

Form W-4 (2008)

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 2008 expires February 16, 2009. See Pub. 505, Tax Withholding and Estimated Tax.

Note. You cannot claim exemption from withholding if (a) your income exceeds \$900 and includes more than \$300 of unearned income (for example, interest and dividends) and (b) another person can claim you as a dependent on their tax return.

Basic instructions. If you are not exempt, complete the **Personal Allowances Worksheet** below. The worksheets on page 2 adjust your withholding allowances based on itemized deductions, certain credits,

adjustments to income, or two-earner/multiple job situations. Complete all worksheets that apply. However, you may claim fewer (or zero) allowances.

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

Exemptions, Standard Deduction, and Filing Information. For information.

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

Nonwage income. If you have a large amount of nonwage income, such as interest or dividends, consider making estimated tax

payments using Form 1040-E9, Estimated Tax for Individuals. Otherwise, you may owe additional tax. If you have pension or annuity income, see Pub. 919 to find out if you should adjust your withholding on Form W-4 or W-4P.

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

Nonresident alien. If you are a nonresident alien, see the instructions for Form 6233 before completing this Form W-4.

Check your withholding. After your Form W-4 takes effect, use Pub. 919 to see how the dollar amount you are having withheld compares to your projected total tax for 2008. See Pub. 919, especially if your earnings exceed \$130,000 (Single) or \$180,000 (Married).

Form W-4 Department of the Treasury Internal Revenue Service	<h2 style="margin: 0;">Employee's Withholding Allowance Certificate</h2> <p style="font-size: small; margin: 5px 0;">▶ Whether you are entitled to claim a certain number of allowances or exemption from withholding is subject to review by the IRS. Your employer may be required to send a copy of this form to the IRS.</p>	OMB No. 1545-0074 2008
1 Type or print your first name and middle initial. Last name		2 Your social security number
Home address (number and street or rural route)		3 <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Married, but withhold at higher Single rate. <small>Note: If married, but legally separated, or spouse is a nonresident alien, check the "Single" box.</small>
City or town, state, and ZIP code		4 If your last name differs from that shown on your social security card, check here. You must call 1-800-772-1213 for a replacement card. <input type="checkbox"/>
5 Total number of allowances you are claiming (from line H above or from the applicable worksheet on page 2)		5 <input style="width: 40px;" type="text"/>
6 Additional amount, if any, you want withheld from each paycheck		6 \$ <input style="width: 80px;" type="text"/>
7 I claim exemption from withholding for 2008, 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 <input style="width: 40px;" type="text"/>
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 (Form is not valid unless you sign it.) ▶		
8 Employer's name and address (Employer: Complete lines 8 and 10 only if sending to the IRS.)		Date ▶
9 Office code (optional)		10 Employer identification number (EIN)

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

Cat. No. 10220Q

Form W-4 (2008)

For New Mexico State Tax Withholding, please withhold as follows:

Filing Status: (check one)

Single _____

Married _____

Married but withholding at single rate _____

Exemptions

Number of exemptions _____

Additional Withholding: (enter \$)

Additional amount, if any, you want withheld from each check \$ _____



CITY OF ALBUQUERQUE

Agreement for SEASONAL EMPLOYMENT

I, _____, understand, acknowledge, and agree that I am being
Printed Name

hired as a seasonal employee for the City of Albuquerque and that any other terms of employment I have had or may have with the City of Albuquerque as a student, seasonal or temporary employee do not infer or imply any permanent status of employment relationship with the City of Albuquerque. I also understand, acknowledge, and agree that I have no property right in my employment and may be terminated at the will of the City for any or no cause, and that the City is not required to give a reason for termination.

I further understand, acknowledge, and agree that my term of service as a seasonal employee may be for up to nine (9) months, either served consecutively or over a twelve (12) month period, but will not exceed twelve (12) months from my effective date of hire.

____ / ____ / ____
Date of Birth

Applicant Signature

Today's Date

APPLICANTS UNDER THE AGE OF 18

I, _____, as the parent or guardian of _____,
Printed Name of Parent/Guardian *Printed Name of Applicant*

and with authority to act on his/her behalf, understand, acknowledge, and agree that the above-mentioned applicant is being hired as a seasonal employee for the City of Albuquerque and that any other terms of employment he/she has had or may have with the City of Albuquerque as a student, seasonal, or temporary employee do not infer or imply any permanent status or employment relationship with the City of Albuquerque. I also understand, acknowledge and agree that he/she has no property right in his/her employment and may be terminated at the will of the City for any and no cause, and that the City is not required to give a reason for termination.

I further understand, acknowledge, and agree that his/her term of service as a seasonal employee may be for up to nine (9) months, either served consecutively or over a twelve (12) month period, but will not exceed twelve (12) months from his/her effective date of hire.

Signature of Parent or Guardian

Today's Date

Address

Phone Number



PUBLIC EMPLOYEES RETIREMENT ASSOCIATION OF NEW MEXICO

PUBLIC EMPLOYEES RETIREMENT BOARD

P.O. Box 2123, Santa Fe, New Mexico 87504-2123

(505) 827-4670 fax (505) 827-4700 voice

www.state.nm.us/pera

EMPLOYEE EXCLUSION FROM PERA MEMBERSHIP

Instructions: Please print or type in black. The original of this form must be completed in its entirety and returned to PERA for processing.

Required fields are in **BOLD ITALICS**

SECTION A - MEMBER INFORMATION

SOCIAL SECURITY NUMBER

FIRST NAME MI **LAST NAME**

ADDRESS TYPE PERMANENT TEMPORARY MAILING **HOME TELEPHONE NO.**

ADDRESS BUSINESS TELEPHONE NO.

EMAIL ADDRESS

CITY **STATE** **ZIP** **SEX** MALE FEMALE

DATE OF BIRTH CITY OF BIRTH STATE OF BIRTH

PLEASE review the employee exclusion categories on the reverse side of this form and check the box that applies to your application for exclusion. (CHECK ONE BOX ONLY)

- SEASONAL EMPLOYEE OR TEMPORARY EMPLOYEE
- PART-TIME EMPLOYEE
- PRIVATE RETIREMENT
- RETIRED MEMBER FROM ERA, JRA, OR MRA
- INDEPENDENT CONTRACTOR
- STUDENT EMPLOYEE
- RETIRED LEGISLATIVE WORKER

PERA retirees are no longer excluded from PERA membership as seasonal employees, temporary employees or part-time employees. PERA retirees should use the Application for A Reemployed PERA Retiree.

MEMBER CERTIFICATION

I understand that I am being excluded from PERA membership due to the exclusion category checked above. I also understand that and agree that being excluded under this designation will disqualify me for normal, disability, or survivor's retirement benefits under PERA, and that I will be ineligible to purchase such excluded service at a future date.

SIGNATURE OF MEMBER

DATE

SECTION B - TO BE COMPLETED BY EMPLOYER - CURRENT EMPLOYMENT INFORMATION

NAME OF EMPLOYER City of Albuquerque

MAILING ADDRESS PO Box 1293

CITY Albuquerque

STATE NM

ZIP 87 102

DATE EMPLOYED (mm/dd/ccyy)

EMPLOYER NUMBER 03-2020-0 15

CURRENT POSITION

PLAN Three

EMPLOYER CERTIFICATION

AUTHORIZED SIGNATURE

DATE OF SIGNATURE (mm/dd/ccyy)

TITLE

BUSINESS TELEPHONE NO.

EMPLOYMENT CHECKLIST

Date In _____

Date Due _____

Last Name _____

First Name _____

DOB _____

SSN _____

DL Number _____

Date

MVD _____

Specialist _____

CCH _____

Juv ___ Indx ___ micro ___

TIB Cr Rec P# _____

TIB Cr Rec S# _____

TIB Web Qry P _____

TIB Web Qry S _____

ACOPS(P600) _____

NEW WORLD _____

STATE _____

SEX OFF REG _____

NCIC WARR _____

WITS WARR _____

DIST CRT _____ New _____

DIST ATTY _____

METRO CRT _____

DEPT _____

Position/Program _____

New Hire _____

Re-Hire _____

Revised 8/22/08

UNDER 18

ALBUQUERQUE POLICE DEPARTMENT BACKGROUND INVESTIGATION WAIVER AND LIABILITY RELEASE FORM

In consideration of the Agency, Albuquerque Police Department, processing my application for employment, I, _____, hereby irrevocably to the following:

1. I understand that a thorough and complete background investigation will be conducted to determine my fitness and desirability as a candidate for employment.
2. I understand that a background investigation is conducted by gathering and recording information about my past conduct and associations from any and all sources that the Agency, in its sole discretion, may deem appropriate, including: criminal or other Governmental files and records, past and present employers, and any other source of information available.
3. I hereby release from liability and agree to hold harmless; under any and all possible Causes of legal action, including negligence, the City of Albuquerque, Bernalillo County, the Albuquerque Police Department Identification Unit, the Agency and any of its officers, agents or employees for any negligent or wrongful statements, acts, omissions made or recorded in the course of my background investigation.
4. I hereby release from liability and agree to hold harmless under any possible cause of Legal action, including negligence, any person or entity which furnishes information or opinions to the Agency as a part of my background investigation.
5. I authorize any person or entity contacted by the Agency during the course of my background investigation to furnish any information or opinions such person or entity may have regarding myself, my conduct or associations, regardless of any statutory or other privilege I may have.
6. I understand the need for confidentiality of sources and information in my background investigation and I expressly agree that I will never attempt to obtain access to any part of the background investigation designated as confidential by the Agency.

This release applies to any cause of action of any nature that might accrue to myself.

Signature of Applicant

Date of Birth

Social Security

Street Address

Parent or Guardian Signature

Date

City/Town

State

Zip



CITY OF ALBUQUERQUE

Employee Statistical/Emergency Contact Data Form

In order to comply with Federal/State Equal Employment Opportunity and statistical record keeping requirements, we require the following information:

PLEASE PRINT

Statistical Data (required):

Name: _____

SSN: _____ - _____ - _____

Birth Date: _____/_____/_____
Month/Day/Year

Sex: Male Female

Emergency Contact Data (required):

Name: _____ Relationship: _____

Physical Address: _____

Daytime Phone: _____ Evening Phone: _____

Personal Data (optional):

Cell Phone: _____ Email Address: _____

Pager Number: _____ Other Phone: _____

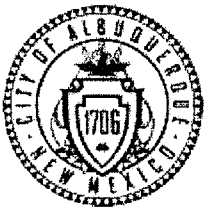
Signature: _____ Date: _____

Ethnic Group - check one, info. used for statistical purposes only (optional):

Black/African American White Hispanic/Latino Asian
Native Hawaiian or Other Pacific Islander American Indian or Alaskan Native

In accordance with the City of Albuquerque Personnel Rules & Regulations, Chapter 1006:

"Employees are responsible for keeping their personnel records updated. This includes, but is not limited to education, experience, address, phone number and emergency notification information."



CITY OF ALBUQUERQUE
Pre-Employment Medical/Substance Abuse
Consent Form

Applicants under the age of 18

I hereby give my permission for the below named applicant to be employed by the City of Albuquerque.

I hereby give my permission to the City of Albuquerque to refer the below named applicant for a complete medical examination and if necessary a TB skin test.

I understand the City of Albuquerque is a drug-free workplace. I hereby give permission for the City of Albuquerque to give the applicant a substance abuse test in accordance with the City of Albuquerque Substance Abuse Policy dated February 7, 2006, including pre-employment, random, post-accident and/or reasonable suspicion testing.

I hereby give the City of Albuquerque permission to refer the below named applicant for treatment of a work-related injury or occupational disease.

Applicant (Print Name)

Signature

Social Security Number

Date of Birth

Parent or Guardian Signature

Date



City of Albuquerque

Medical and Occupational History (Under 18)

Return Completed form to

Employee Health Center

Located on the basement level of Old City Hall

400 Marquette NW

768-4630

This physical exam is intended to verify your physical capability to perform the job for which you are being hired. It is not intended to take the place of exams given by your personal physician.

Name: _____ Date: _____
(Last) (First) (Initial)

Social Security Number: _____ Date of Birth: _____

Reason for Exam: Post-Offer _____ Annual _____ Other _____

Who is currently your primary health care physician? Name: _____

Please check any of these items to which you have had exposures or needed medical treatment.

- | | | | |
|--|---|---|--------------------------------|
| <input type="checkbox"/> Asbestos | <input type="checkbox"/> PCB, PBB | <input type="checkbox"/> Vapors/Gases | <input type="checkbox"/> Other |
| <input type="checkbox"/> Blood/Body Fluids | <input type="checkbox"/> Metals (Fumes/Dusts) | <input type="checkbox"/> Vibration | |
| <input type="checkbox"/> Dusts | <input type="checkbox"/> Noise | <input type="checkbox"/> Heat/Cold Exposure | |
| <input type="checkbox"/> Radiation | <input type="checkbox"/> Carcinogens | <input type="checkbox"/> Pesticides | |

If **YES** to any of the above, describe below including a complete description of the exposure, dates of occurrences and name of physician who treated you. Also list place of employment, if exposure occurred in a work environment.

1. Have you ever been injured on the job in any way?..... Yes No
2. Have you ever gotten sick in any way from something you worked with on the job?..... Yes No
3. Has your work ever caused problems with your joints (wrists, hands, knees, etc), your back, or skin?..... Yes No
4. Have you had any hobbies or jobs in which you use chemicals, metals, loud machines or tools, firearms, music amplifiers or other hazardous substance?..... Yes No.
5. Have you ever claimed Worker's Compensation Benefits? If **YES** explain below..... Yes No

6. Have you ever had to terminate any job for health reasons?..... Yes No
7. Have you ever had to transfer from one job to another or change job duties for health reasons?..... Yes No
8. Have you ever been refused any job for health reasons?..... Yes No
9. Has a doctor ever placed restrictions on the kind of work you should do?..... Yes No
10. Has a doctor ever placed restrictions on your lifting, bending, twisting, walking, standing, sitting or using your hands, arms or back?..... Yes No
11. Have you ever had a back injury or experienced back pain or back strain?..... Yes No
12. Have you ever filed a lawsuit for any injury?..... Yes No

ALLERGIES

List any allergies you have to drugs, foods, pollen, etc.

REVIEW OF SYSTEMS

Indicate whether or not you have a health problem or have had in the past a problem that falls under any of the numbered categories listed below. If you answer is "YES" check the phrases under each category that best describe the problem. Explain in detail at the end of the section.

- | | | |
|--|----|--|
| <input type="checkbox"/> Yes <input type="checkbox"/> No | 1. | Problem with overall fitness and feeling of well-being?
<input type="checkbox"/> Unexplained Fever <input type="checkbox"/> Unexplained Weight Loss/Gain <input type="checkbox"/> Unusual Sweating
<input type="checkbox"/> Weakness <input type="checkbox"/> Fatigue |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | 2. | Problem with Skin?
<input type="checkbox"/> Recurrent or Persistent Rash <input type="checkbox"/> Unexplained itching <input type="checkbox"/> Eczema
<input type="checkbox"/> Allergic Skin Rash <input type="checkbox"/> Acne <input type="checkbox"/> Psoriasis
<input type="checkbox"/> Dry Cracked Skin <input type="checkbox"/> Yellow Color |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | 3. | Problem with Blood or Bleeding?
<input type="checkbox"/> Anemia (Low Blood Count) <input type="checkbox"/> Nose Bleeds <input type="checkbox"/> Bruising
<input type="checkbox"/> Bleeding Trait |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | 4. | Problems with Diabetes? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | 5. | Problem with Muscles, Joints, Back?
<input type="checkbox"/> Painful, Stiff or Swollen Joints <input type="checkbox"/> Arthritis <input type="checkbox"/> Gout
<input type="checkbox"/> Back Pain <input type="checkbox"/> Back injury <input type="checkbox"/> Sciatica <input type="checkbox"/> Sore Muscles |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | 6. | Problem with Eyes or Vision?
<input type="checkbox"/> Wear Glasses/Contacts <input type="checkbox"/> Loss of Vision <input type="checkbox"/> Lazy Eye
<input type="checkbox"/> Glaucoma <input type="checkbox"/> Cataracts <input type="checkbox"/> Yellow eyes |

- Yes No 7. **Problem with the Ears or Hearing?**
 Ringing or Buzzing in the Ears Loss of Hearing Ear Infections
- Yes No 8. **Nose and Throat Problems?**
 Sinus Trouble Hay Fever Recurrent Sore Throats
- Yes No 9. **Breathing or Lung Problems?**
 Shortness of Breath Persistent Cough Bronchitis Tuberculosis
 Coughing up Blood Coughing up Sputum Wheezing (Asthma)
- Yes No 10. **Problem with the Heart or Blood Vessels?**
 Rheumatic Fever Heart Murmur Palpitations Chest Pain
 Phlebitis Heart Attacks Angina Heart Failure
 Varicose Veins Unusually Rapid Heart Beat
- Yes No 11. **High Blood Pressure?**
- Yes No 12. **Problem with the Stomach, Liver or Bowels?**
 Stomach/Abdominal Pain/Discomfort Stomach Ulcer
 Blood in Stool Cirrhosis Recent Change in Bowel Habits
 Hepatitis Heartburn Gallbladder Trouble
 Persistent Diarrhea Hernia Yellow Jaundice
- Yes No 13. **Problem with the Bladder or Kidneys?**
 Urine Infection Frequent Urination Kidney Stone Painful Urination
 Blood in the Urine Difficulty Urinating Kidney Failure
- Yes No 14. **(WOMEN) Are you pregnant now?**
- Yes No 15. **Problems with the Nervous Systems?**
 Seizures or Convulsions Headaches Fainting or Blackouts
 Numbness or Loss of Sensation Weakness of Arm or Leg Stroke
- Yes No 16. **Emotional or Mental Problems?**
 Depression Anxiety Nervous Breakdown
- Yes No 17. **Any other Problem with Pain?**
 Pain/Discomfort in the Chest Pain in the Arms, Wrists, Legs, or Back
- Yes No 18. **Any Swelling in the Legs?**

HEALTH MAINTENANCE RECORD

Are you now under the care of a physician for a health condition? Yes No

If **YES**, what is the condition(s)? _____

When did you last have any of the following?

	Date	Where	Results (if applicable)
Physical Exam	_____	_____	_____
Eye Exam	_____	_____	_____
Chest X-Ray	_____	_____	_____
Back X-Ray	_____	_____	_____
Other X-Rays/ MRI	_____	_____	_____
Tetanus Shot	_____	_____	_____
Skin Test for TB	_____	_____	_____
Hepatitis Vaccine	_____	_____	_____

Have you ever received instruction in back care and lifting techniques? Yes _____ No
(Date)

PAST MEDICAL HISTORY

- Have you ever been hospitalized? Yes No
- Do you have any physical impairments? Yes No
- Were you born with any physical defects? Yes No
- Have you ever had surgery? Yes No
- Have you ever broken a bone? Yes No

If **YES** to any of the above, list the specific details including dates and names of treating physician.

FAMILY HISTORY

Have any of your parents, brothers and/or sisters ever had?

High blood pressure
 Cancer

Heart Problems
 Bleeding disorder

Stroke
 Mental disorder

Diabetes
 Alcoholism

MEDICATIONS

List any medicines including over the counter medicine you are taking?

REVIEW (CONT)

- Yes No 21. History of any kind of Cancer?
- Yes No 22. Persistently Swollen Lymph Glands?
- Yes No 23. Problem with the Thyroid Gland?
- Yes No 24. Any other Health Problems?

Use this space to explain any problem or to complete other sections as needed.

I certify the information contained in this record is correct and complete to the best of my knowledge and belief. I understand that knowingly making a false statement in this record shall be deemed sufficient cause for rejection of my application or dismissal after employment. I understand I shall be entitled to no future worker's compensation benefits if I knowingly and willfully conceal or make false representation about the information requested. I understand that the City of Albuquerque will rely on this Medical and Occupational History.

I AUTHORIZE THE CITY OF ALBUQUERQUE, NOW AND IN THE FUTURE, TO OBTAIN ANY MEDICAL RECORDS WHICH ARE REASONABLY RELATED TO MY ABILITY TO DO MY JOB.

To ensure compliance with Right to Privacy Laws, this form must be sealed in the envelope provided and hand delivered to the Employee Health Center on the day of your physical, and /or drug test. If pre-employment requirements do not include a physical and/or drug test this form must be hand delivered to the Employee Health Center prior to your first day of work.

I HAVE READ AND UNDERSTAND THE ABOVE STATEMENT.

(Signature of Applicant)

(Date)



Direct Deposit Authorization Form

EMPLOYEE NAME _____ (please print)

EMPLOYEE ID _____ WORK PHONE _____

Employee Signature _____ Date: _____

City Policy States: Effective January 1, 1999 all new hires, re-employments and rehires are to be paid via direct payroll deposit. Employees with hire dates of 1/1/1999 or later can change their account but CANNOT cancel a direct deposit.

I hereby authorize the CITY OF ALBUQUERQUE to initiate credit entries and to initiate, if necessary, debit entries and adjustments made to my account in error.

Note: Please attach a voided check or copy of a membership card (for credit unions). New set ups require a pre-note to the bank, so money will not be deposited until the second pay check.

CHECK ONE ACTION BELOW:

_____ **NEW - Net Pay Direct Deposit (100% of NET) to:**

Bank Name _____

ACH Routing No. _____

ACCOUNT# _____ Checking or Savings ←circle one.

_____ **CANCEL - Net Pay Direct Deposit (see above restrictions.)**

BANK NAME _____ ACCOUNT# _____

_____ **NEW - Partial Direct Deposit in the amount of \$ _____ each pay period.**

Bank Name _____

ACH Routing No. _____

ACCOUNT# _____ Checking or Savings ←circle one.

_____ **CHANGE - Partial Direct Deposit amount from \$ _____ to \$ _____**

_____ **CANCEL - Partial Direct Deposit. BANK/ACCT# _____**

SAMPLE THIS FORM WILL BE COMPLETED AT NEW EMPLOYEE ORIENTATION. PLEASE FAMILIARIZE YOURSELF WITH THIS FORM AND THE NECESSARY DOCUMENTATION NEEDED TO COMPLETE THE FORM.

OMB No. 1615-0047; Expires 06/30/08

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

Form I-9, Employment Eligibility Verification

Please 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 eligible individuals. Employers CANNOT specify which document(s) they will accept from an employee. The refusal to hire an individual because the documents have a future expiration date may also constitute illegal discrimination.

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

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

SAMPLE PLEASE READ!

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 or national of the United States
- A lawful permanent resident (Alien #) A _____
- An alien authorized to work until _____
(Alien # or Admission #) _____

Employee's Signature	Date (month/day/year)
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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.

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

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

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

SAMPLE
DO NOT COMPLETE THIS FORM

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

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

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

A. New Name (if applicable)	B. Date of Rehire (month/day/year) (if applicable)	
C. If employee's previous grant of work authorization has expired, provide the information below for the document that establishes current employment eligibility.		
Document Title:	Document #:	Expiration Date (if any):

I attest, under penalty of perjury, that to the best of my knowledge, this employee is eligible to work in the United States, and if the employee presented document(s), the document(s) I have examined appear to be genuine and to relate to the individual.

Signature of Employer or Authorized Representative	Date (month/day/year)
--	-----------------------

*** SAMPLE - DO NOT COMPLETE THIS FORM ***

*** SAMPLE - DO NOT COMPLETE THIS FORM ***

LISTS OF ACCEPTABLE DOCUMENTS

LIST A Documents that Establish Both Identity and Employment Eligibility	LIST B Documents that Establish Identity	LIST C Documents that Establish Employment Eligibility
OR		AND
1. U.S. Passport (unexpired or expired)	1. Driver's license or ID card issued by a state or outlying possession of the United States provided it contains a photograph or information such as name, date of birth, gender, height, eye color and address	1. U.S. Social Security card issued by the Social Security Administration (<i>other than a card stating it is not valid for employment</i>)
2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551)	2. ID card issued by federal, state or local government agencies or entities, provided it contains a photograph or information such as name, date of birth, gender, height, eye color and address	2. Certification of Birth Abroad issued by the Department of State (<i>Form FS-545 or Form DS-1350</i>)
3. An unexpired foreign passport with a temporary I-551 stamp	3. School ID card with a photograph	3. Original or certified copy of a birth certificate issued by a state, county, municipal authority or outlying possession of the United States bearing an official seal
4. An unexpired Employment Authorization Document that contains a photograph (Form I-766, I-688, I-688A, I-688B)	4. Voter's registration card	4. Native American tribal document
	5. U.S. Military card or draft record	5. U.S. Citizen ID Card (<i>Form I-197</i>)
5. An unexpired foreign passport with an unexpired Arrival-Departure Record, Form I-94, bearing the same name as the passport and containing an endorsement of the alien's nonimmigrant status, if that status authorizes the alien to work for the employer	6. Military dependent's ID card	6. ID Card for use of Resident Citizen in the United States (<i>Form I-179</i>)
	7. U.S. Coast Guard Merchant Mariner Card	
	8. Native American tribal document	7. Unexpired employment authorization document issued by DHS (<i>other than those listed under List A</i>)
9. Driver's license issued by a Canadian government authority		
	For persons under age 18 who are unable to present a document listed above:	
	10. School record or report card	
	11. Clinic, doctor or hospital record	
	12. Day-care or nursery school record	

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

Instructions**Please read all instructions carefully before completing this form.**

Anti-Discrimination Notice. It is illegal to discriminate against any individual (other than an alien not authorized to work in the U.S.) in hiring, discharging, or recruiting or referring for a fee because of that individual's national origin or citizenship status. It is illegal to discriminate against work eligible individuals. Employers **CANNOT** specify which document(s) they will accept from an employee. The refusal to hire an individual because the documents presented have a future expiration date may also constitute illegal discrimination.

What Is the Purpose of This Form?

The purpose of this form is to document that each new employee (both citizen and non-citizen) hired after November 6, 1986 is authorized to work in the United States.

When Should the Form I-9 Be Used?

All employees, citizens and noncitizens, hired after November 6, 1986 and working in the United States must complete a Form I-9.

Filling Out the Form I-9

Section 1, Employee: This part of the form must be completed at the time of hire, which is the actual beginning of employment. Providing the Social Security number is voluntary, except for employees hired by employers participating in the USCIS Electronic Employment Eligibility Verification Program (E-Verify). **The employer is responsible for ensuring that Section 1 is timely and properly completed.**

Preparer/Translator Certification. The Preparer/Translator Certification must be completed if **Section 1** is prepared by a person other than the employee. A preparer/translator may be used only when the employee is unable to complete **Section 1** on his/her own. However, the employee must still sign **Section 1** personally.

Section 2, Employer: For the purpose of completing this form, the term "employer" means all employers including those recruiters and referrers for a fee who are agricultural associations, agricultural employers or farm labor contractors.

Employers must complete **Section 2** by examining evidence of identity and employment eligibility within three (3) business days of the date employment begins. If employees are authorized to work, but are unable to present the required

document(s) within three business days, they must present a receipt for the application of the document(s) within three business days and the actual document(s) within ninety (90) days. However, if employers hire individuals for a duration of less than three business days, **Section 2** must be completed at the time employment begins. **Employers must record:**

1. Document title;
2. Issuing authority;
3. Document number;
4. Expiration date, if any; and
5. The date employment begins.

Employers must sign and date the certification. Employees must present original documents. Employers may, but are not required to, photocopy the document(s) presented. These photocopies may only be used for the verification process and must be retained with the Form I-9. **However, employers are still responsible for completing and retaining the Form I-9.**

Section 3, Updating and Reverification: Employers must complete **Section 3** when updating and/or reverifying the Form I-9. Employers must reverify employment eligibility of their employees on or before the expiration date recorded in **Section 1**. Employers **CANNOT** specify which document(s) they will accept from an employee.

- A. If an employee's name has changed at the time this form is being updated/reverified, complete Block A.
- B. If an employee is rehired within three (3) years of the date this form was originally completed and the employee is still eligible to be employed on the same basis as previously indicated on this form (updating), complete Block B and the signature block.
- C. If an employee is rehired within three (3) years of the date this form was originally completed and the employee's work authorization has expired or if a current employee's work authorization is about to expire (reverification), complete Block B and:
 1. Examine any document that reflects that the employee is authorized to work in the U.S. (see List A or C);
 2. Record the document title, document number and expiration date (if any) in Block C, and
 3. Complete the signature block.

What Is the Filing Fee?

There is no associated filing fee for completing the Form I-9. This form is not filed with USCIS or any government agency. The Form I-9 must be retained by the employer and made available for inspection by U.S. Government officials as specified in the Privacy Act Notice below.

USCIS Forms and Information

To order USCIS forms, call our toll-free number at **1-800-870-3676**. Individuals can also get USCIS forms and information on immigration laws, regulations and procedures by telephoning our National Customer Service Center at **1-800-375-5283** or visiting our internet website at **www.uscis.gov**.

Photocopying and Retaining the Form I-9

A blank Form I-9 may be reproduced, provided both sides are copied. The Instructions must be available to all employees completing this form. Employers must retain completed Forms I-9 for three (3) years after the date of hire or one (1) year after the date employment ends, whichever is later.

The Form I-9 may be signed and retained electronically, as authorized in Department of Homeland Security regulations at 8 CFR § 274a.2.

Privacy Act Notice

The authority for collecting this information is the Immigration Reform and Control Act of 1986, Pub. L. 99-603 (8 USC 1324a).

This information is for employers to verify the eligibility of individuals for employment to preclude the unlawful hiring, or recruiting or referring for a fee, of aliens who are not authorized to work in the United States.

This information will be used by employers as a record of their basis for determining eligibility of an employee to work in the United States. The form will be kept by the employer and made available for inspection by officials of U.S. Immigration and Customs Enforcement, Department of Labor and Office of Special Counsel for Immigration Related Unfair Employment Practices.

Submission of the information required in this form is voluntary. However, an individual may not begin employment unless this form is completed, since employers are subject to civil or criminal penalties if they do not comply with the Immigration Reform and Control Act of 1986.

Paperwork Reduction Act

We try to create forms and instructions that are accurate, can be easily understood and which impose the least possible burden on you to provide us with information. Often this is difficult because some immigration laws are very complex. Accordingly, the reporting burden for this collection of information is computed as follows: **1)** learning about this form, and completing the form, 9 minutes; **2)** assembling and filing (recordkeeping) the form, 3 minutes, for an average of 12 minutes per response. If you have comments regarding the accuracy of this burden estimate, or suggestions for making this form simpler, you can write to: U.S. Citizenship and Immigration Services, Regulatory Management Division, 111 Massachusetts Avenue, N.W., 3rd Floor, Suite 3008, Washington, DC 20529. OMB No. 1615-0047.