

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.

2020

Step 1: Enter Personal Information	(a) First name and middle initial	Last name	(b) Social security number
	Address		
	City or town, state, and ZIP code		
	<p>(c) <input type="checkbox"/> Single or Married filing separately <input type="checkbox"/> Married filing jointly (or Qualifying widow(er)) <input type="checkbox"/> 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.)</p>		

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

Step 2: Multiple Jobs or Spouse Works	Complete this step if you (1) hold more than one job at a time, or (2) are married filing jointly and your spouse also works. The correct amount of withholding depends on income earned from all of these jobs. Do only one of the following. (a) Use the estimator at www.irs.gov/W4App for most accurate withholding for this step (and Steps 3–4); or (b) Use the Multiple Jobs Worksheet on page 3 and enter the result in Step 4(c) below for roughly accurate withholding; or (c) If there are only two jobs total, you may check this box. Do the same on Form W-4 for the other job. This option is accurate for jobs with similar pay; otherwise, more tax than necessary may be withheld ► <input type="checkbox"/>
	TIP: To be accurate, submit a 2020 Form W-4 for all other jobs. If you (or your spouse) have self-employment income, including as an independent contractor, use the estimator.

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

Step 3: Claim Dependents	If your income will be \$200,000 or less (\$400,000 or less if married filing jointly): Multiply the number of qualifying children under age 17 by \$2,000 ► \$ _____ Multiply the number of other dependents by \$500 ► \$ _____ Add the amounts above and enter the total here	
		3 \$ _____
Step 4 (optional): Other Adjustments	(a) Other income (not from jobs). If you want tax withheld for other income you expect this year that won't have withholding, enter the amount of other income here. This may include interest, dividends, and retirement income	4(a) \$ _____
	(b) Deductions. If you expect to claim deductions other than the standard deduction and want to reduce your withholding, use the Deductions Worksheet on page 3 and enter the result here	4(b) \$ _____
	(c) Extra withholding. Enter any additional tax you want withheld each pay period	4(c) \$ _____

Step 5: Sign Here	Under penalties of perjury, I declare that this certificate, to the best of my knowledge and belief, is true, correct, and complete.		
	Employee's signature (This form is not valid unless you sign it.)	Date	
Employers Only	Employer's name and address	First date of employment	Employer identification number (EIN)

General Instructions

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.

Exemption from withholding. You may claim exemption from withholding for 2020 if you meet both of the following conditions: you had no federal income tax liability in 2019 **and** you expect to have no federal income tax liability in 2020. You had no federal income tax liability in 2019 if (1) your total tax on line 16 on your 2019 Form 1040 or 1040-SR is zero (or less than the sum of lines 18a, 18b, and 18c), 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 2020 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 16, 2021.

Your privacy. If you prefer to limit information provided in Steps 2 through 4, use the online estimator, which will also increase accuracy.

As an alternative to the estimator: if you have concerns with Step 2(c), you may choose Step 2(b); if you have concerns with Step 4(a), you may enter an additional amount you want withheld per pay period in Step 4(c). If this is the only job in your household, you may instead check the box in Step 2(c), which will increase your withholding and significantly reduce your paycheck (often by thousands of dollars over the year).

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. Have dividend or capital gain income, or are subject to additional taxes, such as the additional Medicare tax;
3. Have self-employment income (see below); or
4. 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.

If you (and your spouse) have a total of only two jobs, you may instead 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 roughly 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. Step 3 of Form W-4 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. 972, Child Tax Credit and Credit for Other Dependents. You can also include **other tax credits** in this step, such as education tax credits and the foreign tax credit. 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 2020 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.

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 2020 itemized deductions (from Schedule A (Form 1040 or 1040-SR)). 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: { • \$24,800 if you're married filing jointly or qualifying widow(er)
• \$18,650 if you're head of household
• \$12,400 if you're single or married filing separately }

2 \$ _____

- 3** If line 1 is greater than line 2, subtract line 2 from line 1. 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 or 1040-SR)). 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 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.

Married Filing Jointly or Qualifying Widow(er)

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	\$220	\$850	\$900	\$1,020	\$1,020	\$1,020	\$1,020	\$1,020	\$1,210	\$1,870	\$1,870
\$10,000 - 19,999	220	1,220	1,900	2,100	2,220	2,220	2,220	2,220	2,410	3,410	4,070	4,070
\$20,000 - 29,999	850	1,900	2,730	2,930	3,050	3,050	3,050	3,240	4,240	5,240	5,900	5,900
\$30,000 - 39,999	900	2,100	2,930	3,130	3,250	3,250	3,440	4,440	5,440	6,440	7,100	7,100
\$40,000 - 49,999	1,020	2,220	3,050	3,250	3,370	3,570	4,570	5,570	6,570	7,570	8,220	8,220
\$50,000 - 59,999	1,020	2,220	3,050	3,250	3,570	4,570	5,570	6,570	7,570	8,570	9,220	9,220
\$60,000 - 69,999	1,020	2,220	3,050	3,440	4,570	5,570	6,570	7,570	8,570	9,570	10,220	10,220
\$70,000 - 79,999	1,020	2,220	3,240	4,440	5,570	6,570	7,570	8,570	9,570	10,570	11,220	11,240
\$80,000 - 99,999	1,060	3,260	5,090	6,290	7,420	8,420	9,420	10,420	11,420	12,420	13,260	13,460
\$100,000 - 149,999	1,870	4,070	5,900	7,100	8,220	9,320	10,520	11,720	12,920	14,120	14,980	15,180
\$150,000 - 239,999	2,040	4,440	6,470	7,870	9,190	10,390	11,590	12,790	13,990	15,190	16,050	16,250
\$240,000 - 259,999	2,040	4,440	6,470	7,870	9,190	10,390	11,590	12,790	13,990	15,520	17,170	18,170
\$260,000 - 279,999	2,040	4,440	6,470	7,870	9,190	10,390	11,590	13,120	15,120	17,120	18,770	19,770
\$280,000 - 299,999	2,040	4,440	6,470	7,870	9,190	10,720	12,720	14,720	16,720	18,720	20,370	21,370
\$300,000 - 319,999	2,040	4,440	6,470	8,200	10,320	12,320	14,320	16,320	18,320	20,320	21,970	22,970
\$320,000 - 364,999	2,720	5,920	8,750	10,950	13,070	15,070	17,070	19,070	21,290	23,590	25,540	26,840
\$365,000 - 524,999	2,970	6,470	9,600	12,100	14,530	16,830	19,130	21,430	23,730	26,030	27,980	29,280
\$525,000 and over	3,140	6,840	10,170	12,870	15,500	18,000	20,500	23,000	25,500	28,000	30,150	31,650

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	\$460	\$940	\$1,020	\$1,020	\$1,470	\$1,870	\$1,870	\$1,870	\$1,870	\$2,040	\$2,040	\$2,040
\$10,000 - 19,999	940	1,530	1,610	2,060	3,060	3,460	3,460	3,460	3,640	3,830	3,830	3,830
\$20,000 - 29,999	1,020	1,610	2,130	3,130	4,130	4,540	4,540	4,720	4,920	5,110	5,110	5,110
\$30,000 - 39,999	1,020	2,060	3,130	4,130	5,130	5,540	5,720	5,920	6,120	6,310	6,310	6,310
\$40,000 - 59,999	1,870	3,460	4,540	5,540	6,690	7,290	7,490	7,690	7,890	8,080	8,080	8,080
\$60,000 - 79,999	1,870	3,460	4,690	5,890	7,090	7,690	7,890	8,090	8,290	8,480	9,260	10,060
\$80,000 - 99,999	2,020	3,810	5,090	6,290	7,490	8,090	8,290	8,490	9,470	10,460	11,260	12,060
\$100,000 - 124,999	2,040	3,830	5,110	6,310	7,510	8,430	9,430	10,430	11,430	12,420	13,520	14,620
\$125,000 - 149,999	2,040	3,830	5,110	7,030	9,030	10,430	11,430	12,580	13,880	15,170	16,270	17,370
\$150,000 - 174,999	2,360	4,950	7,030	9,030	11,030	12,730	14,030	15,330	16,630	17,920	19,020	20,120
\$175,000 - 199,999	2,720	5,310	7,540	9,840	12,140	13,840	15,140	16,440	17,740	19,030	20,130	21,230
\$200,000 - 249,999	2,970	5,860	8,240	10,540	12,840	14,540	15,840	17,140	18,440	19,730	20,830	21,930
\$250,000 - 399,999	2,970	5,860	8,240	10,540	12,840	14,540	15,840	17,140	18,440	19,730	20,830	21,930
\$400,000 - 449,999	2,970	5,860	8,240	10,540	12,840	14,540	15,840	17,140	18,450	19,940	21,240	22,540
\$450,000 and over	3,140	6,230	8,810	11,310	13,810	15,710	17,210	18,710	20,210	21,700	23,000	24,300

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	\$830	\$930	\$1,020	\$1,020	\$1,020	\$1,480	\$1,870	\$1,870	\$1,930	\$2,040	\$2,040
\$10,000 - 19,999	830	1,920	2,130	2,220	2,220	2,680	3,680	4,070	4,130	4,330	4,440	4,440
\$20,000 - 29,999	930	2,130	2,350	2,430	2,900	3,900	4,900	5,340	5,540	5,740	5,850	5,850
\$30,000 - 39,999	1,020	2,220	2,430	2,980	3,980	4,980	6,040	6,630	6,830	7,030	7,140	7,140
\$40,000 - 59,999	1,020	2,530	3,750	4,830	5,860	7,060	8,260	8,850	9,050	9,250	9,360	9,360
\$60,000 - 79,999	1,870	4,070	5,310	6,600	7,800	9,000	10,200	10,780	10,980	11,180	11,580	12,380
\$80,000 - 99,999	1,900	4,300	5,710	7,000	8,200	9,400	10,600	11,180	11,670	12,670	13,580	14,380
\$100,000 - 124,999	2,040	4,440	5,850	7,140	8,340	9,540	11,360	12,750	13,750	14,750	15,770	16,870
\$125,000 - 149,999	2,040	4,440	5,850	7,360	9,360	11,360	13,360	14,750	16,010	17,310	18,520	19,620
\$150,000 - 174,999	2,040	5,060	7,280	9,360	11,360	13,480	15,780	17,460	18,760	20,060	21,270	22,370
\$175,000 - 199,999	2,720	5,920	8,130	10,480	12,780	15,080	17,380	19,070	20,370	21,670	22,880	23,980
\$200,000 - 249,999	2,970	6,470	8,990	11,370	13,670	15,970	18,270	19,960	21,260	22,560	23,770	24,870
\$250,000 - 349,999	2,970	6,470	8,990	11,370	13,670	15,970	18,270	19,960	21,260	22,560	23,770	24,870
\$350,000 - 449,999	2,970	6,470	8,990	11,370	13,670	15,970	18,270	19,960	21,260	22,560	23,900	25,200
\$450,000 and over	3,140	6,840	9,560	12,140	14,640	17,140	19,640	21,530	23,030	24,530	25,940	27,240

Employment Application

An Equal Opportunity Employer

Please Print

Date

Last Name

First Name

Middle

Present Address

No. & Street

City

State

Zip Code

Permanent Address (if different from present address)

No. & Street

City

State

Zip Code

Business Phone

Home Phone

Employment Desired

Position applying for:

Are you applying for:

Regular full-time work?..... Yes No

Regular part-time work?..... Yes No

Temporary work, e.g., summer or holiday work?..... Yes No

What days and hours are you available for work?

If applying for temporary work, during what period of time will you be available?

From: _____ To: _____

Are you available for work on weekends?..... Yes No

Would you be available to work overtime, if necessary?..... Yes No

If hired, what date can you start work?

Employment Application

Personal Information

How did you hear about our company and this job opening? _____

Have you ever applied to or worked for _____ before? Yes No

If yes, when? _____

Why are you applying for work at _____ ?

If hired, would you have a reliable means of transportation to and from work? Yes No

Are you at least 18 years old? (If under 18, hire is subject to verification that you are of minimum legal age.) Yes No

Are you able to perform the essential functions of the job for which you are applying, either with or without reasonable accommodation? Yes No

If no, describe the functions that cannot be performed.

(Note: We comply with the ADA and consider reasonable accommodation measures that may be necessary for eligible applicants/employees to perform essential functions. Hire may be subject to passing a medical examination, and to skill and agility tests.)

We may refuse to hire relatives of present employees if doing so could result in actual or potential problems in supervision, security, safety, or morale, or if doing so could create conflicts of interest.

Employment Application

Education, Training, and Experience

School	Name and Address	No. of Years Completed	Did you Graduate?	Degree or Diploma
High School	Name _____ Address _____	City _____ State _____ Zip Code _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
College/ University	Name _____ Address _____	City _____ State _____ Zip Code _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Vocational/ Business	Name _____ Address _____	City _____ State _____ Zip Code _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Health Care Training	Name _____ Address _____	City _____ State _____ Zip Code _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____

Do you have any other experience, training, qualifications, or skills that you feel make you especially suited for work at _____ ? Yes No

If so, please explain:

Employment Application

Answer the following questions if you are applying for a professional position:

Are you licensed/certified for the job applied for? Yes No

Name of license/certification: _____ Issuing state: _____

License/certification number: _____

Has your license/certification ever been revoked or suspended? Yes No

If yes, state reason(s), date of revocation or suspension, and date of reinstatement.

Employment History

List below all present and past employment starting with your most recent employer (last five years is sufficient). You must complete this section even if attaching a resume.

Name of Employer _____ Phone Number _____

Type of Business _____ Your Supervisor's Name _____

Address & Street _____ City _____ State _____ Zip Code _____

Dates of Employment: _____
From _____ To _____

Your Position and Duties _____

Reason for Leaving _____

Current employer? Yes No

May we contact this employer for a reference? Yes No

Name of Employer _____ Phone Number _____

Type of Business _____ Your Supervisor's Name _____

Address & Street _____ City _____ State _____ Zip Code _____

Dates of Employment: _____
From _____ To _____

Your Position and Duties _____

Reason for Leaving _____

May we contact this employer for a reference? Yes No

Employment Application

Employment History, continued

Name of Employer _____ Phone Number _____
Type of Business _____ Your Supervisor's Name _____
Address & Street _____ City _____ State _____ Zip Code _____

Dates of Employment: _____
From _____ To _____

Your Position and Duties _____

Reason for Leaving _____

May we contact this employer for a reference? Yes No

Name of Employer _____ Phone Number _____
Type of Business _____ Your Supervisor's Name _____
Address & Street _____ City _____ State _____ Zip Code _____

Dates of Employment: _____
From _____ To _____

Your Position and Duties _____

Reason for Leaving _____

May we contact this employer for a reference? Yes No

Name of Employer _____ Phone Number _____
Type of Business _____ Your Supervisor's Name _____
Address & Street _____ City _____ State _____ Zip Code _____

Dates of Employment: _____
From _____ To _____

Your Position and Duties _____

Reason for Leaving _____

May we contact this employer for a reference? Yes No

Employment Application

References

List below three persons not related to you who have knowledge of your work performance within the last three years.

First Name _____ Last Name _____ Phone Number _____

Address & Street _____ City _____ State _____ Zip Code _____

Occupation _____ No. of Years Acquainted _____

First Name _____ Last Name _____ Phone Number _____

Address & Street _____ City _____ State _____ Zip Code _____

Occupation _____ No. of Years Acquainted _____

First Name _____ Last Name _____ Phone Number _____

Address & Street _____ City _____ State _____ Zip Code _____

Occupation _____ No. of Years Acquainted _____

Employment Application

Please Read Carefully, Initial Each Paragraph and Sign Below

Initials

I hereby certify that I have not knowingly withheld any information that might adversely affect my chances for employment and that the answers given by me are true and correct to the best of my knowledge. I further certify that I, the undersigned applicant, have personally completed this application. I understand that any omission or misstatement of material fact on this application or on any document used to secure employment shall be grounds for rejection of this application or for immediate discharge if I am employed, regardless of the time elapsed before discovery.

Initials

I hereby authorize _____ to thoroughly investigate my references, work record, education and other matters related to my suitability for employment unless otherwise specified above. I further, authorize the references I have listed to disclose to the company any and all letters, reports and other information related to my work records, without giving me prior notice of such disclosure. In addition, I hereby release the Company, my former employers and all other persons, corporations, partnerships and associations from any and all claims, demands or liabilities arising out of or in any way related to such investigation or disclosure.

Initials

I understand that nothing contained in the application, or conveyed during any interview which may be granted or during my employment, if hired, is intended to create an employment contract between me and the Company. In addition, I understand and agree that if I am employed, my employment is for no definite or determinable period and may be terminated at any time, with or without prior notice, at the option of either myself or the Company, and that no promises or representations contrary to the foregoing are binding on the company unless made in writing and signed by me and the Company's designated representative.

Initials

In compliance with federal law, all persons hired will be required to verify identity and eligibility to work in the United States and to complete the required employment eligibility verification document form upon hire.

Date

Applicant's Signature

Employment Application

Optional

The information requested below is necessary for the specific position for which you are applying. A "yes" answer will not necessarily disqualify you from the position. The nature of the offense, the date of the offense, the surrounding circumstances and the relevance of the offense to the position applied for may, however, be considered.

Any information regarding criminal history will be maintained confidentially.

Have you ever been convicted of a criminal offense (felony or misdemeanor)?

Please do not list: misdemeanor convictions for marijuana-related offenses that are more than two years old; infractions; records relating to diversion programs; convictions that have been judicially dismissed, expunged or ordered sealed pursuant to law; or any convictions, adjudications or other court actions by a juvenile court Yes No

If yes, please list the crime(s) you were convicted of and when and where convicted. Please also include any other information you want to share with us about this conviction, any mitigating circumstances or any additional information you believe may be relevant.

Date _____

Applicant's Signature

Employment Application

Optional

Initials _____ This Company conducts internal background checks and may search public records. I am entitled to copies of any such public records obtained by the Company unless I mark the check box below.

If I am not hired as a result of such information, I am entitled to a copy of any such records even though I have checked the box below.

"Public records" are defined by California state law and means records documenting an "arrest, indictment, conviction, civil judicial action, tax lien, or outstanding judgment." (Civil Code section 1786.53) **Any public records request performed by internal personnel employed by the Company will only be conducted and used to the extent allowed by federal, state or local law, including any laws governing use of criminal history information.**

I waive receipt of a copy of any public record described in the paragraph above.

Date

Applicant's Signature

Must Have Copies of the Following

1. Twic Card
2. Driver License
3. Social Security Card
4. Medical Card
5. Voided Check
6. Print out from DMV of driving record

Extreme Transportation Inc.'s

Driver Safety Notice & Procedures

Drivers:

1. Must wear NON-Slip enclosed shoes (NO Tennis Shoes)
2. Gloves (No Jewelry)
3. Safety Vest (Wear when required)
4. Extreme work shirts & jackets (Only)

Please slow down and take all precautions when loading & unloading vehicles. Be aware of your surroundings, this is for your own **SAFETY!**

Loading Procedures:

1. Do NOT drive fast in yards!!!!!!
2. Check that all vehicles are tied down properly
3. NO loading of convertibles, camper shells or trucks with tonneau covers backward on trailer
(Not following this procedure of loading will result in severe damages! If discovered that these types of vehicles were loading improper and caused damage you will be terminated immediately.)
4. Avoid if possible from loading convertible on bottom of trailers

Truck Gear:

1. Jump Boxes (If you don't have one in the truck now because you have left it somewhere, you are allowed to go get ONE more. Next one will be one you!)
2. Kitty Litter (This is for oil leaks etc. must have for yards)
3. Triangle safety cones

Paperwork Requirement:

1. Must have if you want to get paid for load:
 - A. Date
 - B. Truck Number
 - C. Driver Signed Name
 - D. Full address of pick-up & drop off locations
 - E. Complete inspections of vehicles

Please sign and return to office. This ensures that you have read and understand this notice.

Driver's Signature: _____ Date: _____

DRIVER NOTICE

PAPERWORK

ALL paperwork must be in the office every MONDAY AM!!!! NO EXCEPTIONS.

EXTRA PASSENGERS

Effective Immediately: Non - Employee's of Extreme Transportation Inc. are **NOT** allowed to ride in company trucks, drive or pull cars, help load or unload vehicles on or off trailer. This includes all family members, friends etc. This is an insurance issue and will **NOT** be allowed.

Please sign and return this letter acknowledging you have read, understand and will follow these regulations.

Driver Signature

Date

Extreme Transportation Inc
400 Mile of Cars Way
Ste C
National City CA 91950
(619) 292-2830
(951)346-3760 Fax

Driver's Notice

(Company Drug & Alcohol Policy)

Please read carefully: This is a company driver's notice to inform you that here at Extreme Transportation Inc. has a NO tolerance policy to testing positive to any types of drugs or alcohol. This means you will be terminated immediately as a driver from Extreme Transportation Inc.

If Extreme Transportation Inc. decides to keep you employed after testing positive you will have to go through a drug and alcohol substance class that will be recommended to you by our drug management company (CMCI). You will not be eligible to drive until course is complete and a new drug & alcohol test is completed with a negative result.

This letter must be signed by you the driver and returned immediately to office. This shows that you have read and completely agree to all terms of being employed as a driver by Extreme Transportation Inc.

Nikki Perham - V.P.

Date

Driver

Date

Extreme Transportation Inc.
2525 Southport Way
Suite B
National City CA 91950
619-292-2830

Driver Notice

Several texts and verbal notifications have gone out regarding Vin #'s, Damage Reports etc. This is to clearly STATE there will be ZERO exceptions on the following:

1. **Vin#** on unit is short (need last 8) you will NOT be paid for unit unless the correct Vin# is provided... No guessing of numbers!
2. **Lost keys** to units are 100% drivers responsibility to keep in there safe possession until unit is delivered. Lost

keys to cars will be at drivers expense NOT Extreme Transportation Inc.

3. Inspections - drivers must do a complete inspection of vehicles. If Extreme Transportation Inc. receives a claim for such vehicles and the original documentation does NOT show a driver inspection it will be 100% of the drivers responsibility to pay for damaged vehicle. You all have been made aware of this policy time and time again. Our vendors expect and demand inspections of vehicles. Every military vehicle hauled must have the current mileage noted on paperwork. Truck #, Driver Name (Clearly Written) Date....

We are not out there with each and every one of you when you load. These all are considered drivers responsibility of transporting someone's vehicle. Please sign and return to office by fax, mail or email ASAP that you have read and understand notice.

Drivers

Signature: _____ Date: _____



2434 Southport Way, STE F, National City, CA 91950

To: All New Drivers hired by Extreme Transportation

If you are a driver seeking employment with Extreme Transportation Inc., the hiring policy includes the following stipulation:

Any driver applicant that does not have previous vehicle hauling experience, and is trained by Extreme Transportation Inc., is required to commit to a period of 1 (one) year of service after hiring and will NOT seek employment with a competing Auto-Hauling Company. The initial 90-day probationary period is included in the year time frame.

By signing this agreement, the Driver Applicant agrees to this provision.

Driver Applicant

Date



Enrollment Form

LAST NAME		FIRST NAME		MI
STREET ADDRESS		CITY	STATE	ZIP CODE
MAILING ADDRESS (IF DIFFERENT)		CITY	STATE	ZIP CODE
COUNTY OF RESIDENCE	HOME PHONE	MESSAGE / CELL PHONE		
EMAIL ADDRESS		EMERGENCY CONTACT	PHONE NUMBER	
DATE OF BIRTH	IF YOU ARE UNDER 18 YEARS OLD DO YOU HAVE A WORK PERMIT?		<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	SSN #
EMPLOYER NAME	EXTREME TRANSPORTATION, INC		TITLE / POSITION	
DATE OF HIRE WITH YOUR EMPLOYER	DEPARTMENT		EMPLOYEE ID #	

Acknowledgment

- Introduction to BBSI.** Your Worksite Employer is the company or organization where you report to work and/or that supervises you. Your Worksite Employer has entered into a contract with Barrett Business Services, Inc. ("BBSI") to assist with human resources related matters, such as payroll and workers' compensation insurance. The term "Worksite Employee" refers to you.
- Your Worksite Employer.** You acknowledge that your Worksite Employer, and not BBSI, is the Primary Employer for purposes of the services or work you perform and safety in the workplace. Your Worksite Employer retains control of the worksite, supervises and directs your day-to-day work activities, provides the facilities and furnishes the equipment and supplies for your work (including personal protective equipment, if any is required to perform your job duties), determines your work schedule, monitors your workload and productivity, ensures that you are properly trained to perform your job safely, ensures that you are covered by an effective Injury and Illness Prevention Program, and determines your rate of pay and job classification. You acknowledge that Worksite Employer, and not BBSI, receives the economic benefit of the services or work you perform. BBSI will take responsibility for certain administrative functions, as agreed upon between BBSI and your Worksite Employer.
- At-Will Status.** Your employment relationship with Worksite Employer remains at-will, which means it can be terminated by you or Worksite Employer with or without cause and with or without advance notice, unless you have a written employment contract with Worksite Employer providing you with something other than at-will employment with Worksite Employer. Regardless of the nature of your employment relationship with Worksite Employer, your status with BBSI can be terminated with or without cause and with or without advance notice. If your employment relationship with Worksite Employer ends, your status with BBSI will also end at that time. However, if your Worksite Employer and BBSI end their contract with one another, thereby terminating your status with BBSI, that event alone would not result in the termination of your employment relationship with Worksite Employer.
- Worksite Employer Paid Time Off and Other Benefits.** In the event that Worksite Employer maintains policies providing paid time off from work, such as vacation, sick leave, PTO, or paid leave for specific reasons such as pregnancy, Worksite Employer is solely responsible for funding or determining eligibility for benefits under such policies. BBSI does not provide, and has no policy providing, vacation or other paid time off benefits, except to the extent required by law. To the extent paid time off benefits are paid through BBSI's payroll, it is solely as an administrative service on behalf of Worksite Employer. Similarly, to the extent Worksite Employer provides other benefits pursuant to policies to which BBSI is not a party, such as severance pay, stock options, bonuses, profit sharing, retirement benefits, disability insurance, and so forth, Worksite Employer is solely responsible for providing such benefits (or procuring the benefits from third parties). To the extent state or local paid sick leave laws apply to you, Worksite Employer is responsible for providing such benefits both on behalf of Worksite Employer and on behalf of BBSI (to the extent BBSI has any obligations under such laws). By providing examples of potential Worksite Employer benefits, this Acknowledgment does not create any right to such benefits or imply that any such benefits exist.

5. **Discrimination, Harassment and Other Unlawful Treatment.** If you feel that you have been subjected to discrimination, harassment, retaliation, denied a legally-mandated leave, or experienced other unlawful treatment in your employment, or if you require an accommodation to perform the essential functions of your job and/or for your religious beliefs or observances, immediately contact your supervisor or another member of management at your Worksite Employer. If you do not feel comfortable contacting anyone at Worksite Employer, or if you feel that Worksite Employer has not adequately addressed your concerns, notify BBSI immediately. The accommodations referenced herein include, but are not limited to, lactation accommodation. Unlawful discrimination, harassment, and retaliation are defined and discussed in separate policies that have been provided to you. Please be certain you read and understand those policies. If such written policies are not yet available to you at a time when you need to review and understand your entitlements, obligations, and rights with regard to these subjects, contact BBSI for assistance.
6. **Wage and Hour Compliance.** Although BBSI processes the payroll for your compensation and may assist Worksite Employer with other administrative matters involving your compensation, only your Worksite Employer is able to ensure that: your hours of work are all captured and reported correctly for payment; you are classified correctly as exempt or non-exempt; you are paid overtime if overtime is applicable to you; you are reimbursed for reasonable work-related expenses; and you receive the breaks to which you may be entitled. You agree that Worksite Employer has sole control of these topics, and that therefore Worksite Employer is solely responsible for any claims you may have related to these topics.
7. **Accidents and Injuries.** Immediately report work related injuries or accidents, or unsafe working conditions to your supervisor, and contact BBSI if the situation is not timely addressed by your supervisor. You should immediately stop working if you feel your work area is unsafe. Additionally, if you are assigned work that you reasonably believe to be dangerous, you may refuse to do that work, and you should contact your supervisor or BBSI. Worksite Employer and BBSI reserve the right to require post-accident/post-injury drug and alcohol screening when permitted by law. Refer to the applicable drug and alcohol policy for more information on drug and alcohol screening.
8. **Alcohol and Drug Testing.** In the discretion of your Worksite Employer, you may be tested for Drugs (as defined below) and/or alcohol to the full extent permitted by the law of the state where you are employed, including but not limited to random, periodic, safety sensitive, post-accident, post-injury, and "cause" or "reasonable suspicion" testing. You may be suspended pending the results of the test. The conditions of the suspension will depend on the circumstances. Refusal to submit to drug and/or alcohol testing on a timely and cooperative basis, or tampering with the process or sample, will subject you to discipline up to and including termination. Possession, sale and/or use of drugs while on duty, during business travel, while operating a Worksite Employer owned vehicle, and/or while on Worksite Employer premises (or customer premises), is forbidden. Similarly, possession and/or consumption of alcoholic beverages, or being under the influence of alcohol, or having Drugs in your system, is prohibited in those same circumstances. For purposes of this policy, "Drugs" include unlawful substance, a lawful substance used or acquired unlawfully, and lawfully acquired and used drugs that may cause a safety hazard when used in conjunction with your job. An employee using prescription or over-the-counter drugs that may impair the employee's ability to safely perform the job, or affect the safety of others, must notify a supervisor immediately before starting or resuming work. In order to enforce this policy, the Worksite Employer reserves the right to conduct searches of Worksite Employer property, employees and/or personal property, and to implement other measures necessary to deter and detect violation of this policy. Failure to comply with these rules regarding drugs and alcohol will subject you to discipline up to and including termination.
9. **Employee Expense Reimbursements.** Although BBSI may disperse expense reimbursements related to your work for your Worksite Employer, your Worksite Employer is solely responsible for determining the amount of reimbursement owed and administering all expense reimbursement programs and policies. BBSI's only role with respect to expense reimbursement is disbursement of the funds provided by Worksite Employer in amounts determined by Worksite Employer.
10. **Other Worksite Employer Policies.** Your Worksite Employer will have other rules, policies and procedures you must follow. If you have any questions about those items, please consult your supervisor or another member of management at your Worksite Employer. It is your responsibility to remain informed regarding changes or updates in rules, policies, and procedures.
11. **Agreement.** Your signature below confirms that you understand, acknowledge, and agree to the terms, conditions, facts, and policies set forth in this document. This document is not a contract for continued employment nor does it guarantee the provision of any set benefit or wage. This Acknowledgment supersedes any prior verbal or written promises or discussions regarding the subjects set forth herein. Should any term or provision of this Acknowledgment, or portion thereof, be declared void or unenforceable it shall be severed and the remainder of this Acknowledgment shall be enforceable. The terms of this Acknowledgment may only be changed in writing, by an authorized representative of BBSI.

WORKSITE EMPLOYEE SIGNATURE

WORKSITE EMPLOYEE NAME (PRINT)

DATE

EEO / AFFIRMATIVE ACTION / VETERAN DISCLOSURE FORM

DATE: _____

NAME: _____

LAST FOUR DIGITS OF SOCIAL SECURITY #: _____

PLEASE PRINT THE EXACT JOB TITLE FOR WHICH YOU ARE APPLYING:

Barrett Business Services, Inc. is committed to **EQUAL EMPLOYMENT OPPORTUNITY (EEO)**, employment practices. We ask that all applicants VOLUNTARILY provide the following information to assist us in fulfilling that commitment and ensuring compliance with various governmental requirements.

Thank you for your cooperation.

CHECK ALL THAT APPLY:

- | | |
|--------------------------------------------------------|---------------------------------------------------------------------------------|
| <input type="checkbox"/> MALE [M] | <input type="checkbox"/> WHITE [W] |
| <input type="checkbox"/> FEMALE [F] | <input type="checkbox"/> AMERICAN INDIAN / ALASKAN NATIVE [I] |
| <input type="checkbox"/> ASIAN [A] | <input type="checkbox"/> NATIVE HAWAIIAN/PACIFIC ISLANDER [P] |
| <input type="checkbox"/> BLACK OR AFRICAN-AMERICAN [B] | <input type="checkbox"/> TWO OR MORE RACES [T] |
| <input type="checkbox"/> HISPANIC OR LATINO [H] | <input type="checkbox"/> I choose not to provide the information requested. [Z] |

VIETNAM ERA VETERAN

 No Yes

Served on active duty for a period of more than 180 days, any part of which occurred between 8/5/64 and 5/7/75, and was discharged or released with other than a dishonorable discharge or because of a service connected disability.

SPECIAL DISABLED VETERAN

 No Yes

Entitled to disability compensation under laws administered by the Veteran's Administration for a disability rated 30 percent or more or rated at 10-20 percent in the case of a veteran who has been determined under Section 1506 of Title 38, U.S.C., to have a serious employment disability, or charged/released from active duty because of a service connected disability.

NEWLY SEPARATED VETERAN

 No Yes

Released or discharged from active duty within last one year period.

Employee Acknowledgement of the Medical Provider Network

In order to provide the most timely and suitable quality medical care in the event of an injury on the job, we have instituted a Medical Provider Network for Workers' Compensation purposes.

The following procedures must be followed for all work related injuries and illnesses.

- Report promptly any work related injury to the supervisor.
- For a referral to a medical provider specialist, contact your employer or claims adjuster.
- Ensure all medical treatment is handled only through the MPN (Medical Provider Network) unless otherwise authorized.
- Direct all questions about the level of care to the PCP (Primary Care Physician), who is the focal point for all medical treatment.
- A directory of medical care providers is available at my request through my employer.

Please sign below to indicate that you have read and understand the procedures to follow in the event of an injury and your duties under our Medical Provider Network.

Print Name _____
 Employee Signature _____
 Employee Number (Optional) _____

Date _____ EXTREME TRANSPORTATION, INC
 Employer _____

A COPY OF THE MPN DIRECTORY IS AVAILABLE FROM YOUR EMPLOYER OR ADJUSTER UPON YOUR REQUEST.

Reconocimiento Del Empleado De La Medical Provider Network

Para brindar atención médica de la más rápida y de apropiada calidad en el evento de una lesión ocasionada en el trabajo, hemos instituido una Red de Proveedores Médicos para propósitos Compensación Laboral.

Los procedimientos siguientes deben ser seguidos para todas las lesiones y enfermedades ocasionadas en el trabajo.

- Reporte inmediatamente a su supervisor cualquier lesión ocasionada en el trabajo.
- Para una referencia a un médico especialista, comuníquese con su empleador o ajustador de reclamos.
- Cerciórese que todo tratamiento médico sea manejado únicamente por la MPN (Red de Proveedores Médicos), a menos que de otro modo autorizado
- Dirija toda pregunta sobre el nivel de cuidado al PCP (Primary Care Physician – Médico de Cabecera), quien es el punto de referencia para todo tratamiento médico.
- Un directorio de proveedores de cuidado médico está disponible al solicitarlo a través de mi empleador.

Por favor firmar abajo para indicar que usted ha leído y entendido los procedimientos que se siguen en el evento de una lesión y sus responsabilidades bajo nuestra Red de Proveedores Médicos.

Nombre en Imprenta _____
 Firma del Empleado _____
 Número del Empleado (Opcional) _____

Fecha _____
 Empleador _____

UNA COPIA DEL DIRECTORIO DE LA MPN ESTA DISPONIBLE DE SU EMPLEADOR O AJUSTADOR AL SOLICITARLO.

DO NOT COPY

Notification to the Workers' Compensation Insurance Fraud Division

The law requires that BBSI notify the Workers' Compensation Insurance Fraud Division of any concerns of false or fraudulent claims.

Any person who makes or causes to be made any knowingly false or fraudulent material statement or material misrepresentation for the purpose of obtaining or denying workers' compensation benefits or payments is guilty of a felony and may be fined and imprisoned.

A violation of this law is punishable by imprisonment for one to five years, or by a fine not exceeding \$150,000 or double the value of the fraud, whichever is greater, or both imprisonment and fine. Additional civil penalties may be in order.

BBSI will pursue every suspected case of workers' compensation fraud, and will prosecute to the fullest extent of the law.

I have read and understand this policy.

- ✓ Name: _____
- ✓ Signature: _____
- ✓ Social Security Number: XXX-XX-_____
- ✓ Date: _____

EMPLOYEE RESPONSIBILITY AND ACKNOWLEDGMENT

I understand that it is my responsibility to comply with and observe all company safety and health rules and apply the principles of accident prevention in my day-to-day duties as outlined in this Employee Safety Handbook and the Code of Safe Practices contained within this document.

I agree to cooperate fully with my employer's safety programs and initiatives, follow all safety rules, and to report any unsafe work conditions to my employer and injuries to my employer and BBSI immediately upon discovery.

✓ I have been shown the location of the following (✓ all that apply):

- | | | |
|------------------------------------------|--------------------------------------|----------------------------------------------------|
| <input type="radio"/> Fire Extinguishers | <input type="radio"/> First Aid Kits | <input type="radio"/> Material Safety Data Sheets |
| <input type="radio"/> Emergency Exits | <input type="radio"/> Restrooms | <input type="radio"/> Designated Break/Lunch Areas |

✓ I have been issued the following (✓ all that apply):

- | | | |
|------------------------------------------|----------------------------------------------|-------------------------------------------------|
| <input type="radio"/> Safety Glasses | <input type="radio"/> Face Shield | <input type="radio"/> Respirators/Dust Masks |
| <input type="radio"/> Aprons/Chaps | <input type="radio"/> Shoes | <input type="radio"/> Fall Protection Equipment |
| <input type="radio"/> Hearing Protection | <input type="radio"/> Gloves/Hand Protection | <input type="radio"/> Hard Hat/Head Protection |

✓ I have read the Employee Safety Handbook and completed the following:

- | | |
|------------------------------------|------------------------------------|
| <input type="radio"/> Safety Quiz | <input type="radio"/> Other: _____ |
| <input type="radio"/> Other: _____ | <input type="radio"/> Other: _____ |
| <input type="radio"/> Other: _____ | <input type="radio"/> Other: _____ |

Employee Section

<input checked="" type="checkbox"/>	Employee's Name (Print)	Employee's Signature	<input checked="" type="checkbox"/>
<input checked="" type="checkbox"/>	XXX-XX-	Employment Start Date	
	Employee's Social Security Number		

Manager/Supervisor/Trainer Section

Manager/Trainer Name (Print)	Manager/Trainer Signature	Date
------------------------------	---------------------------	------

Form W-4 (2017)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Personal Allowances Worksheet (Keep for your records.)

- | | | |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---|
| A | Enter "1" for yourself if no one else can claim you as a dependent | A |
| B | Enter "1" if: { • You're single and have only one job; or
• You're married, have only one job, and your spouse doesn't work; or
• Your wages from a second job or your spouse's wages (or the total of both) are \$1,500 or less. } | B |
| C | Enter "1" for your spouse . But, you may choose to enter "-0-" if you are married and have either a working spouse or more than one job. (Entering "-0-" may help you avoid having too little tax withheld.) | C |
| D | Enter number of dependents (other than your spouse or yourself) you will claim on your tax return | D |
| E | Enter "1" if you will file as head of household on your tax return (see conditions under Head of household above) | E |
| F | Enter "1" if you have at least \$2,000 of child or dependent care expenses for which you plan to claim a credit | 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 \$70,000 (\$100,000 if married), enter "2" for each eligible child; then less "1" if you have two to four eligible children or less "2" if you have five or more eligible children.
• If your total income will be between \$70,000 and \$84,000 (\$100,000 and \$119,000 if married), enter "1" for each eligible child. G | 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 | H |
| For accuracy,
complete all
worksheets
that apply. {
• If you plan to itemize or claim adjustments to income and want to reduce your withholding, see the Deductions and Adjustments Worksheet on page 2.
• If you are single and have more than one job or are married and you and your spouse both work and the combined earnings from all jobs exceed \$50,000 (\$20,000 if married), see the Two-Earners/Multiple Jobs Worksheet on page 2 to avoid having too little tax withheld.
• If neither of the above situations applies , stop here and enter the number from line H on line 5 of Form W-4 below. | | |

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

W-4		Employee's Withholding Allowance Certificate	OMB No. 1545-0074
Form Department of the Treasury Internal Revenue Service		► 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.	2017
1 Your first name and middle initial	Last name	2 Your social security number	
Home address (number and street or rural route)		3 <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> 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. ► <input type="checkbox"/>	
5 Total number of allowances you are claiming (from line H above or from the applicable worksheet on page 2) 5			
6 Additional amount, if any, you want withheld from each paycheck 6 \$			
7 I claim exemption from withholding for 2017, and I certify that I meet both of the following conditions for exemption. • Last year I had a right to a refund of all federal income tax withheld because I had no tax liability , and • This year I expect a refund of all federal income tax withheld because I expect to have no tax liability . If you meet both conditions, write "Exempt" here. ► 7			

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

Employee's signature

(This form is not valid unless you sign it.) ►

Date ►

8 Employer's name and address (Employer: Complete lines 8 and 10 only if sending to the IRS.) EXTREME TRANSPORTATION, INC	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 (2017)

DO NOT COPY

Deductions and Adjustments Worksheet

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

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

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

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

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

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

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

Table 1

Married Filing Jointly		All Others		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	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 - \$7,000	0	\$0 - \$8,000	0	\$0 - \$75,000	\$610	\$0 - \$38,000	\$610
7,001 - 14,000	1	8,001 - 16,000	1	75,001 - 135,000	1,010	38,001 - 85,000	1,010
14,001 - 22,000	2	16,001 - 26,000	2	135,001 - 205,000	1,130	85,001 - 185,000	1,130
22,001 - 27,000	3	26,001 - 34,000	3	205,001 - 360,000	1,340	185,001 - 400,000	1,340
27,001 - 35,000	4	34,001 - 44,000	4	360,001 - 405,000	1,420	400,001 and over	1,600
35,001 - 44,000	5	44,001 - 70,000	5	405,001 and over	1,600		
44,001 - 55,000	6	70,001 - 85,000	6				
55,001 - 65,000	7	85,001 - 110,000	7				
65,001 - 75,000	8	110,001 - 125,000	8				
75,001 - 80,000	9	125,001 - 140,000	9				
80,001 - 95,000	10	140,001 and over	10				
95,001 - 115,000	11						
115,001 - 130,000	12						
130,001 - 140,000	13						
140,001 - 150,000	14						
150,001 and over	15						

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.



**Employment Eligibility Verification
Department of Homeland Security
U.S. Citizenship and Immigration Services**

**USCIS
Form I-9**

OMB No. 1615-0047
Expires 08/31/2019

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

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

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

Last Name (Family Name)	First Name (Given Name)	Middle Initial	Other Last Names Used (if any)	
Address (Street Number and Name)		Apt. Number	City or Town	State ZIP Code
Date of Birth (mm/dd/yyyy)	U.S. Social Security Number	Employee's E-mail Address		Employee's Telephone Number

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

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

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

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

- 1. Alien Registration Number/USCIS Number: _____
OR _____
- 2. Form I-94 Admission Number: _____
OR _____
- 3. Foreign Passport Number: _____
Country of Issuance: _____

QR Code - Section 1
Do Not Write In This Space

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

Preparer and/or Translator Certification (check one):

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

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

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

Signature of Preparer or Translator	Today's Date (mm/dd/yyyy)		
Last Name (Family Name)	First Name (Given Name)		
Address (Street Number and Name)	City or Town	State	ZIP Code

STOP Employer Completes Next Page **STOP**



Employment Eligibility Verification
Department of Homeland Security
U.S. Citizenship and Immigration Services

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

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	Document Title	
Issuing Authority	Issuing Authority	Issuing Authority	Issuing Authority	
Document Number	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)	Expiration Date (if any) (mm/dd/yyyy)	
Document Title	Additional Information			QR Code - Sections 2 & 3 Do Not Write In This Space
Issuing Authority				
Document Number				
Expiration Date (if any) (mm/dd/yyyy)				
Document Title				
Issuing Authority				
Document Number				
Expiration Date (if any) (mm/dd/yyyy)				

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 EXTREME TRANSPORTATION, INC	
Employer's Business or Organization Address (Street Number and Name) 2434 SOUTHPORt WAY SUITE F	City or Town National City	State CA	ZIP Code 91950

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		5. U.S. Citizen ID Card (Form I-197)
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		6. Military dependent's ID card		6. Identification Card for Use of Resident Citizen in the United States (Form I-179)
		7. U.S. Coast Guard Merchant Mariner Card		7. Employment authorization document issued by the Department of Homeland Security
		8. Native American tribal document		
		9. Driver's license issued by a Canadian government authority		
		For persons under age 18 who are unable to present a document listed above:		
		10. School record or report card		
		11. Clinic, doctor, or hospital record		
		12. Day-care or nursery school record		

Examples of many of these documents appear in Part 13 of the Handbook for Employers (M-274).

Refer to the instructions for more information about acceptable receipts.

Payroll Election Form

- Worksite Employer: EXTREME TRANSPORTATION, INC Date: _____ ✓
 Employee Name (print): _____ Email: _____ ✓
 Employee Signature: _____ Social Security #: _____ ✓

 New Enrollment **Enroll in Direct Deposit to a Bank Account:**

Please complete the section above and attach a voided check, or a copy of a voided check, or a printed confirmation of the ABA Transit Routing Number and your Account Number as it should appear in BBSI's payroll database

 Deposit \$ _____ on each pay date

(Enter "Net" if electing to deposit all net pay into this account)

Name of Financial Institution: _____

ABA Transit Routing Number AND Account Number: _____

Checking Savings Account

 Deposit my remaining (if any) net pay to:

ABA Transit Routing Number AND Account Number: _____

Checking Savings Account

 Enroll in Direct Deposit to a Visa Payroll Card:

Please complete the section above and attach a voided check, or a copy of a voided check, or a printed confirmation of the ABA Transit Routing Number and your Account Number as it should appear in BBSI's payroll database

 Deposit \$ _____ on each pay date (Enter "net" if electing to deposit all net pay)

By checking this box, you are choosing to have your pay direct deposited on a Visa payroll card and agree to the following:

Consent to Payroll Card Account: I hereby designate MetaBank™ as my financial institution to accept the direct deposit of my wages from my employer into an account at MetaBank. I choose to receive a payroll card in my name issued by MetaBank for the purpose of accessing my wages from my Payroll Card account. I acknowledge that third parties other than MetaBank may impose fees and charges in connection with the use of the Payroll Card; however, I understand that I may choose one of several transactions each pay period, which are outlined in the Cardholder Terms and Conditions, by which I can withdraw my entire net pay without the payment of a fee. I declare the foregoing to be true and complete to the best of my knowledge. I authorize Company to deposit my wages each payday directly into my Payroll Card account. This authority remains in effect until I have given written notice by writing to BBSI, Payroll Administrator that I want it terminated. If funds to which I am not entitled are deposited into my Card Account, I authorize BBSI to direct MetaBank to return said funds. I also understand that it is my responsibility to verify deposits prior to any transactions against the Card balance.

 Change Enrollment**Change in Direct Deposit:**

For any changes to original enrollment, please check this box and make the changes in the spaces provided above. A voided check, copy of a voided check or a printed confirmation of the ABA Transit Routing Number and your account number must be attached if you change financial institutions.

 Cancel Enrollment**Cancel Direct Deposit Option:**

Please indicate effective Date of Cancellation: _____

If you do not wish to participate in Direct Deposit please contact your BBSI representative for instructions.

I hereby authorize BBSI and the financial institution listed above to initiate entries into the account number listed on this Agreement. In the event that the financial institution is notified by BBSI that funds to which the employee is not entitled to have been deposited in error to the above listed account, I authorize the financial institution to return such funds to BBSI.

Please note: To ensure prompt and accurate processing of enrollment/change request, forward all employee applications including a voided check (no deposit slips) to BBSI as soon as completed. This agreement may only be terminated as outlined in the CANCEL DIRECT DEPOSIT option listed above. Direct Deposits will typically be effective within 14 days from the date this form is received by BBSI.

If you do not choose one of the direct deposit options above, and you do not complete the Direct Deposit Opt Out form on the reverse, you will automatically receive a Visa payroll card.

**** Direct Deposit into a Bank Account will not be entered without one of the below items.
(Not applicable for Visa Payroll Card.)**

**ATTACH
Voided Check OR Bank Printout of Account and ABA Routing Number**
No Deposit Slips**

The PaychekPLUS! Elite Visa Payroll Card is issued by MetaBank™ pursuant to a license from Visa U.S.A. Inc.



Printed Name

Signature

Date

Payroll Election Form Rev 092017

clear form

DO NOT COPY

EMPLOYEE ACKNOWLEDGEMENT FORM

I have reviewed and understand the Drug and Alcohol Policy. I understand that the Policy will apply to me if I am hired and that compliance with it is a condition of employment my Worksite Employer.

I also understand that I will have to take and pass a drug test for illegal or controlled substances such as (but not limited to) marijuana, cocaine, methamphetamines, amphetamines, and opiates if I want to be hired. If I am hired, I understand that I may be subject to testing as set forth in the Drug and Alcohol Policy, including, but not limited to, testing on a random basis (if applicable and only as legally permissible), after accidents, and if and when the Company or Client concludes that there is reasonable suspicion to believe that I am using, possessing or impaired by drugs or alcohol while I am working, present on Company or Client premises, on Company or Client business, in Company or Client uniform, or while on Company or Client travel (including when I am driving a Company, Client or personal vehicle for work-related purposes).

I understand that I will be subject to discharge if I refuse to cooperate in any of the tests identified in the Drug and Alcohol Policy, fail sufficiently to explain any positive test result to the Company's Medical Review Officer, or otherwise violate the Drug and Alcohol Policy. I also understand that I will not be eligible for hire if I refuse to sign this Acknowledgement Form.

If I am hired, I will abide by the terms of the Drug and Alcohol Policy during my employment with my Worksite Employer.

Employee's Signature

____ / ____ / ____
Date

NOTICE TO EMPLOYEE Labor Code section 2810.5

This form is not intended to alter the at-will nature of your employment, which means the employment relationship can be terminated at-will by any party, at any time, with or without cause or advance notice.

EMPLOYEE

Employee Name: _____ Start Date: _____

EMPLOYER

Legal Name of Hiring Employer: **EXTREME TRANSPORTATION, INC**

Other Names Employer is doing business as (if applicable): _____

Physical Address of Main Office: **2434 SOUTHPORT WAY SUITE F** National City CA 91950

Employer's Mailing Address (if different than above): _____

Employer's Telephone Number: _____

The Company outsources certain employer related functions to Barrett Business Services, Inc. (BBSI). BBSI's main office or principal place of business is located at 8100 NE Parkway Drive, Suite 200, Vancouver, WA 98662. BBSI's phone number is (360) 828-0700.

WAGE INFORMATION

Rate(s) of Pay: _____ Overtime Rate(s) of Pay: _____

Rate by (check box): Hour Shift Day Week Salary Piece rate Commission

Other (provide specifics): _____

Does a written agreement exist providing the rate(s) of pay? (check box): Yes No

If yes, are all rate(s) of pay and bases thereof contained in that written agreement? Yes No

Allowances, if any, claimed as part of minimum wage (including meal or lodging allowances): _____

(If the employee has signed the acknowledgment of receipt below, it does not constitute a voluntary written agreement as required under the law between the employer and employee in order to credit any meals or lodging against the minimum wage. Any such voluntary written agreement must be evidenced by a separate document.)

Regular Pay Day: _____

WORKERS' COMPENSATION

Workers' compensation coverage is provided through Ace American Insurance Co. The contact information for the program is as follows: CorVel Corporation, P.O. Box 277550, Sacramento, CA 95827. The phone number is (916) 605-3800.

Current policy number: _____

Any work related injuries or accidents should be immediately reported to your supervisor and the Company is to contact BBSI immediately thereafter. You will be required to submit to post-accident drug/alcohol testing to the extent permitted by law.

PAID SICK LEAVE

Unless exempt, the employee identified on this notice is entitled to minimum requirements for paid sick leave under state law which provides that an employee:

- a. May accrue paid sick leave and may request and use up to 3 days or 24 hours of accrued paid sick leave per year;
- b. May not be terminated or retaliated against for using or requesting the use of accrued paid sick leave; and
- c. Has the right to file a complaint against an employer who retaliates or discriminates against an employee for
 1. requesting or using accrued sick days;
 2. attempting to exercise the right to use accrued paid sick days;
 3. filing a complaint or alleging a violation of Article 1.5 section 245 et seq. of the California Labor Code;
 4. cooperating in an investigation or prosecution of an alleged violation of this Article or opposing any policy or practice or act that is prohibited by Article 1.5 section 245 et seq. of the California Labor Code.

The following applies to the employee identified on this notice: (Check one box)

1. Accrues paid sick leave only pursuant to the minimum requirements stated in Labor Code §245 et seq. with no other employer policy providing additional or different terms for accrual and use of paid sick leave.
2. Accrues paid sick leave pursuant to the employer's policy which satisfies or exceeds the accrual, carryover, and use requirements of Labor Code §246.
3. Employer provides no less than 24 hours (or 3 days) of paid sick leave at the beginning of each 12-month period.

4. The employee is exempt from paid sick leave protection by Labor Code §245.5. (State exemption and specific subsection for exemption): _____

5. Paid sick leave policy effective date: _____

ACKNOWLEDGMENT OF RECEIPT

(PRINT NAME of Employer representative) _____

(PRINT NAME of Employee) _____

(SIGNATURE of Employer representative) _____

(SIGNATURE of Employee) _____

(Date) _____

(Date) _____

Labor Code section 2810.5(b) requires that the employer notify you in writing of any changes to the information set forth in this Notice within seven calendar days after the time of the changes, unless one of the following applies: (a) All changes are reflected on a timely wage statement furnished in accordance with Labor Code section 226; (b) Notice of all changes is provided in another writing require by law within seven days of the changes.

**Employee Acknowledgment of Receipt of Policy Against
Unlawful Harassment and Discrimination, Policy Against Retaliation
and Personal Appearance and Behavior Policy**

This will acknowledge that I received a copy of the Policy Against Unlawful Harassment and Discrimination, Policy Against Retaliation and Personal Appearance and Behavior Policy and that I will comply with its requirements. I understand that under California law, I will be held personally liable for harassing conduct that violates the California Fair Employment and Housing Act.

PRINT FULL NAME _____

SIGNED _____

DATE _____

(RETAIN IN EMPLOYEE'S PERSONNEL FILE)

EMPLOYMENT-AT-WILL AND ARBITRATION AGREEMENT

1. I acknowledge that my employment, position, and compensation at **EXTREME TRANSPORTATION** (the "Company") are at-will, shall be for no specific duration, and may be changed or terminated at the will of the Company. Both I and the Company have the right to terminate my employment at any time, with or without cause or prior notice. By signing below, I certify that I understand that employment at-will is the sole and entire agreement between myself and the Company concerning the duration of my employment and the circumstances under which my employment may be terminated. It supersedes all prior agreements, understandings, and representations (whether written or oral) concerning the duration of my employment with the Company and/or the circumstances under which my employment may be terminated. My employment-at-will status may only be changed in a written document signed by the President of the Company.

2. I and the Company agree to utilize binding individual arbitration as the sole and exclusive means to resolve all disputes that may arise out of or be related in any way to my employment, including but not limited to the termination of my employment and my compensation. I and the Company each specifically waive and relinquish our respective rights to bring a claim against the other in a court of law. Both I and the Company agree that any claim, dispute, and/or controversy that I may have against the Company (or its owners, directors, officers, managers, employees, or agents), or the Company may have against me, shall be submitted to and determined exclusively by binding arbitration under the Federal Arbitration Act ("FAA"), in conformity with the procedures of the California Arbitration Act (Cal. Code Civ. Proc. sec 1280 et seq., including section 1283.05 and all of the Act's other mandatory and permissive rights to discovery). The FAA applies to this Agreement because the Company's business involves interstate commerce. Included within the scope of this Agreement are all disputes, whether based on tort, contract, statute (including, but not limited to, any claims of discrimination, harassment and/or retaliation, whether they be based on the California Fair Employment and Housing Act, Title VII of the Civil Rights Act of 1964, as amended, or any other state or federal law or regulation), equitable law, or otherwise. The only exception to the requirement of binding arbitration shall be for claims arising under the National Labor Relations Act which are brought before the National Labor Relations Board, claims for medical and disability benefits under the California Workers' Compensation Act, Employment Development Department claims, or other claims that are not subject to arbitration under current law. However, nothing herein shall prevent me from filing and pursuing proceedings before the California Department of Fair Employment and Housing, or the United States Equal Employment Opportunity Commission (although if I choose to pursue a claim following the exhaustion of such administrative remedies, that claim would be subject to the provisions of this Agreement). By this binding arbitration provision, I acknowledge and agree that both the Company and I give up our respective rights to trial by jury of any claim I or the Company may have against the other.

3. All claims brought under this binding arbitration Agreement shall be brought in the individual capacity of myself or the Company. This binding arbitration Agreement shall not be construed to allow or permit the consolidation or joinder of other claims or controversies involving any other employees or parties, or permit such claims or controversies to proceed as a class or collective action. No arbitrator shall have the authority under this agreement to order any such class or collective action. By signing this agreement, I am agreeing to waive any substantive or procedural rights that I may have to bring an action on a class or collective basis.

4. In addition to any other requirements imposed by law, the arbitrator selected to hear claims under this Agreement shall be a retired California Superior Court Judge, or an otherwise qualified individual to whom the parties mutually agree, and shall be subject to disqualification on the same grounds as would apply to a judge of such court. All rules of pleading (including the right of demurrer), all rules of evidence, all rights to resolution of the dispute by means of motions for summary judgment, judgment on the pleadings, and judgment under Code of Civil Procedure Section 631.8 shall apply and be observed. The arbitrator shall have the immunity of a judicial

officer from civil liability when acting in the capacity of an arbitrator, which immunity supplements any other existing immunity. Likewise, all communications during or in connection with the arbitration proceedings are privileged in accordance with Cal. Civil Code Section 47(b). As reasonably required to allow full use and benefit of this agreement's modifications to the Act's procedures, the arbitrator shall extend the times set by the Act for the giving of notices and setting of hearings. Awards shall include the arbitrator's written reasoned opinion. Resolution of all disputes shall be based solely upon the law governing the claims and defenses pleaded, and the arbitrator may not invoke any basis (including but not limited to, notions of "just cause") other than such controlling law.

5. This is the entire agreement between myself and the Company regarding dispute resolution, the length of my employment, and the reasons for termination of my employment, and this agreement supersedes any and all prior agreements regarding these issues. Oral representations or agreements made before or after my employment do not alter this Agreement. If any term, provision or portion of this Agreement is determined to be void or unenforceable it shall be severed and the remainder of this Agreement shall be fully enforceable.

MY SIGNATURE BELOW ATTESTS TO THE FACT THAT I HAVE READ, UNDERSTAND, AND AGREE TO BE LEGALLY BOUND TO ALL OF THE ABOVE TERMS. I FURTHER UNDERSTAND THAT THIS AGREEMENT REQUIRES ME TO ARBITRATE ANY AND ALL DISPUTES THAT ARISE OUT OF MY EMPLOYMENT.

DO NOT SIGN UNTIL YOU HAVE READ THE ABOVE ACKNOWLEDGMENT AND AGREEMENT.

Print Full Name

Signature

Date

[RETAIN IN EMPLOYEE PERSONNEL FILE]



A PART OF NATIONAL COMPLIANCE SOLUTIONS

DOT/FMCSA

Previous Employee Investigation & Inquiries

Section 1: Previous employee information & release

Name: _____ SSN: _____
DOB: _____ Driver License #: _____ State Issued: _____

I hereby authorize _____ to release the following requested information to CDTA, A Part of National Compliance Solutions Inc., 1011 Camino del Rio S #200, San Diego, CA 92108, (888) 908-2381, for the purpose of investigation to qualify me to drive a commercial motor vehicle as required by the U. S. Department of Transportation & Federal Motor Carrier Safety Regulations Parts 382, 391, 392 & 49 CFR Part 40. I understand that information to be released in Section 2 by my previous employer is limited to the following DOT-regulated testing items:

1. Alcohol test with results of 0.04 or higher;
2. Verified positive drug tests;
3. Refusals to be tested;
4. Other violations of DOT agency drug and alcohol testing regulations;
5. Information obtained from previous employers of a drug and alcohol rule violation;
6. Documentation, if any, of completion of the return-to-duty process following a rule violation.

Driver Signature: _____ Date: _____

Section 2: Previous employee work history

Employed from _____ to _____ as a _____.

Did previous employee drive a motor vehicle for you? Yes No

If yes, please indicate the specific type of vehicle and time driven for you:

Tractor/Semi-Trailer _____ years _____ months

Straight Truck _____ years _____ months

Other (please specify) _____ : _____ years _____ months

What type trailer? Tanker Flat* Doubles Van Reefer

*What type cargo if you checked flat?

Was previous employee a safe and efficient driver? Yes No

Was previous employee's general conduct satisfactory? Yes No

Reasons for leaving your employment: Discharged Resigned Laid Off Other

Is previous employee eligible for rehire? Yes No Upon Review

In the past three years did previous employee have any accidents/incidents? Yes No

If yes, * _____ DOT

* _____ NON-DOT

Signature: _____ Date: _____

Section 3: Note Regulations of the Dept. of Transportation (49 CFR part 40)

Requires your company to provide us with information concerning named driver's past drug and alcohol test results, including refusals to be tested.

In the past three years has the previously named applicant ever:

- | | | |
|------------------------------------------------------------------------------------------------------------|------------------------------|-----------------------------|
| • Tested positive for a controlled substance? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| • Tested with an alcohol concentration of 0.04 or higher? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| • Refused to submit to a DOT drug or alcohol test, including a verified adulterated or substituted result? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| • Had any other violations of DOT drug/alcohol testing requirements? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| • Had any other violations of drug/alcohol regulations from previous employers? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

NOTE: If you answered 'yes' to any of the above items, did the employee complete the return-to-duty process?

N/A Yes No

Your Name (print): _____ Title: _____

Your signature: _____ Date: _____

Section 4: General Background Information Release

This information will, in whole or in part, be obtained from CDTA, A Part of National Compliance Solutions Inc., 1011 Camino del Rio S #200, San Diego, CA 92108, (888) 908-2381. These reports will include information as to my work habits, performance and experience along with reasons for termination of past employment from previous employers. Further, I understand that you will be requesting information from various federal, state and other agencies which maintain records concerning my past activities relating to my driving, credit, civil and other experiences as well as notable criminal activity & claims involving me in the files of insurance companies. This release may also be used to obtain worker's compensation and education records.

By signing below, I also acknowledge that I have read and understand the summary of my rights under The Fair Credit Reporting Act, Pub. L. 111-203, H. R. 4173

Driver signature: _____

Current address: _____



**DRUG & ALCOHOL TEST
NOTICE TO REPORT
CDTA • (888) 908-2382**

Date: January 16, 2018

Time: 9:25 AM

Authorized by:

Company: Extreme Transportation, Inc.

DER: Vince Ichihara
(Designated Employer Representative)

Employee Name:

Phone:

Test For: Drug (Urine) Alcohol (Breath)

Test Type: DOT Non-DOT

DOT Agency: FMCSA FAA FRA
 FTA PHMSA USCG

Reason: Pre-Employment Random Post-Accident
 Reasonable Suspicion Return-to-Duty Follow-up

If for any reason the test cannot be performed, call the DER immediately

Fax copy of Custody and Control Form and/or Breath Alcohol Test Result to:

Dr. Donald Weiss
Medical Review Officer
Fax: (619) 209-2103

Collection Site Name:

Collection Site Phone:

Collection Site Address:

C/TPA for Company Named Above:

CDTA
1011 Camino del Rio South, Suite 200
San Diego, CA 92108
Phone: (619) 209-2102
Fax: (619) 209-2103



A DISA GLOBAL SOLUTIONS COMPANY

DOT and FMCSA History Form

Previous Employee Investigation & Inquiries

Section 1: Previous employee information & release

Name: _____ SSN: _____

DOB: _____ Driver License #: _____ State Issued: _____

I hereby authorize _____ to release the following requested Information to CDTA, A DISA Global Solutions Company, 1011 Camino del Rio S •200, San Diego, CA 92108, on behalf of prospective employer for the purpose of investigation to qualify me to drive a commercial motor vehicle as required by the U. S Department of Transportation & Federal Motor Carrier Safety Administration regulations 49 CFR Part 40.25 and 391.23. As the Applicant named above, I hereby authorize the previous employer listed below to release information from my Department of Transportation regulated drug and alcohol testing records and safety performance history in accordance with 49 CFR Part 40.25 and 391.23.

Driver Signature: _____ Date: _____

SECTION 2: NOTE REGULATIONS OF THE DEPARTMENT OF TRANSPORTATION (49 CFR part 40)

Requires your company to provide us with information concerning named drivers past drug and alcohol test results, including refusals to be tested.

In the past three years has the previously named applicant ever:

- | | | | |
|--------------------------------------------------------------------------------------------------------------|------------------------------|------------------------------|-----------------------------|
| Tested positive for a controlled substance? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | |
| Tested with a n alcohol concentration of 0.04 or higher? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | |
| Refused to submit to a DOT drug or alcohol test including a verified adulterated or substituted result? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | |
| Had and other violations of DOT drug/alcohol testing requirements? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | |
| Had a n 4 other violations of drug /alcohol regulations from previous employers? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | |
| NOTE: If you answered 'yes' to any of the above items, did the employee complete the return-to-duty process? | <input type="checkbox"/> N/A | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

• Did the above named individual drive a commercial motor vehicle (CMV) for you?

Yes No

• Please provide the dates employed: _____ to _____

• Reason for leaving your company:

Discharged Resignation Layoff Military Duty Other (specify): _____

Yes No

• While a CMV driver for you, was the individual involved in any accidents as defined in 390.5?

Yes No

If yes, please supply the following information for any accident on your accident register (390.15(b)) that involved the above named individual for the three (3) years prior to the date next to their signature.

Date	Location	# of Injuries	# of Fatalities	Hazmat Spill?
1.				<input type="checkbox"/> Yes <input type="checkbox"/> No
2.				<input type="checkbox"/> Yes <input type="checkbox"/> No
3.				<input type="checkbox"/> Yes <input type="checkbox"/> No

(If you marked yes please provide the SAP contact Information):

NAME OF SAP SPECIALIST _____ PHONE _____

ADDRESS EMAIL _____

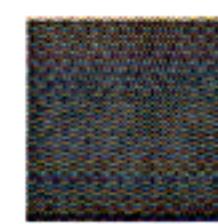
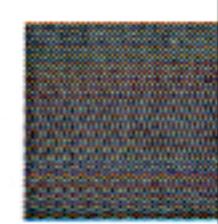
YourName (Print): _____ Title: _____

YourSignature: _____ Date: _____

For more information call us:

888.908.2382

www.cdtaconline.com



1011 Camino del Rio S •200, San Diego, CA 92108