Resource Management Systems, Inc.
P. O. Box 113
Georgetown, Georgia 39854
Phone: (229) 732-2291 Fax: (229) 732-~~2346~~
229 732-2342

Qualified Drivers: Needed for local community transit system startup. Applications may be picked up from the Ben Hill County Commissioners office at 402A E. Pine St., Fitzgerald, Ga. 31750. Return applications to the Ben Hill County Commissioners office along with a copy of a valid driver's license, social security card and a clean 7-year motor vehicle report. A clean driving record is required. A CDL is not necessary. EOE. Drug testing is a condition of employment.

Please scan and forward your completed application and release form to:

MICHAEL ERWIN

sterwin321
~~jmerwin~~@gmail.com

IF YOU HAVE ANY QUESTIONS, COMMENTS, AND/OR CONCERNS REGARDING THE APPLICATION AND/OR RELEASE FORM, PLEASE CONTACT:

RESOURCE MANAGEMENT SYSTEMS, INC.

229.732.2291 (OFFICE)

229-732.2346 (~~FAX~~ office)

229.732.2342 (fax)

EMPLOYMENT RECORD SERVICE
TRUST BUT VERIFY

AUTHORITY TO RELEASE INFORMATION

To: Any person having knowledge of my conduct or activities, or any past, present or future Employer, Credit Bureau, Bank, Financial Institution, Dean, Registrar, Principal, Counselor, Instructor, or School, Doctor, Hospital, Clinic or Medical Facility, Law Enforcement Agency, Government Agency or Armed Forces:

Employment Record Service LLC has been engaged, to conduct an appropriate background investigation of me and prepare a consumer report or investigative consumer report which may be used as a factor in determining my eligibility for employment, promotion or retention as governed by the Fair Credit Reporting Act (FCRA) Public Law 91-508.

I understand this report may include information from personal interviews about my character, general reputation, personal characteristics and mode of living as well as both public and private sources including but not limited to information contained in federal, state and local records, public and private databases and repositories, criminal records, my credit report, employment records, school records, driving records or abstracts, licensing boards and registries, etc. I understand I may be entitled to certain disclosures and have been given a copy of "A Summary of Your Rights Under the FCRA", a document prescribed by the Federal Trade Commission.

I hereby authorize all persons who may have information relevant to this investigation to disclose it to Employment Record Service LLC or their agents, and I release all persons from any liability on account of such disclosure. I hereby further authorize that a photocopy of this authorization may be considered as valid as an original.

Signature: _____ Date: _____

Furnished for the purpose of positive identification: (Print Clearly)

First: _____ MI: _____ Last: _____

Address: _____

City: _____ State: _____ Zip: _____

A.K.A. (include maiden name): _____

SSN: _____-_____-_____ DOB: _____/_____/_____

Driver License#: _____ State: _____

Address History (Past 7 Years)

_____

_____

_____

Notice to California, Minnesota and Oklahoma Residents

Under California, Minnesota and Oklahoma law, you have a right to receive a free copy of your consumer report by checking the appropriate box below.

Under California law, any consumer reports order on you for employment purposes within the State of California are defined as investigative consumer reports. These reports may contain information on your character, general reputation, personal characteristics and mode of living.

Under section 1786.22 of the California Civil Code, you may view the file maintained on you by during normal business hours. You may also obtain a copy of this file upon submitting proper identification and paying the costs of duplication services, by appearing at Pinpoint America in person, by mail, or by telephone. Pinpoint America has trained personnel available to explain your file to you and as well as any coded information appearing in your file. If you appear in person, a person of your choice may accompany you, provided that this person furnishes proper identification.

Employment Record Service LLC
PO Box 11188 Fairfield, NJ 07004
800 775 2956

☐ California applicants only I request to receive a free copy of any investigative consumer report ordered on me by checking this box.
☐ Minnesota Applicants Only: I request a copy of any consumer report requested on me.
☐ Oklahoma Applicants Only: I request a copy of any *credit* report requested on me.

Employment Record Service LLC

Important Notices to All Applicants

- Resource Management Systems, Inc. is an Equal Opportunity Employer and adheres to a policy of making employment decisions without regard to race, sex, color, age, religion, national origin, disability, or marital status.
- Resource Management Systems, Inc. complies with Americans with Disabilities Act of 1990 (ADA). During the interview process, you may be asked questions concerning your ability to perform essential job-related functions.
- Resumes are not accepted in lieu of completing this application so, please answer all questions completely. This application will only be valid for a period of ninety (90) days. If you wish to be considered for employment beyond ninety (90) days, you must reapply at our main office.
- I certify that the answers I have given are true and complete t the best of my knowledge. I authorize the investigation of all matters contained in this application and hereby give the Employer permission to contact schools, previous employers, references, and others (unless designated "DO NOT CONTACT"). And hereby give my permission to schools, previous employers, references, and others to release all applicable information to the Employer and release the Employer and schools, previous employers, references, and others from any liability as a result of such contact or information.
- I agree that if I am subjected to any of discrimination including sex, race, religion, national origin, disability, or marital status, or if I am subjected to any type of harassment, including sexual harassment, at any time during my employment or during the employment process. I will immediately contact the President of Resource Management Systems, Inc. to obtain assistance in resolving these matters.
- I understand that, if employed, my employment with the Employer is for no specific term and may be terminated "at-will" by me or the Employer at any time, with or without cause or notice. I further understand that no oral promise, Employer policy, custom, business practice, or other procedure (including the Employer's employee handbook" or any personnel manual) constitutes an employment contract or modification of the "at-will" employment relationship between me and the Employer.
- The contents of any employee handbooks or manuals, as well as other Employer policies and practices, are subject to change or modification by the Employer, solely at its discretion, without notice. I also understand that no supervisor or other official of the Employer (except its President in writing) has the authority to enter into any agreement with me or to make any agreement contrary to the foregoing.

- I understand that there is a possibility of conflict with respect to the application of the Workers Compensation Laws because my employment is entered into in Georgia and all or some portion of my work may be performed in different states. Therefore, if employed, I agree to be bound by the Workers' Compensation Laws of the State of Georgia and will only be entitled to Georgia Compensation benefits regardless of where the injury occurred or where the disease was contracted. I also agree that, if employed, the State of Georgia shall be the exclusive remedy against the employer on account of injury, disease or death in the course of and arising out of employment.
- We conduct our business with the highest degree of safety and efficiency and promote a "Drug-Free" workplace. You are required to submit to pre-employment drug and alcohol screening and random drug and alcohol screening for all safety sensitive positions.
- I certify that I have not tested positive, or refused to test, on a pre-employment drug or alcohol test administered by an employer to which I applied for, and did not obtain a safety-sensitive transportation job covered by DOT agency drug and alcohol testing rules during the past two years.
- I understand that my signature below means I understand and accept all the above conditions.

Applicant Signature _____

Date Signed _____

Post-Employment Offer Medical Questionnaire

This form will not become part of your personnel file and will remain confidential

The Georgia Subsequent Injury Trust Fund protects employers from excess liability for workers compensation when an injury to a worker merges with a preexisting impairment to cause a greater liability than would have resulted from the subsequent injury alone. In order to qualify for this protection, we must have prior knowledge of any pre-existing illness or other ailment/injury you may have sustained in the past that may contribute to a percentage of permanent impairment. The presence of one or more impairment does not automatically render you unfit as an employee. All decisions will be made on job-related criteria. If appropriate, a reasonable accommodation may be made provided it does not pose an undue hardship upon the company making the conditional job offer.

Name: _____ Client:_____ Soc. Sec. #:_____

If there are any questions or statement on this form that you do not understand, ask for assistance from the person interviewing you.

Yes	No	Asthma	Yes	No	Hay Fever
Yes	No	Migraine Headaches	Yes	No	Diabetes
Yes	No	Head Injuries	Yes	No	Color Blindness
Yes	No	Fear of Heights	Yes	No	Amputated foot, leg, arm, hand
Yes	No	Heart Trouble	Yes	No	Loss of sight of one or both eyes
Yes	No	Fainting spells or Dizziness	Yes	No	Cerebral Palsy
Yes	No	Swelling of the Legs or Ankles	Yes	No	Multiple Sclerosis
Yes	No	Skin rashes or Eczema	Yes	No	Parkinson's Disease
Yes	No	Joint Pain or Arthritis	Yes	No	Cardiovascular Disorder
Yes	No	Epilepsy	Yes	No	Tuberculosis
Yes	No	Cancer	Yes	No	Mental Retardation

Yes No Varicose Veins

Yes No Sickle Cell Anemia

Yes No Tendonitis

Yes No Hemophilia

Yes No Chronic Infection of bone

Yes No Muscular Dystrophy

Yes No Repetitive Motion Disorder

Yes No Ruptured Disc or any disc injury

Yes No Stiffness of major wt bearing joints

Yes No Nervous trouble or treatment

Yes No Kidney Problems

Yes No Depression

Yes No Knee Problems

Yes No Hypoglycemia

Yes No Pulmonary Disease

Yes No Compressed air sequel (damage to lungs, ruptured ear drum, due to explosion, air concussion, etc.)

Yes No Ankylosis (immobility) of major weight bearing joints (ankles, knees, hips)

Yes No Do you have partial loss of hearing?

Yes No Have you ever had an audiogram (hearing test)? If yes results_____

Yes No Do you need glasses to read or for distance?

Yes No Any serious wrist problems including Carpal Tunnel Syndrome?

Yes No Any broken bones? If so which ones and when:_____

Yes No High blood pressure? If yes, do you take medication? _____

Yes No Any serious injuries? Month _____ Year _____ Nature_____

Yes No A hernia or rupture? Month _____ Year _____

Yes No Any neck pain or neck problems? Month _____ Year _____

Yes No Back Injuries? Month _____ Year _____

Yes No Surgery? Month _____ Year _____

Yes No Ever refused surgery? If yes, why? _____

Yes No Any allergic reaction to any drugs? Which drugs? _____

Yes No Partial loss of uncorrected vision of more than 75% bilaterally?_____

Yes No Psychoneurotic disability following confinement for treatment in a recognized medical or mental institution for a period in excess of six months?

Yes No Any permanent condition that constitutes 20% impairment of a leg, hand, arm, or the body as a whole?

Yes No Do you now or have you in the past participated in recreational drug use?

Yes No Have you ever participated in a drug abuse treatment program? Where? _____

Yes No Do you currently take any prescription medications? If so, what? _____

Yes No Do you have any condition or have you sustained any injury that would have an effect on your ability to perform the duties of this position without reasonable accommodations?

Yes No Have you ever been hurt on the job or filed a worker's compensation claim in the past? If yes, how many times? _____ Years _____? Estimate the numbers of workdays you have lost in the past two years. _____ Please list the names of any Doctors you have seen during the past two years. List family Dr. first. _____Please provide pertinent facts to every previous ailment or injury contributing to impairment, as well as all previous workers compensation claims in the space provided below.

Yes No Have you ever been treated for back pain?

Yes No Have you ever been treated for neck pain?

Yes No Have you ever been treated for hand pain?

Yes No Have you ever been treated for mental conditions?

Yes No Have you ever been refused employment or unable to hold a job because of sensitivity to dust?

Yes No Have you ever been refused employment or unable to hold a job because of inability to assume certain positions?

Yes No Have you ever been refused employment or unable to hold a job because of inability to perform certain motions?

Yes No Have you ever refused employment or unable to hold a job because of other medical reasons? If yes, list why._____

_____

_____Our workers compensation insurance carrier checks for previous claims by name and social security. If you had a previous claim or injury and failed to make us aware of it, you may legally be denied in events of new injury by operation of landmark Rycroft ruling.

_____

_____I certify that all information I have provided is true, accurate and complete in all respects. I understand if any information is found to be false, misleading or incomplete in any respect, I will be subject to immediate dismissal.

_____

Employee Signature: _____ Date: _____

RECEIPT OF SAFETY AND WORKERS' COMPENSATION INFORMATION

This company is committed to safety and has developed the following policies, procedures, and rules in an effort to promote a safe workplace and safe working habits. Please read the following safety procedures carefully, you are required to observe them at all times.

- This company strives to operate and maintain a drug free workplace.
- Report any job accident or "near miss" to your supervisor and to Resource Management Systems, Inc. immediately after the accident occurs.
- Lockout, tag and try procedures must be used, before beginning machinery maintenance or repair.
- The use of seatbelts is required at all times while driving on company business.
- Do not remove or bypass any guard or safety device on any machinery.
- Use proper Material Handling/Lifting Techniques. (lift with your legs not your back)
- Advise your supervisor immediately of any unsafe act or hazardous conditions.

I understand that no workers' compensation benefits will be paid for the following:

- Injuries, disease or sickness not sustained in the curse or scope of employment.
- Injuries caused by the employee willful misconduct or intentional self-injury.
- Injuries caused by the employee willful breach of a posted Safety Rule or Procedure.
- Injuries as a result o fan employee intoxication or illegal drug usage.
- Injuries occurring during an employee participation in recreational activity.
- An injury caused by a condition in which the employee lied in order to obtain employment.

- Complications of or for an injury in which the employee refused to undergo treatment or refused follow-up treatment.

Employee Acknowledgements

_____I understand that Resource Managements System, Inc. utilizes a Managed Care Organization to treat my work-related injuries. If I am involved in an "on the job" injury, I must accept the services of a Managed Care Provider from Resource Management Systems, Inc. posted "Panel of Physicians" and I have received instructions as to where the Physicians Panel and employee Bill of Rights are posted. If I am dissatisfied with the physicians selected, I can make one (1) change to a second physician that is also listed on the panel. Any further changes required the permission of Resource Management Systems, Inc. and the State Board of Workers' Compensation. I also understand that receiving services from a physician not listed on the Panel or failing to personally notify Resource Management Systems, Inc. of an injury may result in denial of payment for medical services as well as lost wages. In accordance with Georgia Law, lost wage benefits are not payable for the first seven (7) days of disability.

This company is firmly committed to providing modified or "light-duty" jobs to those workers suffering from related injuries. Refusal of "light-duty" assignments will result in immediate suspension and/or denial of benefits, as well as termination of employment.

Employee Acknowledgements

_____I understand that there is a possibility of conflict with respect to the application of the Workers Compensation Laws because my employment is entered into Georgia and all or some portion of my work may be performed in different states. Therefore, I agree to be bound by the Workers' Compensation Laws of the State of Georgia and will only be entitled to Georgia Compensation benefits regardless of where the injury occurred, or where the disease was contracted. I also agree that the State of Georgia shall be the exclusive remedy against the employer on account of injury, disease or death in the course of and arising out of employment.

_____I have received the Resource Management Systems, Inc. Safety Guidelines and understand them and agree to abide by them. I also understand that it is my responsibility to comply with any revisions made to it.

Signature: _____ Date: _____

Witness: _____ Date: _____

Policy against Harassment

_____It has always been a policy of Resource Management Systems, Inc. to maintain the best possible employment atmosphere for its employees. This policy includes the rights of employees to be free from all forms of harassment of any kind by anyone in connection with their employment. We prohibit harassment because of a person's race, color, religion, gender, national origin, age, disability, sexual orientation, or any other characteristic protected by applicable federal, state, or local laws.

_____It is also this Company's policy to prohibit sexual harassment of any kind by anyone in connection with their employment. If it is determined that inappropriate conduct has occurred, we will act promptly to eliminate the offending conduct, and where it is appropriate we will also impose disciplinary action up to and including discharge for violation of this policy.

_____Any employee who feels they have been sexually and or unlawfully harassed should promptly report the matter to his or her supervisor and Resource Management Systems, Inc. Human Resource department. If the supervisor is unavailable or the employee believes it would be inappropriate to contact that person, the employee should immediately contact any other member of management.

Employee Acknowledgement

As a new employee of Resource Management Systems, Inc. and its client company, I acknowledge that I understand the company's policy prohibiting sexual harassment, and I agree to abide by that policy.

Employee Signature: _____ Date: _____

Application for Employment

Please fill out form completely for employment consideration. Print and fax or mail when completed.

Prospective employees will receive consideration without discrimination because of race, creed, color, sex, age, national origin or handicap. We are an equal opportunity employer.

Personal Information

Last Name First Middle	Date
Street Address	Home Phone ( ) -
City, State, Zip	
Business Phone ( ) -	Email Address:
What was your previous address?	How long at present address? _____ Years _____ Months
Are you over 18 years of age? ☐ Yes ☐ No If not, employment is subject to verification of minimum legal age.	How long at present address? _____ Years _____ Months
Have you ever applied for employment with us? ☐ Yes ☐ No If Yes: Month and Year_____ Location_____	Social Security No. - -
How did you learn of our organization?	
Are you legally eligible for employment in the United States?	When will you be able to work?
Are you employed now?	If so, may we inquire of your present employer?
Have you been convicted of a crime in the past ten years, excluding misdemeanors and summary offenses, which has not been annulled, expunged or sealed by a court? ☐ Yes ☐ No If Yes, describe in full.	

Are there any reasons for which you might not be able to perform the job duties (with a reasonable accommodation)? ☐ Yes ☐ No If Yes, please explain.		
Drivers License#	State	Any Violations? ☐ Yes ☐ No

Education

School	Name and location of school	Course of study	No. of years completed	Did you graduate?	Degree or diploma
College				☐ Yes ☐ No	
High				☐ Yes ☐ No	
Trade School				☐ Yes ☐ No	
Other				☐ Yes ☐ No	

Military

Complete this section if you served in the U.S. Armed Forces	Branch of Service
Describe your duties and any special training	Period of Active Duty (Month & Year) From To
	Rank at Discharge
	Date of Final Discharge

Employment History Please give accurate, complete full-time and part-time employment record. Start with present or most recent employer.

1.	Company Name	Telephone ( ) -
	Address	Employed (Start Month and Year) From To
	Name of Supervisor	Hourly Rate Start Last
	Start Job Title and Describe Your Work	Reason for Leaving

2.	Company Name	Telephone ( ) -
	Address	Employed (Start Month and Year) From To
	Name of Supervisor	Hourly Rate Start Last
	Start Job Title and Describe Your Work	Reason for Leaving
3.	Company Name	Telephone ( ) -
	Address	Employed (Start Month and Year) From To
	Name of Supervisor	Hourly Rate Start Last
	Start Job Title and Describe Your Work	Reason for Leaving
4.	Company Name	Telephone ( ) -
	Address	Employed (Start Month and Year) From To
	Name of Supervisor	Hourly Rate Start Last
	Start Job Title and Describe Your Work	Reason for Leaving

We may contact the employers listed above unless you indicate those you do not want us to contact.	Do not contact Employer Number(s)_____ Reason_____

References: Give below the names of three persons not related to you, whom you have known at least one year.

Name	Address	Business	Years Acquainted
1.			
2.			
3.			

The information provided in this Application for Employment is true, correct and complete. If employed, any misstatements or omissions of fact on this application may result in my dismissal.
I understand that acceptance of an offer of employment does not create a contractual obligation upon the employer to continue to employ me in the future.
If you decide to engage an investigative consumer reporting agency to report on my credit and personal history, I authorize you to do so.
If a report is obtained you must provide, at my request, the name and address of the agency so I may obtain from them the nature and substance of the information contained in the report.

Date	Signature

Form W-4 (2011)

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

Exemption from withholding. If you are exempt, complete **only** lines 1, 2, 3, 4, and 7 and sign the form to validate it. Your exemption for 2011 expires February 16, 2012. See Pub. 505, Tax Withholding and Estimated Tax.

Note. If another person can claim you as a dependent on his or her tax return, you cannot claim exemption from withholding if your income exceeds $950 and includes more than $300 of unearned income (for example, interest and dividends).

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

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

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

Tax credits. You can take projected tax credits into account in figuring your allowable number of withholding allowances. Credits for child or dependent care expenses and the child tax credit may be claimed using the **Personal Allowances Worksheet** below. See Pub. 919, How Do I Adjust My Tax Withholding, for information on converting your other credits into withholding allowances.

Nonwage income. If you have a large amount of nonwage income, such as interest or dividends, consider making estimated tax payments using Form 1040-ES, Estimated Tax for Individuals. Otherwise, you may owe additional tax. If you have pension or annuity income, see Pub. 919 to find out if you should adjust your withholding on Form W-4 or W-4P.

Two earners or multiple jobs. If you have a working spouse or more than one job, figure the total number of allowances you are entitled to claim on all jobs using worksheets from only one Form W-4. Your withholding usually will be most accurate when all allowances are claimed on the Form W-4 for the highest paying job and zero allowances are claimed on the others. See Pub. 919 for details.

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

Check your withholding. After your Form W-4 takes effect, use Pub. 919 to see how the amount you are having withheld compares to your projected total tax for 2011. See Pub. 919, especially if your earnings exceed $130,000 (Single) or $180,000 (Married).

Personal Allowances Worksheet (Keep for your records.)

A Enter "1" for **yourself** if no one else can claim you as a dependent . . . . . A _____

B Enter "1" if:
- You are single and have only one job; or
- You are married, have only one job, and your spouse does not work; or
- Your wages from a second job or your spouse's wages (or the total of both) are $1,500 or less. . . . B _____

C Enter "1" for your **spouse.** But, you may choose to enter "-0-" if you are married and have either a working spouse or more than one job. (Entering "-0-" may help you avoid having too little tax withheld.) . . . . . C _____

D Enter number of **dependents** (other than your spouse or yourself) you will claim on your tax return . . . . . D _____

E Enter "1" if you will file as **head of household** on your tax return (see conditions under **Head of household** above) . . E _____

F Enter "1" if you have at least $1,900 of **child or dependent care expenses** for which you plan to claim a credit . . . F _____
(**Note.** Do **not** include child support payments. See Pub. 503, Child and Dependent Care Expenses, for details.)

G **Child Tax Credit** (including additional child tax credit). See Pub. 972, Child Tax Credit, for more information.
- If your total income will be less than $61,000 ($90,000 if married), enter "2" for each eligible child; then **less** "1" if you have three or more eligible children.
- If your total income will be between $61,000 and $84,000 ($90,000 and $119,000 if married), enter "1" for each eligible child plus "1" **additional** if you have six or more eligible children . . . . . G _____

H Add lines A through G and enter total here. (**Note.** This may be different from the number of exemptions you claim on your tax return.) ▶ H _____

For accuracy, **complete all worksheets that apply.**
- If you plan to **itemize** or **claim adjustments to income** and want to reduce your withholding, see the **Deductions and Adjustments Worksheet** on page 2.
- If you have **more than one job** or are **married and you and your spouse both work** and the combined earnings from all jobs exceed $40,000 ($10,000 if married), see the **Two-Earners/Multiple Jobs Worksheet** on page 2 to avoid having too little tax withheld.
- If **neither** of the above situations applies, **stop here** and enter the number from line H on line 5 of Form W-4 below.

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

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

Employee's Withholding Allowance Certificate

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

OMB No. 1545-0074
2011

1 Type or print your first name and middle initial. | Last name | 2 **Your social security number**

Home address (number and street or rural route) | 3 ☐ Single ☐ Married ☐ Married, but withhold at higher Single rate.
Note. If married, but legally separated, or spouse is a nonresident alien, check the "Single" box.

City or town, state, and ZIP code | 4 **If your last name differs from that shown on your social security card, check here. You must call 1-800-772-1213 for a replacement card.** ▶ ☐

5 Total number of allowances you are claiming (from line **H** above **or** from the applicable worksheet on page 2) | 5

6 Additional amount, if any, you want withheld from each paycheck . . . . . | 6 $

7 I claim exemption from withholding for 2011, and I certify that I meet **both** of the following conditions for exemption.
- Last year I had a right to a refund of **all** federal income tax withheld because I had **no** tax liability **and**
- This year I expect a refund of **all** federal income tax withheld because I expect to have **no** tax liability.

If you meet both conditions, write "Exempt" here . . . . . ▶ 7

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

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

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

For Privacy Act and Paperwork Reduction Act Notice, see page 2.

Cat. No. 10220Q Form **W-4** (2011)

Deductions and Adjustments Worksheet

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

1	Enter an estimate of your 2011 itemized deductions. These include qualifying home mortgage interest, charitable contributions, state and local taxes, medical expenses in excess of 7.5% of your income, and miscellaneous deductions	1	$
2	Enter: { $11,600 if married filing jointly or qualifying widow(er); $8,500 if head of household; $5,800 if single or married filing separately }	2	$
3	**Subtract** line 2 from line 1. If zero or less, enter "-0-"	3	$
4	Enter an estimate of your 2011 adjustments to income and any additional standard deduction (see Pub. 919)	4	$
5	**Add** lines 3 and 4 and enter the total. (Include any amount for credits from the *Converting Credits to Withholding Allowances for 2011 Form W-4 Worksheet* in Pub. 919.)	5	$
6	Enter an estimate of your 2011 nonwage income (such as dividends or interest)	6	$
7	**Subtract** line 6 from line 5. If zero or less, enter "-0-"	7	$
8	**Divide** the amount on line 7 by $3,700 and enter the result here. Drop any fraction	8	
9	Enter the number from the **Personal Allowances Worksheet,** line H, page 1	9	
10	**Add** lines 8 and 9 and enter the total here. If you plan to use the **Two-Earners/Multiple Jobs Worksheet,** also enter this total on line 1 below. Otherwise, **stop here** and enter this total on Form W-4, line 5, page 1	10	

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

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

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

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

4	Enter the number from line 2 of this worksheet	4			
5	Enter the number from line 1 of this worksheet	5			
6	**Subtract** line 5 from line 4			6	
7	Find the amount in **Table 2** below that applies to the **HIGHEST** paying job and enter it here			7	$
8	**Multiply** line 7 by line 6 and enter the result here. This is the additional annual withholding needed			8	$
9	Divide line 8 by the number of pay periods remaining in 2011. For example, divide by 26 if you are paid every two weeks and you complete this form in December 2010. Enter the result here and on Form W-4, line 6, page 1. This is the additional amount to be withheld from each paycheck			9	$

Table 1

Married Filing Jointly		All Others	
If wages from **LOWEST** paying job are—	Enter on line 2 above	If wages from **LOWEST** paying job are—	Enter on line 2 above
$0 - $5,000 -	0	$0 - $8,000 -	0
5,001 - 12,000 -	1	8,001 - 15,000 -	1
12,001 - 22,000 -	2	15,001 - 25,000 -	2
22,001 - 25,000 -	3	25,001 - 30,000 -	3
25,001 - 30,000 -	4	30,001 - 40,000 -	4
30,001 - 40,000 -	5	40,001 - 50,000 -	5
40,001 - 48,000 -	6	50,001 - 65,000 -	6
48,001 - 55,000 -	7	65,001 - 80,000 -	7
55,001 - 65,000 -	8	80,001 - 95,000 -	8
65,001 - 72,000 -	9	95,001 -120,000 -	9
72,001 - 85,000 -	10	120,001 and over	10
85,001 - 97,000 -	11		
97,001 -110,000 -	12		
110,001 -120,000 -	13		
120,001 -135,000 -	14		
135,001 and over	15		

Table 2

Married Filing Jointly		All Others	
If wages from **HIGHEST** paying job are—	Enter on line 7 above	If wages from **HIGHEST** paying job are—	Enter on line 7 above
$0 - $65,000	$560	$0 - $35,000	$560
65,001 - 125,000	930	35,001 - 90,000	930
125,001 - 185,000	1,040	90,001 - 165,000	1,040
185,001 - 335,000	1,220	165,001 - 370,000	1,220
335,001 and over	1,300	370,001 and over	1,300

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

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

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

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

Form G-4 (Rev. 12/09)

STATE OF GEORGIA EMPLOYEE'S WITHHOLDING ALLOWANCE CERTIFICATE

1a. YOUR FULL NAME	1b. YOUR SOCIAL SECURITY NUMBER
2a. HOME ADDRESS (Number, Street, or Rural Route)	2b. CITY, STATE AND ZIP CODE

PLEASE READ INSTRUCTIONS ON REVERSE SIDE BEFORE COMPLETING LINES 3 – 8

3. MARITAL STATUS

(If you do not wish to claim an allowance, enter "0" in the brackets beside your marital status.)

A. Single: Enter 0 or 1 ..... [ ]

B. Married Filing Joint, both spouses working:
Enter 0 or 1 or 2 ..... [ ]

C. Married Filing Joint, one spouse working:
Enter 0 or 1 or 2 ..... [ ]

D. Married Filing Separate:
Enter 0 or 1 or 2 ..... [ ]

E. Head of Household:
Enter 0 or 1 or 2 ..... [ ]

4. DEPENDENT ALLOWANCES [ ]

5. ADDITIONAL ALLOWANCES [ ]
(worksheet below must be completed)

6. ADDITIONAL WITHHOLDING $_____

WORKSHEET FOR CALCULATING ADDITIONAL ALLOWANCES
(Must be completed only if step 5 is greater than zero)

1. COMPLETE THIS LINE ONLY IF USING STANDARD DEDUCTION:
   Yourself: ☐ Age 65 or over ☐ Blind
   Spouse: ☐ Age 65 or over ☐ Blind Number of boxes checked _____ x 1300..... $_____
2. ADDITIONAL ALLOWANCES FOR DEDUCTIONS:

A. Federal Estimated Itemized Deductions ..... $_____

B. Georgia Standard Deduction (enter one): Single/Head of Household $2,300
   Each Spouse $1,500 $_____

C. Subtract Line B from Line A ..... $_____

D. Allowable Deductions to Federal Adjusted Gross Income ..... $_____

E. Add the Amounts on Lines 1, 2C, and 2D ..... $_____

F. Estimate of Taxable Income not Subject to Withholding ..... $_____

G. Subtract Line F from Line E (if zero or less, stop here) ..... $_____

H. Divide the Amount on Line G by $3,000. Enter total here and on Line 5 above ..... _____

(This is the maximum number of additional allowances you can claim. If the remainder is over $1,500 round up)

7. LETTER USED (Marital Status A, B, C, D, or E) _____ **TOTAL ALLOWANCES** (Total of Lines 3 - 5) _____
(Employer: The letter indicates the tax tables in the Employer's Tax Guide)

8. EXEMPT: (Do not complete Lines 3 - 7 if claiming exempt) **Read the Line 8 instructions on page 2 before completing this section.**

a) I claim exemption from withholding because I incurred no Georgia income tax liability last year **and** I do not expect to have a Georgia income tax liability this year. **Check here** ☐

b) I certify that I am not subject to Georgia withholding because I meet the conditions set forth under the Servicemembers Civil Relief Act as amended by the Military Spouses Residency Relief Act as provided on page 2. My state of residence is _____ My spouse's (servicemember) state of residence is _____ The states of residence must be the same to be exempt. **Check here** ☐

I certify under penalty of perjury that I am entitled to the number of withholding allowances or the exemption from withholding status claimed on this Form G-4. Also, I authorize my employer to deduct per pay period the additional amount listed above.

Employee's Signature _____ Date _____

Employer: Complete Line 9 and mail entire form only if the employee claims over 14 allowances or exempt from withholding.
If necessary, mail form to: Georgia Department of Revenue, Withholding Tax Unit, P. O. Box 49432, Atlanta, GA 30359.

9. EMPLOYER'S NAME AND ADDRESS:

EMPLOYER'S FEIN: _____

EMPLOYER'S WH#: _____

Do not accept forms claiming additional allowances unless the worksheet has been completed. Do not accept forms claiming exempt if numbers are written on Lines 3 - 7.

INSTRUCTIONS FOR COMPLETING FORM G-4

Enter your full name, address and social security number in boxes 1a through 2b.

Line 3: Write the number of allowances you are claiming in the brackets beside your marital status.

A. Single - enter 1 if you are claiming yourself
B. Married Filing Joint, both spouses working - enter 1 if you claim yourself or 2 if you claim yourself and your spouse
C. Married Filing Joint, one spouse working - enter 1 if you claim yourself or 2 if you claim yourself and your spouse
D. Married Filing Separate - enter 1 if you claim yourself or 2 if you claim yourself and your spouse
E. Head of Household - enter 1 if you claim yourself but the individual(s) for whom you maintain a home does not qualify as a dependent; or 2 if you claim yourself and a qualified dependent for whom you maintain a home

Do not claim a deduction on Line 4 for a dependent used to qualify you as head of household

Line 4: Enter the number of dependent allowances you are entitled to claim.

Line 5: Complete the worksheet on Form G-4 if you claim additional allowances. Enter the number on Line H here.

Failure to complete and submit the worksheet will result in automatic denial of your claim.

Line 6: Enter a specific dollar amount that you authorize your employer to withhold in addition to the tax withheld based on your marital status and number of allowances.

Line 7: Enter the letter of your marital status from Line 3. Enter total of the numbers on Lines 3 - 5.

Line 8:

a) Check the first box if you qualify to claim exempt from withholding. You can claim exempt if you filed a Georgia income tax return last year and the amount on Line 4 of Form 500EZ or Line 16 of Form 500 was zero, **and** you expect to file a Georgia tax return this year and will not have a tax liability. You can not claim exempt if you did not file a Georgia income tax return for the previous tax year. **Receiving a refund in the previous tax year does not qualify you to claim exempt.**

EXAMPLES: Your employer withheld $500 of Georgia income tax from your wages. The amount on Line 4 of Form 500EZ (or Line 16 of Form 500) was $100. Your tax liability is the amount on Line 4 (or Line 16); therefore, you **do not qualify** to claim exempt.

Your employer withheld $500 of Georgia income tax from your wages. The amount on Line 4 of Form 500EZ (or Line 16 of Form 500) was $0 (zero). Your tax liability is the amount on Line 4 (or Line 16) and you filed a prior year income tax return; therefore, you **qualify** to claim exempt.

b) Check the second box if you are not subject to Georgia withholding and meet the conditions set forth under the Servicemembers Civil Relief Act, as amended by the Military Spouses Residency Relief Act. Under the Act, a spouse of a servicemember may be exempt from Georgia income tax on income from services performed in Georgia if:

1. The servicemember is present in Georgia in compliance with military orders;
2. The spouse is in Georgia solely to be with the servicemember;
3. The spouse maintains domicile in another state; and
4. The domicile of the spouse is the same as the domicile of the servicemember.

Additional information for employers regarding the Military Spouses Residency Relief Act:

1. On the W-2 for 2009, the employer should report all wages earned during the year as Georgia wages. On the W-2 for 2010 and any year thereafter, the employer should not report any of the wages as Georgia wages on the W-2.
2. If the spouse of a servicemember is entitled to the protection of the Military Spouses Residency Relief Act in another state and files a withholding exemption form in such other state, the spouse is required to submit a Georgia Form G-4 so that withholding will occur as is required by Georgia Law when a Georgia domiciliary works in another state and withholding is not required by such other state. If the spouse does not fill out the form, the employer shall withhold Georgia income tax as if the spouse is single with zero allowances.

Do not complete Lines 3 - 7 if claiming exempt.

O.C.G.A. § 48-7-102 requires you to complete and submit Form G-4 to your employer in order to have tax withheld from your wages. By correctly completing this form, you can adjust the amount of tax withheld to meet your tax liability. Failure to submit a properly completed Form G-4 will result in your employer withholding tax as though you are single with zero allowances.

Employers are required to mail any Form G-4 claiming more than 14 allowances or exempt from withholding to the Georgia Department of Revenue for approval. Employers will honor the properly completed form as submitted pending notification from the Withholding Tax Unit. Upon approval, such forms remain in effect until changed or until February 15 of the following year. Employers who know that a G-4 is erroneous should not honor the form and should withhold as if the employee is single claiming zero allowances until a corrected form has been received.

OMB No. 1615-0047; Expires 08/31/12

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

Form I-9, Employment Eligibility Verification

Read instructions carefully before completing this form. The instructions must be available during completion of this form.

ANTI-DISCRIMINATION NOTICE: It is illegal to discriminate against work-authorized individuals. Employers CANNOT specify which document(s) they will accept from an employee. The refusal to hire an individual because the documents have a future expiration date may also constitute illegal discrimination.

Section 1. Employee Information and Verification *(To be completed and signed by employee at the time employment begins.)*

Print Name: Last	First	Middle Initial	Maiden Name
Address *(Street Name and Number)*		Apt. #	Date of Birth *(month/day/year)*
City	State	Zip Code	Social Security #

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):

- ☐ A citizen of the United States
- ☐ A noncitizen national of the United States (see instructions)
- ☐ A lawful permanent resident (Alien #) _____
- ☐ An alien authorized to work (Alien # or Admission #) _____ until (expiration date, if applicable - *month/day/year*)

Employee's Signature | Date *(month/day/year)*

Preparer and/or Translator Certification *(To be completed and signed if Section I is prepared by a person other than the employee.) I attest, under penalty of perjury, that I have assisted in the completion of this form and that to the best of my knowledge the information is true and correct.*

Preparer's/Translator's Signature	Print Name
Address *(Street Name and Number, City, State, Zip Code)*	Date *(month/day/year)*

Section 2. Employer Review and Verification *(To be completed and signed by employer. Examine one document from List A OR examine one document from List B and one from List C, as listed on the reverse of this form, and record the title, number, and expiration date, if any, of the document(s).)*

	List A	OR	List B	AND	List C
Document title:					
Issuing authority:					
Document #:					
Expiration Date *(if any)*:					
Document #:					
Expiration Date *(if any)*:					

CERTIFICATION: I attest, under penalty of perjury, that I have examined the document(s) presented by the above-named employee, that the above-listed document(s) appear to be genuine and to relate to the employee named, that the employee began employment on *(month/day/year)* _____ and that to the best of my knowledge the employee is authorized to work in the United States. (State employment agencies may omit the date the employee began employment.)

Signature of Employer or Authorized Representative	Print Name	Title
Business or Organization Name and Address *(Street Name and Number, City, State, Zip Code)*		Date *(month/day/year)*

Section 3. Updating and Reverification *(To be completed and signed by employer.)*

A. New Name *(if applicable)*	B. Date of Rehire *(month/day/year) (if applicable)*

C. If employee's previous grant of work authorization has expired, provide the information below for the document that establishes current employment authorization.

Document Title: _____ Document #: _____ Expiration Date *(if any)*: _____

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	Date *(month/day/year)*

Corporate Payroll Services

Authorization Agreement For Direct Deposit Employees

For direct deposit employees, this Authorization Agreement along with voided check(s) or deposit ticket(s) must be received a minimum of 5 banking days before the first direct deposit pay date. This Authorization Agreement may be initially faxed along with a copy of voided check(s) or deposit ticket(s) to CPS at (770) 263-6433. Originals must be received by us within 5 business days.

Employee Name _____ Employee ID # _____

Company Name _____ Cust. ID # RESMAN

Corporate Payroll Services cannot set up direct deposits for "credit only" accounts. These accounts do not allow debit entries, which are necessary for voiding and reissuing checks. All banks must be located in the territorial jurisdiction of the United States.

If you only have one account, simply write 100 next to the % sign in the first row. You may choose up to 4 accounts into which your net pay is deposited. Please enter either a dollar amount or a percentage for all accounts. If you choose the Dollar method, all remaining amounts will be directed to the first account listed below. If using the Percentage method, the total of the percentages must equal 100%.

$ All Remaining **OR** _____% * Bank Name _____ Checking____ Savings____

Routing _____ Acct# _____

$_____.____ **OR** _____% * Bank Name _____ Checking____ Savings____

Routing _____ Acct# _____

$_____.____ **OR** _____% * Bank Name _____ Checking____ Savings____

Routing _____ Acct# _____

$_____.____ **OR** _____% * Bank Name _____ Checking____ Savings____

*Total for ALL % amounts must = 100 Routing _____ Acct# _____

I hereby authorize Corporate Payroll Services, its agents and the bank named above to initiate credit and any necessary adjusting debit entries to my account(s) indicated above. This Authority is to remain in effect until Corporate Payroll Services and the bank have received written notice from me of its termination in such time and manner as to afford Corporate Payroll Services and the bank a reasonable opportunity to act on it.

Signature _____ Date ___/___/___

Staple copy of voided check(s) to this form when sending originals

*Have each employee that wants Direct Deposit complete this form.

EMPLOYMENT RECORD SERVICE
TRUST BUT VERIFY

AUTHORITY TO RELEASE INFORMATION

To: Any person having knowledge of my conduct or activities, or any past, present or future Employer, Credit Bureau, Bank, Financial Institution, Dean, Registrar, Principal, Counselor, Instructor, or School, Doctor, Hospital, Clinic or Medical Facility, Law Enforcement Agency, Government Agency or Armed Forces:

Employment Record Service LLC has been engaged, to conduct an appropriate background investigation of me and prepare a consumer report or investigative consumer report which may be used as a factor in determining my eligibility for employment, promotion or retention as governed by the Fair Credit Reporting Act (FCRA) Public Law 91-508.

I understand this report may include information from personal interviews about my character, general reputation, personal characteristics and mode of living as well as both public and private sources including but not limited to information contained in federal, state and local records, public and private databases and repositories, criminal records, my credit report, employment records, school records, driving records or abstracts, licensing boards and registries, etc. I understand I may be entitled to certain disclosures and have been given a copy of "A Summary of Your Rights Under the FCRA", a document prescribed by the Federal Trade Commission.

I hereby authorize all persons who may have information relevant to this investigation to disclose it to Employment Record Service LLC or their agents, and I release all persons from any liability on account of such disclosure. I hereby further authorize that a photocopy of this authorization may be considered as valid as an original.

Signature: _____ Date: _____

Furnished for the purpose of positive identification: (Print Clearly)

First: _____ MI: _____ Last: _____

Address: _____

City: _____ State: _____ Zip: _____

A.K.A. (include maiden name): _____

SSN: _____-_____-_____ DOB: _____/_____/_____

Driver License#: _____ State: _____

Address History (Past 7 Years)

_____

_____

_____

Notice to California, Minnesota and Oklahoma Residents

Under California, Minnesota and Oklahoma law, you have a right to receive a free copy of your consumer report by checking the appropriate box below.

Under California law, any consumer reports order on you for employment purposes within the State of California are defined as investigative consumer reports. These reports may contain information on your character, general reputation, personal characteristics and mode of living.

Under section 1786.22 of the California Civil Code, you may view the file maintained on you by during normal business hours. You may also obtain a copy of this file upon submitting proper identification and paying the costs of duplication services, by appearing at Pinpoint America in person, by mail, or by telephone. Pinpoint America has trained personnel available to explain your file to you and as well as any coded information appearing in your file. If you appear in person, a person of your choice may accompany you, provided that this person furnishes proper identification.

Employment Record Service LLC
PO Box 11198 Fairfield, NJ 07004
800 775 2958

☐ California applicants only I request to receive a free copy of any investigative consumer report ordered on me by checking this box.
☐ Minnesota Applicants Only: I request a copy of any consumer report requested on me.
☐ Oklahoma Applicants Only: I request a copy of any *credit* report requested on me.