ENROLLMENT FORM FOR GROUP INSURANCE

Your employer provided information used to create this enrollment form.

Group ID:	Class:	Billing Division or Location:
MT00623	**AAFTE**	

Employee Information (Complete for ALL Enrollments)

Employer Name/Company Name:	Employer ZIP:	State:
West Carroll Health Systems, LLC	**71263**	**LA**

Employee First Name / Middle Initial / Last Name:	Social Security Number:	Date of Birth:

Street Address:	City:	State:	Zip:

Gender:	Phone:	Email Address:

Employee Work Information (Complete for ALL Enrollments)

Average Work Week Hours:	Occupation:	Earnings:	Full-Time Employment Date:

Product Selection (Complete for ALL Enrollments)

Class	Type of Coverage	Amount of coverage	Premium
All Active Full Time Employees	**Basic Life ☒Yes ☐No***	**$10,000**	**Employer Paid**

Product Selection (Complete for ALL Enrollments)

Type of Coverage	Selecting yes authorizes my employer to payroll deduct premium(s)	Amount of Coverage	Bi-Weekly Premium
Medical – West Carroll Health Systems Medical Provided By: Insurance Systems	☐**Yes** ☐**No***	☐**Employee Only** ☐**Employee and Spouse** ☐**Employee and Child(ren)** ☐**Employee/Spouse/Children**	**$65.97** **$344.24** **$277.42** **$610.20**
Voluntary Dental Provided By: Equitable	☐**Yes** ☐**No***	☐**Employee Only** ☐**Employee and Spouse** ☐**Employee and Child(ren)** ☐**Employee/Spouse/Children**	**$17.87** **$27.61** **$36.53** **$46.27**
Voluntary Vision Provided By: Equitable	☐**Yes** ☐**No***	☐**Employee Only** ☐**Employee and Spouse** ☐**Employee and Child(ren)** ☐**Employee/Spouse/Children**	**$3.04** **$6.09** **$6.51** **$10.41**
Voluntary Short-Term Disability 60% salary up to max $1,000 Provided By: Equitable	☐**Yes** ☐**No***	**Weekly Benefit:** ☐ **60% of salary**	**Age Rated**
Voluntary Long-Term Disability 60% salary up to max $6,000 Provided By: Equitable	☐**Yes** ☐**No***	**Monthly Benefit:** ☐ **60% of salary**	**Age Rated**

Voluntary Employee Life/AD&D Provided By: Equitable	☐ **Yes** ☐ **No*** **Guarantee Issue $250,000** **Age Reduction: 33% at age 70**	☐ **$20,000** ☐ **$50,000** ☐ **$80,000** ☐ **$100,000** ☐ **Other Amount _____**	**Age Rated**
Voluntary Spouse Life/AD&D Spouse amount **cannot** exceed 50% of the employees elected amount. *Rates and age deductions are based on Employee's Age Provided By: Equitable	☐ **Yes** ☐ **No*** **Guarantee Issue $150,000** **Age Reduction: 33% at age 70**	☐ **$10,000** ☐ **$25,000** ☐ **$40,000** ☐ **$50,000** ☐ **Other Amount _____**	**Age Rated – Employee Age**
Voluntary Child Life/AD&D *Children to age 26 Provided By: Equitable	☐ **Yes** ☐ **No***	☐ **$10,000**	**$0.60**

*By selecting no, application for coverage at a later date may require further medical information and/or a physical exam, which will be at my own expense

-- Actual deductions may vary slightly from above illustration due to rounding –

Dependent Information (Complete for Dependent Coverage)

	Last Name	First Name	Social Security Number	Gender	Date of Birth
Spouse:					
Children:					

Beneficiary Information (Complete for Basic Life/AD&D and Voluntary Life/AD&D Enrollments)

Primary Beneficiary's Last Name, First, MI:	Relationship of Beneficiary:	Phone Number:	
Street Address:	City:	State:	Zip:
Contingent Beneficiary's Last Name, First, MI:	Relationship of Beneficiary:	Phone Number:	
Street Address:	City:	State:	Zip:

Note: A Contingent Beneficiary will receive benefits only if the Primary Beneficiary does not survive you. If you wish to designate more than one Primary or Contingent Beneficiary, please attach a separate sheet of paper.

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Signature Section:

My signature below indicates that I have read the descriptive material provided and understand the options available to me. I have indicated my elections above and authorize my Employer to reduce my paycheck in an amount equivalent to the required contribution for the benefits I have elected. I understand that my payroll deduction amount will change if my coverage or costs change. I understand that the elections I have made will remain in effect for the entire Plan year and may be changed only at the annual enrollment period or within 31 days of a qualifying event or change in family status.

On behalf of myself and as agent of my spouse and all my named dependents, if any, I hereby authorize the release of any and all medical information and/or records in the possession of any health care provider, insurance company, or other person and/or company or its agents. The release shall continue to be in effect for the duration of my coverage and so long as necessary to determine benefits provided by the program. I represent that the information provided on this form is correct and complete to the best of my knowledge and that I have read and do hereby agree to the conditions of enrollment set forth above.

Employee Full Name: _____

Employee Signature: _____ **Date:** _____

WEST CARROLL HEALTH SYSTEM
EMPLOYEE BENEFITS ENROLLMENT FORM

A. Employee Information (Please Print)

Division:_____ Social Security Number:_____

Employee Name:_____

Address:_____

City: _____ State:_____ Zip:_____ Date of Birth:_____

☐ Male ☐ Female ☐ Married ☐ Single Home Phone:_____ Work Phone: _____

Date of Hire:_____ Benefits Eligibility Date:_____ Effective Date of Coverage:_____

B. Dependent Information (Complete for ALL Dependents Covered)

Dependent Name	Relationship	Social Security No.	Coverage	Sex	Date of Birth
Dependent Children are eligible for Medical until the end of the month in which they turn age 26. Spouse's that are eligible for coverage through their employer are not eligible for coverage under West Carroll Heath Systems' Medical Plan.					
	Spouse		☐ Medical		
	Child		☐ Medical		
	Child		☐ Medical		
	Child		☐ Medical		
	Child		☐ Medical		
	Child		☐ Medical		
	Child		☐ Medical		

C. Medicare Coverage Designation

Employees that cover dependents and become eligible for Medicare while enrolled may opt to disenroll from the health plan and enroll in Medicare. By signing below, the Employee verifies that he/she is Medicare eligible, and that his/her dependents are not eligible for any other coverage. The Employee also agrees to maintain coverage on his/her dependent(s) at the rate specified below.

Employee's Signature _____ Date _____

D. Premiums * (Bi-Weekly - 26 Pay Periods)

☐ **Employee Only $65.97** ☐ **Emp + Spouse $344.24** ☐ **Emp + Child(ren) $277.42** ☐ **Family $610.20**

I certify the above information to be true to the best of my knowledge and that the children for whom I am enrolling either reside with me in a parent-child relationship or are legally dependent on me for their support. I further understand that the Health Plan deductions will be deducted before taxes and will be in effect for the entire plan year and cannot be revoked except as permitted by federal law.

Signature _____ Date _____

Waiver of Group Health Benefits &
Notice of Special Enrollment Rights

I am waiving my employer's group health coverage due to:

- ○ My preference not to have coverage:
- ○ Coverage under my spouse's plan – name of carrier: _____
- ○ Other coverage – name of carrier:_____

This other coverage is:

- ○ Individual
- ○ COBRA
- ○ Medicare
- ○ TRICARE (formerly CHAMPUS)
- ○ Medicaid
- ○ Employer-Sponsored Group Plan

Special Enrollment Notice and Certification – *Please review and sign below if you wish to waive coverage.*

By signing below, I certify that I have been given an opportunity to apply for coverage for myself and my eligible dependents, if any. I am declining enrollment as indicated above. I understand that if I am declining enrollment for myself or my eligible dependents (including my spouse) because of other health insurance or group health plan coverage, I may be able to enroll myself and my eligible dependents in this plan if I lose, or my eligible dependents lose, eligibility for that other coverage (or if the employer stops contributing towards my or my eligible dependents' other coverage).

I understand that I must request enrollment no more than 30 days after the date the other health plan coverage ends (or after the employer stops contributing toward the other coverage). If I do not do so, I will not be able to enroll until my employer's next annual open enrollment period.

In addition, I understand that if I have an eligible dependent as a result of marriage, birth, adoption, or placement for adoption, I may be able to enroll myself and my eligible dependent(s). However, I must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

I understand that in order to request special enrollment or obtain more information, I should contact my group administrator.

Signature **Date**

TO: **West Carroll Parish Sheriff Dept.**
305 East Main Street
P.O. Box 744
Oak Grove, LA. 71263

FROM: **West Carroll Memorial Hospital**
REQUESTING NAME OF FACILITY/AGENT/ETC.

706 Ross Street, Oak Grove, LA. 71263
MAILING ADDRESS, CITY, STATE, ZIP

Amanda Grey, RHIT, CCS **318-428-3237**
Corporate Compliance Officer Facility Phone Number

RE: **Authorization to Disclose Criminal History Records Information**

As a new or prospective employee of the above facility or agency, I understand a thorough investigation of any record of past criminal activities will be conducted by the West Carroll Parish Sheriff Department.

By my signature below, I hereby authorize such an investigation and further authorize the West Carroll Parish Sheriff Department to release all criminal record information maintained in their files which may confirm or deny my eligibility for employment with the facility or agency named above.

APPLICANT'S FULL NAME(Printed)_____

APPLICANT'S SIGNATURE_____

APPLICANT'S SOCIAL SECURITY #_____**DATE OF BIRTH**_____

APPLICANT'S JOB TITLE_____

APPLICANT'S DRIVERS LICENSE # _____

RACE_____ **SEX**_____

DATE_____**WITNESS**_____

PLEASE CHECK ONE:

WORKING WITH CHILDREN: _____ HEALTH PROVIDER: _____ OTHER:_____

NOTE: THERE IS A $20 FEE FOR THIS SERVICE

*****Department Heads: Please give this sheet to Mandy Hibbard.

HEPATITIS B VIRUS VACCINE CONSENT/DECLINATION

BLOODBORNE PATHOGENS

I have been informed of the symptoms and modes of transmission of bloodborne pathogens including hepatitis B virus (HBV). I know about the facility's infection control program and understand the procedure to follow if any exposure incident occurs.

I understand that the hepatitis B vaccine is available, at no cost to employees whose jobs involve the risk of directly contacting blood or other potentially infectious materials. I understand that vaccinations shall be given according to recommendation for standard medical practice in the community.

HEPATITIS B VACCINE CONSENT

I consent to the administration of the hepatitis B vaccine. I have been informed of the method of administration, the risks, complications, and expected benefits of the vaccine. I understand that the facility is not responsible for any reactions caused by this vaccine.

X_____ _____/_____/_____
Signature of the Employee Date

_____
Print Employee's Name

HEPATITIS B VACCINE DECLINATION

Appendix A to Section 1910.1030

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

X_____ _____/_____/_____
Signature of the Employee Date

_____
Print Employee's Name

HBV VACCINATION RECORD

Employee______________________________ Social Security No. ________________________
(Print name & title)

Pre-Vaccine: Tested for HBV antibody? ☐No ☐Yes; Date____________ Results____________________

Post-Vaccine: Tested for HBV antibody? ☐No ☐Yes; Date____________ Results____________________

HBV VACCINATION: ____
(Manufacturer name, lot #, expiration date)

Administered by: ______________________________ Date: ________________

Adverse reaction? ☐No ☐Yes; Explain____________________________________

__________________________ __________________________ Date__________
Signature and Title of Person Completing Form Print Name and Title

---

HBV VACCINATION: ____
(Manufacturer name, lot #, expiration date)

Administered by: ______________________________ Date: ________________

Adverse reaction? ☐No ☐Yes; Explain____________________________________

__________________________ __________________________ Date__________
Signature and Title of Person Completing Form Print Name and Title

---

HBV VACCINATION: ____
(Manufacturer name, lot #, expiration date)

Administered by: ______________________________ Date: ________________

Adverse reaction? ☐No ☐Yes; Explain____________________________________

__________________________ __________________________ Date__________
Signature and Title of Person Completing Form Print Name and Title

---

*** HBV VACCINATION BOOSTER:** __________________________________
(Manufacturer name, lot #, expiration date)

Administered by: ______________________________ Date: ________________

Adverse reaction? ☐No ☐Yes; Explain____________________________________

__________________________ __________________________ Date__________
Signature and Title of Person Completing Form Print Name and Title

---

*** HBV VACCINATION:** ____
(Manufacturer name, lot #, expiration date)

Administered by: ______________________________ Date: ________________

Adverse reaction? ☐No ☐Yes; Explain____________________________________

__________________________ __________________________ Date__________
Signature and Title of Person Completing Form Print Name and Title

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* As stated in the OSHA Regulations published in the December 6, 1991 Federal Register 1910.1030 (f) (2) (v), if a routine booster dose(s) of hepatitis B vaccine is recommended by the U.S. Public Health Service <u>at a future date, such booster dose(s) shall be made available in accordance</u> with section (f) (l) (ii).

QUIZ

1.	True	False	Covered entities healthcare providers, health plans and healthcare clearinghouses.
2.	True	False	The HIPAA Privacy Rule is all about the use and disclosure of Protected Health Information.
3.	True	False	Protected Health Information includes any patient's data, whether or not it contains personal information.
4.	True	False	Incidental use and disclosure includes the normal, day-to-day operations of caregiving such as discussing a patient's care with other healthcare providers.
5.	True	False	The Minimum Necessary Rule does not apply to treatment.
6.	True	False	You are not permitted to keep a patient's chart at the bedside.
7.	True	False	PHI can be shared without permission or authorization if it is in the interest of public health and safety.
8.	True	False	A signed patient's authorization is not required for disclosure of psychotherapy notes about private counseling sessions.
9.	True	False	Authorization is required before using/disclosing PHI to encourage recipients to purchase a product or service.
10.	True	False	If you need to use PHI to inform family members or others involved in a patient's care, you do not need to get the patient's authorization first.
11.	True	False	Patients now have the right to request a history of when their PHI has been used for treatment.
12.	True	False	Patients can request restrictions on use and disclosure of their PHI.
13.	True	False	Patients are not permitted to access psychotherapy notes about private counseling sessions.
14.	True	False	With certain exceptions, parents are permitted to access their minor children's PHI.

15. True False A designated personal representative is allowed to exercise all the rights of the patient they represent.

16. True False Husbands and wives of patients are also permitted to access their spouses PHI.

17. True False You can inform relatives or friends who accompanied a patient to the ER – when they are incapacitated- about the patient's progress.

18. True False Patients may inspect their PHI as many times as they wish, without an explanation as to why.

19. True False Ensuring that your patients can exercise their privacy rights is your responsibility

20. True False When you do your job and exercise your professional judgement, you protect everyone's right to privacy.

ACKNOWLEDGMENT OF TRAINING

I have read and understand West Carroll Health Systems' *HIPAA Privacy Compliance Training Handbook.* I have also completed and passed the comprehensive quiz at the conclusion of the handbook.

Employee Date

PLEASE GIVE THE QUIZ TO CORPORATE COMPLIANCE OFFICER UPON COMPLETION.

Percent correct:_____

Additional training needed:_____

_____

_____

Privacy Officer:_____

R-1300 (4/11)

LDR
Contributing to a better quality of life

Employee Withholding Exemption Certificate (L-4)

Louisiana Department of Revenue

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

Instructions: Employees who are subject to state withholding should complete the personal allowances worksheet indicating the number of withholding personal exemptions in Block A and the number of dependency credits in Block B.

- Employees must file a new withholding exemption certificate within 10 days if the number of their exemptions decreases, except if the change is the result of the death of a spouse or a dependent.
- Employees may file a new certificate any time the number of their exemptions increases.
- Line 8 should be used to increase or decrease the tax withheld for each pay period. Decreases should be indicated as a negative amount.

Penalties will be imposed for willfully supplying false information or willful failure to supply information that would reduce the withholding exemption.

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

Note to Employer: Keep this certificate with your records. If you believe that an employee has improperly claimed too many exemptions or dependency credits, please forward a copy of the employee's signed L-4 form with an explanation as to why you believe that the employee improperly completed this form and any other supporting documentation. The information should be sent to the Louisiana Department of Revenue, Criminal Investigations Division, PO Box 2389, Baton Rouge, LA 70821-2389.

Block A

- Enter "0" to claim neither yourself nor your spouse, and check "*No exemptions or dependents claimed*" under number 3 below. You may enter "0" if you are married, and have a working spouse or more than one job to avoid having too little tax withheld.
- Enter "1" to claim yourself, and check "*Single*" under number 3 below. if you did not claim this exemption in connection with other employment, or if your spouse has not claimed your exemption. Enter "1" to claim one personal exemption if you will file as head of household, and check "Single" under number 3 below.
- Enter "2" to claim yourself and your spouse, and check "Married" under number 3 below.

A.

Block B

- Enter the number of dependents, not including yourself or your spouse, whom you will claim on your tax return. If no dependents are claimed, enter "0."

B.

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

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

Employee's Withholding Allowance Certificate

1. Type or print first name and middle initial	Last name
2. Social Security Number	**3.** Select one ☐ No exemptions or dependents claimed ☐ Single ☐ Married

4. Home address (number and street or rural route)

5. City	State	ZIP

6. Total number of exemptions claimed in Block A	**6.**
7. Total number of dependents claimed in Block B	**7.**
8. Increase or decrease in the amount to be withheld each pay period. Decreases should be indicated as a negative amount.	**8.**

I declare under the penalties imposed for filing false reports that the number of exemptions and dependency credits claimed on this certificate do not exceed the number to which I am entitled.

Employee's signature	Date

The following is to be completed by employer.

9. Employer's name and address	**10.** Employer's state withholding account number

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

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

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

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

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

EMPLOYEE WARNING

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

Employee Signature: _____ Date: _____

Employer Representative Signature: _____ Date: _____

Employer Name: _____

Employee Name: _____

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

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

Home Address: _____

Telephone Number: (____) _____

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

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

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

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

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

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

Y N

☐ ☐ Spinal Disc Surgery Year (approximate if unsure)_____

☐ ☐ Spinal Fusion Surgery Year (approximate if unsure)_____

☐ ☐ Amputated Foot Left ☐ Right ☐ Year (approx. if unsure) _____

☐ ☐ Amputated Leg Left ☐ Right ☐ Year (approx. if unsure) _____

☐ ☐ Amputated Arm Left ☐ Right ☐ Year (approx. if unsure) _____

☐ ☐ Amputated Hand Left ☐ Right ☐ Year (approx. if unsure) _____

☐ ☐ Knee Replacement Left ☐ Right ☐ Year (approx. if unsure) _____

☐ ☐ Hip Replacement Left ☐ Right ☐ Year (approx. if unsure) _____

☐ ☐ Other Joint Replacement Joint _____ Year _____

☐ ☐ Other Surgical Procedure Procedure _____ Year _____

☐ ☐ Other Surgical Procedure Procedure _____ Year _____

☐ ☐ Other Surgical Procedure Procedure _____ Year _____

☐ ☐ Other Surgical Procedure Procedure _____ Year _____

Employee Signature:_____ Date: _____

Employer Representative: _____ Date: _____

EXPLANATION PAGE

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

CONDITION:____ Year Diagnosed (approx):________________

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

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

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

Brief Explanation: ____

CONDITION:____ Year Diagnosed (approx):________________

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

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

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

Brief Explanation: ____

CONDITION:____ Year Diagnosed (approx):________________

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

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

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

Brief Explanation: ____

CONDITION:____ Year Diagnosed (approx):________________

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

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

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

Brief Explanation: ____

Employee Signature:____ Date: ____________________________

Employer Representative: _______________________________________ Date: ____________________________

Please answer the following questions.

1. Has any doctor ever restricted your activities? Yes ☐ No ☐
   If "Yes," please list the restrictions: _____
   Were the restrictions: Permanent ____ Temporary ____
   Are your activities currently restricted? Yes ☐ No ☐
   What is the medical condition for which you have restrictions? _____

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

   Please list the medical condition being treated: _____

   Doctor's Name: _____Specialty: _____

   Doctor's Address: _____

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

   Medication: _____Prescribing Doctor: _____

   Medication: _____Prescribing Doctor: _____

4. Have you ever had an on the job accident? Yes ☐ No ☐
   If you answered "YES," please provide the date for each injury and the nature of the injury:

   _____

   How long were you on compensation? _____

   Name of Employer: _____

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

   Recommended surgery: _____

   Approximate date of recommendation: _____

   Doctor's Name: _____Specialty: _____

   Doctor's Address: _____

Employee Signature: _____ Date: _____

Employer Representative: _____ Date: _____

TO BE COMPLETED BY EMPLOYEE

EMPLOYEE WARNING

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

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

Employee Signature:_____ Date: _____

Employee Printed Name: _____

TO BE COMPLETED BY EMPLOYER REPRESENTATIVE

EMPLOYER WARNING

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

You must certify the following:

1. That I am an authorized representative of the employer designated to obtain and review the information provided by the employee on this questionnaire;

2. That I have provided the employee with as many copies of the Explanation Page as needed and have confirmed the number of and labeled the pages of this questionnaire;

3. That I have provided assistance to the employee (if requested) in responding to the questions on this questionnaire;

4. That the information sought by this authorization is made on an applicant for employment only after a conditional job offer has been made and accepted, or on a current employee; and

5. That the information obtained in the authorization will **NOT** be used to discriminate in any manner against the individual who is the subject of this authorization on any basis, in violation of the Americans with Disabilities Act of 1990, 42 U.S.C. §12101, *et seq*., or any other state or federal law;

6. That if requested, a photocopy of this fully completed and signed form will be provided to the employee.

Employer Representative Signature:_____ Date: _____

Employer Representative Printed Name: _____

Title: _____

LICENSURE VERIFICATION

This hereby certifies that I have personally inspected the license of the person listed below and attest to the validity and currency of the license.

Employee:_____ License Number:_____

Inspector:_____ Date of Inspection:_____

CUMULATIVE SANCTIONS REPORT

This hereby certifies that I have examined the Cumulative Sanctions Report and found no listing on the below named employee.

Employee:_____

Inspector:_____ Date of Inspection:_____

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		**Does your name match the name on your social security card?** If not, to ensure you get credit for your earnings, contact SSA at 800-772-1213 or go to *www.ssa.gov*.
City or town, state, and ZIP code		

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

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

PAYROLL NOTICE

NEW EMPLOYEES

Employee's Full Name:	Effective Date:
Address:	Job Description:

Social Security No. :	Department:
Paid Per: ☐Hour ☐Salary	Rate:
FTE Budget:	Adm. Approval:
Employment Status:	Marital Status:
Federal W/H:	Sex:
State W/H:	Date of Birth:
Telephone:	Race:
☐Benefit Pkg. ☐No-Benefit Pkg.	☐ Healthland ☐ Clinicals
☐Phone ☐Copier	☐ Scheduler
Comments:	

CHANGE IN CURRENT EMPLOYEE STATUS

Employee:	Dept:	Effective Date:

Please change the following:	
OLD	**NEW**
Name:	
Address:	
Department:	
Rate of Pay:	

WEST CARROLL HEALTH SYSTEMS

EMPLOYEE: _____

I release West Carroll Health Systems from any liability connected with the administration and results of my TB skin test.

_____

Employee Signature Date

_____

_____

TB Skin Test Negative _____
Positive _____

I have read the results of the TB skin test administered to the above employee

_____

Signature Date

NS-15-20

PRE-EMPLOYMENT DRUG SCREEN

Name:_____ Dept:_____

Department Head:_____

The above named employee has completed their pre-employment drug screen.

Lab Tech:_____ Date:_____

- -

IDENTIFICATION BADGE

(*circle one*) NEW EMPLOYEE RETAKE (*collect $5.00*)

Name (print):_____

Department:_____

Job Title:_____

Hire Date:_____

Return to Brittany in HIM

Employment Eligibility Verification

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

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

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

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

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

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

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

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

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

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

☐ 1. A citizen of the United States

☐ 2. A noncitizen national of the United States *(See instructions)*

☐ 3. A lawful permanent resident (Alien Registration Number/USCIS Number): _____

☐ 4. An alien authorized to work until (expiration date, if applicable, mm/dd/yyyy): _____
Some aliens may write "N/A" in the expiration date field. *(See instructions)*

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

1. Alien Registration Number/USCIS Number: _____

OR

2. Form I-94 Admission Number: _____

OR

3. Foreign Passport Number: _____

Country of Issuance: _____

QR Code - Section 1
Do Not Write In This Space

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

Preparer and/or Translator Certification (check one):

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

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

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

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

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

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

STOP *Employer Completes Next Page* STOP

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 report of birth issued by the Department of State (Forms DS-1350, FS-545, FS-240)
3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa		**3.** School ID card with a photograph		**3.** Original or certified copy of birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal
4. Employment Authorization Document that contains a photograph (Form I-766)		**4.** Voter's registration card		**4.** Native American tribal document
5. For 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 **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		**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
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		**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		

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

Refer to the instructions for more information about acceptable receipts.

ACKNOWLEDGMENT

Initials

_____ I hereby acknowledge that I have read the Employee Standards and Code of Conduct as part of my in-service education on Corporate Compliance. I have access to the Employee Standards and Code of Conduct as a personal reference. I have received training in the False Claims Act as well as received a copy of the written policy. I was given opportunity to ask questions and receive clarification.

_____ I have read and been given instructions to access the following manuals online. I was given opportunity to ask any questions and receive clarifications on any areas that were not understood. I agree that it is my responsibility to familiarize myself with all the policies and procedures found in these documents. I agree to ask my supervisor any time I have questions. Lack of understanding regarding policies and procedures will not excuse noncompliance.

Personal Manual
HIPAA Training
Fire Plan
Violence Program Manual
EMTALA Training

_____ I hereby acknowledge that I have been inserviced on sexual harassment and the sexual harassment policy of West Carroll Health Systems. I understand what sexual harassment is and the consequences of such. I understand that I am to report any sexual harassment to my department head immediately. I was given an opportunity to ask any questions I may have had on sexual harassment and the policy.

_____ I hereby acknowledge that I have been instructed on where to park and other specific policies regarding cell phone usage, social media regarding the workplace, breaks, and professional conduct. I have been given the opportunity to ask any questions or clarification on any policies and procedures. I understand the chain-of-command, including who to ask with any questions or guidance I may need.

_____ _____

Employee Date Supervisor Date

WEST CARROLL HEALTH SYSTEMS
COVID-19 Vaccination Status Self-reporting Form

This form is to be used to self-report COVID-19 vaccination status. You may decline to disclose your vaccination status. However, if you choose to disclose your status, that information must be accurate. WCHS may request additional information to verify the information reported on this form, as needed.

Please provide no further information than what is directly asked of you below. Do not submit any additional medical or family history information in response to any question on the form.

Please reach out to your department head with any questions related to this form or COVID-19 vaccination policies.

Employee Name *(Printed)*	Job Title/Department

Please check one of the following and complete any additional follow-up fields:

☐ I am fully vaccinated (attach copy of card)

_____ | ___ /___ /_____ and ___ /___ /_____

Vaccine manufacturer *(e.g., Pfizer-BioNTech, Moderna or Johnson & Johnson)*

Dates of vaccination *(MM/DD/YYYY)*

☐ I am partially vaccinated *(i.e., received only one dose of a two-shot regimen),* **and** …

〉 *Circle one*:

I (**do** | **don't**) intend to receive my final vaccine dose.

☐ I am currently unvaccinated.

☐ I have a medical exemption.

☐ I have a religious exemption.

☐ I do not wish to disclose my vaccination status.

I attest that the above information is accurate and truthful.

Employee Signature	**Date**

West Carroll Health Systems

706 Ross Street
Oak Grove, LA 71263
318.428.3237
www.wchsystems.com

West Carroll Health System Employee Health Benefits

Employee & Eligible Dependents with WCHS Vantage Health Plan or any other medical insurance coverage:

- Employees and eligible dependents listed on your Vantage Health Plan or other commercial insurance card will not be required to pay a co-pay or deductible as applicable for medical services provided by West Carroll Health Systems.
- You must also present your WCHS Self Insurance card along with your Vantage Health Plan card or other commercial insurance card at the time of service in order for deductibles and copays to be waived.

Employees & Eligible Dependents with WCHS Employee Self-Insurance coverage only:

- Eligible employees and or eligible dependents may receive healthcare services provided by West Carroll Health Systems as a benefit at no cost to the employee.
- To receive this benefit the employee or dependent must present their West Carroll Health Systems Self Insurance card at each visit or time of service. Dependent coverage will be only for eligible dependents listed on the benefit card.
- To receive the West Carroll Health Systems Self Insurance benefit card for your spouse or dependents you must complete the application form and provide a copy of your most recent income tax filed. Only dependents claimed on your tax form will be eligible to be listed on your benefit card to receive services.
- Part time employees may apply for free care services directly with any WCHS Rural Health Clinic by completing the application form, and providing required documentation.

Eligible Employee:
Full time working a minimum of 30 hours per week

Eligible Spouse or Dependent:
Individuals listed as dependent on tax return

West Carroll Health Systems

706 Ross Street
Oak Grove, LA 71263
318.428.3237
www.wchsystems.com

West Carroll Health Systems Employee Self Insurance Benefit Card Application

To be eligible for the West Carroll Health Systems Employee Self Insured card you must complete and return this application with a copy of your most recent filed tax return. You may mark over income information.

Only fulltime employees, eligible spouse, and dependents listed on your tax return are eligible to receive the West Carroll Health Systems Benefit Card.

Employee: _____

Department: _____

Please check yes or no if your spouse or dependents are covered under any other health insurance including Medicare or Medicaid.

Legal Spouse: _____ Yes ____ No ____

Dependents: _____ Yes ____ No ____

_____ Yes ____ No ____

_____ Yes ____ No ____

_____ Yes ____ No ____

_____ Yes ____ No ____

Please list and additional Insurance coverage you may have:

_____

I hereby certify the persons listed above are my legal spouse and dependents and all other information I have provided is true and correct.

_____ _____

Employee Date

_____

Administrative Approval

3.21.2016

West Carroll Care Center

Emp Name- _____

Email Address (Personal)- _____

Make sure address is readable

Home Phone- _____

Cell Phone- _____

Complete and return to Supervisor

West Carroll Health Systems

Emp Name- _____

Email Address (Personal)- _____

Make sure address is readable

Home Phone- _____

Cell Phone- _____

Complete and return to Supervisor

WEST CARROLL HEALTH SYSTEM

DIRECT DEPOSIT AUTHORIZATION — One Account

I (we) hereby authorize West Carroll Health Systems, hereinafter called "COMPANY", to initiate credit entries and, if necessary, debit correction and adjustment entries to my (our) account at the financial institution listed below, hereinafter called DEPOSITORY. I (we) acknowledge that the origination of ACH transactions to my (our) account must comply with the provisions of U.S. laws and regulations.

Depository Name _____ Branch _____

Address _____ City _____ State _____ Zip _____

Routing & Transit Number _____ Account Number _____

Account Type: □ Checking/Draft

This authorization is to remain in full force and effect until COMPANY has received written notification from me (or either of us) of its termination in such a time and manner as to afford COMPANY and DEPOSITORY a reasonable time to act upon it.

Name(s) _____ SS Number _____
(Please Print)

Date _____ Signature(s) _____

Please attach a voided check or financial institution account verification letter to this form. Check or verification letter must have your name preprinted on form.

Note: Written credit authorization must provide that the receiver may revoke the authorization only by notifying the orginator in the manner specified in the authorization.

Direct Deposit

West Carroll Home Care

Emp Name- _____

Email Address (Personal)- _____

Make sure address is readable

Home Phone- _____

Cell Phone- _____

Complete and return to Supervisor

WEST CARROLL HOME CARE

DIRECT DEPOSIT AUTHORIZATION — One Account

I (we) hereby authorize West Carroll Health Systems, hereinafter called "COMPANY", to initiate credit entries and, if necessary, debit correction and adjustment entries to my (our) account at the financial institution listed below, hereinafter called DEPOSITORY. I (we) acknowledge that the origination of ACH transactions to my (our) account must comply with the provisions of U.S. laws and regulations.

Depository Name _____ Branch _____

Address _____ City _____ State _____ Zip _____

Routing & Transit Number _____ Account Number _____

Account Type: □ Checking/Draft

This authorization is to remain in full force and effect until COMPANY has received written notification from me (or either of us) of its termination in such a time and manner as to afford COMPANY and DEPOSITORY a reasonable time to act upon it.

Name(s) _____ SS Number _____
(Please Print)

Date _____ Signature(s) _____

Please attach a voided check or financial institution account verification letter to this form. Check or verification letter must have your name preprinted on form.

Note: Written credit authorization must provide that the receiver may revoke the authorization only by notifying the orginator in the manner specified in the authorization.

Direct Deposit

WEST CARROLL CARE CENTER

DIRECT DEPOSIT AUTHORIZATION — One Account

I (we) hereby authorize West Carroll Health Systems, hereinafter called "COMPANY", to initiate credit entries and, if necessary, debit correction and adjustment entries to my (our) account at the financial institution listed below, hereinafter called DEPOSITORY. I (we) acknowledge that the origination of ACH transactions to my (our) account must comply with the provisions of U.S. laws and regulations.

Depository Name _____ Branch _____

Address _____ City _____ State _____ Zip _____

Routing & Transit Number _____ Account Number _____

Account Type: □ Checking/Draft

This authorization is to remain in full force and effect until COMPANY has received written notification from me (or either of us) of its termination in such a time and manner as to afford COMPANY and DEPOSITORY a reasonable time to act upon it.

Name(s) _____ SS Number _____
(Please Print)

Date _____ Signature(s) _____

Please attach a voided check or financial institution account verification letter to this form. Check or verification letter must have your name preprinted on form.

Note: Written credit authorization must provide that the receiver may revoke the authorization only by notifying the orginator in the manner specified in the authorization.

Direct Deposit

EMPLOYEE FACT SHEET

Welcome to West Carroll Health Systems! We are pleased that you have chosen to join our team. Please do not hesitate to ask your Department Head about any areas of concern. Listed below are a few basic rules. For more in-depth information, please refer to the Personnel Manual.

PARKING Employees may park in any space that is not designated **Guest Parking**. There is ample employee parking. Available spaces include the concrete lot next to the baseball field, lot behind Central Billing, lot behind the old EMS building, and the lot on Gaddis Street across from the Central Billing parking lot.

CHECK STUBS It is the employee's responsibility to keep check stubs for verification of wages. The Payroll Department does not verify wages for employees.

LUNCH AND BREAKS The lunch or dinner break, depending on your shift, is 30 minutes. There are two 15-minute breaks allowed during each shift. The breaks **cannot** be combined, nor can they be combined with the lunch/dinner break. Any employee that works more than 5 ½ hours on a shift is required to take a lunch/dinner break.

SMOKING AREA For health reasons, employees are strongly encouraged not to smoke. However, there is a covered designated employee smoking area located in the Maintenance Building/Central Supply parking lot. No employee shall be allowed to smoke in any other area, regardless of their shift. Employees may smoke only during their designated breaks and must let their supervisor know when they are taking a break.

CONFIDENTIALITY All information regarding patients, physicians, family members, staff, etc. is strictly confidential. Any breech of this standard may result in immediate termination.

INSERVICE Periodic inservices are held to offer continuing education to employees. These inservices are mandatory. If an employee misses an inservice, the employee will be given a written notice of the infraction. If an employee receives three notices, the employee may be terminated. Attendance to inservice education is considered when evaluating employees.

CHAIN OF COMMAND Each employee works in a department. That department has a department head. If an employee has a problem, questions, complaint, suggestion, etc., they are to go to their department head. If after speaking to the department head without resolution or satisfaction, the employee may ask to speak to the COO.

MEDICAL RECORDS If an employee leaves employment at West Carroll Health Systems for any reason, the employee has the right to obtain a copy of the employee health record from the Health Information Management department.

PLEASE GIVE THIS FACT SHEET TO THE EMPLOYEE TO KEEP