# LABOR & MARINE SERVICES

EQUAL EMPLOYMENT OPPORTUNITY. It is our policy to seek and employ the best qualified personnel in all of our facilities and to provide equal opportunity for the advancement of employees and to administer all of our personnel policies in a manner that will not discriminate against any person because of race, color, religion, age, sex, marital or veteran status, national origin, ancestry, disability (physical or mental handicap) or any other legally protected status.

| LAST NAME | FIRST NAME | MIDDLE INT. | DATE |
|---|---|---|---|
| STREET ADDRESS | | | APT. NO. |
| CITY | | STATE | ZIP CODE |
| TELEPHONE NO. | | | SOCIAL SECURITY NO. |

HOW DID YOU HEAR ABOUT SAVARD?

_______________________________________________

**POLICY REGARDING DISPATCH PROCEDURES, EMPLOYMENT AND ARBITRATION**

I understand that I am not required to work on any particular day and whether I report in to SAVARD dispatch hall is always my choice. Whenever I wish to register my availability to work, I will visit the dispatch hall and sign in. I know that SAVARD is not required to find work for me and is not required to contact me in any way in order to make work available to me. If I do not report to the dispatch hall and sign in, SAVARD may assume that I am not available for work on that day.

I understand that after receiving a job assignment, I am free on my own time to leave the dispatch hall and do as I wish until the job assignment starts. I understand the importance of never being late for a job assignment.

If I have a REPEAT TICKET (defined as a request to return to the same job at a later date), I know that I am required to report my availability to SAVARD in the manner indicated by the dispatcher at least one (1) hour before the scheduled start time and that if I do not, then SAVARD may assume I am not available to work.

I understand that my employment with SAVARD is on a day-to-day basis. That is, at the end of the work day, I will be deemed to have quit unless and until I request to receive a work assignment at a later date

I agree that any disputes arising out of my employment, including any claims of discrimination, harassment or wrongful termination that I believe I have against SAVARD and all other employment related issues (excluding only claims arising under the National Labor Relations act or otherwise within the jurisdiction of the National Labor Relations Board) will be resolved by arbitration as my sole remedy. The arbitration shall be conducted by the American Arbitration Association under its Commercial Arbitration Rules and the decision of the arbitrator shall be final and binding. I understand that SAVARD also agrees to arbitrate in the same manner any claims which the company believes it has against me.

I HAVE READ AND AGREE TO THE ABOVE STATEMENTS.

_______________________________ EMPLOYEE SIGNATURE

_______________ DATE

**WORK EXPERIENCE AND TRADE SKILLS**

IF YOU HAVE ONE OR MORE YEARS PROFESSIONAL EXPERIENCE IN ANY OF THE FOLLOWING TRADES, PLEASE INDICATE IN THE SPACE BELOW. PLEASE INDICATE NUMBER OF YEARS EXPERIENCE FOR EACH TRADE.

| INDUSTRIAL TRADE | YEARS |
|---|---|
| Asbestos Abatement | ______ |
| Assembly | ______ |
| Auto Mechanic | ______ |
| Bartender | ______ |
| Bilingual | ______ |
| Boiler Rebuilders | ______ |
| Cashiers | ______ |
| CNA | ______ |
| Commercial Drivers License (CDL) | ______ |
| Forklift Operator | ______ |
| Furniture Mover | ______ |
| HVAC | ______ |
| Hazwhopper | ______ |
| Hotel/Motel Housekeeping | ______ |
| Inventory/Shipping/Receiving | ______ |
| Landscape Maintenance | ______ |
| Machine Shop | ______ |
| Manufacturing/Fabrication | ______ |
| OSHA | ______ |
| Printing Shop | ______ |
| Restaurant | ______ |
| Asphalt/Paving | ______ |
| Carpentry | ______ |
| Carpet Installation | ______ |
| Cement Work | ______ |
| Diesel Mechanic | ______ |
| Drywall | ______ |
| Electrical Wiring | ______ |
| Fencing | ______ |
| Flagging | ______ |
| Heavy Equipment Operator | ______ |
| Hydroblasting | ______ |
| Industrial Mechanic | ______ |
| Masonry (Brick, Tile, etc.) | ______ |
| Millwright | ______ |
| Painting | ______ |
| Pipefitting | ______ |
| Plumbing | ______ |
| Roofing | ______ |
| Sandblasting | ______ |
| Scaffolding | ______ |
| Welding | ______ |

| PROFESSIONAL TRADE | YEARS |
|---|---|
| Access | ______ |
| Accounting | ______ |
| Accounts Receivables/Payables | ______ |
| Administration Assistant | ______ |
| Architecture | ______ |
| Attorney | ______ |
| Biology | ______ |
| Bilingual | ______ |
| Bookkeeping | ______ |
| Business Administration | ______ |
| CMAS | ______ |
| Chemistry | ______ |
| Collections | ______ |
| Computer Programmer | ______ |
| Counseling | ______ |
| Data Entry | ______ |
| Engineering/Drafting | ______ |
| Genetics | ______ |
| Harvard Graphics | ______ |
| Host | ______ |
| Inventory Management | ______ |
| Legal Secretary | ______ |
| Lotus 123 | ______ |
| MAS 90 | ______ |
| MS Word | ______ |
| Management | ______ |
| Medic | ______ |
| Mobius | ______ |
| Monarch | ______ |
| Novell | ______ |
| Occupational Therapy | ______ |
| Pathology | ______ |
| Payroll | ______ |
| Pascal | ______ |
| Peachtree | ______ |
| Pharmacy | ______ |
| Physical Therapy | ______ |
| Physics | ______ |
| Physiology | ______ |
| Quattro Pro | ______ |
| Receptionist | ______ |
| Registered Nurse | ______ |
| Sales | ______ |
| Secretary | ______ |
| Speech Pathologist | ______ |
| Switchboard | ______ |
| Telemarketing | ______ |

PLEASE USE THIS SPACE BELOW TO LIST ANY ADDITIONAL TRADE SKILLS, CERTIFICATIONS (such as OSHA), TOOLS, ETC. WHICH MIGHT BE USEFUL IN DETERMINING JOB ASSIGNMENT FOR YOU.

________________________________________

________________________________________

________________________________________

DO YOU HAVE:

RELIABLE TRANSPORTATION? ________________

VALID DRIVER'S LICENSE? ________________

AUTO INSURANCE? ________________

Please check all of the following which apply to the employment you are seeking

[ ] Full time / Permanent
[ ] Full time / Temporary
[ ] Part time / Permanent
[ ] Part time / Temporary
[ ] Preferred geographic work location ________________________

Please list below any other specifications which need to be considered in your placement.

________________________________________

________________________________________

________________________________________

________________________________________

________________________________________

________________________________________

________________________________________

________________________________________

**HAVE YOU EVER WORKED FOR TEMPORARY EMPLOYMENT SERVICE BEFORE?**
**Yes ___________________ No __________________**

**IF SO WHICH SERVICE(S)?________________________________________________________**

**WHERE WERE YOU ASSIGNED TO WORK?**

| NAME OF BUSINESS | TYPE OF WORK |
|---|---|
| | |
| | |
| | |
| | |

## RELEASE OF CLAIMS AGAINST THE SAVARD CUSTOMERS

I am either a temporary worker for SAVARD (the "Company") or am applying for temporary work assignments with the Company.

I understand that the Company provides temporary workers for its customers to work at the customer's project site. In accepting any work assignment, I acknowledge that I am a temporary employee of the Company and am not an employee of the Company's customer.

If I am injured in the course of my work for the Company, I agree that I will look only to the Company's Workers' Compensation coverage and not to the Company's customer for any recovery. For myself, and on behalf of my heirs, executor, personal representative and assigns, I waive, release and forever discharge any claim that I may now have or that may later accrue against any customer of the Company which directly or indirectly arises out of any injuries which may occur to me while on a temporary work assignment for the Company.

In signing this Release, I understand that I am waiving or releasing any claims which I may have against the Worker's Compensation coverage provided by the Company.

______________________________
SIGNED

______________________________
PRINT NAME

______________________________
DATE

## EMPLOYMENT AUTHORIZATION

This authorization entitles the bearer (or sender), or any representative thereof, to contact my present and past employer(s) for the purpose of confirming my length of employment, wages and other relevant employment data.

I understand that SAVARD may check all available records, criminal records and other records maintained and available for these.

______________________________
SIGNED

______________________________
NAME (PLEASE PRINT)

## CONSENT TO DRUG/ALCOHOL TESTING IN THE EVENT OF WORK-RELATED INJURY OR ILLNESS

I understand that as part of its regular employment policy, SAVARD requires any employee who suffers a work related injury or illness to be tested for the presence of drugs and/or alcohol. This testing is to be done at the location where initial treatment for the injury/illness is provided and is to be conducted in accordance with acceptable medical procedures. I understand that if I refuse to submit to testing, it will be considered as a refusal to comply with a reasonable request by my clients for any and all consequences arising from my testing positive for the use and/or influence of drugs to alcohol at the time of my injury or illness.

______________________________ _______________
Employee’s Signature Date

## YOU MUST READ AND SIGN THE FOLLOWING CONDITIONS AND CERTIFICATIONS

In consideration of my employment, I agree to conform to the rules and regulations of SAVARD and I understand that my employment by SAVARD may be terminated at any time by me or SAVARD with or without notice, for any reason. I understand that no General Manager, Assistant Manager or any other employee or representative of SAVARD other than the President of SAVARD has any authority to enter into any agreement for employment for any specified period of time, or to make any agreement contrary to any of the foregoing.

CONFIDENTIALITY STATEMENT: Employees are prohibited from releasing to any other party any information whatsoever about SAVARD which is of a confidential nature or which could be deemed to constitute a “trade secret”. Employees or former employees are further prohibited from using, in any manner whatsoever, information which is confidential, proprietary, or privileged, whether for their personal benefit or gain, or for that of any other person. Any information which has not been disclosed publicly in writing should be treated as confidential and proprietary.

I understand the duties, including physical requirements of the position for which I am applying with SAVARD and I certify that I am capable of performing the required tasks with or without reasonable accommodation. If any accommodation is necessary, I will describe the purposed accommodations on an attached sheet.

______________________________ _______________
Employee’s Signature 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 (*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**

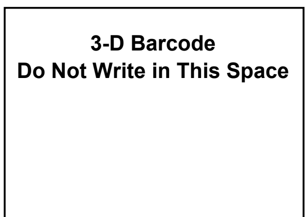
**2.** Form I-94 Admission Number: ____________________

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*)



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

| 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 |
|---|---|---|---|
| | | | |

***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**<br>**Identity and Employment Authorization** | **OR** | **List B**<br>**Identity** | **AND** | **List C**<br>**Employment Authorization** |
|---|---|---|---|---|
| Document Title: | | Document Title: | | Document Title: |
| Issuing Authority: | | Issuing Authority: | | Issuing Authority: |
| Document Number: | | Document Number: | | Document Number: |
| Expiration Date *(if any)(mm/dd/yyyy)*: | | Expiration Date *(if any)(mm/dd/yyyy)*: | | Expiration Date *(if any)(mm/dd/yyyy)*: |
| Document Title: | | | | |
| Issuing Authority: | | | | |
| Document Number: | | | | |
| Expiration Date *(if any)(mm/dd/yyyy)*: | | | | **3-D Barcode**<br>**Do Not Write in This Space** |
| Document Title: | | | | |
| Issuing Authority: | | | | |
| Document Number: | | | | |
| Expiration Date *(if any)(mm/dd/yyyy)*: | | | | |

## Certification

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

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

| Signature of Employer or Authorized Representative | Date *(mm/dd/yyyy)* | Title of Employer or Authorized Representative |
|---|---|---|
| | | |

| Last Name *(Family Name)* | First Name *(Given Name)* | Employer's Business or Organization Name |
|---|---|---|
| | | |

| Employer's Business or Organization Address *(Street Number and Name)* | City or Town | State | Zip Code |
|---|---|---|---|
| | | | |

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

| **A.** New Name *(if applicable)* 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: |
|---|---|---|
| | | |

LABOR & MARINE SERVICES

Employee Registration for
Skilled job descriptions

Employee name ______________________________ Date ________________ Birth _____________
SS# ___________________________________ Phone # _____________________________________
Address ______________________________________ Skill __________________________________

**Indicate most recent positions first**

Company __________________________________ From ________________ to _______________
Address ___________________________________________________________________________
Phone ________________________________ Supervisor _________________________________
Reason for leaving _________________________________________________________________
Duties ____________________________________________________________________________
________________________________________________________________________________

Company __________________________________ From ________________ to _______________
Address ___________________________________________________________________________
Phone ________________________________ Supervisor _________________________________
Reason for leaving _________________________________________________________________
Duties ____________________________________________________________________________
________________________________________________________________________________

Company __________________________________ From ________________ to _______________
Address ___________________________________________________________________________
Phone ________________________________ Supervisor _________________________________
Reason for leaving _________________________________________________________________
Duties ____________________________________________________________________________
________________________________________________________________________________

Company __________________________________ From ________________ to _______________
Address ___________________________________________________________________________
Phone ________________________________ Supervisor _________________________________
Reason for leaving _________________________________________________________________
Duties ____________________________________________________________________________
________________________________________________________________________________

Schools: _______________________________________________________ Date ________________
Schools: _______________________________________________________ Date ________________
Schools: _______________________________________________________ Date ________________
Certifications ______________________________________________________________________

# EMPLOYEE
# CERTIFICATE OF COMPLIANCE

**You must submit this form to your employer's workers' compensation insurer or to your employer within 14 days of its receipt.** Your workers' compensation **benefits may be suspended if you do not timely submit this Certification.** You would be entitled to all suspended benefits after this Certification is provided to your insurer, if you are otherwise eligible for benefits.

**It is unlawful for you to work and receive workers' compensation disability benefits, except for supplemental earning benefits.** Supplemental earnings benefits are paid when an employee is able to work, but is unable to earn 90% or more of his pre-injury wages as a result of a job related accident. As an injured worker, you must notify your employer or insurer of the earning of any wages, changes in employment or medical status, receipt of unemployment benefits, receipt of social security benefits and receipt of retirement benefits. If you receive benefits for more than 30 days, you will be required to certify your earning to your insurer quarterly.

**It is unlawful for you to receive workers' compensation indemnity disability benefits and unemployment benefits at the same time, except for permanent partial disability benefits.** Permanent partial disability befits are paid solely for amputation or for anatomical loss of use of a body part or function. If you violate this provision, you may be fined up to $10,000, imprisoned up to 90 days, or both.

**It is unlawful for you to willfully make, or to assist or counsel someone else to make, a false statement or representation in order to obtain or defeat workers' compensation benefits.** If you violate this provision, you may be fined, imprisoned, or both as follows:

| Unlawful Benefits Paid or Claimed | Fine | Imprisonment |
|---|---|---|
| $10,000 or more | up to $10,000 | Up to 10 years, with or without hard labor |
| $2,500 or more but less than $10,000 | up to $5,000 | Up to 5 years, with or without hard labor |
| less than $2,500 | up to $500 | Up to 6 months |

In addition to these criminal penalties, you may be assessed a civil penalty of up to $5,000 and may forfeit your right to receive workers' compensation benefits.

## EMPLOYEE CERTIFICATION

I certify that I understand the contents of this entire document, and that I understand I am held responsible for this information. I certify my compliance with the above stated requirements regarding receipt of workers' compensation benefits.

Print Name ______ Signature ______ Social Security Number ______ Date ______

Address ______ City ______ State/Zip ______ ( ) ______ Phone Number

Note: Only one copy is required per case from the employee
**Please mail this form to your employer or your employer's insurer.**

**LDOL-WC-1025.EE**
**REVISED 12/2000**

LDR — Contributing to a better quality of life

# Employee Withholding Exemption Certificate (L-4)

Louisiana Department of Revenue

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

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

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

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

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

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

**Block A**

- Enter "0" to claim neither yourself nor your spouse. You may enter "0" if you are married, and have a working spouse or more than one job to avoid having too little tax withheld.
- Enter "1" to claim yourself if you did not claim this exemption in connection with other employment, or if your spouse has not claimed your exemption. Enter "1" to claim one personal exemption if you will file as head of household.
- Enter "2" to claim yourself and your spouse.

**A.**

**Block B**

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

**B.**

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

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

# Employee's Withholding Allowance Certificate

| | | |
|---|---|---|
| **1.** Type or print first name and middle initial | Last name | |
| **2.** Social Security Number | **3.** ☐ No exemptions or dependents claimed ☐ Single ☐ Married | |
| **4.** Home address (number and street or rural route) | | |
| **5.** City | State | ZIP |
| **6.** Total number of exemptions claimed in Block A | | **6.** |
| **7.** Total number of dependents claimed in Block B | | **7.** |
| **8.** Increase or decrease in the amount to be withheld each pay period. Decreases should be indicated as a negative amount. | | **8.** |

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

| Employee's signature | Date |
|---|---|

**The following is to be completed by employer.**

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

# Form W-4 (2013)

**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 2013 expires February 17, 2014. 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 $1,000 and includes more than $350 of unearned income (for example, interest and dividends).

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

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

**Head of household.** Generally, you 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 2013. See Pub. 505, especially if your earnings exceed $130,000 (Single) or $180,000 (Married).

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

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

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

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

. . . **B** ______

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

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

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

**F** Enter "1" if you have at least $1,900 of **child or dependent care expenses** for which you plan to claim a credit . . . **F** ______

(**Note.** Do **not** include child support payments. See Pub. 503, Child and Dependent Care Expenses, for details.)

**G** **Child Tax Credit** (including additional child tax credit). See Pub. 972, Child Tax Credit, for more information.
- If your total income will be less than $65,000 ($95,000 if married), enter "2" for each eligible child; then **less** "1" 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 $65,000 and $84,000 ($95,000 and $119,000 if married), enter "1" for each eligible child . . . **G** ______

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

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

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

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

## Employee's Withholding Allowance Certificate

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

OMB No. 1545-0074

**2013**

| 1 Your first name and middle initial | Last name | 2 **Your social security number** |
|---|---|---|
| Home address (number and street or rural route) | 3 ☐ Single ☐ Married ☐ Married, but withhold at higher Single rate. **Note.** If married, but legally separated, or spouse is a nonresident alien, check the "Single" box. | |
| City or town, state, and ZIP code | 4 **If your last name differs from that shown on your social security card, check here. You must call 1-800-772-1213 for a replacement card.** ► ☐ | |

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

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

**7** I claim exemption from withholding for 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.

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

**Date** ►

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

1001 North 23rd Street
Post Office Box 44187
Baton Rouge, LA 70804-4187

(O) 225-342-7866
800-201-2493
(F) 225-219-5968

**Bobby Jindal**, Governor
**Curt Eysink**, Executive Director

**Office of Workers' Compensation Administration**
Second Injury Board

# LA OWCA Second Injury Board Knowledge Questionnaire

The following questionnaire should only be completed by individuals that have been hired for employment. Your employer may ask that you complete this questionnaire following your initial hire and periodically thereafter.

The questionnaire may be used in the establishment of prior knowledge for the purpose of obtaining Second Injury Fund relief from the Second Injury Board. The Second Injury Board may reimburse your employer for workers' compensation claims that meet certain criteria should you become injured on the job. This reimbursement in no way affects the benefits owed to you by your employer or their insurance company under the Louisiana Workers' Compensation Act, La. R.S. 23:1021-1361.

## WARNING

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

Employer: ______________________________

Employee Name: ______________________________

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

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

Home Address: ______________________________

Telephone Number: ( ____ ) ________________

Employee Signature: ______________________ Date: ______________

Employer Witness: ______________________ Date: ______________



www.laworks.net

| Equal Opportunity Employer/Program | Auxiliary aids and services are available upon request to individuals with disabilities • TDD# 800-259-5154 |

Please place a check in the appropriate box next to each medical condition listed below. Each illness or condition requires a Yes (Y) or No (N) answer. For all conditions that you check yes, write a brief explanation on the Explanation Page.

**Disease and Other Medical Conditions** [Please check the appropriate box. Each illness/injury requires a Yes (Y) or No (N) answer.]

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

**Surgical Treatment** [Please check the appropriate box. Each illness/injury requires a Yes (Y) or No (N) answer.]

Y N

☐ ☐ Spinal Disc Surgery — Year (approximate if unsure)___________

☐ ☐ Spinal Fusion Surgery — Year (approximate if unsure)___________

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

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

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

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

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

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

☐ ☐ Other Joint Replacement — Joint ______________________ Year _______________

☐ ☐ Other Surgical Procedure — Procedure __________________ Year _______________

Employee Signature:________________________________________ Date: _________________________

Employer Witness: __________________________________________ Date: _________________________

## EXPLANATION PAGE

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

CONDITION: ____________________ Year Diagnosed (approx): __________

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

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

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

Brief Explanation: ____________________

---

CONDITION: ____________________ Year Diagnosed (approx): __________

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

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

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

Brief Explanation: ____________________

---

CONDITION: ____________________ Year Diagnosed (approx): __________

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

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

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

Brief Explanation: ____________________

---

CONDITION: ____________________ Year Diagnosed (approx): __________

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

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

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

Brief Explanation: ____________________

---

Employee Signature: ____________________ Date: __________

Employer Witness: ____________________ Date: __________

Please answer the following questions.

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

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

   Please list the medical condition being treated: ______________________________

   Doctor's Name: ______________________________ Specialty: ______________________________

   Doctor's Address: ______________________________

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

   Medication: ______________________________ Prescribing Doctor: ______________________________

   Medication: ______________________________ Prescribing Doctor: ______________________________

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

   ______________________________

   How long were you on compensation? ______________________________

   Name of Employer: ______________________________

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

   Recommended surgery: ______________________________

   Approximate date of recommendation: ______________________________

   Doctor's Name: ______________________________ Specialty: ______________________________

   Doctor's Address: ______________________________

Employee Signature: ______________________________ Date: ______________________________

Employer Witness: ______________________________ Date: ______________________________

## WARNING

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

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

Employee Signature:______________________________ Date: ____________________

Employee Printed: ______________________________

**I am an authorized representative of the employer designated to obtain and review the information provided by the employee on this questionnaire. I have confirmed that the employee understands the consequences associated with providing false information or omitting pertinent information. I have confirmed that the employee is able to read and understand the information provided on this questionnaire or I have personally read the questionnaire to the employee. I have provided the employee with as many copies of the Explanation Page as needed. I have confirmed the number of and labeled the pages of this questionnaire.**

Employer Witness: ______________________________ Date: ____________________

Employer Witness Printed: ______________________________________________

Title: ______________________________________________________________