

## APPLICATION FOR EMPLOYMENT

Pre-Employment Questionnaire • An Equal Opportunity Employer

### PERSONAL INFORMATION

DATE: \_\_\_\_\_

LAST NAME: \_\_\_\_\_ MIDDLE: \_\_\_\_\_ FIRST NAME: \_\_\_\_\_

PRESENT ADDR: \_\_\_\_\_ CITY, STATE, ZIP: \_\_\_\_\_

PERMANENT ADDR: \_\_\_\_\_ CITY, STATE, ZIP: \_\_\_\_\_

PHONE NO: \_\_\_\_\_ ARE YOU 18 YEARS OR OLDER? ☐ YES ☐ NO

Are you prevented from lawfully becoming employed in this country Because of visa or immigration status? ☐ YES ☐ NO

### EMPLOYMENT DESIRED

POSITION: \_\_\_\_\_ DATE YOU CAN START: \_\_\_\_\_ SALARY DESIRED: \_\_\_\_\_

ARE YOU CURRENTLY EMPLOYED: \_\_\_\_\_ IF SO MAY WE INQUIRE OF YOUR PRESENT EMPLOYER?: \_\_\_\_\_

EVER APPLIED TO THIS COMPANY BEFORE? \_\_\_\_\_ WHERE? \_\_\_\_\_ WHEN? \_\_\_\_\_

REFERRED BY: \_\_\_\_\_

EDUCATION	NAME AND LOCATION OF SCHOOL	YEARS	DID YOU GRADUATE	SUBJECTS STUDIED
GRAMMAR SCHOOL	_____	_____	_____	_____
HIGH SCHOOL	_____	_____	_____	_____
COLLEGE	_____	_____	_____	_____
OTHER SCHOOLING (TRADE, BUSINESS OR CORRESPONDENCE)	_____	_____	_____	_____

### SPECIAL SKILLS / QUALIFICATIONS

List all special skills, qualifications, licences and certifications:

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### FORMER EMPLOYERS

DATE (MONTH/YEAR)	NAME & ADDRESS	SALARY	POSITION	REASON FOR LEAVING
FROM _____ TO _____	_____	_____	_____	_____
FROM _____ TO _____	_____	_____	_____	_____
FROM _____ TO _____	_____	_____	_____	_____
FROM _____ TO _____	_____	_____	_____	_____

WHICH OF THESE JOBS DID YOU LIKE BEST? \_\_\_\_\_

WHAT DID YOU LIKE MOST ABOUT THIS JOB? \_\_\_\_\_



**REFERENCES:** GIVE THE NAMES OF THREE PERSONS NOT RELATED TO YOU, WHOM YOU HAVE KNOWN AT LEAST ONE YEAR.

NAME	ADDRESS	BUSINESS	YEARS ACQUAINTED
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____

**IN CASE OF EMERGENCY NOTIFY:**

<b>NAME</b>	<b>ADDRESS</b>	<b>PHONE NO.</b>

"I CERTIFY THAT ALL THE INFORMATION SUBMITTED BY ME ON THIS APPLICATION IS TRUE AND COMPLETE, AND I UNDERSTAND THAT IF ANY FALSE INFORMATION, OMISSIONS, OR MISREPRESENTATIONS ARE DISCOVERED, MY APPLICATION MAY BE REJECTED AND, IF I AM EMPLOYED, MY EMPLOYMENT MAY BE TERMINATED AT ANY TIME. IN CONSIDERATION OF MY EMPLOYMENT, I AGREE TO CONFORM TO THE COMPANY'S RULES AND REGULATIONS, AND I AGREE THAT MY EMPLOYMENT AND COMPENSATION CAN BE TERMINATED, WITH OR WITHOUT CAUSE. AND WITH OR WITHOUT NOTICE, AT ANY TIME, AT EITHER MY OR THE COMPANY'S OPTION. I ALSO UNDERSTAND AND AGREE THAT THE TERMS AND CONDITIONS OF MY EMPLOYMENT MAY BE CHANGED, WITH OR WITHOUT CAUSE, AND WITH OR WITHOUT NOTICE, AT ANY TIME BY THE COMPANY. I UNDERSTAND THAT NO COMPANY REPRESENTATIVE, OTHER THAN IT'S PRESIDENT, AND THEN ONLY WHEN IN WRONG AND SIGNED BY THE PRESIDENT, HAS ANY AUTHORITY TO ENTER INTO ANY AGREEMENT FOR EMPLOYMENT FOR ANY SPECIFIC PERIOD OF TIME, OR TO MAKE ANY AGREEMENT CONTRARY TO THE FOREGOING.

► Signature: \_\_\_\_\_ Date: \_\_\_\_\_

---

DO NOT WRITE BELOW THIS LINE

INTERVIEWED BY: \_\_\_\_\_ Date: \_\_\_\_\_

REMARKS:

NEATNESS: \_\_\_\_\_ ABILITY: \_\_\_\_\_

HIRED: ☐ YES ☐ NO    POSITION: \_\_\_\_\_ DEPT: \_\_\_\_\_

SALARY/WAGE: \_\_\_\_\_ DATE REPORTING TO WORK: \_\_\_\_\_

APPROVED: \_\_\_\_\_

1. EMPLOYMENT MANAGER	2. DEPT. HEAD	3. GENERAL MANAGER
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This form has been designed to strictly comply with State and Federal fair employment practice laws prohibiting employment discrimination. This Application for Employment Form is sold for general use throughout the United States. TOPS assumes no responsibility for the inclusion in said form of any questions which, when asked by the Employer of the Job Applicant, may violate State and/or Federal Law.

\*This form has been revised to comply with the provisions of the Americans with Disabilities Act and the final regulations and interpretive guidance promulgated by the EEOC on July 26, 1991.

**FOR OFFICE USE ONLY**

CASH#: \_\_\_\_\_

FEE: **\$36**

UID: \_\_\_\_\_ PREV. UID: \_\_\_\_\_ CLASS: \_\_\_\_\_ CODE: \_\_\_\_\_

## Employee Statement and Security Guard Application

NYS Department of State  
Division of Licensing Services  
P.O. Box 22001  
Albany, NY 12201-2001  
Customer Service: (518) 474-7569  
www.dos.ny.gov

**INSTRUCTIONS:** Forms must be completed in blue or black ink. Incomplete forms will not be processed. Please refer to pages 5 and 6 for further instructions on completing this form.

### APPLICANT INFORMATION SECTION

**APPLICATION AS** (Check only ONE): ☐ Security Guard ☐ Armed Security Guard

**Social Security Number:**

(See Instructions-Privacy Notification) \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

**Birth Date:**

\_\_\_\_ - \_\_\_\_ - \_\_\_\_ (Must be at least 18 years old to apply.)  
M M D D Y Y Y Y

**Applicant's Name:** LAST NAME

FIRST NAME

MIDDLE NAME

NAME SUFFIX (For example: Sr. / Jr. / III )

**Gender:**

**Race:**

☐ Male ☐ Female ☐ White ☐ Black ☐ American Indian or Alaskan Native ☐ Asian or Pacific Islander ☐ Other ☐ Unknown

### RESIDENCE ADDRESS

STREET ADDRESS (Required - P.O. Box may be added to ensure delivery)

APT/UNIT/PO BOX

CITY

STATE

ZIP+4

COUNTY (Enter only if in New York State)

COUNTRY/NATION (Of above address)

DAYTIME PHONE (INCLUDING AREA CODE)

FAX NUMBER - IF ANY (INCLUDING AREA CODE)

E-MAIL ADDRESS (IF ANY)

### DMV Consent Section - IMPORTANT INFORMATION Regarding Your Photo ID

The Department of State produces photo ID cards in cooperation with the NYS Department of Motor Vehicles (DMV). If you have a current NYS Driver License or Non-Driver ID card, please provide your 9-digit DMV ID Number in the space provided below. Then read the informed consent and sign this form. If you do not have a current NYS photo Driver License or Non-Driver ID card, please have your photo taken at any nearby DMV office BEFORE you complete this application. For more details, refer to our notice, "Request for Photo ID."

**INFORMED CONSENT:** I authorize the NYS Department of State and the NYS Department of Motor Vehicles (DMV) to produce an ID card bearing my DMV photo. I understand that DMV will send this card to the address I maintain with the Department of State. I also understand that the Department of State and DMV will use my DMV photo to produce all my subsequent ID Cards for as long as I maintain my license/registration with the Department of State.

DMV ID#

\_\_\_\_ - \_\_\_\_ - \_\_\_\_

**X**

Applicant's Signature

Date Signed

*Employee Statement and Security Guard Application*

**EMPLOYMENT HISTORY**

**Please enter the complete record of your occupation during the last five years. You may copy this page and attach as many sheets as needed.**

**Company One Information:**

NAME OF COMPANY	EMPLOYMENT STATUS ( <i>Full-Time OR Part-Time</i> )	HOURS PER WEEK WORKED
<hr/>		
COMPANY ADDRESS		
<hr/>		
BUSINESS TELEPHONE	SUPERVISOR	DATES OF EMPLOYMENT ( <i>From -To</i> )
<hr/>		
POSITION	DUTIES	
<hr/>		

**Company Two Information:**

NAME OF COMPANY	EMPLOYMENT STATUS ( <i>Full-Time OR Part-Time</i> )	HOURS PER WEEK WORKED
<hr/>		
COMPANY ADDRESS		
<hr/>		
BUSINESS TELEPHONE	SUPERVISOR	DATES OF EMPLOYMENT ( <i>From -To</i> )
<hr/>		
POSITION	DUTIES	
<hr/>		

**Company Three Information:**

NAME OF COMPANY	EMPLOYMENT STATUS ( <i>Full-Time OR Part-Time</i> )	HOURS PER WEEK WORKED
<hr/>		
COMPANY ADDRESS		
<hr/>		
BUSINESS TELEPHONE	SUPERVISOR	DATES OF EMPLOYMENT ( <i>From -To</i> )
<hr/>		
POSITION	DUTIES	
<hr/>		

**Company Four Information:**

NAME OF COMPANY	EMPLOYMENT STATUS ( <i>Full-Time OR Part-Time</i> )	HOURS PER WEEK WORKED
<hr/>		
COMPANY ADDRESS		
<hr/>		
BUSINESS TELEPHONE	SUPERVISOR	DATES OF EMPLOYMENT ( <i>From -To</i> )
<hr/>		
POSITION	DUTIES	
<hr/>		

## **NOTICE TO ALL PARTICIPANTS DRUG SCREENING REQUIREMENTS**

As part of the employment process and after a conditional offer of employment has been extended, potential employees will be required to cooperate in the collection of a urine specimen administered by qualified medical or laboratory personnel designated by the company. Testing of the specimen will be conducted by a company-approved biomedical testing laboratory with demonstrated expertise and procedure to ensure proper handling and reporting of results. In the event of a confirmed positive test result, the conditional offer of employment will be revoked and the hiring process will be terminated immediately.

### **APPLICANT INFORMED CONSENT TO DRUG TESTING AND RELEASE OF LIABILITY AND MEDICAL INFORMATION**

I understand and agree that I am required, as a potential employee, to submit a sample of my urine for chemical testing as a part of my pre-employment screening. It is understood that the urine sample will be taken in the offices of a company designated laboratory and analyzed by qualified medical or laboratory personnel. Further, I understand this analysis will be used to determine the presence, if any, of non-prescribed, unauthorized or prohibited controlled substances in my urine.

I freely and voluntarily consent to this request for a urine specimen. I hereby release and hold harmless the Company, the laboratory, the property owner and their respective employees, agents, contractors, officers, directors and affiliates from any liability whatsoever arising from the request for a urine sample, the testing of the urine sample, and any decisions made on the basis of analysis. I further freely voluntarily authorize the company-designated laboratory to release to the Company all test results of the drug screening urine test as permitted by law.

I understand that a document chain of specimen custody will be made to ensure the identity and integrity of my urine sample throughout the collection and testing process.

X \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Applicant Date Signature of Witness Date

Social Security Number: \_\_\_\_\_

**AUTHORIZATION FOR RELEASE OF INFORMATION**

I hereby authorize ISSM P.S. and/or any of their managed properties and its designated agents and representatives to conduct a comprehensive review of my background through a consumer report/investigative consumer report to be generated for employment, promotion, reassignment, or retention as an employee. I understand that the scope of the consumer report/investigative consumer report may include, but is not limited to the following areas: verification of social security number, current and previous residences, employment history including all personnel files, education, character references, credit history and reports, criminal history records from any criminal justice agency in any or all federal, state county jurisdictions, motor vehicle records to include traffic citations and registration and any other public records.

I authorize the complete release of these records or data pertaining to me which an individual, company, firm, corporation, or public agency may have. I hereby authorize and request any present or former employer, school, police department, financial institution or other persons having personal knowledge of me, to furnish bearer with any and all information in their possession regarding me in connection with an application for employment. This authorization and consent shall be valid in original, fax, or copy form.

I hereby release ISSM P.S. and/or any of their managed properties, and its agents, officials, representatives, or assigned agencies, including officers, employees, or related personnel both individually and collectively, from any and all liability for damages of whatever kind, which may at any time, result to me because of compliance with this authorization. Information on this application and results of the background investigation will be maintained in confidence in accordance with company hiring practices.

PLEASE PRINT:

(First Name)	(Middle Name)	(Maiden/Former Name)	(Last Name)
(Current address, city, state, & zip)			
(Social Security Number)	(Date of Birth)*		
(Driver License Number)	(State of Issue)		
(Signature)		(Date)	

I understand that the company will provide me with a copy of any such report as pursuant to the federal Fair Credit Reporting Act or I may request a copy of any report that is prepared, along with the name and address of the reporting agency that produced the report regarding me and "A Summary of Your Rights under the Fair Credit Reporting Act."

\* I understand that I must provide my date of birth to adequately complete said screening and acknowledge that my date of birth will not affect any hiring decisions.

**8850**  
Form  
(Rev. March 2015)  
Department of the Treasury  
Internal Revenue Service

## Pre-Screening Notice and Certification Request for the Work Opportunity Credit

OMB No. 1545-1500

► Information about Form 8850 and its separate instructions is at [www.irs.gov/form8850](http://www.irs.gov/form8850).

**Job applicant: Fill in the lines below and check any boxes that apply. Complete only this side.**

Your name \_\_\_\_\_ Social security number ► \_\_\_\_\_

Street address where you live \_\_\_\_\_

City or town, state, and ZIP code \_\_\_\_\_

County \_\_\_\_\_ Telephone number \_\_\_\_\_

If you are under age 40, enter your date of birth (month, day, year) \_\_\_\_\_

- 1 ☐ Check here if you received a conditional certification from the state workforce agency (SWA) or a participating local agency for the work opportunity credit.
  
- 2 ☐ Check here if **any** of the following statements apply to you.
  - I am a member of a family that has received assistance from Temporary Assistance for Needy Families (TANF) for any 9 months during the past 18 months.
  - I am a veteran and a member of a family that received Supplemental Nutrition Assistance Program (SNAP) benefits (food stamps) for at least a 3-month period during the past 15 months.
  - I was referred here by a rehabilitation agency approved by the state, an employment network under the Ticket to Work program, or the Department of Veterans Affairs.
  - I am at least age 18 but **not** age 40 or older and I am a member of a family that:
    - a. Received SNAP benefits (food stamps) for the past 6 months; **or**
    - b. Received SNAP benefits (food stamps) for at least 3 of the past 5 months, **but** is no longer eligible to receive them.
  - During the past year, I was convicted of a felony or released from prison for a felony.
  - I received supplemental security income (SSI) benefits for any month ending during the past 60 days.
  - I am a veteran and I was unemployed for a period or periods totaling at least 4 weeks but less than 6 months during the past year.
  
- 3 ☐ Check here if you are a veteran and you were unemployed for a period or periods totaling at least 6 months during the past year.
  
- 4 ☐ Check here if you are a veteran entitled to compensation for a service-connected disability and you were discharged or released from active duty in the U.S. Armed Forces during the past year.
  
- 5 ☐ Check here if you are a veteran entitled to compensation for a service-connected disability and you were unemployed for a period or periods totaling at least 6 months during the past year.
  
- 6 ☐ Check here if you are a member of a family that:
  - Received TANF payments for at least the past 18 months; **or**
  - Received TANF payments for any 18 months beginning after August 5, 1997, **and** the earliest 18-month period beginning after August 5, 1997, ended during the past 2 years; **or**
  - Stopped being eligible for TANF payments during the past 2 years because federal or state law limited the maximum time those payments could be made.

### Signature—All Applicants Must Sign

Under penalties of perjury, I declare that I gave the above information to the employer on or before the day I was offered a job, and it is, to the best of my knowledge, true, correct, and complete.

**Job applicant's signature ►**

**Date**

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

Cat. No. 22851L

Form **8850** (Rev. 3-2015)

**For Employer's Use Only**

Employer's name \_\_\_\_\_ Telephone no. \_\_\_\_\_ EIN ► \_\_\_\_\_

Street address \_\_\_\_\_

City or town, state, and ZIP code \_\_\_\_\_

Person to contact, if different from above \_\_\_\_\_ Telephone no. \_\_\_\_\_

Street address \_\_\_\_\_

City or town, state, and ZIP code \_\_\_\_\_

If, based on the individual's age and home address, he or she is a member of group 4 or 6 (as described under *Members of Targeted Groups* in the separate instructions), enter that group number (4 or 6) . . . . . ► \_\_\_\_\_

Date applicant:

Gave information \_\_\_\_\_ Was offered job \_\_\_\_\_ Was hired \_\_\_\_\_ Started job \_\_\_\_\_

Under penalties of perjury, I declare that the applicant provided the information on this form on or before the day a job was offered to the applicant and that the information I have furnished is, to the best of my knowledge, true, correct, and complete. Based on the information the job applicant furnished on page 1, I believe the individual is a member of a targeted group. I hereby request a certification that the individual is a member of a targeted group.

Employer's signature ►	Title	Date
<p><b>Privacy Act and Paperwork Reduction Act Notice</b></p> <p><i>Section references are to the Internal Revenue Code.</i></p> <p>Section 51(d)(13) permits a prospective employer to request the applicant to complete this form and give it to the prospective employer. The information will be used by the employer to complete the employer's federal tax return. Completion of this form is voluntary and may assist members of targeted groups in securing employment. Routine uses of this form include giving it to the state workforce agency (SWA), which will contact appropriate sources to confirm that the applicant is a member of a targeted group. This form may also be given to the Internal Revenue Service for administration of the Internal Revenue laws, to the Department of Justice for civil and</p>	<p>criminal litigation, to the Department of Labor for oversight of the certifications performed by the SWA, and to cities, states, and the District of Columbia for use in administering their tax laws. 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.</p> <p>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 section 6103.</p>	<p>The time needed to complete and file this form will vary depending on individual circumstances. The estimated average time is:</p> <p><b>Recordkeeping</b> . . . 6 hr., 27 min.</p> <p><b>Learning about the law or the form</b> . . . . . 24 min.</p> <p><b>Preparing and sending this form to the SWA</b> . . . . . 31 min.</p> <p>If you have comments concerning the accuracy of these time estimates or suggestions for making this form simpler, we would be happy to hear from you. You can send us comments from <a href="http://www.irs.gov/formspubs">www.irs.gov/formspubs</a>. Click on "More Information" and then on "Give us feedback." Or you can send your comments to:</p> <p>Internal Revenue Service Tax Forms and Publications 1111 Constitution Ave. NW, IR-6526 Washington, DC 20224</p> <p>Do not send this form to this address. Instead, see <i>When and Where To File</i> in the separate instructions.</p>





U.S. Department Labor  
Employment and Training Administration

OMB No. 1205-0371  
Expiration Date: June 30, 2015

**Individual Characteristics Form (ICF)**

**Work Opportunity Tax Credit**

1. Control No. (For Agency use only)	<b>APPLICANT INFORMATION</b> (See instructions on reverse)		2. Date Received (For Agency Use only)
<b>EMPLOYER INFORMATION</b>			
3. Employer Name	4. Employer Address and Telephone	5. Employer Federal ID Number (EIN)	
<b>APPLICANT INFORMATION</b>			
6. Applicant Name (Last, First, MI)	7. Social Security Number	8. Have you worked for this employer before? Yes ____ No ____  If YES, enter last date of employment: _____	
<b>APPLICANT CHARACTERISTICS FOR WOTC TARGET GROUP CERTIFICATION</b>			
9. Employment Start Date	10. Starting Wage	11. Position	
12. Are you at least age 16, but under age 40? Yes ____ No ____ If YES, enter your <i>date of birth</i> _____			
13. Are you a Veteran of the U.S. Armed Forces? Yes ____ No ____ If NO, go to Box 14. If YES, are you a member of a family that received Supplemental Nutrition Assistance Program (SNAP) benefits (Food Stamps) for at least 3 months during the 15 months before you were hired? Yes ____ No ____ If YES, enter name of <i>primary recipient</i> _____ and <i>city and state</i> where benefits were received _____. OR, are you a veteran entitled to compensation for a service-connected disability? Yes ____ No ____ If YES, were you discharged or released from active duty within a year before you were hired? Yes ____ No ____ OR, were you unemployed for a combined period of at least 6 months (whether or not consecutive) during the year before you were hired? Yes ____ No ____			
14. Are you a member of a family that received Supplemental Nutrition Assistance Program (SNAP) (formerly Food Stamps) benefits for the 6 months before you were hired? Yes ____ No ____ OR, received SNAP benefits for at least a 3-month period within the last 5 months But you are no longer receiving them? Yes ____ No ____ If YES to either question, enter name of <i>primary recipient</i> _____ and <i>city and state</i> where benefits were received _____.			
15. Were you referred to an employer by a Vocational Rehabilitation Agency approved by a State? Yes ____ No ____ OR, by an Employment Network under the Ticket to Work Program? Yes ____ No ____ OR, by the Department of Veterans Affairs? Yes ____ No ____			

ETA Form 9061 – (Rev. July 2013)

**BENEFITS PLAN PRE-TAX ELECTION FORM**

Employee Name: \_\_\_\_\_  
 Employee Home Address: \_\_\_\_\_  
 Employee Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Email: \_\_\_\_\_  
 Plan Year \_\_\_\_\_ through \_\_\_\_\_

Employer health insurance premiums continue to increase drastically and ISSM continues to strive to offer you health insurance coverage.

Our insurance broker has researched all options and after much time and evaluation, we will continue offering our group health insurance. Attached you will find a summary of benefits of the product/s being offered to you. As an eligible participant you acknowledge that you have received the plan outline and understand the benefits available to you. Upon our group's renewal the below contribution changes will take effect, please check off the below contribution pertaining to you:

☐ ***I elect Medical***

	plan 1
Employee Only	

☐ ***I elect to waive Medical Coverage***

I understand that if I waive I will not be able to participate in the plan until next open enrolment or a qualifying event. In the event of a qualifying event, I will notify my employer and request an enrolment form.

**TERMS & CONDITIONS**

I recognize that:

- If I or any of my dependents are a Medicare eligible employee it is my responsibility to check with Medicare that my coverage is considered Credible Coverage by Medicare part D (For more information about Medicare, call 1-800-633-4227). I am aware that by taking coverage through my employer I may inquire an ongoing fine if the RX is not credible coverage. (the current coverage is Non credible)
- Any adjustment to the payroll deduction for the elected benefits are increased or decreased while the agreement remains in effect, my payroll deduction will be adjusted automatically. If my payroll deduction is greater than 9.5% of my household income, I will notify my employer immediately.
- This payroll deduction will replace any previous payroll deduction for Medical Insurance.
- Any returns of premiums from the carrier which may occur due to lower than expected loss ratios etc. will go towards the employer portion of the contribution to help reduce the cost for the company.
- I acknowledge that I am entitled to cobra for me and my family that are covered under the existing plan when I stop getting the insurance through my company and I was offered detailed outlines of the plan options.
- Please note: all employee looking to enrol in the group health insurance, you have the right to enrol on the exchange verses as part of the group insurance, which may reduce the cost of your health insurance for you and can be taken off before taxes. More information can be obtained at [www.healthcare.gov](http://www.healthcare.gov).
- I acknowledge that I received a copy of the SBC and SPD, if you would like a duplicate copy of the plan (SBC or SPD) please contact the payroll/ HR office.

I hereby agree to all of what I have read on this document.

Employee Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Accepted and agreed to by Authorized Representative.

By: \_\_\_\_\_ Date: \_\_\_\_\_

## **NYS LICENSING REGISTRATION FEE**

The General Business Law requires that all emplacement, retirement, resignation or termination of security guards be reported to the NYS Department of State, Division of Licensing Services within 15 calendar days.

The fee for reporting employment of a guard is \$25.00 per guard. This fee will be taken out of your first pay check to ensure that you are registered with the NYS Division of Licensing Services to work for our company.

I, \_\_\_\_\_, authorize ISSM Protective Services to deduct a non-refundable \$25.00 fee from my first pay check to cover the registration fee.

Sign: \_\_\_\_\_ Date: \_\_\_\_\_

## Form W-4 (2016)

**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 2016 expires February 15, 2017. See Pub. 505, Tax Withholding and Estimated Tax.

**Note:** If another person can claim you as a dependent on his or her tax return, you cannot claim exemption from withholding if your income exceeds \$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 do not apply to supplemental wages greater than \$1,000,000.

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

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

**Head of household.** Generally, you 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 2016. 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](http://www.irs.gov/w4).

### Personal Allowances Worksheet (Keep for your records.)

<b>A</b>	Enter "1" for <b>yourself</b> if no one else can claim you as a dependent . . . . .	<b>A</b>	
<b>B</b>	Enter "1" if: <div style="display: inline-block; vertical-align: middle;"> <div style="display: inline-block; vertical-align: middle;"> <ul style="list-style-type: none"> <li>• You are single and have only one job; or</li> <li>• You are married, have only one job, and your spouse does not work; or</li> <li>• Your wages from a second job or your spouse's wages (or the total of both) are \$1,500 or less.</li> </ul> </div> </div>	<b>B</b>	
<b>C</b>	Enter "1" for your <b>spouse</b> . 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.) . . . . .	<b>C</b>	
<b>D</b>	Enter number of <b>dependents</b> (other than your spouse or yourself) you will claim on your tax return . . . . .	<b>D</b>	
<b>E</b>	Enter "1" if you will file as <b>head of household</b> on your tax return (see conditions under <b>Head of household</b> above) . . . . .	<b>E</b>	
<b>F</b>	Enter "1" if you have at least \$2,000 of <b>child or dependent care expenses</b> for which you plan to claim a credit . . . . . ( <b>Note:</b> Do <b>not</b> include child support payments. See Pub. 503, Child and Dependent Care Expenses, for details.)	<b>F</b>	
<b>G</b>	<b>Child Tax Credit</b> (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 <b>less</b> "1" if you have two to four eligible children or <b>less</b> "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 . . . . .	<b>G</b>	
<b>H</b>	Add lines A through G and enter total here. ( <b>Note:</b> This may be different from the number of exemptions you claim on your tax return.) ►	<b>H</b>	

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. -----

<div style="display: flex; justify-content: space-between;"> <div style="width: 20%;"> <p><b>Form W-4</b></p> <p>Department of the Treasury Internal Revenue Service</p> </div> <div style="width: 60%; text-align: center;"> <h3>Employee's Withholding Allowance Certificate</h3> <p>► 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.</p> </div> <div style="width: 20%; text-align: right;"> <p>OMB No. 1545-0074</p> <p style="font-size: 2em; font-weight: bold;">2016</p> </div> </div>	
<p><b>1</b> Your first name and middle initial _____</p> <p style="text-align: right;">Last name _____</p>	<p><b>2</b> Your social security number _____</p>
<p>Home address (number and street or rural route) _____</p> <p>City or town, state, and ZIP code _____</p>	
<p><b>3</b> <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Married, but withhold at higher Single rate. <b>Note:</b> If married, but legally separated, or spouse is a nonresident alien, check the "Single" box.</p> <p><b>4</b> 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"/></p>	
<p><b>5</b> Total number of allowances you are claiming (from line <b>H</b> above or from the applicable worksheet on page 2) <span style="float: right;"><b>5</b></span></p> <p><b>6</b> Additional amount, if any, you want withheld from each paycheck <span style="float: right;"><b>6</b> \$</span></p> <p><b>7</b> I claim exemption from withholding for 2016, and I certify that I meet <b>both</b> of the following conditions for exemption.          • Last year I had a right to a refund of <b>all</b> federal income tax withheld because I had <b>no</b> tax liability, <b>and</b>          • This year I expect a refund of <b>all</b> federal income tax withheld because I expect to have <b>no</b> tax liability.          If you meet both conditions, write "Exempt" here . . . . . ► <span style="float: right;"><b>7</b></span></p>	<div style="border: 1px solid black; height: 100px; width: 100%;"></div>

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** ► \_\_\_\_\_

<b>8</b> Employer's name and address (Employer: Complete lines 8 and 10 only if sending to the IRS.) _____	<b>9</b> Office code (optional) _____	<b>10</b> Employer identification number (EIN) _____
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## PHOTO RELEASE FORM

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I hereby give my employer ISSM Protective Services, Inc. consent to record, videotape and photograph my image and/or voice to be used in the following ways:

- Company intranet accessible by employees only
- Company internet accessible via the World Wide Web to anyone
- Printed employee newsletter
- Printed client/customer newsletter
- Printed annual report

I further understand that no special compensation will be provided to me for use of my image and that I may not be informed in advance of the specific use of my image.

\_\_\_\_\_  
Employee Name (Please Print)

\_\_\_\_\_  
Employee Signature

\_\_\_\_/\_\_\_\_/\_\_\_\_  
Date