



Welcome To  
Pulaski County Special  
School District

# Please print this New Hire Packet. Complete and bring with you to one of the scheduled New Hire Meetings.

The New Hire Paperwork and Insurance meetings have been scheduled for the following dates at 1:00 PM in the Board Room at Central Office

(you do NOT have call and schedule an appointment):

Monday July 13, Tuesday July 14, Thursday July 23, Monday July 27, Tuesday July 28, Tuesday August 4 and Monday August 10.

**I will review your file with you at the New Hire Meeting one-on-one to make sure we have everything that you need to get paid.**

# Required Documentation for your Personnel File

**It is Mandatory to provide originals of the following documents:**

- ❖ **Arkansas Teaching Certificate**  
(1 original) not a color copy
- ❖ **All College transcripts**  
(official) not a color copy

**Copies, faxes or email are sufficient for the following documents:**

- ❖ Social Security Card
- ❖ Drivers License
- ❖ Birth Certificate or Passport
- ❖ PRAXIS or NTE scores



# Pulaski County Special School District

Kristy Manees, Personnel Specialist  
kmanees@pcssd.org

Phone: 501-234-2035  
Fax: 501-490-9897

## MEMO

**TO: New Certified Employees**

**FROM:** Kristy Manees, Certified Personnel Specialist

**RE:** 2015-2016 New Employee New Hire requirements

The information listed below is provided to create your personnel file with PCSSD and to help guide you through your first year with us.

When you come to Human Resources you we will complete several documents for your file. The following forms will be provided to you:

- **Arkansas Teacher Retirement packet**
- **Background check release**
- **Arkansas Child Maltreatment form**
- **I-9**
- **W-4**
- **Substitute information**
- **Verification of Experience (for previous employment experience)**
- **Direct deposit authorization**
- **Insurance applications (Juliet Bogy at 501-234-2127)**

It is mandatory to provide originals of the following documents:

- **AR Teaching Certificate (1 original) not a color copy**
- **All college transcripts (originals) not a color copy**

Copies, faxes or email [kmanees@pcssd.org](mailto:kmanees@pcssd.org) are sufficient for the following documents:

- **Social Security card**
- **Driver's license**
- **Birth certificate or a passport**
- **PRAXIS or NTE scores**

If you do not turn in one or more of the required documents it may result in forfeiture of benefits, non-payment, substitute or incorrect salary, or a delay in receiving your contract that may take 2-4 weeks to correct.

It is your responsibility to submit the documentation within 30 days of hire to receive the salary and benefits you're eligible to receive. If you realize you have submitted the correct documentation and you are being paid incorrectly please contact us as soon as possible. I can be contacted by phone at 501-234-2035, email [kmanees@pcssd.org](mailto:kmanees@pcssd.org) or fax at 501-490-9897.

Thank you for joining us at PCSSD. I hope 2015-2016 is a productive and rewarding year.

The New Hire Paperwork and Insurance meeting have been schedule for the following dates at 1 p.m. in the Board Room at Central Office (you do NOT have call and schedule an appointment):

**Monday, July 13 • Tuesday, July 14 • Thursday, July 23 • Monday, July 27 • Tuesday, July 28 • Tuesday, August 4 and Monday, August 10.**

## Employee Information for Disaster Plan

Name: \_\_\_\_\_ Employee Number: \_\_\_\_\_

Home Number: \_\_\_\_\_ Mobile Number: \_\_\_\_\_

### Emergency Contact:

Name: \_\_\_\_\_

Phone Number: \_\_\_\_\_

**Special Skill Sets:** Please check any that pertain to you

<input type="checkbox"/> CPR Certified	<input type="checkbox"/> Food Service Supervisor
<input type="checkbox"/> Amateur Radio Operator	<input type="checkbox"/> Races Certified – Radio Amateur Civil Emergency Services
<input type="checkbox"/> First Aid Certified	<input type="checkbox"/> Emergency Medical Technician
<input type="checkbox"/> Certified Counselor	<input type="checkbox"/> Paramedic
<input type="checkbox"/> Fluent in Spanish	<input type="checkbox"/> Lives 0 to 2 miles from work
<input type="checkbox"/> Fire Fighter	<input type="checkbox"/> Lives 2 to 5 miles from work
<input type="checkbox"/> Crisis Counselor	<input type="checkbox"/> Lives 5 to 10 miles from work
<input type="checkbox"/> Automatic External Defibrillator (AED) Trained	<input type="checkbox"/> Lives more than 10 miles from work
<input type="checkbox"/> Registered Nurse	<input type="checkbox"/> Active or Reserve Military
<input type="checkbox"/> Search and Rescue Certified	<input type="checkbox"/> HVAC Mechanic
<input type="checkbox"/> Law Enforcement Officer	<input type="checkbox"/> Licensed Plumber
<input type="checkbox"/> Licensed Practical Nurse	<input type="checkbox"/> APSCN Student System Trained
<input type="checkbox"/> Master Electrician	

Other Skills or Comments: \_\_\_\_\_

\_\_\_\_\_

# Employee Information for Disaster Plan Form

Fill out all information

Special Skill Sets  
(Please check any boxes  
that pertain to you.)

*At least ONE Box will  
pertain to everyone!*

# Employee Information for Disaster Plan

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Name: \_\_\_\_\_ Employee Number: \_\_\_\_\_

Home Number: \_\_\_\_\_ Mobile Number: \_\_\_\_\_

## Emergency Contact:

Name: \_\_\_\_\_

Phone Number: \_\_\_\_\_

## Special Skill Sets: Please check any that pertain to you

<input type="checkbox"/> CPR Certified	<input type="checkbox"/> Food Service Supervisor
<input type="checkbox"/> Amateur Radio Operator	<input type="checkbox"/> Races Certified – Radio Amateur Civil Emergency Services
<input type="checkbox"/> First Aid Certified	<input type="checkbox"/> Emergency Medical Technician
<input type="checkbox"/> Certified Counselor	<input type="checkbox"/> Paramedic
<input type="checkbox"/> Fluent in Spanish	<input type="checkbox"/> Lives 0 to 2 miles from work
<input type="checkbox"/> Fire Fighter	<input type="checkbox"/> Lives 2 to 5 miles from work
<input type="checkbox"/> Crisis Counselor	<input type="checkbox"/> Lives 5 to 10 miles from work
<input type="checkbox"/> Automatic External Defibrillator (AED) Trained	<input type="checkbox"/> Lives more than 10 miles from work
<input type="checkbox"/> Registered Nurse	<input type="checkbox"/> Active or Reserve Military
<input type="checkbox"/> Search and Rescue Certified	<input type="checkbox"/> HVAC Mechanic
<input type="checkbox"/> Law Enforcement Officer	<input type="checkbox"/> Licensed Plumber
<input type="checkbox"/> Licensed Practical Nurse	<input type="checkbox"/> APSCN Student System Trained
<input type="checkbox"/> Master Electrician	

Other Skills or Comments: \_\_\_\_\_

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NOTIFICATION LETTER

Dear Employee:

ACA § 6-24-101 requires full open disclosure and approval before a school district employee may sell, lease, provide services, or enter into other transactions with the school district where he/she is employed.

A.C.A. § 6-24-101 does not apply to reimbursements paid for proper work-related expenses. However, in the case of hiring family members of administrators and/or board members, the district must meet all requirements set forth in A.C.A. § 6-24-101 and Act 1381 of 2005.

A.C.A. § 6-24-101 applies when the school employee is financially interested in the transaction. Financially interested means ownership or more than 5% interest; holding a position of director, partner, or top level management; and/or the employee's compensation is based on the transaction with the district.

Therefore, employees of this district have an affirmative obligation under A.C.A. § 6-24-101 to disclose relationships with vendors before the district enters into the contract or before services are performed. Disclosure is to be made to the superintendent of the district. Forms for this purpose will be provided by the district.

Technology employees who establish specifications or approve technology purchases and their family members must disclose relationships and financial interest before the district may enter into technology transactions with the technology employee or a family member.

A.C.A. § 6-24-101 requires proper disclosure and approval of the transaction at an open board meeting. In certain instances, approval by the Commissioner of the Department of Education is required.

Therefore, every district employee will be required to disclose any potential vendor relationship by completing a disclosure form provided by the district. Failure to fully disclose could result in criminal felony charges being brought against the employee. A copy of A.C.A. § 6-24-101 is available in the central office if you wish to review the law. The Act may also be viewed at [www.azleg.state.az.us](http://www.azleg.state.az.us).

Sincerely,



Superintendent



# Notification Letter

## Please Read and Sign.



# Pulaski County Special School District

Dr. Jerry Guess, Superintendent  
925 East Dixon Road  
Little Rock, AR 72206

Phone: 501.490.2000  
Fax: 501.490.0483

## Notification Letter

Dear Employee:

ACA §6-24-101 requires full open disclosure and approval before a school district employee may sell, lease, provide services, or enter into other transactions with the school district where he/she is employed.

ACA §6-24-101 does not apply to reimbursements paid for proper work-related expenses. However, in the case of hiring family members of administrators and/or board members, the district must meet all requirements set forth in ACA §6-24-101 and Act 1381 of 2005.

ACA §6-24-101 applies when the school employee is financially interested in the transaction. Financially interested means ownership or more than 5% interest; holding a position of director, partner, or top level management; and/or the employee's compensation is based on the transaction with the district.

Therefore, employees of this district have an affirmative obligation under ACA §6-24-101 to disclose relationships with vendors before the district enters into the contract or before services are performed. Disclosure is to be made to the superintendent of the district. Forms for this purpose will be provided by the district.

Technology employees who establish specifications or approve technology purchases and their family members must disclose relationships and financial interest before the district may enter into technology transactions with the technology employee or a family member.

ACA §6-24-101 requires proper disclosure and approval of the transaction at an open board meeting. In certain instances, approval by the Commissioner of the Department of Education is required.

Therefore, every district employee will be required to disclose any potential vendor relationship by completing a disclosure form provided by the district. Failure to fully disclose could result in criminal felony charges being brought against the employee. A copy of ACA §6-24-101 is available in the central office if you wish to review the law. The Act may also be viewed at [www.arkleg.state.ar.us](http://www.arkleg.state.ar.us).

Sincerely,

Superintendent

Please sign below to acknowledge receipt of this notification.

School Employee (Print Name and Location) \_\_\_\_\_

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date



School Districts



Form # 1  
Revised 8/2009  
1400 West Third, Little Rock, AR 72201  
Phone (501) 682-1517 or (800) 686-2877  
Fax (501) 682-2329  
Website - <http://www.artrs.gov>

**Membership Data Form**  
To be Completed by Member

Member's Social Security Number \_\_\_\_\_

Name (Last, First, Middle) \_\_\_\_\_

Maiden Name (if applicable) \_\_\_\_\_

Address \_\_\_\_\_

Male  Female Member's Date of Birth \_\_\_\_\_

County of Residence \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Member's Telephone Number Work ( ) \_\_\_\_\_ Home ( ) \_\_\_\_\_

Name of Spouse (Last, First, Middle) \_\_\_\_\_

Spouse's Date of Birth \_\_\_\_\_

Member's Signature \_\_\_\_\_ Date \_\_\_\_\_

**Member History**

**Previous Service:**

Arkansas Public Schools	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Dates _____
Arkansas State Agency	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Dates _____
Arkansas Highway Dept	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Dates _____
Arkansas State Police	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Dates _____
Private Schools	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Dates _____
Out-of-State Service	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Dates _____
Active Military Service	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Dates _____

Have you ever participated in an Alternate Retirement Plan? (in TIAA-Cref, Valic)  Yes  No

Have you ever been a member of ARTRS?  Yes  No

Have you ever received a refund?  Yes  No

**To be Completed by Employer**

School District Pulaski County Special School District Employer Code 00211

Member's Primary Position \_\_\_\_\_

Is Member a contract Employee?  Yes  No If yes, number of days? \_\_\_\_\_

Employee enrolled as  Contributory  Noncontributory Verified by ARTRS \_\_\_\_\_

Member's first paid day of service (Month/Day/Year) \_\_\_\_\_

# ARTRS Membership Data Form

Page 1

Please print legibly and fill out the first two sections completely.



### Membership Data Form

#### To be Completed by Member

Member's Social Security Number \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Name (Last, First, Middle) \_\_\_\_\_

Maiden Name (If applicable) \_\_\_\_\_

Address \_\_\_\_\_

Male       Female      Member's Date of Birth \_\_\_\_\_

County of Residence \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Member's Telephone Number    Work (    ) \_\_\_\_\_    Home (    ) \_\_\_\_\_

Name of Spouse (Last, First, Middle) \_\_\_\_\_

Spouse's Date of Birth \_\_\_\_\_

Member's Signature \_\_\_\_\_ Date \_\_\_\_\_

#### Member History

**Previous Service:**

- Arkansas Public Schools     Yes     No    Dates \_\_\_\_\_
- Arkansas State Agency     Yes     No    Dates \_\_\_\_\_
- Arkansas Highway Dept     Yes     No    Dates \_\_\_\_\_
- Arkansas State Police     Yes     No    Dates \_\_\_\_\_
- Private Schools     Yes     No    Dates \_\_\_\_\_
- Out-of-State Service     Yes     No    Dates \_\_\_\_\_
- Active Military Service     Yes     No    Dates \_\_\_\_\_

Have you ever participated in an Alternate Retirement Plan? (ie. TIAA-Cref, Valic)     Yes     No

Have you ever been a member of ATRS?     Yes     No

Have you ever received a refund?     Yes     No

#### To be Completed by Employer

School District Pulaski County Special School District    Employer Code 00211

Member's Primary Position \_\_\_\_\_

Is Member a contract Employee?     Yes     No    If yes, number of days? \_\_\_\_\_

Employee enrolled as     Contributory     Noncontributory    Verified by ATRS \_\_\_\_\_


Member's first paid day of service (Month/Day/Year) \_\_\_\_\_

# ARTRS Membership Data Form

*(Please fill out both forms provided. They are NOT the same.)*

## Lump Sum Death Benefit

## Disposition of Residue



Arkansas Teacher Retirement System

Form # 9  
Effective 7/1/2007  
1400 West Third, Little Rock, AR 72201  
Phone (501) 682-1517 or (800) 686-2877  
Fax (501) 682-2359  
Website - <http://www.artrs.gov>

**LUMP SUM DEATH BENEFIT - BENEFICIARY DESIGNATION FORM**

Arkansas Code Annotated § 24-7-720 provides that upon the death of an active or retired member of the Arkansas Teacher Retirement System (ARTRS), with 10 or more years of actual service, a Lump Sum Death Benefit payment in an amount set by the Board of Trustees shall be paid to such person(s) as the member has designated in writing and filed with ARTRS. Effective for a member dying after June 30, 2006, if there is no designated person surviving, the lump sum shall be paid to the member's estate.

Member's Name \_\_\_\_\_ Social Security Number \_\_\_\_\_  
 Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**PART 1 - Designation of Primary Beneficiary(ies)**

I hereby designate the following as the primary beneficiary(ies) of the Lump Sum Death Benefit due from ARTRS. In the event of my death, I authorize ARTRS to make payment of the benefit to such beneficiary(ies) who are living at the time of my death. I understand that equal shares will be distributed among multiple surviving primary beneficiaries. At least one primary beneficiary must be listed.

Name of Primary Beneficiary(ies)	SSN	Date of Birth	Relationship	Address

**PART 2 - Designation of Contingent Beneficiary(ies) - OPTIONAL**

A contingent beneficiary will receive all benefits upon the member's death only if all primary beneficiaries predecease the member. I hereby designate the following as contingent beneficiary(ies) of the Lump Sum Death Benefit. I understand that equal shares will be distributed among multiple surviving contingent beneficiaries.

Name of Contingent Beneficiary(ies)	SSN	Date of Birth	Relationship	Address

This Beneficiary Designation shall become effective on the date received by ARTRS and shall supersede and cancel all Lump Sum Death Beneficiary Designations filed previously with ARTRS.


Member Signature \_\_\_\_\_ Date \_\_\_\_\_

**To Be Completed By Notary Public**

State of \_\_\_\_\_ )  
 County of \_\_\_\_\_ ) (Notary Seal)

Subscribed and Sworn before me on this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_.

Notary Signature \_\_\_\_\_ My commission expires: \_\_\_\_\_



Arkansas Teacher Retirement System

Form # 4  
Effective 7/1/2006  
1400 West Third, Little Rock, AR 72201  
Phone (501) 682-1517 or (800) 686-2877  
Fax (501) 682-2359  
Website - <http://www.artrs.gov>

**DISPOSITION OF RESIDUE - BENEFICIARY DESIGNATION FORM**

Arkansas Code Annotated § 24-7-709 provides that if a member of the Arkansas Teacher Retirement System (ARTRS) dies prior to receiving annuity benefits equal to the amount of accumulated contributions (if any) standing in the member's credit at his/her death, the residual balance will be paid to such person(s) as the member has designated in writing and filed with ARTRS. Effective for a member dying after June 30, 2006, if there is no designated person surviving, the residue shall be paid to the member's estate. [Note that the residual balance is only paid to beneficiaries if a survivor or retirement option annuity does not become payable at the member's death.]

Member's Name \_\_\_\_\_ Social Security Number \_\_\_\_\_  
 Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**PART 1 - Designation of Primary Beneficiary(ies)**

I hereby designate the following as the primary beneficiary(ies) of any residual balance due from ARTRS. In the event of my death, I authorize ARTRS to make payment of the benefit to such beneficiary(ies) who are living at the time of my death. I understand that equal shares will be distributed among multiple surviving primary beneficiaries. At least one primary beneficiary must be listed.

Name of Primary Beneficiary(ies)	SSN	Date of Birth	Relationship	Address

**PART 2 - Designation of Contingent Beneficiary(ies) - OPTIONAL**

A contingent beneficiary will receive all benefits upon the member's death only if all primary beneficiaries predecease the member. I hereby designate the following as contingent beneficiary(ies) of any residual balance. I understand that equal shares will be distributed among multiple surviving contingent beneficiaries.

Name of Contingent Beneficiary(ies)	SSN	Date of Birth	Relationship	Address

This Beneficiary Designation shall become effective on the date received by ARTRS and shall supersede and cancel all Residue Death Beneficiary Designations filed previously with ARTRS.

Member Signature \_\_\_\_\_ Date \_\_\_\_\_

**To Be Completed By Notary Public**

State of \_\_\_\_\_ )  
 County of \_\_\_\_\_ ) (Notary Seal)

Subscribed and Sworn before me on this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_.

Notary Signature \_\_\_\_\_ My commission expires: \_\_\_\_\_



## LUMP SUM DEATH BENEFIT - BENEFICIARY DESIGNATION FORM

Arkansas Code Annotated § 24-7-720 provides that upon the death of an active or retired member of the Arkansas Teacher Retirement System (ATRS), with 10 or more years of actual service, a Lump Sum Death Benefit payment in an amount set by the Board of Trustees shall be paid to such person(s) as the member has designated in writing and filed with ATRS. Effective for a member dying after June 30, 2006, if there is no designated person surviving, the lump sum shall be paid to the member's estate.

Member's Name \_\_\_\_\_ Social Security Number \_\_\_\_\_  
 Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

### PART 1 - Designation of Primary Beneficiary(ies)

I hereby designate the following as the primary beneficiary(ies) of the Lump Sum Death Benefit due from ATRS. In the event of my death, I authorize ATRS to make payment of the benefit to such beneficiary(ies) who are living at the time of my death. I understand that equal shares will be distributed among multiple surviving primary beneficiaries. At least one primary beneficiary must be listed.

Name of Primary Beneficiary(ies)	SSN	Date of Birth	Relationship	Address

### PART 2 - Designation of Contingent Beneficiary(ies) - OPTIONAL

A contingent beneficiary will receive all benefits upon the member's death only if all primary beneficiaries predecease the member. I hereby designate the following as contingent beneficiary(ies) of the Lump Sum Death Benefit. I understand that equal shares will be distributed among multiple surviving contingent beneficiaries.

Name of Contingent Beneficiary(ies)	SSN	Date of Birth	Relationship	Address

**This Beneficiary Designation shall become effective on the date received by ATRS and shall supersede and cancel all Lump Sum Death Beneficiary Designations filed previously with ATRS.**

Member Signature \_\_\_\_\_ Date \_\_\_\_\_

### To Be Completed By Notary Public

State of \_\_\_\_\_ ) (Notary Seal)  
 County of \_\_\_\_\_ )

Subscribed and Sworn before me on this \_\_\_\_\_ day of \_\_\_\_\_, 20 \_\_\_\_.

Notary Signature \_\_\_\_\_ My commission expires: \_\_\_\_\_

**DISPOSITION OF RESIDUE - BENEFICIARY DESIGNATION FORM**

If a member of the Arkansas Teacher Retirement System (ATRS) dies with residual account balance(s) standing to the member's credit at his/her death, the residual balance(s) will be paid to such person(s) as the member has designated in writing and filed with ATRS. Effective for a member dying after June 30, 2006, if there is no designated person surviving, the residue shall be paid to the member's estate. [Note that the residual contribution and T-DROP balances are only paid to beneficiaries if a survivor or retirement option annuity does not become payable at the member's death.]

Member's Name \_\_\_\_\_ Social Security Number \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**PART 1 - Designation of Primary Beneficiary(ies)**

I hereby designate the following as the primary beneficiary(ies) of any residual balance due from ATRS. In the event of my death, I authorize ATRS to make payment of the benefit to such beneficiary(ies) who are living at the time of my death. I understand that equal shares will be distributed among multiple surviving primary beneficiaries. At least one primary beneficiary must be listed.

Name of Primary Beneficiary(ies)	SSN	Date of Birth	Relationship	Address

**PART 2 - Designation of Contingent Beneficiary(ies) - OPTIONAL**

A contingent beneficiary will receive all benefits upon the member's death only if all primary beneficiaries predecease the member. I hereby designate the following as contingent beneficiary(ies) of any residual balance. I understand that equal shares will be distributed among multiple surviving contingent beneficiaries.

Name of Contingent Beneficiary(ies)	SSN	Date of Birth	Relationship	Address

**This Beneficiary Designation shall become effective on the date received by ATRS and shall supersede and cancel all Residue Designations filed previously with ATRS.**

Member Signature \_\_\_\_\_ Date \_\_\_\_\_

**To Be Completed By Notary Public**

(Notary Seal)

State of \_\_\_\_\_ )  
County of \_\_\_\_\_ )

Subscribed and Sworn before me on this \_\_\_\_\_ day of \_\_\_\_\_, 20 \_\_\_\_.

Notary Signature \_\_\_\_\_ My commission expires: \_\_\_\_\_

**Employment Eligibility Verification** USCIS  
Form I-9  
OMB No. 1615-0047  
Expires 03/31/2016

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

▶ **START HERE.** Read instructions carefully before completing this form. The instructions must be available during completion of this form.

**ANTI-DISCRIMINATION NOTICE:** It is illegal to discriminate against work-authorized individuals. Employees CANNOT specify which document(s) they will accept from an employee. The refusal to hire 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 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 \_\_\_\_\_ E-mail Address \_\_\_\_\_ 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):

A citizen of the United States

A noncitizen national of the United States (See instructions)

A lawful permanent resident (Alien Registration Number/USCIS Number): \_\_\_\_\_

An alien authorized to work until (expiration date, if applicable, mm/dd/yyyy) \_\_\_\_\_. Some aliens may write "N/A" in this field. (See instructions)

For aliens authorized to work, provide your Alien Registration Number/USCIS Number OR Form I-94 Admission Number:

1. Alien Registration Number/USCIS Number: \_\_\_\_\_

**OR**

2. Form I-94 Admission Number: \_\_\_\_\_

3-D Barcode  
Do Not Write in This Space

If you obtained your admission number from CBP in connection with your arrival in the United States, include the following:

Foreign Passport Number: \_\_\_\_\_

Country of Issuance: \_\_\_\_\_

Some aliens may write "N/A" on the Foreign Passport Number and Country of Issuance fields. (See instructions)

Signature of Employee: \_\_\_\_\_ Date (mm/dd/yyyy): \_\_\_\_\_

**Preparer and/or Translator Certification** (To be completed and signed if Section 1 is prepared by a person other than the employee.)

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

Signature of Preparer or Translator: \_\_\_\_\_ 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**

Form I-9 03/08/13 H Page 7 of 9

# Form I-9 Employment Eligibility Verification

Please fill out  
section 1  
Be sure to sign  
and date



# Employment Eligibility Verification

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

USCIS  
Form I-9  
OMB No. 1615-0047  
Expires 03/31/2016

▶ **START HERE.** Read instructions carefully before completing this form. The instructions must be available during completion of this form.

**ANTI-DISCRIMINATION NOTICE:** It is illegal to discriminate against work-authorized individuals. Employers **CANNOT** specify which document(s) they will accept from an employee. The refusal to hire an individual because the 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 ( <i>Family Name</i> )		First Name ( <i>Given Name</i> )		Middle Initial	Other Names Used ( <i>if any</i> )	
Address ( <i>Street Number and Name</i> )			Apt. Number	City or Town		State Zip Code
Date of Birth ( <i>mm/dd/yyyy</i> )	U.S. Social Security Number [ ][ ]-[ ][ ]-[ ][ ][ ][ ]	E-mail Address			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):

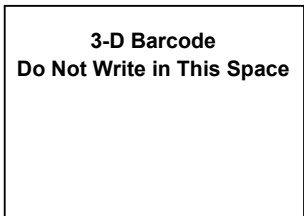
- A citizen of the United States
- A noncitizen national of the United States (*See instructions*)
- A lawful permanent resident (Alien Registration Number/USCIS Number): \_\_\_\_\_
- An alien authorized to work until (expiration date, if applicable, mm/dd/yyyy) \_\_\_\_\_. Some aliens may write "N/A"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

For aliens authorized to work, provide your Alien Registration Number/USCIS Number **OR** Form I-94 Admission Number:

1. Alien Registration Number/USCIS Number: \_\_\_\_\_

**OR**

2. Form I-94 Admission Number: \_\_\_\_\_



If you obtained your admission number from CBP in connection with your arrival in the United States, include the following:

Foreign Passport Number: \_\_\_\_\_

Country of Issuance: \_\_\_\_\_

Some aliens may write "N/A" on the Foreign Passport Number and Country of Issuance fields. (*See instructions*)

Signature of Employee:	Date ( <i>mm/dd/yyyy</i> ):
------------------------	-----------------------------

**Preparer and/or Translator Certification** (*To be completed and signed if Section 1 is prepared by a person other than the employee.*)

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

Signature of Preparer or Translator:		Date ( <i>mm/dd/yyyy</i> ):	
Last Name ( <i>Family Name</i> )		First Name ( <i>Given Name</i> )	
Address ( <i>Street Number and Name</i> )		City or Town	State Zip Code



*Employer Completes Next Page*





## 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 examine a combination of one document from List B and one document from List C as listed on the "Lists of Acceptable Documents" on the next page of this form. For each document you review, record the following information: document title, issuing authority, document number, and expiration date, if any.)

Employee Last Name, First Name and Middle Initial from Section 1:

List A Identity and Employment Authorization	OR	List B Identity	AND	List C Employment Authorization
Document Title:		Document Title: Driver's License		Document Title: Social Security Card
Issuing Authority:		Issuing Authority: State of Arkansas		Issuing Authority: SS Admin/US Government
Document Number:		Document Number:		Document Number:
Expiration Date (if any)(mm/dd/yyyy):		Expiration Date (if any)(mm/dd/yyyy):		Expiration Date (if any)(mm/dd/yyyy):
Document Title:				
Issuing Authority:				
Document Number:				
Expiration Date (if any)(mm/dd/yyyy):				
Document Title:				
Issuing Authority:				
Document Number:				
Expiration Date (if any)(mm/dd/yyyy):				

**3-D Barcode**  
Do Not Write in This Space

### Certification

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

The employee's first day of employment (mm/dd/yyyy): \_\_\_\_\_ (See instructions for exemptions.)

Signature of Employer or Authorized Representative		Date (mm/dd/yyyy)	Title of Employer or Authorized Representative	
Last Name (Family Name)		First Name (Given Name)	Employer's Business or Organization Name Pulaski Co. Special School District	
Employer's Business or Organization Address (Street Number and Name) 925 E. Dixon Road		City or Town Little Rock	State AR	Zip Code 72206

### Section 3. Reverification and Rehires (To be completed and signed by employer or authorized representative.)

A. New Name (if applicable) Last Name (Family Name) First Name (Given Name) Middle Initial	B. Date of Rehire (if applicable) (mm/dd/yyyy):
--	---

C. If employee's previous grant of employment authorization has expired, provide the information for the document from List A or List C the employee presented that establishes current 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:	Date (mm/dd/yyyy):	Print 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
<ol style="list-style-type: none"> <li>1. U.S. Passport or U.S. Passport Card</li> <li>2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551)</li> <li>3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa</li> <li>4. Employment Authorization Document that contains a photograph (Form I-766)</li> <li>5. For a nonimmigrant alien authorized to work for a specific employer because of his or her status:               <ol style="list-style-type: none"> <li>a. Foreign passport; and</li> <li>b. Form I-94 or Form I-94A that has the following:                   <ol style="list-style-type: none"> <li>(1) The same name as the passport; and</li> <li>(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.</li> </ol> </li> </ol> </li> <li>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</li> </ol>	OR	<ol style="list-style-type: none"> <li>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</li> <li>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</li> <li>3. School ID card with a photograph</li> <li>4. Voter's registration card</li> <li>5. U.S. Military card or draft record</li> <li>6. Military dependent's ID card</li> <li>7. U.S. Coast Guard Merchant Mariner Card</li> <li>8. Native American tribal document</li> <li>9. Driver's license issued by a Canadian government authority</li> <li style="text-align: center;"><b>For persons under age 18 who are unable to present a document listed above:</b></li> <li>10. School record or report card</li> <li>11. Clinic, doctor, or hospital record</li> <li>12. Day-care or nursery school record</li> </ol>	AND	<ol style="list-style-type: none"> <li>1. A Social Security Account Number card, unless the card includes one of the following restrictions:               <ol style="list-style-type: none"> <li>(1) NOT VALID FOR EMPLOYMENT</li> <li>(2) VALID FOR WORK ONLY WITH INS AUTHORIZATION</li> <li>(3) VALID FOR WORK ONLY WITH DHS AUTHORIZATION</li> </ol> </li> <li>2. Certification of Birth Abroad issued by the Department of State (Form FS-545)</li> <li>3. Certification of Report of Birth issued by the Department of State (Form DS-1350)</li> <li>4. Original or certified copy of birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal</li> <li>5. Native American tribal document</li> <li>6. U.S. Citizen ID Card (Form I-197)</li> <li>7. Identification Card for Use of Resident Citizen in the United States (Form I-179)</li> <li>8. Employment authorization document issued by the Department of Homeland Security</li> </ol>

**Illustrations of many of these documents appear in Part 8 of the Handbook for Employers (M-274).**

**Refer to Section 2 of the instructions, titled "Employer or Authorized Representative Review and Verification," for more information about acceptable receipts.**

# W-4 Form

Fill out the bottom part of this form.

Please be sure to put the number of exemptions you want to claim in box 5.

(Example if you want zero dependents write 0 in box 5. Don't leave it blank.)

**Form W-4 (2013)**

Complete all worksheets that apply. However, you may check boxes for 2013 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 only if you are unmarried and you are claimed as a dependent or other qualifying individual. See Pub. 502, Exemptions, Standard Deduction, and Filing Information, for information.

**Tax credits.** You can take regular tax credits like account in figuring your allowable number of withholding allowances. Credits for children and dependent care expenses and the child tax credit may be claimed using the Personal Allowances Worksheet below. See Pub. 502 for information on claiming your other credits on withholding allowances.

**Business income.** If you have a large amount of business income, such as interest or dividends, consider making additional tax payments using Form 1042-ES, Estimated Tax for Individuals. Otherwise, you may owe additional tax. For more information, see Pub. 502.

**Income tax.** 2013 is the end of if you should submit your withholding on Form W-4 or W-4P.

**Two sources or more.** If you have a working spouse or more than one job, figure the total number of allowances you are entitled to claim on all your wages and other income from 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 your allowances are allocated in the other. See Pub. 502 for details.

**Household allowances.** For more information, see Notice 1302, Regime for Form W-4, Introduction for Household Filers, before completing this form.

**Check your withholding.** After your Form W-4 is taken into effect, use Pub. 505 to see how the amount you are withholding compares to your estimated liability for 2013. Use Pub. 505, especially if your savings account is not a 529 plan or a 529 ABLE plan.

**Future developments.** Information about any future developments affecting Form W-4 will be published periodically after we release it will be posted at [www.irs.gov](http://www.irs.gov).

**Personal Allowances Worksheet (Keep for your records)**

**A** Enter "1" for yourself if you are also claiming you as a dependent. . . . . **A**

**B** Enter "1" if: **B**

- You are single and have only one job, or
- You are married, have only one job, and your spouse does not work, or
- Your wages from a second job or your spouse's wages for the total body are \$1,000 or less.

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

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

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

**F** Enter "1" if you have at least \$1,500 of child or dependent care expenses for which you plan to claim a credit. (Note: Do not include child support payments. See Pub. 502, Child and Dependent Care Expenses, for details.) . . . . . **F**

**G** **Child Tax Credit** (including additional child tax credit). See Pub. 502, Child Tax Credit, for more information.

- If your total income will be more than \$45,000 (if married, enter "2" for each eligible child; see item "I" if you have three to six eligible children or less "2" if you have seven or more eligible children.
- If your total income will be between \$45,000 and \$44,000 (if married, enter "1" for each eligible child . . . . . **G**

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

For accuracy, complete all worksheets and Attachments Worksheet on page 2.

- If you plan to handle or make adjustments to income and want to reduce your withholding, see the Deductions 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 \$4,000 (if married, enter "2" for each eligible child; see item "I" if you have three to six eligible children or less "2" if you have seven or more eligible children.
- If neither of the above situations apply, skip lines 6 and 7 and enter the number from line 8 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.

**Form W-4 Employee's Withholding Allowance Certificate (OMB No. 1545-0047) 2013**

Download the Treasury Internal Revenue Service Form W-4 (2013) at [www.irs.gov](http://www.irs.gov)

1 Your full name and address (last, first, and middle initial) Last name: \_\_\_\_\_ First name: \_\_\_\_\_ Middle initial: \_\_\_\_\_

2 Home address (number and street or rural route) \_\_\_\_\_

3 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.  Yes  No

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 2013, 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.

Employer's signature (This line is not valid unless you sign it.) \_\_\_\_\_ Date: \_\_\_\_\_

8 Employer's name and address (employer). Complete lines 8 and 9 and 10 according to the 801.  8  9  10

9 Employer's identification number (EIN)  9

10 Employer's federal tax deposit number (FDTN)  10

For Privacy Act and Paperwork Reduction Act Notice, see page 2. Cat. No. 151002 Form W-4 (2013)

# Form W-4 (2015)

**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 2015 expires February 16, 2016. 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 2015. 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: <span style="font-size: 2em; vertical-align: middle;">{</span> <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> <span style="font-size: 2em; vertical-align: middle;">}</span> . . . . .	<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 \$65,000 (\$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 \$65,000 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>			
<table border="0" style="width: 100%;"> <tr> <td style="width: 15%; vertical-align: top;">For accuracy, complete all worksheets that apply.</td> <td style="width: 85%; vertical-align: top;"> <ul style="list-style-type: none"> <li>• If you plan to <b>itemize</b> or <b>claim adjustments to income</b> and want to reduce your withholding, see the <b>Deductions and Adjustments Worksheet</b> on page 2.</li> <li>• If you are <b>single and have more than one job</b> or are <b>married and you and your spouse both work</b> and the combined earnings from all jobs exceed \$50,000 (\$20,000 if married), see the <b>Two-Earners/Multiple Jobs Worksheet</b> on page 2 to avoid having too little tax withheld.</li> <li>• If <b>neither</b> of the above situations applies, <b>stop here</b> and enter the number from line H on line 5 of Form W-4 below.</li> </ul> </td> </tr> </table>				For accuracy, complete all worksheets that apply.	<ul style="list-style-type: none"> <li>• If you plan to <b>itemize</b> or <b>claim adjustments to income</b> and want to reduce your withholding, see the <b>Deductions and Adjustments Worksheet</b> on page 2.</li> <li>• If you are <b>single and have more than one job</b> or are <b>married and you and your spouse both work</b> and the combined earnings from all jobs exceed \$50,000 (\$20,000 if married), see the <b>Two-Earners/Multiple Jobs Worksheet</b> on page 2 to avoid having too little tax withheld.</li> <li>• If <b>neither</b> of the above situations applies, <b>stop here</b> and enter the number from line H on line 5 of Form W-4 below.</li> </ul>
For accuracy, complete all worksheets that apply.	<ul style="list-style-type: none"> <li>• If you plan to <b>itemize</b> or <b>claim adjustments to income</b> and want to reduce your withholding, see the <b>Deductions and Adjustments Worksheet</b> on page 2.</li> <li>• If you are <b>single and have more than one job</b> or are <b>married and you and your spouse both work</b> and the combined earnings from all jobs exceed \$50,000 (\$20,000 if married), see the <b>Two-Earners/Multiple Jobs Worksheet</b> on page 2 to avoid having too little tax withheld.</li> <li>• If <b>neither</b> of the above situations applies, <b>stop here</b> and enter the number from line H on line 5 of Form W-4 below.</li> </ul>				

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

<b>W-4</b>	<b>Employee's Withholding Allowance Certificate</b>	OMB No. 1545-0074
Form Department of the Treasury Internal Revenue Service	▶ <b>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.</b>	2015
<b>1</b> Your first name and middle initial	Last name	<b>2</b> Your social security number
Home address (number and street or rural route)		<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.
City or town, state, and ZIP code		<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"/>
<b>5</b> Total number of allowances you are claiming (from line <b>H</b> above <b>or</b> from the applicable worksheet on page 2)	<b>5</b>	
<b>6</b> Additional amount, if any, you want withheld from each paycheck	<b>6</b>	\$
<b>7</b> I claim exemption from withholding for 2015, 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 . . . . . ▶		
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.		
<b>Employee's signature</b> (This form is not valid unless you sign it.) ▶		<b>Date</b> ▶
<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)
<b>Pulaski County Special School District 925 E Dixon Road Little Rock AR 72206</b>		<b>716020058</b>

### Deductions and Adjustments Worksheet

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

<b>1</b>	Enter an estimate of your 2015 itemized deductions. These include qualifying home mortgage interest, charitable contributions, state and local taxes, medical expenses in excess of 10% (7.5% if either you or your spouse was born before January 2, 1951) of your income, and miscellaneous deductions. For 2015, you may have to reduce your itemized deductions if your income is over \$309,900 and you are married filing jointly or are a qualifying widow(er); \$284,050 if you are head of household; \$258,250 if you are single and not head of household or a qualifying widow(er); or \$154,950 if you are married filing separately. See Pub. 505 for details . . . . .	<b>1</b>	\$ _____
<b>2</b>	Enter: $\left\{ \begin{array}{l} \$12,600 \text{ if married filing jointly or qualifying widow(er)} \\ \$9,250 \text{ if head of household} \\ \$6,300 \text{ if single or married filing separately} \end{array} \right\}$ . . . . .	<b>2</b>	\$ _____
<b>3</b>	<b>Subtract</b> line 2 from line 1. If zero or less, enter “-0-” . . . . .	<b>3</b>	\$ _____
<b>4</b>	Enter an estimate of your 2015 adjustments to income and any additional standard deduction (see Pub. 505) . . . . .	<b>4</b>	\$ _____
<b>5</b>	<b>Add</b> lines 3 and 4 and enter the total. (Include any amount for credits from the <i>Converting Credits to Withholding Allowances for 2015 Form W-4</i> worksheet in Pub. 505.) . . . . .	<b>5</b>	\$ _____
<b>6</b>	Enter an estimate of your 2015 nonwage income (such as dividends or interest) . . . . .	<b>6</b>	\$ _____
<b>7</b>	<b>Subtract</b> line 6 from line 5. If zero or less, enter “-0-” . . . . .	<b>7</b>	\$ _____
<b>8</b>	<b>Divide</b> the amount on line 7 by \$4,000 and enter the result here. Drop any fraction . . . . .	<b>8</b>	_____
<b>9</b>	Enter the number from the <b>Personal Allowances Worksheet</b> , line H, page 1 . . . . .	<b>9</b>	_____
<b>10</b>	<b>Add</b> lines 8 and 9 and enter the total here. If you plan to use the <b>Two-Earners/Multiple Jobs Worksheet</b> , also enter this total on line 1 below. Otherwise, <b>stop here</b> and enter this total on Form W-4, line 5, page 1 . . . . .	<b>10</b>	_____

### 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.

<b>1</b>	Enter the number from line H, page 1 (or from line 10 above if you used the <b>Deductions and Adjustments Worksheet</b> ) . . . . .	<b>1</b>	_____
<b>2</b>	Find the number in <b>Table 1</b> below that applies to the <b>LOWEST</b> paying job and enter it here. <b>However</b> , if you are married filing jointly and wages from the highest paying job are \$65,000 or less, do not enter more than “3” . . . . .	<b>2</b>	_____
<b>3</b>	If line 1 is <b>more than or equal to</b> 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. <b>Do not</b> use the rest of this worksheet . . . . .	<b>3</b>	_____
<b>Note.</b> If line 1 is <b>less than</b> 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.			
<b>4</b>	Enter the number from line 2 of this worksheet . . . . .	<b>4</b>	_____
<b>5</b>	Enter the number from line 1 of this worksheet . . . . .	<b>5</b>	_____
<b>6</b>	<b>Subtract</b> line 5 from line 4 . . . . .	<b>6</b>	_____
<b>7</b>	Find the amount in <b>Table 2</b> below that applies to the <b>HIGHEST</b> paying job and enter it here . . . . .	<b>7</b>	\$ _____
<b>8</b>	<b>Multiply</b> line 7 by line 6 and enter the result here. This is the additional annual withholding needed . . . . .	<b>8</b>	\$ _____
<b>9</b>	Divide line 8 by the number of pay periods remaining in 2015. 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 2015. Enter the result here and on Form W-4, line 6, page 1. This is the additional amount to be withheld from each paycheck . . . . .	<b>9</b>	\$ _____

**Table 1**

**Table 2**

Married Filing Jointly		All Others		Married Filing Jointly		All Others	
If wages from <b>LOWEST</b> paying job are—	Enter on line 2 above	If wages from <b>LOWEST</b> paying job are—	Enter on line 2 above	If wages from <b>HIGHEST</b> paying job are—	Enter on line 7 above	If wages from <b>HIGHEST</b> paying job are—	Enter on line 7 above
\$0 - \$6,000	0	\$0 - \$8,000	0	\$0 - \$75,000	\$600	\$0 - \$38,000	\$600
6,001 - 13,000	1	8,001 - 17,000	1	75,001 - 135,000	1,000	38,001 - 83,000	1,000
13,001 - 24,000	2	17,001 - 26,000	2	135,001 - 205,000	1,120	83,001 - 180,000	1,120
24,001 - 26,000	3	26,001 - 34,000	3	205,001 - 360,000	1,320	180,001 - 395,000	1,320
26,001 - 34,000	4	34,001 - 44,000	4	360,001 - 405,000	1,400	395,001 and over	1,580
34,001 - 44,000	5	44,001 - 75,000	5	405,001 and over	1,580		
44,001 - 50,000	6	75,001 - 85,000	6				
50,001 - 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 - 100,000	10	140,001 and over	10				
100,001 - 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.





## Front of card

Last Name First Middle

Bank Name

Employee Id Number or Social Security

Bank Routing Number

\*Please sign and date on the reverse side

Employee Checking or Savings Number

## Back of card

REQUIRED: Attach a Blank Voided Check

### EMPLOYEE'S AUTHORIZATION

I authorize Pulaski County Special School District to automatically deposit my pay in my account described on the reverse side of this agreement.

I authorize Pulaski County Special School District to initiate a reversing debit entry to authorize my bank to refund to PCSSD a deposit made in error to my account.

This authority is to remain in full force and effect until my employer has received written notification from me of its termination in such time and in such manner as to afford my employer a reasonable opportunity to act on it.

Date

Signature

Please complete reverse side

# Direct Deposit Is Mandatory for All Employees

*Direct deposit cards will be available the day of the new hire meeting. Be sure to bring a VOIDED check with you to the meeting.*









**Pulaski County Special School District**

**RELEASE OF INFORMATION AND  
CRIMINAL BACKGROUND CHECK**

I authorize Pulaski County Special School District, or its agent, to investigate my background, prior employment, and criminal history. I understand that I may have the right to request disclosure of certain information obtained by the District in the course of its investigation of my background and experience. To request this information, contact CS Background 30 Riverview, Batesville AR, 72501 870-613-0509.

I authorize my prior employers, references, and any other individuals contacted by the District to release any and all information requested and absolves those parties who provide information requested from any and all liability related to their doing so.

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

Signature: \_\_\_\_\_

Print Name: \_\_\_\_\_ Maiden Name (If applicable): \_\_\_\_\_

Social Security#: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

I understand that failure to sign this release will prohibit me from working with the Pulaski County Special School District.

**PULASKI COUNTY SPECIAL SCHOOL DISTRICT**

The following information requested is strictly voluntary. It will not be part of your application for employment. This information is used for statistical purposes only. Please check appropriate box.

- White
- Black
- Asian
- American Indian
- Hispanic
- Other

- Female
- Male

# Release of Information and Criminal Background Check

This give us authorization to run a background check



***Pulaski County Special School District***  
 925 East Dixon Road/PO Box 8601 Little Rock, AR 72216-8601

**RELEASE OF INFORMATION/CRIMINAL BACKGROUND CHECK**

I authorize Pulaski County Special School District, or its agent, to investigate my background, prior employment, and criminal history. I understand that I may have the right to request disclosures of certain information obtained by the District in the course of its investigation of my background and experience.

I authorize my prior employers, references and any other individuals contacted by the District to release any and all information requested and absolve those parties who provide information requested from any and all liability related to their doing so.

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

Signature: \_\_\_\_\_

Print Name: \_\_\_\_\_

Social Security #: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

I understand that failure to sign this release will prohibit me from working with the Pulaski County Special School District.

-----  
**PULASKI COUNTY SPECIAL SCHOOL DISTRICT**

Name \_\_\_\_\_ Date \_\_\_\_\_

Social Security Number \_\_\_\_\_ Male \_\_\_\_ Female \_\_\_\_

Date of Birth \_\_\_\_\_

The following information requested is strictly voluntary. It will not be part of your application for employment. This information is used for statistical purposes only.

Please check appropriate box.

- White
- Black
- Asian
- American Indian
- Hispanic
- Other

# Arkansas Child Maltreatment Central Registry & Fingerprinting

**ONLY FOR ARKANSAS DEPARTMENT OF EDUCATION USE**  
**AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION**  
 By the Arkansas Child Maltreatment Central Registry

**Applicant Instructions:** Complete this form, have it notarized, and submit a preprinted check or a U.S. money order for \$10.00 made payable to the Arkansas Department of Human Services. DO NOT SEND CASH OR A TEMPORARY CHECK-YOUR REQUEST WILL NOT BE PROCESSED. Make and keep a copy of this form for your records.

INCOMPLETE OR UNNOTARIZED FORMS WILL NOT BE PROCESSED BY THE CENTRAL REGISTRY OR THE ADEI

Mail this form to and the fee payment to: Arkansas Child Maltreatment Central Registry  
 P.O. Box 1437, Slot S 566  
 Little Rock, Arkansas 72203

Applicant - Check Only One:  
 Licensed Teacher  
 Non-licensed/Classified

Applicant's full name (print or type):  
 First \_\_\_\_\_ Middle \_\_\_\_\_ Last \_\_\_\_\_

List ALL other names used: \_\_\_\_\_

Applicant's Social Security Number: \_\_\_\_\_

Applicant's Birth Date (Day/Month/Year): \_\_\_\_\_ Age: \_\_\_\_\_ Race/Ethnicity: \_\_\_\_\_ Gender: \_\_\_\_\_

Applicant's mailing address: Street or P.O. Box \_\_\_\_\_ Physical Address: Street \_\_\_\_\_  
 City State Zip Code \_\_\_\_\_ City State Zip Code \_\_\_\_\_

Applicant's phone number: \_\_\_\_\_ (home) \_\_\_\_\_ (cell) \_\_\_\_\_ (other) \_\_\_\_\_

List the full name and date of birth (Day/Month/Year) for all of the applicant's children, attach additional paper if necessary:

1. Child's Full Name:	Child's Date of Birth:
2. Child's Full Name:	Child's Date of Birth:
3. Child's Full Name:	Child's Date of Birth:

I hereby request that the Arkansas Child Maltreatment Central Registry release my information their files may contain indicating the undersigned applicant as an offender of a true report of child maltreatment to the ARKANSAS DEPARTMENT OF EDUCATION. By signing below, I swear or affirm that the foregoing statements are true to the best of my knowledge and belief under penalty of perjury.

Applicant's Signature: \_\_\_\_\_ Date \_\_\_\_\_

State of Arkansas County of \_\_\_\_\_

On this the \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_, before me, \_\_\_\_\_ (name of notary), the undersigned notary, personally appeared \_\_\_\_\_ (applicant's name) known to me (or satisfactorily proven) to be the person whose name(s) is/are subscribed to the within instrument and acknowledged that he/she/they executed the same for the purposes therein contained.

In witness whereof I hereunto set my hand and official seal.

Notary Public: \_\_\_\_\_ My Commission Expires: \_\_\_\_\_

(APPLICANTS DO NOT WRITE BELOW THIS LINE)

Paul Brower	501-234-2032	501-490-0897
School District Contact Person	District Phone Number	District Fax
625 East Dixon Rd	Pulaski County Special School District	6003
School Mailing Address	School District	LEA Number

ADE Form Effective Date 01/15/17

**DO NOT MAIL THIS FORM. BRING IT TO THE NEW HIRE MEETING TO SUBMIT TO PCSSD.**

**The District pays all fees for these background checks.**

**ONLY FOR ARKANSAS DEPARTMENT OF EDUCATION USE**  
**AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION**

By the Arkansas Child Maltreatment Central Registry

Applicant Instructions: Complete this form.

INCOMPLETE OR UNNOTARIZED FORMS WILL NOT BE PROCESSED BY THE CENTRAL REGISTRY OR THE ADE!

Applicant- Check Only One:

Licensed Teacher

Non-licensed/Classified

Applicant's full name (print or type):

\_\_\_\_\_

First

Middle

Last

List ALL other names used:

\_\_\_\_\_

Applicant's Social Security Number:

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

Applicant's Birth Date (Month/Day/Year):

\_\_\_\_\_ Age: \_\_\_\_\_ Race/ethnicity: \_\_\_\_\_ Gender: \_\_\_\_\_

Applicant's mailing address:

\_\_\_\_\_

Street or P.O. Box

Physical Address:

\_\_\_\_\_

Street

\_\_\_\_\_

City

State

Zip Code

\_\_\_\_\_

City

State

Zip Code

Applicant's phone number:

\_\_\_\_\_ (home) \_\_\_\_\_ (cell) \_\_\_\_\_ (other)

List the full name and date of birth (Month/Day/Year) for **all** of the applicant's children, attach additional paper if necessary:

1. Child's Full Name:

Child's Date of Birth:

2. Child's Full Name:

Child's Date of Birth:

3. Child's Full Name:

Child's Date of Birth:

I hereby request that the Arkansas Child Maltreatment Central Registry release any information their files may contain indicating the undersigned applicant as an offender of a true report of child maltreatment to the **ARKANSAS DEPARTMENT OF EDUCATION**. **By signing below, I swear or affirm that the foregoing statements are true to the best of my knowledge and belief under penalty of perjury.**

Applicant's Signature: \_\_\_\_\_ Date \_\_\_\_\_

State of Arkansas County of \_\_\_\_\_

On this the \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_, before me, \_\_\_\_\_ (name of notary), the undersigned notary, personally appeared \_\_\_\_\_ (**applicant's name**) known to me (or satisfactorily proven) to be the person whose name(s) is/are subscribed to the within instrument and acknowledged that he/she/they executed the same for the purposes therein contained.

In witness whereof I hereunto set my hand and official seal.

Notary Public: \_\_\_\_\_

My Commission Expires: \_\_\_\_\_

(APPLICANTS DO NOT WRITE BELOW THIS LINE)

Paul Brewer  
School/District Contact Person

501-234-2000  
District Phone Number

501-490-9897  
District Fax

925 East Dixon Rd Little Rock AR 72206 Pulaski County Special School Dist 6003  
School Mailing Address

School District

LEA Number



# Certified Fingerprinting Information Form

Please Print

First Name \_\_\_\_\_

Last Name \_\_\_\_\_

Social Security Number      -      -      \_\_\_\_\_

Race \_\_\_\_\_

Gender       Female       Male

Height \_\_\_\_\_

Weight \_\_\_\_\_

Eye Color \_\_\_\_\_

Hair Color \_\_\_\_\_

Date of Birth \_\_\_\_\_

Place of Birth \_\_\_\_\_

# Information for Substitute Calling System

***INFORMATION FOR SUBSTITUTE CALLING SYSTEM***

Name: \_\_\_\_\_

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

Address: \_\_\_\_\_  
STREET CITY, AR ZIP CODE

Phone: \_\_\_\_\_

Gender: \_\_\_\_\_ Ethnicity: \_\_\_\_\_

Teaching Assignment(s): \_\_\_\_\_  
\_\_\_\_\_

School Location \_\_\_\_\_

# ***INFORMATION FOR SUBSTITUTE CALLING SYSTEM***

Name: \_\_\_\_\_

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

Address: \_\_\_\_\_  
STREET CITY, AR ZIP CODE

Phone: \_\_\_\_\_

Gender: \_\_\_\_\_ Ethnicity: \_\_\_\_\_

Teaching Assignment(s): \_\_\_\_\_  
\_\_\_\_\_

School Location \_\_\_\_\_