5,670	7,070	8,270	9,470	10,670	11,870	12,720	12,920	13,120	13,450
$100,000 - 124,999	2,020	4,420	6,160	7,560	8,760	9,960	11,160	12,360	13,210	13,880	14,880	15,880
$125,000 - 149,999	2,040	4,440	6,180	7,580	8,780	9,980	11,250	13,250	14,900	15,900	16,900	17,900
$150,000 - 174,999	2,040	4,440	6,180	7,580	9,250	11,250	13,250	15,250	16,900	18,030	19,330	20,630
$175,000 - 199,999	2,040	4,510	7,050	9,250	11,250	13,250	15,250	17,530	19,480	20,780	22,080	23,380
$200,000 - 249,999	2,720	5,920	8,620	11,120	13,420	15,720	18,020	20,320	22,270	23,570	24,870	26,170
$250,000 - 449,999	2,970	6,470	9,310	11,810	14,110	16,410	18,710	21,010	22,960	24,260	25,560	26,860
$450,000 and over	3,140	6,840	9,880	12,580	15,080	17,580	20,080	22,580	24,730	26,230	27,730	29,230

Form WH-4
State Form 48845
(R7 / 9-20)

State of Indiana
Employee's Withholding Exemption and County Status Certificate

This form is for the employer's records. Do not send this form to the Department of Revenue.
The completed form should be returned to your employer.

Full Name ____________________ Social Security Number or ITIN ____________________

Home Address ____________________ City ____________________ State ______ Zip Code ____________________

Indiana County of Residence as of January 1: ____________________ (See instructions)

Indiana County of Principal Employment as of January 1: ____________________ (See instructions)

How to Claim Your Withholding Exemptions

1. You are entitled to one exemption. If you wish to claim the exemption, enter "1" .... ________
   Nonresident aliens must skip lines 2 through 6. See instructions
2. If you are married and your spouse does not claim his/her exemption, you may claim it, enter "1" .... ________
3. You are allowed one (1) exemption for each dependent. Enter number claimed .... ________
4. Additional exemptions are allowed if: (a) you and/or your spouse are over the age of 65 and/or
   (b) if you and/or your spouse are legally blind.

   Check box(es) for additional exemptions: You are 65 or older ☐ or blind ☐ Spouse is 65 or older ☐ or blind ☐
   Enter the total number of boxes checked .... ________
5. Add lines 1, 2, 3, and 4. Enter the total here .... ► ☐
6. You are entitled to claim an additional exemption for each qualifying dependent (see instructions) .... ► ☐
7. Enter the amount of additional state withholding (if any) you want withheld each pay period .... $________
8. Enter the amount of additional county withholding (if any) you want withheld each pay period .... $________

   I hereby declare that to the best of my knowledge the above statements are true.

Signature: ____________________ Date: ____________________

Instructions for Completing Form WH-4

This form should be completed by all resident and nonresident employees having income subject to Indiana state and/or county income tax.

Print or type your full name, Social Security number or ITIN and home address. Enter your Indiana county of residence and county of principal employment as of January 1 of the current year. If you neither lived nor worked in Indiana on January 1 of the current year, enter 'not applicable' on the line(s). If you move to (or work in) another county after January 1, your county status will not change until the next calendar tax year.

Nonresident alien limitation. A nonresident alien is allowed to claim only one exemption for withholding tax purposes. If you are a nonresident alien, enter "1" on line 1, then skip to line 7. You are considered to be a nonresident alien if you are not a citizen of the United States and do not meet the green card test and the substantial presence test (get Publication 519 from www.irs.gov for information about these tests).

All other employees should complete lines 1 through 7.

Lines 1 & 2 - You are allowed to claim one exemption for yourself and one for your spouse (if he/she does not claim the exemption for him/herself). If a parent or legal guardian claims you on their federal tax return, you may still claim an exemption for yourself for Indiana purposes. You cannot claim more than the correct number of exemptions; however, you are permitted to claim a lesser number of exemptions if you wish additional withholding to be deducted.

Line 3 - Dependent Exemptions: You are allowed one exemption for each of your dependents based on state guidelines. To qualify as your dependent, a person must receive more than one-half of his/her support from you for the tax year and must have less than $4,300 gross income during the tax year (unless the person is your child and is under age 19 or under age 24 and a full-time student at least during 5 months of the tax year at a qualified educational institution).

Line 4 - Additional Exemptions. You are also allowed one exemption each for you and/or your spouse if either is 65 or older and/or blind.

Line 5 - Add the total of exemptions claimed on lines 1, 2, 3, and 4. Enter the total in the box provided.

Line 6 - Additional Dependent Exemptions. An additional exemption is allowed for certain dependent children that are included on line 3. The dependent child must be a son, stepson, daughter, stepdaughter, foster child, and/or child for whom you are a legal guardian.

Lines 7 & 8 - If you would like an additional amount to be withheld from your wages each pay period, enter the amount on the line provided. **NOTE:** An entry on this line does not obligate your employer to withhold the amount. You are still liable for any additional taxes due at the end of the tax year. If the employer does withhold the additional amount, it should be submitted along with the regular state and county tax withholding.

You may file a new Form WH-4 at any time if the number of exemptions **increases**. You must file a new Form WH-4 within 10 days if the number of exemptions previously claimed by you **decreases** for any of the following reasons:
(a) you divorce (or are legally separated from) your spouse for whom you have been claiming an exemption or your spouse claims him/herself on a separate Form WH-4; or
(b) someone else takes over the support of a dependent you claim or you no longer provide more than one-half of the person's support for the tax year.

Penalties are imposed for willingly supplying false information or information which would reduce the withholding exemption.