VICTORIOUS HOME HEALTH CARE LIMITED

414 Dixie Highway Chicago Heights. Illinois, 60411

APPLICATION REQUIREMENTS

Please complete the application forms/provide the original copies of the below

- Resume
- State ID or Driver's license
- High school Diploma or GED
- Car insurance
- Current physical Examination result
- Current TB Test results
- First Aid
- CPR Card
- Current RN/LPN License
- CNA License
- W-4 State and Federal IRS
- Work Permit/Green card/US Passport
- Form I-94 (Immigration) and Delay filled Form I-9
- Emergency Contacts, Names and phone numbers
- Duly Filled Victorious Home Health Application Form

VICTORIOUS HOME HEALTHCARE LTD

411 Dixie Highway Chicago Heights IL, 60411. PH(815)464-9201 victorioushh@gmail.com.Fax (815) 464-9202

EMPLOYMENT APPLICATION:

An Equal Opportunity Employer: *We consider applicants for all positions without regard to race, color, religion, creed, gender, national origin, age, disability, marital of veteran status, or any other legally protected status. In order to be considered an applicant, you must complete this form.*

General Information

Date of Application

Please select

Position Applying for: RN/NP Home Care Aide LPN CNA

Full Name | Date Of Birth

E-Mail | Social Security Number

Address | Phone

1. Do any of your friends or relatives work here? Yes No

   If yes, state full name and relationship.

2. Are you legally eligible for employment in this country? (Proof of citizenship or immigration status will be required upon employment) Yes No
3. Have you been convicted of a felony within the last 7 years? Yes No
4. Are you currently employed? Yes No
5. If you are currently employed, may we contact your employer? Yes No

Work Preferences & Availability

1. Are you looking for a full-time or part-time position?
2. Are you available to work weekends?
3. Are you willing and able to service clients throughout the Cook County / Will County / Kankakee County (whether by driving or using public transportation)?

Education

Type of School	NAME OF SCHOOL	LOCATION (City, State)	NUMBER OF YEARS COMPLETED	MAJOR & DEGREE
High School				
College				
Bus. Or Trade School				
Professional School				

Have you ever been convicted of a crime? Yes No

If yes, explain number of conviction(s), nature of offense(s) leading to conviction(s), how recently such offense(s) was/were committed, sentence(s) imposed, and type(s) of rehabilitation (A conviction will not necessarily result in the denial of employment):

Have you ever worked under a different name? Yes No

If YES, what was it and what was the reason?

Do you have any relatives or friends that work for the Company? Yes No

If YES, what is their name?

In Case of Emergency, Please Contact:

Name Relation

Phone Number

Previous Employment/Work History

Company: Telephone Number:

Supervisor: Date Started:

Job Title: Date Ended:

Job Duties: Reason for Leaving: Address:

Company: Telephone Number:

Supervisor: Date Started:

Job Title: Date Ended:

Job Duties: Reason for Leaving:

Address:

Company:

Supervisor: Telephone Number:

Job Title: Date Started:

Job Duties: Date Ended:

Address: Reason for Leaving:

WHAT POSITION ARE YOU APPLYING FOR?

POSITION: _____

COMPANY NAME: _____

TITLE: _____

VICTORIOUS HOME HEALTHCARE

Job Description: Registered Nurse

Responsible to: Director of Nursing

Qualifications:

- Graduate of a National League of Nursing accredited School of nursing
- Current Illinois Registered Nurse License
- Willing to travel
- Bachelor's degree and prior home health experience preferred Job

Duties:

1, Patient Care

a. Adheres to the Nursing Practice when providing patient care
b. Respects the patient's privacy and property
c. Uses correct body mechanics when providing care to prevent injury to self and patient
d. Conducts comprehensive physical assessments and obtains medical histories on patients in the home setting
e. Develops nursing diagnoses and plans of care according to individual patient assessments, and health care needs
f. Uses effective communication techniques with patients and families
g. Educates patients and families according to the plan of care
h. Identifies when patient goals are achieved; identifies and acts to resolve any barriers to go.id achievement
i. Maintains high standards and provides high quality, culturally competent nursing care
j. Continually re-evaluates and 11Pdates the plan of care
k. Uses effective time management skills
l. Conserves agency resources as appropriate
m. Identifies changes in the patient condition and informs the physician and other appropriate patient caregiver:
n. Functions as a case manager in coordinating care between all disciplines, Contacts physicians to obtain new orders p. Communicates clinical information to the Director of Nursing/Nursing Supervisor at start of care and periodically throughout the certification period with changes in patient condition and discharge plans
q. Completes and submits documentation according to agency regulation
r. Attains and maintains proficiency in the following skills:

. Infection Control
. Venipuncture
. Wound care
. Infusion Therapy and Central Line care Colostomy Care
. Gastrostomy care and Enteral Feedings
. Tracheostomy Care and Oxygen Therapy
. Foley Catheter Care and Insertion
. Glucometer

Job Description: Registered Nurse

2. Supervision

   a. Responsible for supervising and instructing Licensed Practical Nurses and Home Health Aides
   b. Reports deficiencies to the Director of Nursing c, Assists with the orientation of new personnel

3. Personal / Professional Standards

   a. Attends in-services and communicates learning needs to the Director of Nursing
   b. Sets personal and professional goals
   c. Maintains a professional demeanor and appearance while interacting, with patients and workers
   d. Exhibits critical thinking abilities to analyze and optimize work processes
   e. Cooperates with co-workers and management and utilizes the chain command to resolve
   f. Upholds a strong work ethic and applies -the agency's missions and standards
   g. Adheres to the agency's policies and procedures.
   h. Contributes to the agency's quality improvement program
   i. Maintains patient and employee confidentiality.
   j. Requires minimal supervision and is self-directed

4. Willing / able to accept the following job demands

Condition	Rarely	Occasionally	Frequently
Sitting			X
Standing			X
Kneeling		X	
Walking			X
Lifting, Carrying, Pushing, or Pulling			
10 lbs			X
20 lbs			X
50 lbs		X	
Travel 20 miles			X
Travel over 20 miles		X	
Inclement weather		X	
Temperatures above 90° F and under 20° F		X	
Exposure to infectious Waste		X	
Exposure to blood and body fluids			X
Needles		X	

I verify that I meet the above requirements. I understand my job description and agree to perform the functions as stated above.

Signature: _____ Date: _____

RN SKILLS ASSESSMENT

Employee_____

DIRECTIONS: Score the self-evaluation 1, 2 or 3 based on the Key
Key: 1- Experienced/proficient 2- Prior experience/need review 3- No experience/need training

Procedure	Self-evaluation	Competent	Date competency verified if needed	Method	Comments
Infection control					
Bag technique					
Bio-hazard waste disposal					
Care/storage of equipment					
Handwashing					
Cardiovascular					
Compression wraps					
Internal defibrillators					
Pacemakers					
Pulmonary					
Chest physiotherapy					
Pleurex catheters					
CPAP					
Nebulizer					
Oxygen concentrator					
Liquid oxygen					
Suctioning					
Tracheostomy site care					
Change of outer cannula					
Change of inner cannula					
GI					
Colostomy care					
G-tubes					
T-Tubes					
GU					
Foley insertion- male					
Foley insertion- male					
External male catheter					
Suprapubic catheter					
Urostomy					
Nephrostomy					
Neuromuscular					
ROM exercises					
Transfers- max assist					
Transfers- Hoyer lifts					
Orthotics					
IVs					
Groshong catheter					
Port a cath					
PICC					
Peripheral IV insertion					
TPN					
Blood draw thru central line					
Central line dressing change					
IV per gravity					

Procedure	Self-evaluation	Competent	Date competency verified if needed	Method	Comments
IV per pump					
IV per ambulatory pump					
IV push administration					
Labs					
Protime machine					
Staight cath for urine C&S					
Venipuncture					
Wound culture					
Wound care					
Calcium alginates					
Foam dressing					
Hydrocolloids					
Hydrogel					
Surgical dressings					
Unna boot					
Wound vac					
Disease Process Assessment and Mgmt					
Alzheimers					
Cancer/Terminal Care					
CHF					
Disease mgmt teaching					
Edema mgmt					
Lung sounds					
Pedal pulse assessment					
COPD					
Disease mgmt teaching					
Lung sounds					
Pulse oximeter					
CVA					
Diabetes					
Disease mgmt teaching					
Glucometer					
Osteoarthritis					
Pain management					
Renal Disease					
Rheumatoid arthritis					
Wounds					
Arterial ulcers					
Decubitus ulcers					
Diabetic ulcers					
Surgical dehiscence					
Venous stasis ulcers					

Any area answered 2 or 3 will require competency verification prior to providing the service to a patient

Competency method key: PC= Patient care SD= Skill demonstration V= Verbal recall W= Written exam

Employee signature **Date**

Director of Nursing signature

VICTORIOUS HOME HALTHCARE L T D

ACKNOWLEDMENT OF JOB DESCRIPTION

VICTORIOUS HOME HEALTH CARE does not discriminate on the basis of race, color, religion, national origin, sex, handicap or age.

I have read this job description and fully understand the requirements set forth therein.

I hereby accept the position of Home Healthcare provider and agree to perform the identified essential functions in a safe manner and in accordance with *VICTORIOUS HOME HEALTHCARE LTD* established procedures.

I understand that as a result of my employment, I may be exposed to blood, body fluids, infectious diseases, air contaminants, and hazardous chemicals and that *VICTORIOUS HOME HEALTHCARE* will provide to me instruction on how to prevent and control such exposure.

I further understand that I may also be exposed to the Hepatitis B virus and that *VICTORIOUS HOME HEALTHCARE LTD* will make available to me, free of charge, the Hepatitis B vaccination.

I understand that my employment is at will, and thereby understand that my employment may be terminated at-will either by *VICTORIOUS HOME HEALTHCARE LTD.* or myself and that such determination can be made with or without notice.

Signature - Home Healthcare Provider Worker

Regarding Employment Application for ***VICTORIOUS HOME HEALTHCARE LTD***

I certify that the information contained in this application and in any resume provided by me or any party representing my interests is correct and complete to the best of my knowledge. I understand that any false statements, misinterpretations, or omissions made by me on this application or any supplement to it, will be sufficient grounds for rejection of this application or discharge after employment.

I grant VICTORIOUS HOME HEALTH CARE LTD the right to obtain pertinent information concerning me from former employers, educational institutions, and others, and I release all those providing or requesting such information from any liability that may arise by truthful disclosures or such investigations.

If I am hired, I understand that I am free to resign at any time, with or without cause and without prior notice, and the Company reserves the same right to terminate my employment at any time with or without cause and without prior notice, except as may be required by law. This application does not constitute an agreement or contract for employment for any specified period or definite duration. I understand that no representative of the Company, other than an authorized officer, has the authority to make any assurances to the contrary. I further understand that any such assurances must be in writing and signed by an authorized officer.

I understand it is the Company's policy not to refuse to hire a qualified individual with a disability because of that person's need for a reasonable accommodation as required by the Americans with Disabilities Act.

I also understand that if I am hired, I will be required to provide proof of identity and legal work authorization.

Your signature acknowledges you have read and agree to the above.

Applicant signature: _____ Date_____

VICTORIOUS HOME HEALTHCARE L T D

PRE-SERVICE EXEMPTION

Employee Name

Reason New Employee Is Exempt from Pre-service Training:

☐ Has had previous documented and supervised training withing the past 2 years prior to this employment, equivalent to 24 hours of homecare aide pre-service training, as determined by the provider with appropriate documentation in the employee's personnel file; OR

☐ Has successfully completed RN, LPN, MD, physician assistant or CNA training in the past and has been employed in the field within the past 2 years, OR

☐ Has been employed as a CCP homecare aide withing the past year, verification by supervisor with signed statement in HR file; (complete verification form and attach)

This form completed by:

SUPERVISOR

EMPLOYEE SIGNATURE_____

TRANSPORTATION

Many Healthcare provider positions require the healthcare provider to transport a client.

Do you have a dependable transportation

Yes No

Make and moder car

License Plate #

Driver License #

Auto Insurance Policy #

Insurance Company

Insurance Agent Name

Insurance Agent Phone #

EMPLOYEE AUTOMOBILE RELEASE OF LAIBILITY

I _____, understand that at my discretion I will be using my automobile as part of the duties in the care of patients assigned to me.

I acknowledge that I have the primary responsibility for my automobile insurance. I agree to hold *VICTORIOUS HOME HEALTHCARE LTD* harmless in the event that there is an accident in which there is damage to my automobile or injury to its occupants.

I hereby provide a copy of my car insurance card.

Employee Signature _____ Date _____

CONFIDENTIALITY OF CLIENT INFORMATION

Please read carefully as this is a legally binding document.

By accepting employment with *VICTORIOUS HOME HEALTHCARE LTD*, I agree to carefully refrain from discussing any client's condition or personal affairs with anyone outside the agency, unless expressly authorized to do so. I will not share any medical information with other clients or visitors without clear instruction provided to the agency. I acknowledge that all information seen or heard regarding clients, directly or indirectly, is completely confidential and is not to be discussed, even with my family and coworkers. My job as an employee requires that I govern myself by high ethical standards. Failure to recognize the importance of confidentiality is not only a breach of professional ethics but can also involve an employee in legal proceedings. I will not share any information about clients or the agency with the media. This is essential for the protection of both the client and Agency.

I have read and fully understand the above statement and agree to abide by these policies.

I understand that a breach of policy may result in disciplinary action and possible dismissal from employment.

_____ _____

Applicant Signature Date

VICTORIOUS HOME HEALTHCARE LTD
414 Dixie Highway Chicago Heights IL, 60411. PH: 815-464-9201/Fax: 815-464-9202.
victorioushh@gmail.com

AUTHORIZATION TO PERFORM CRIMINAL BACKGROUND CHECK

I, _____, authorize *VICTORIOUS HOME HEALTHCARE LTD* to perform a criminal background check on me for purposes of employment only. I understand that I may request, in writing, a copy of the results of my criminal background check processed by *VICTORIOUS HOME HEALTHCARE LTD*.

_____ _____
Signature Of Applicant Date

_____ _____
WITNESS Date

A conviction on your criminal background history does not affect *VICTORIOUS HOME HEALTHCARE LTD* decision for employment provided you have supporting documentation to waive the conviction statement on your criminal record history.

VICTORIOUS HOME HEALTHCARE LTD
414 Dixie Highway Chicago Heights IL, 60411. PH: 815-464-9201/Fax: 815-464-9202.
victorioushh@gmail.com

SEXUAL HARASSMENT TRAINING ACKNOWLEDGEMENT FORM

I, _____, acknowledge that I have completed 1 hour of Sexual Harassment Training as required by the Illinois Human Rights Act while working at *VICTORIOUS HOME HEALTHCARE LTD* I understand that this training is mandatory for all employees, and I have completed the training in accordance with the Company's policies and procedures.

I acknowledge that sexual harassment in the workplace is prohibited by law and is not tolerated by *VICTORIOUS HOME HEALTHCARE.* I understand that I have a responsibility to maintain a workplace free from sexual harassment and to report any instances of sexual harassment to my supervisor or Human Resources department.

I understand that sexual harassment can take many forms, including but not limited to, unwanted sexual advances, requests for sexual favors, inappropriate physical contact, and verbal or physical conduct of a sexual nature. I understand that such behavior is unacceptable and may result in disciplinary action, up to and including termination of employment.

I understand that it is important to recognize the signs of sexual harassment and to know how to respond if it occurs. I have received training on how to recognize, prevent, and report sexual harassment in the workplace.

By signing below, I acknowledge that I have completed the sexual harassment training and that I understand my responsibilities as an employee of *VICTORIOUS HOME EALTHCARE LTD* in maintaining a workplace free from sexual harassment.

_____ _____

Employee Signature Date

_____ _____

Supervisor Signature Date

ELECTRONIC SIGNATURE AGREEMENT

This Electronic Signature Agreement ("Agreement") is made and entered into by and between *VICTORIOUS HOME HEALTHCARE LTD* ("Company"), and staff _____ ("Signer"), for the purpose of electronic signature for documentation purposes.

Purpose
The purpose of this Agreement is to allow Signer to use electronic signature to sign Company's documents for documentation purposes.

Consent to Use Electronic Signature
By signing this Agreement, Signer consents to the use of electronic signatures for all Company's documents that require Signer's signature. Signer acknowledges that electronic signatures are legally binding and have the same effect as signatures in writing.

Method of Electronic Signature
Signer's electronic signature will be accomplished by using a secure and approved electronic signature system. Signer understands that electronic signatures are subject to authentication and security measures to prevent unauthorized use.

Responsibility for Security
Signer is responsible for maintaining the security and confidentiality of their electronic signature, including keeping passwords or other access codes confidential and not sharing them with others.

Signature Authentication
Signer's electronic signature is deemed to be valid and enforceable to the same extent as a handwritten signature once Signer has been authenticated through the electronic signature system.

Revocation of Signature
Signers have the right to revoke their electronic signature at any time by providing written notice to the Company. Such revocation will not affect the validity of any signed documents before the revocation.

Confirmation of Signature
Signer acknowledges and agrees that their electronic signature will constitute confirmation of the contents of the document signed, and will not dispute the validity or enforceability of the document based solely on the use of electronic signature.

Entire Agreement
This Agreement constitutes the entire understanding and agreement between the Company and Signer concerning the use of electronic signatures for documentation purposes.

Governing Law
This Agreement shall be governed by and construed in accordance with the laws of the state in which the Company operates.

Acceptance of Agreement

By electronically signing this Agreement, Signer acknowledges that they have read, understood, and agreed to be bound by all the terms and conditions contained in this Agreement.

Staff Name:_____ Signature: _____

Date: _____

State of Illinois
Illinois Department of Public Health

Health Care Worker Background Check

Authorization and Disclosure for Criminal History Records Information (CHRI) Check

I hereby authorize the Illinois Department of Public Health (the Department), the Department's designee, educational entities that train and/or test health care workers, staffing agencies, my current or potential employer, or a health care facility where I want to volunteer to initiate/request a CHRI check on me. I further authorize the Illinois State Police (ISP) and/or the Federal Bureau of Investigation (FBI) to release information and photographs relative to the existence or nonexistence of any criminal record, which it might have concerning me, to any initiator/requestor solely to determine my suitability for training or testing in health care training program, employment, continued employment, or to work as a volunteer. I further authorize any entity that maintains criminal records and photographs relating to me, including but not limited to a local unit of government in any State, to release those records and photographs to the ISP, FBI, or the Department. I authorize the Department to provide any health care facility, training program or staffing agency, to which I have provided this authorization and disclosure form, a copy of my ISP CHRI and a determination of eligibility of the FBI CHRI. I certify that the ISP, FBI, any entity that maintains criminal records and photographs, the Department, and any of their employees or officers who furnish this information shall be held harmless from all liability, which may be incurred as a result of releasing such information. I further acknowledge that a educational entity or a health care employer shall not be liable for the failure to hire or retain me as an applicant, student, employee, or volunteer if I have been convicted of committing or attempting to commit one or more of the offenses stated in the Health Care Worker Background Check Act (225 ILCS 46/25).

I understand that any false statements or deliberate omissions on this document may be grounds for disqualification from employment, training, or volunteering, if discovered after employment, training, or volunteering begins, and can result in discipline up to and including my termination of employment, being a volunteer, or a student.

I understand that the information requested below regarding gender, race, height, eye color, hair color, weight, place of birth and date of birth is for the sole purpose of identification and the accurate gathering of the criminal history record information, and that it will not be used to discriminate against me in violation of the law. I understand that the provision of my Social Security number is required by law. A facsimile or photographic copy of this authorization will be as valid as the original.

First Name_____ Full Middle Name_____ Last Name_____

Mailing Address_____ City_____ State____ Zip Code _____

Other Names Used _____ Telephone_____

States Where You Have Lived? _____

○ Male ○ Female Race_____ Height 5' , 0" " Weight_____ lbs Date of Birth_____ Social Security Number ☐☐☐ - ☐☐ - ☐☐☐☐

(Enter a letter from below)

Hair Color_____ Eye Color_____ City/State of Birth _____

Race	**A**	Chinese, Japanese, Filipino, Korean, Polynesian, Indian, Indonesian, Asian Indian, Samoan, or any other Pacific Islander.
	B	Black or African American (Not Hispanic or Latino)
	H	Hispanic or Latino (Mexican, Puerto Rican, Cuban, Central or South American, or other Spanish culture or origin)
	I	American Indian, Eskimo, or Alaskan native, or a person having origins in any of the 48 contiguous states of the United States or Alaska who maintains cultural identification through tribal affiliation or community recognition.
	U	Of undeterminable race. Of Untold mixture.
	W	Caucasian (not Hispanic or Latino)

Have you ever had an administrative finding of Abuse, Neglect or Theft? ◯ Yes ◯ No

If "Yes," give full details and state.

Have you ever been convicted of a criminal offense other than a minor traffic violation (do not include convictions that have been expunged, sealed or adjudicated delinquent)? ◯ Yes ◯ No If "Yes," give full details of each offense and the state in which convicted.

I certify that the above is true and correct and give my consent for my name to appear on Department's Health Care Worker Registry with the results of my criminal history records check.

_____ _____

(Signature) (Date)

As the parent or guardian of the above named individual, who is younger than the age of 17, I give my consent for this named individual to have a criminal history records check.

_____ _____

(Signature of Parent or Guardian when applicable) (Date)

Health Care Worker Registry, 525 W. Jefferson St., Springfield, IL 62761 Phone: 217-785-5133

*** ALL FIELDS MUST BE COMPLETED OR APPLICATION WILL NOT BE PROCESSED***

PRINT

CLEAR FORM

LISTS OF ACCEPTABLE DOCUMENTS

All documents containing an expiration date must be unexpired.
* Documents extended by the issuing authority are considered unexpired.
Employees may present one selection from List A or a
combination of one selection from List B and one selection from List C.
Examples of many of these documents appear in the Handbook for Employers (M-274).

LIST A **Documents that Establish Both Identity and Employment Authorization**	OR	LIST B **Documents that Establish Identity**	AND	LIST C **Documents that Establish Employment Authorization**
1. U.S. Passport or U.S. Passport Card		**1.** Driver's license or ID card issued by a State or outlying possession of the United States provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		**1.** A Social Security Account Number card, unless the card includes one of the following restrictions: **(1)** NOT VALID FOR EMPLOYMENT **(2)** VALID FOR WORK ONLY WITH INS AUTHORIZATION **(3)** VALID FOR WORK ONLY WITH DHS AUTHORIZATION
2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551)		**2.** ID card issued by federal, state or local government agencies or entities, provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		**2.** Certification of report of birth issued by the Department of State (Forms DS-1350, FS-545, FS-240)
3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa		**3.** School ID card with a photograph		**3.** Original or certified copy of birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal
4. Employment Authorization Document that contains a photograph (Form I-766)		**4.** Voter's registration card		**4.** Native American tribal document
5. For an individual temporarily authorized to work for a specific employer because of his or her status or parole: **a.** Foreign passport; and **b.** Form I-94 or Form I-94A that has the following: **(1)** The same name as the passport; and **(2)** An endorsement of the individual's status or parole as long as that period of endorsement has not yet expired and the proposed employment is not in conflict with any restrictions or limitations identified on the form.		**5.** U.S. Military card or draft record		**5.** U.S. Citizen ID Card (Form I-197)
		6. Military dependent's ID card		**6.** Identification Card for Use of Resident Citizen in the United States (Form I-179)
		7. U.S. Coast Guard Merchant Mariner Card		**7.** Employment authorization document issued by the Department of Homeland Security For examples, see **Section 7** and **Section 13** of the M-274 on **uscis.gov/i-9-central**. The Form I-766, Employment Authorization Document, is a List A, **Item Number 4.** document, not a List C document.
		8. Native American tribal document		
		9. Driver's license issued by a Canadian government authority		
		For persons under age 18 who are unable to present a document listed above:		
		10. School record or report card		
		11. Clinic, doctor, or hospital record		
		12. Day-care or nursery school record		
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				

Acceptable Receipts

May be presented in lieu of a document listed above for a temporary period.
For receipt validity dates, see the M-274.

• Receipt for a replacement of a lost, stolen, or damaged List A document. • Form I-94 issued to a lawful permanent resident that contains an I-551 stamp and a photograph of the individual. • Form I-94 with "RE" notation or refugee stamp issued to a refugee.	OR	Receipt for a replacement of a lost, stolen, or damaged List B document.	Receipt for a replacement of a lost, stolen, or damaged List C document.

*Refer to the Employment Authorization Extensions page on **I-9 Central** for more information.

Supplement A,
Preparer and/or Translator Certification for Section 1

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

USCIS
Form I-9
Supplement A
OMB No. 1615-0047
Expires 07/31/2026

Last Name *(Family Name)* from **Section 1.**	First Name *(Given Name)* from **Section 1.**	Middle initial (if any) from **Section 1.**

Instructions: This supplement must be completed by any preparer and/or translator who assists an employee in completing Section 1 of Form I-9. The preparer and/or translator must enter the employee's name in the spaces provided above. Each preparer or translator must complete, sign, and date a separate certification area. Employers must retain completed supplement sheets with the employee's completed Form I-9.

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

Signature of Preparer or Translator			Date *(mm/dd/yyyy)*
Last Name *(Family Name)*	First Name *(Given Name)*		Middle Initial *(if any)*
Address *(Street Number and Name)*	City or Town	State	ZIP Code

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

Signature of Preparer or Translator			Date *(mm/dd/yyyy)*
Last Name *(Family Name)*	First Name *(Given Name)*		Middle Initial *(if any)*
Address *(Street Number and Name)*	City or Town	State	ZIP Code

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

Signature of Preparer or Translator			Date *(mm/dd/yyyy)*
Last Name *(Family Name)*	First Name *(Given Name)*		Middle Initial *(if any)*
Address *(Street Number and Name)*	City or Town	State	ZIP Code

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

Signature of Preparer or Translator			Date *(mm/dd/yyyy)*
Last Name *(Family Name)*	First Name *(Given Name)*		Middle Initial *(if any)*
Address *(Street Number and Name)*	City or Town	State	ZIP Code

Supplement B,
Reverification and Rehire (formerly Section 3)

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

USCIS
Form I-9
Supplement B
OMB No. 1615-0047
Expires 07/31/2026

Last Name *(Family Name)* from **Section 1.**	First Name *(Given Name)* from **Section 1.**	Middle initial (if any) from **Section 1.**

Instructions: This supplement replaces Section 3 on the previous version of Form I-9. Only use this page if your employee requires reverification, is rehired within three years of the date the original Form I-9 was completed, or provides proof of a legal name change. Enter the employee's name in the fields above. Use a new section for each reverification or rehire. Review the Form I-9 instructions before completing this page. Keep this page as part of the employee's Form I-9 record. Additional guidance can be found in the Handbook for Employers: Guidance for Completing Form I-9 (M-274)

Date of Rehire *(if applicable)*	New Name *(if applicable)*		
Date *(mm/dd/yyyy)*	Last Name (Family Name)	First Name (Given Name)	Middle Initial

Reverification: If the employee requires reverification, your employee can choose to present any acceptable List A or List C documentation to show continued employment authorization. Enter the document information in the spaces below.

Document Title	Document Number (if any)	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 documentation, the documentation I examined appears to be genuine and to relate to the individual who presented it.

Name of Employer or Authorized Representative	Signature of Employer or Authorized Representative	Today's Date *(mm/dd/yyyy)*

Additional Information (Initial and date each notation.)

☐ Check here if you used an alternative procedure authorized by DHS to examine documents.

Date of Rehire *(if applicable)*	New Name *(if applicable)*		
Date *(mm/dd/yyyy)*	Last Name (Family Name)	First Name (Given Name)	Middle Initial

Reverification: If the employee requires reverification, your employee can choose to present any acceptable List A or List C documentation to show continued employment authorization. Enter the document information in the spaces below.

Document Title	Document Number (if any)	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 documentation, the documentation I examined appears to be genuine and to relate to the individual who presented it.

Name of Employer or Authorized Representative	Signature of Employer or Authorized Representative	Today's Date *(mm/dd/yyyy)*

Additional Information (Initial and date each notation.)

☐ Check here if you used an alternative procedure authorized by DHS to examine documents.

Date of Rehire *(if applicable)*	New Name *(if applicable)*		
Date *(mm/dd/yyyy)*	Last Name (Family Name)	First Name (Given Name)	Middle Initial

Reverification: If the employee requires reverification, your employee can choose to present any acceptable List A or List C documentation to show continued employment authorization. Enter the document information in the spaces below.

Document Title	Document Number (if any)	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 documentation, the documentation I examined appears to be genuine and to relate to the individual who presented it.

Name of Employer or Authorized Representative	Signature of Employer or Authorized Representative	Today's Date *(mm/dd/yyyy)*

Additional Information (Initial and date each notation.)

☐ Check here if you used an alternative procedure authorized by DHS to examine documents.

Form **W-4**

Department of the Treasury
Internal Revenue Service

Employee's Withholding Certificate

Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay.
Give Form W-4 to your employer.
Your withholding is subject to review by the IRS.

OMB No. 1545-0074

2024

Step 1: Enter Personal Information

(a) First name and middle initial	Last name	(b) Social security number
Address		**Does your name match the name on your social security card?** If not, to ensure you get credit for your earnings, contact SSA at 800-772-1213 or go to *www.ssa.gov*.
City or town, state, and ZIP code		

(c) ☐ **Single** or **Married filing separately**
☐ **Married filing jointly** or **Qualifying surviving spouse**
☐ **Head of household** (Check only if you're unmarried and pay more than half the costs of keeping up a home for yourself and a qualifying individual.)

Complete Steps 2–4 ONLY if they apply to you; otherwise, skip to Step 5. See page 2 for more information on each step, who can claim exemption from withholding, and when to use the estimator at *www.irs.gov/W4App*.

Step 2: Multiple Jobs or Spouse Works

Complete this step if you (1) hold more than one job at a time, or (2) are married filing jointly and your spouse also works. The correct amount of withholding depends on income earned from all of these jobs.

Do **only one** of the following.

(a) Use the estimator at *www.irs.gov/W4App* for most accurate withholding for this step (and Steps 3–4). If you or your spouse have self-employment income, use this option; **or**

(b) Use the Multiple Jobs Worksheet on page 3 and enter the result in Step 4(c) below; **or**

(c) If there are only two jobs total, you may check this box. Do the same on Form W-4 for the other job. This option is generally more accurate than (b) if pay at the lower paying job is more than half of the pay at the higher paying job. Otherwise, (b) is more accurate . . . . . ☐

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

Step 3: Claim Dependent and Other Credits

If your total income will be $200,000 or less ($400,000 or less if married filing jointly):

Multiply the number of qualifying children under age 17 by $2,000 $ _____

Multiply the number of other dependents by $500 . . . . . $ _____

Add the amounts above for qualifying children and other dependents. You may add to this the amount of any other credits. Enter the total here . . . . . **3** $

Step 4 (optional): Other Adjustments

(a) Other income (not from jobs). If you want tax withheld for other income you expect this year that won't have withholding, enter the amount of other income here. This may include interest, dividends, and retirement income . . . . . **4(a)** $

(b) Deductions. If you expect to claim deductions other than the standard deduction and want to reduce your withholding, use the Deductions Worksheet on page 3 and enter the result here . . . . . **4(b)** $

(c) Extra withholding. Enter any additional tax you want withheld each **pay period** . . **4(c)** $

Step 5: Sign Here

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

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

Employers Only

Employer's name and address	First date of employment	Employer identification number (EIN)

General Instructions

Section references are to the Internal Revenue Code.

Future Developments

For the latest information about developments related to Form W-4, such as legislation enacted after it was published, go to *www.irs.gov/FormW4*.

Purpose of Form

Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay. If too little is withheld, you will generally owe tax when you file your tax return and may owe a penalty. If too much is withheld, you will generally be due a refund. Complete a new Form W-4 when changes to your personal or financial situation would change the entries on the form. For more information on withholding and when you must furnish a new Form W-4, see Pub. 505, Tax Withholding and Estimated Tax.

Exemption from withholding. You may claim exemption from withholding for 2024 if you meet both of the following conditions: you had no federal income tax liability in 2023 **and** you expect to have no federal income tax liability in 2024. You had no federal income tax liability in 2023 if (1) your total tax on line 24 on your 2023 Form 1040 or 1040-SR is zero (or less than the sum of lines 27, 28, and 29), or (2) you were not required to file a return because your income was below the filing threshold for your correct filing status. If you claim exemption, you will have no income tax withheld from your paycheck and may owe taxes and penalties when you file your 2024 tax return. To claim exemption from withholding, certify that you meet both of the conditions above by writing "Exempt" on Form W-4 in the space below Step 4(c). Then, complete Steps 1(a), 1(b), and 5. Do not complete any other steps. You will need to submit a new Form W-4 by February 15, 2025.

Your privacy. Steps 2(c) and 4(a) ask for information regarding income you received from sources other than the job associated with this Form W-4. If you have concerns with providing the information asked for in Step 2(c), you may choose Step 2(b) as an alternative; if you have concerns with providing the information asked for in Step 4(a), you may enter an additional amount you want withheld per pay period in Step 4(c) as an alternative.

When to use the estimator. Consider using the estimator at *www.irs.gov/W4App* if you:

1. Expect to work only part of the year;

2. Receive dividends, capital gains, social security, bonuses, or business income, or are subject to the Additional Medicare Tax or Net Investment Income Tax; or

3. Prefer the most accurate withholding for multiple job situations.

Self-employment. Generally, you will owe both income and self-employment taxes on any self-employment income you receive separate from the wages you receive as an employee. If you want to pay these taxes through withholding from your wages, use the estimator at *www.irs.gov/W4App* to figure the amount to have withheld.

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

Specific Instructions

Step 1(c). Check your anticipated filing status. This will determine the standard deduction and tax rates used to compute your withholding.

Step 2. Use this step if you (1) have more than one job at the same time, or (2) are married filing jointly and you and your spouse both work.

Option **(a)** most accurately calculates the additional tax you need to have withheld, while option **(b)** does so with a little less accuracy.

Instead, if you (and your spouse) have a total of only two jobs, you may check the box in option **(c)**. The box must also be checked on the Form W-4 for the other job. If the box is checked, the standard deduction and tax brackets will be cut in half for each job to calculate withholding. This option is accurate for jobs with similar pay; otherwise, more tax than necessary may be withheld, and this extra amount will be larger the greater the difference in pay is between the two jobs.

CAUTION ***Multiple jobs.*** *Complete Steps 3 through 4(b) on only one Form W-4. Withholding will be most accurate if you do this on the Form W-4 for the highest paying job.*

Step 3. This step provides instructions for determining the amount of the child tax credit and the credit for other dependents that you may be able to claim when you file your tax return. To qualify for the child tax credit, the child must be under age 17 as of December 31, must be your dependent who generally lives with you for more than half the year, and must have the required social security number. You may be able to claim a credit for other dependents for whom a child tax credit can't be claimed, such as an older child or a qualifying relative. For additional eligibility requirements for these credits, see Pub. 501, Dependents, Standard Deduction, and Filing Information. You can also include **other tax credits** for which you are eligible in this step, such as the foreign tax credit and the education tax credits. To do so, add an estimate of the amount for the year to your credits for dependents and enter the total amount in Step 3. Including these credits will increase your paycheck and reduce the amount of any refund you may receive when you file your tax return.

Step 4 (optional).

Step 4(a). Enter in this step the total of your other estimated income for the year, if any. You shouldn't include income from any jobs or self-employment. If you complete Step 4(a), you likely won't have to make estimated tax payments for that income. If you prefer to pay estimated tax rather than having tax on other income withheld from your paycheck, see Form 1040-ES, Estimated Tax for Individuals.

Step 4(b). Enter in this step the amount from the Deductions Worksheet, line 5, if you expect to claim deductions other than the basic standard deduction on your 2024 tax return and want to reduce your withholding to account for these deductions. This includes both itemized deductions and other deductions such as for student loan interest and IRAs.

Step 4(c). Enter in this step any additional tax you want withheld from your pay **each pay period**, including any amounts from the Multiple Jobs Worksheet, line 4. Entering an amount here will reduce your paycheck and will either increase your refund or reduce any amount of tax that you owe.

Step 2(b)—Multiple Jobs Worksheet *(Keep for your records.)*

If you choose the option in Step 2(b) on Form W-4, complete this worksheet (which calculates the total extra tax for all jobs) on **only ONE** Form W-4. Withholding will be most accurate if you complete the worksheet and enter the result on the Form W-4 for the highest paying job. To be accurate, submit a new Form W-4 for all other jobs if you have not updated your withholding since 2019.

Note: If more than one job has annual wages of more than $120,000 or there are more than three jobs, see Pub. 505 for additional tables; or, you can use the online withholding estimator at *www.irs.gov/W4App*.

1 **Two jobs.** If you have two jobs or you're married filing jointly and you and your spouse each have one job, find the amount from the appropriate table on page 4. Using the "Higher Paying Job" row and the "Lower Paying Job" column, find the value at the intersection of the two household salaries and enter that value on line 1. Then, **skip** to line 3 . . . . . 1 $

2 **Three jobs.** If you and/or your spouse have three jobs at the same time, complete lines 2a, 2b, and 2c below. Otherwise, skip to line 3.

a Find the amount from the appropriate table on page 4 using the annual wages from the highest paying job in the "Higher Paying Job" row and the annual wages for your next highest paying job in the "Lower Paying Job" column. Find the value at the intersection of the two household salaries and enter that value on line 2a . . . . . 2a $

b Add the annual wages of the two highest paying jobs from line 2a together and use the total as the wages in the "Higher Paying Job" row and use the annual wages for your third job in the "Lower Paying Job" column to find the amount from the appropriate table on page 4 and enter this amount on line 2b . . . . . 2b $

c Add the amounts from lines 2a and 2b and enter the result on line 2c . . . . . 2c $

3 Enter the number of pay periods per year for the highest paying job. For example, if that job pays weekly, enter 52; if it pays every other week, enter 26; if it pays monthly, enter 12, etc. 3

4 **Divide** the annual amount on line 1 or line 2c by the number of pay periods on line 3. Enter this amount here and in **Step 4(c)** of Form W-4 for the highest paying job (along with any other additional amount you want withheld) . . . . . 4 $

Step 4(b)—Deductions Worksheet *(Keep for your records.)*

1 Enter an estimate of your 2024 itemized deductions (from Schedule A (Form 1040)). Such deductions may include qualifying home mortgage interest, charitable contributions, state and local taxes (up to $10,000), and medical expenses in excess of 7.5% of your income . . . . . 1 $

2 Enter:
- $29,200 if you're married filing jointly or a qualifying surviving spouse
- $21,900 if you're head of household
- $14,600 if you're single or married filing separately

. . . . . 2 $

3 If line 1 is greater than line 2, subtract line 2 from line 1 and enter the result here. If line 2 is greater than line 1, enter "-0-" . . . . . 3 $

4 Enter an estimate of your student loan interest, deductible IRA contributions, and certain other adjustments (from Part II of Schedule 1 (Form 1040)). See Pub. 505 for more information . . . . 4 $

5 **Add** lines 3 and 4. Enter the result here and in **Step 4(b)** of Form W-4 . . . . . 5 $

Privacy Act and Paperwork Reduction Act Notice. We ask for the information on this form to carry out the Internal Revenue laws of the United States. Internal Revenue Code sections 3402(f)(2) and 6109 and their regulations require you to provide this information; your employer uses it to determine your federal income tax withholding. Failure to provide a properly completed form will result in your being treated as a single person with no other entries on the form; providing fraudulent information may subject you to penalties. Routine uses of this information include giving it to the Department of Justice for civil and criminal litigation; to cities, states, the District of Columbia, and U.S. commonwealths and territories for use in administering their tax laws; and to the Department of Health and Human Services for use in the National Directory of New Hires. We may also disclose this information to other countries under a tax treaty, to federal and state agencies to enforce federal nontax criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism.

You are not required to provide the information requested on a form that is subject to the Paperwork Reduction Act unless the form displays a valid OMB control number. Books or records relating to a form or its instructions must be retained as long as their contents may become material in the administration of any Internal Revenue law. Generally, tax returns and return information are confidential, as required by Code section 6103.

The average time and expenses required to complete and file this form will vary depending on individual circumstances. For estimated averages, see the instructions for your income tax return.

If you have suggestions for making this form simpler, we would be happy to hear from you. See the instructions for your income tax return.

Married Filing Jointly or Qualifying Surviving Spouse

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	$0 - 9,999	$10,000 - 19,999	$20,000 - 29,999	$30,000 - 39,999	$40,000 - 49,999	$50,000 - 59,999	$60,000 - 69,999	$70,000 - 79,999	$80,000 - 89,999	$90,000 - 99,999	$100,000 - 109,999	$110,000 - 120,000
$0 - 9,999	$0	$0	$780	$850	$940	$1,020	$1,020	$1,020	$1,020	$1,020	$1,020	$1,370
$10,000 - 19,999	0	780	1,780	1,940	2,140	2,220	2,220	2,220	2,220	2,220	2,570	3,570
$20,000 - 29,999	780	1,780	2,870	3,140	3,340	3,420	3,420	3,420	3,420	3,770	4,770	5,770
$30,000 - 39,999	850	1,940	3,140	3,410	3,610	3,690	3,690	3,690	4,040	5,040	6,040	7,040
$40,000 - 49,999	940	2,140	3,340	3,610	3,810	3,890	3,890	4,240	5,240	6,240	7,240	8,240
$50,000 - 59,999	1,020	2,220	3,420	3,690	3,890	3,970	4,320	5,320	6,320	7,320	8,320	9,320
$60,000 - 69,999	1,020	2,220	3,420	3,690	3,890	4,320	5,320	6,320	7,320	8,320	9,320	10,320
$70,000 - 79,999	1,020	2,220	3,420	3,690	4,240	5,320	6,320	7,320	8,320	9,320	10,320	11,320
$80,000 - 99,999	1,020	2,220	3,620	4,890	6,090	7,170	8,170	9,170	10,170	11,170	12,170	13,170
$100,000 - 149,999	1,870	4,070	6,270	7,540	8,740	9,820	10,820	11,820	12,830	14,030	15,230	16,430
$150,000 - 239,999	1,960	4,360	6,760	8,230	9,630	10,910	12,110	13,310	14,510	15,710	16,910	18,110
$240,000 - 259,999	2,040	4,440	6,840	8,310	9,710	10,990	12,190	13,390	14,590	15,790	16,990	18,190
$260,000 - 279,999	2,040	4,440	6,840	8,310	9,710	10,990	12,190	13,390	14,590	15,790	16,990	18,190
$280,000 - 299,999	2,040	4,440	6,840	8,310	9,710	10,990	12,190	13,390	14,590	15,790	16,990	18,380
$300,000 - 319,999	2,040	4,440	6,840	8,310	9,710	10,990	12,190	13,390	14,590	15,980	17,980	19,980
$320,000 - 364,999	2,040	4,440	6,840	8,310	9,710	11,280	13,280	15,280	17,280	19,280	21,280	23,280
$365,000 - 524,999	2,720	6,010	9,510	12,080	14,580	16,950	19,250	21,550	23,850	26,150	28,450	30,750
$525,000 and over	3,140	6,840	10,540	13,310	16,010	18,590	21,090	23,590	26,090	28,590	31,090	33,590

Single or Married Filing Separately

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	$0 - 9,999	$10,000 - 19,999	$20,000 - 29,999	$30,000 - 39,999	$40,000 - 49,999	$50,000 - 59,999	$60,000 - 69,999	$70,000 - 79,999	$80,000 - 89,999	$90,000 - 99,999	$100,000 - 109,999	$110,000 - 120,000
$0 - 9,999	$240	$870	$1,020	$1,020	$1,020	$1,540	$1,870	$1,870	$1,870	$1,870	$1,910	$2,040
$10,000 - 19,999	870	1,680	1,830	1,830	2,350	3,350	3,680	3,680	3,680	3,720	3,920	4,050
$20,000 - 29,999	1,020	1,830	1,980	2,510	3,510	4,510	4,830	4,830	4,870	5,070	5,270	5,400
$30,000 - 39,999	1,020	1,830	2,510	3,510	4,510	5,510	5,830	5,870	6,070	6,270	6,470	6,600
$40,000 - 59,999	1,390	3,200	4,360	5,360	6,360	7,370	7,890	8,090	8,290	8,490	8,690	8,820
$60,000 - 79,999	1,870	3,680	4,830	5,840	7,040	8,240	8,770	8,970	9,170	9,370	9,570	9,700
$80,000 - 99,999	1,870	3,690	5,040	6,240	7,440	8,640	9,170	9,370	9,570	9,770	9,970	10,810
$100,000 - 124,999	2,040	4,050	5,400	6,600	7,800	9,000	9,530	9,730	10,180	11,180	12,180	13,120
$125,000 - 149,999	2,040	4,050	5,400	6,600	7,800	9,000	10,180	11,180	12,180	13,180	14,180	15,310
$150,000 - 174,999	2,040	4,050	5,400	6,860	8,860	10,860	12,180	13,180	14,230	15,530	16,830	18,060
$175,000 - 199,999	2,040	4,710	6,860	8,860	10,860	12,860	14,380	15,680	16,980	18,280	19,580	20,810
$200,000 - 249,999	2,720	5,610	8,060	10,360	12,660	14,960	16,590	17,890	19,190	20,490	21,790	23,020
$250,000 - 399,999	2,970	6,080	8,540	10,840	13,140	15,440	17,060	18,360	19,660	20,960	22,260	23,500
$400,000 - 449,999	2,970	6,080	8,540	10,840	13,140	15,440	17,060	18,360	19,660	20,960	22,260	23,500
$450,000 and over	3,140	6,450	9,110	11,610	14,110	16,610	18,430	19,930	21,430	22,930	24,430	25,870

Head of Household

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	$0 - 9,999	$10,000 - 19,999	$20,000 - 29,999	$30,000 - 39,999	$40,000 - 49,999	$50,000 - 59,999	$60,000 - 69,999	$70,000 - 79,999	$80,000 - 89,999	$90,000 - 99,999	$100,000 - 109,999	$110,000 - 120,000
$0 - 9,999	$0	$510	$850	$1,020	$1,020	$1,020	$1,020	$1,220	$1,870	$1,870	$1,870	$1,960
$10,000 - 19,999	510	1,510	2,020	2,220	2,220	2,220	2,420	3,420	4,070	4,070	4,160	4,360
$20,000 - 29,999	850	2,020	2,560	2,760	2,760	2,960	3,960	4,960	5,610	5,700	5,900	6,100
$30,000 - 39,999	1,020	2,220	2,760	2,960	3,160	4,160	5,160	6,160	6,900	7,100	7,300	7,500
$40,000 - 59,999	1,020	2,220	2,810	4,010	5,010	6,010	7,070	8,270	9,120	9,320	9,520	9,720
$60,000 - 79,999	1,070	3,270	4,810	6,010	7,070	8,270	9,470	10,670	11,520	11,720	11,920	12,120
$80,000 - 99,999	1,870	4,070	5,670	7,070	8,270	9,470	10,670	11,870	12,720	12,920	13,120	13,450
$100,000 - 124,999	2,020	4,420	6,160	7,560	8,760	9,960	11,160	12,360	13,210	13,880	14,880	15,880
$125,000 - 149,999	2,040	4,440	6,180	7,580	8,780	9,980	11,250	13,250	14,900	15,900	16,900	17,900
$150,000 - 174,999	2,040	4,440	6,180	7,580	9,250	11,250	13,250	15,250	16,900	18,030	19,330	20,630
$175,000 - 199,999	2,040	4,510	7,050	9,250	11,250	13,250	15,250	17,530	19,480	20,780	22,080	23,380
$200,000 - 249,999	2,720	5,920	8,620	11,120	13,420	15,720	18,020	20,320	22,270	23,570	24,870	26,170
$250,000 - 449,999	2,970	6,470	9,310	11,810	14,110	16,410	18,710	21,010	22,960	24,260	25,560	26,860
$450,000 and over	3,140	6,840	9,880	12,580	15,080	17,580	20,080	22,580	24,730	26,230	27,730	29,230

VICTORIOUS HOME HEALTHCARE LTD

DIRECT DEPOSIT FORM

Employee Information:

Full Name:_____

Banking information:

Bank Name:_____

Routing Number:_____

Account Number:_____

Account Type:_____ Checking/_____ Savings (Select One)

I hereby authorize VICTORIOUS HOME HEALTHCARE LTD to initiate credit entries to my account indicated above and to credit the same such account. I acknowledge that the amount of credit may be adjusted as necessary to correct any errors in processing.

I certify that the above information is true and correct to the best of my knowledge. I understand that it is my responsibility to promptly notify VICTORIOUSHOME HEALTHCARE LTD of any changes to my banking information.

_____ _____

Employee Signature Date

_____ _____

HR Representative Signature Date

VICTORIOUS HOME HEALTHCARE LIMITED

HIRE RATE OF PAY FORM

Employee name: _____

Date: _____

Rate of Pay: _____

Employer/Human Resources Department: _____

CHANGES IN RATE OF PAY

Date: _____

Rate of pay: _____

Pay Period Is: _____

Pay day Is: _____

Signature of Employee _____

Signature of Employer _____

CHANGES IN RATE OF PAY

Date: _____

Rate of pay: _____

Signature of Employee: _____

Signature of Employer: _____