NEW – Bi-Weekly Employment Packet
Print Double-Sided if possible

Bi-Weekly Information

Date Completed: _____

Name: _____ _____ _____
Last First Middle Initial

Chadron Address: _____

Permanent Address: _____
(home mailing) PO Box or Street

_____ _____ _____
City State Zip Code

Cell Phone: (____)_____- _____

Emergency Contact Name: _____

Emergency Cell Phone: (____)_____-_____ Other Phone: (___)_____ - _____

Personal Demographics:

Sex: ◯ Male ◯ Female

Citizenship: ◯ US Citizen ◯ Non-Citizen ◯ Non-Resident Alien
Country: ___

Ethnic Group: ☐ White ☐ Black/African American ☐ Hispanic/Latino

☐ Asian/Pasific Islander ☐ Native American/Alaskan ☐ No Response

Military Status: ☐ Vietnam Vet ☐ Vietnam Vet, Disabled ☐ Active National Guard

☐ Other Vet ☐ Other Vet, Disabled ☐ Not Applicable

Instructions for the I-9 Form are available at https://www.uscis.gov/i-9

For Payroll Use:Personnel #_____Position #_____Hiring Sheet:_____ E-Verify_____Bkgrd_____

Rev 7-2017

NEBRASKA STATE COLLEGE SYSTEM MULTIPLE DIRECT DEPOSIT FORM

CHADRON STATE COLLEGE
PERU STATE COLLEGE
WAYNE STATE COLLEGE
SYSTEM OFFICE

Employee Name _____
Last Name First Name MI

PAYROLL DIRECT DEPOSIT OPTION(S)

You MUST ATTACH a preprinted original or photocopy of a blank check, OR a voided check OR top of a financial statement showing a preprinted account number for EACH option selected below.

Option 1	Add	☐
	Change	☐
	Cancel	☐
Option 2	Add	☐
	Change	☐
	Cancel	☐
Option 3	Add	☐
	Change	☐
	Cancel	☐
Option 4	Add	☐
	Change	☐
	Cancel	☐

PRIMARY Financial Institution Name | **Route Transit #** | **Account Number:** | **Checking** ☐

ALL NET PAY WILL BE DEPOSITED –NO DOLLAR AMOUNT NEEDED **Savings** ☐

SECOND Financial Institution Name | **Route Transit #** | **Account Number:** | **Checking** ☐

DOLLAR AMOUNT DEPOSITED EACH PAYDAY $ | **Savings** ☐

THIRD Financial Institution Name | **Route Transit #** | **Account Number:** | **Checking** ☐

DOLLAR AMOUNT DEPOSITED EACH PAYDAY $ | **Savings** ☐

FOURTH Financial Institution Name | **Route Transit #** | **Account Number:** | **Checking** ☐

DOLLAR AMOUNT DEPOSITED EACH PAYDAY $ | **Savings** ☐

I hereby authorize the Nebraska State College System to directly deposit into the Financial Institution account number(s) listed above, as well as authorize the Institution(s) to post the pay to the above listed account(s). I authorize the college to initiate debit entries to above designated account(s) as may be necessary to correct erroneous credit entries and authorize the listed Financial Institution(s) to subtract such entries from the above designated account(s).

This agreement is effective on the next payroll processing after the signature date below and will remain in force until the college receives notice of change or cancellation from me. Any notice of cancellation must be received by the college in such a manner as to afford the college reasonable opportunity to act on it.

I understand and approve the authorization(s) or cancellation(s) as indicated above. This agreement supersedes all prior Direct Deposit Authorization forms with a prior date and must be signed and dated for any action on the part of the college.

EMPLOYEE SIGNATURE: _____ **DATE:** _____

Please Note: There have been recent changes to the payment system rules for direct deposit of payroll. If you receive your payroll via direct deposit at a bank located in the United States and then have the entire payroll amount forwarded to a bank in another country, please advise the payroll department (or specific individual with your department). There are new formatting requirements for these transactions that the NSCS needs to follow. It will not impact your payroll.

Employment Eligibility Verification

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

USCIS Form I-9
OMB No.1615-0047
Expires 05/31/2027

START HERE: Employers must ensure the form instructions are available to employees when completing this form. Employers are liable for failing to comply with the requirements for completing this form. See below and the Instructions.

ANTI-DISCRIMINATION NOTICE: All employees can choose which acceptable documentation to present for Form I-9. Employers cannot ask employees for documentation to verify information in **Section 1**, or specify which acceptable documentation employees must present for **Section 2** or Supplement B, Reverification and Rehire. Treating employees differently based on their citizenship, immigration status, or national origin may be illegal.

Section 1. Employee Information and Attestation: Employees must complete and sign Section 1 of Form I-9 no later than the first day of employment, but not before accepting a job offer.

Last Name (Family Name)	First Name (Given Name)	Middle Initial (if any)	Other Last Names Used (if any)

Address (Street Number and Name)	Apt. Number (if any)	City or Town	State	ZIP Code

Date of Birth (mm/dd/yyyy)	U.S. Social Security Number	Employee's Email Address	Employee's Telephone Number

I am aware that federal law provides for imprisonment and/or fines for false statements, or the use of false documents, in connection with the completion of this form. I attest, under penalty of perjury, that this information, including my selection of the box attesting to my citizenship or immigration status, is true and correct.

Check one of the following boxes to attest to your citizenship or immigration status (See page 2 and 3 of the instructions.):

- ☐ 1. A citizen of the United States
- ☐ 2. A noncitizen national of the United States (See Instructions.)
- ☐ 3. A lawful permanent resident (Enter USCIS or A-Number.)
- ☐ 4. A noncitizen (other than **Item Numbers 2.** and **3.** above) authorized to work until (exp. date, if any)

If you check **Item Number 4.**, enter one of these:

USCIS A-Number	OR	Form I-94 Admission Number	OR	Foreign Passport Number and Country of Issuance

Signature of Employee	Today's Date (mm/dd/yyyy)

If a preparer and/or translator assisted you in completing Section 1, that person MUST complete the Preparer and/or Translator Certification on Page 3.

Section 2. Employer Review and Verification: Employers or their authorized representative must complete and sign Section 2 within three business days after the employee's first day of employment, and must physically examine, or examine consistent with an alternative procedure authorized by the Secretary of DHS, documentation from List A OR a combination of documentation from List B and List C. Enter any additional documentation in the Additional Information box; see Instructions.

	List A	OR	List B	AND	List C
Document Title 1					
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					
Document Title 2 (if any)					
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					
Document Title 3 (if any)					
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					

Additional Information

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

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

First Day of Employment (mm/dd/yyyy):

Last Name, First Name and Title of Employer or Authorized Representative	Signature of Employer or Authorized Representative	Today's Date (mm/dd/yyyy)

Employer's Business or Organization Name	Employer's Business or Organization Address, City or Town, State, ZIP Code

For reverification or rehire, complete Supplement B, Reverification and Rehire on Page 4.

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.
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		**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		

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 05/31/2027

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

Chadron State College

DRUG-FREE WORKPLACE, DRUG ABUSE AWARENESS AND REASONABLE CAUSE DRUG & ALCOHOL TESTING ACKNOWLEDGEMENT FORM

The Board of Trustees of the Nebraska State College System recognizes and affirms the responsibility and vital interest in maintaining a drug-free, safe, healthy and efficient work environment as expressed in Board Policies 5006 and 5009. Policy 5006 prohibits the illegal manufacture, possession, distribution or use of controlled substances or alcohol in the workplace unless alcohol is allowed at an event authorized and hosted by the President as outlined in Board Policy 8035. Policy 5009 provides notice of the intent to test for alcohol and illegal drug use when cause exists in the workplace so as to maintain a safe, healthy, and efficient workplace for all employees, and to protect the College's property, information, equipment, and reputation.

The purpose of the testing program is to help in the treatment and elimination of alcohol and illegal drug use and abuse in the workplace while protecting employee rights.

Copies of Board Policies 5006 and 5009 are available in Human Resources (Sparks Hall 122) or online at www.nscs.edu or www.csc.edu/hr/student .

I hereby affirm and certify that:

- I have been provided information and access to the Nebraska State College Board of Trustees Policies 5006 & 5009; Drug-Free Workplace and Guidelines for Reasonable Cause Drug and Alcohol Testing.

- I understand and will abide by the Drug-Free Workplace and the Reasonable Cause Drug and Alcohol Testing policies.

- I have knowledge of the disciplinary actions which may be imposed for violations of the Drug- Free Workplace and/or Reasonable Cause Drug and Alcohol Testing policies.

Signature	Printed Name	Date

Student Worker Agreement

Please sign and return this form to Human Resources with your hiring documents. By accepting

the student worker position, I understand the following:

Student worker positions are only available to students who are enrolled, regularly attending classes at, and working for Chadron State College as a form of merit based student financial assistance provided through Chadron State College. Student worker employees are not eligible to receive Nebraska Unemployment compensation benefits.

Signature of Student Worker	Printed name of Student Worker	Date

Return completed form to Human Resources Sparks 122.

This form will be maintained in your personnel file.

07.27.17

CSC
CHADRON STATE COLLEGE

Human Resources
1000 Main Street
Chadron, NE 69337
308-432-6224

APPLICATION FOR EMPLOYMENT

Please complete all items.

Last Name: _____ First Name: _____ Middle Name: _____

Cell Phone: ( ) _____ Home Phone: ( ) _____ Work Phone: ( ) _____

MAILING ADDRESS

Street _____ City _____ State _____ Zip code _____

Email:

Are you legally entitled to work in the U.S.? ☐ Yes ☐ No

Do you have a valid Driver's License? ☐ Yes ☐ No State Issued by:

Are you related to anyone employed by CSC? ☐ Yes ☐ No

Employee Name: _____

Do you require sponsorship for this position? ☐ Yes ☐ No

Have you ever been employed by Chadron, Wayne, or Peru State College or the Nebraska State College System?

☐ Yes ☐ No When: _____ Where: _____

Are you 18 years of age or over? ☐ Yes ☐ No

Do you wish to claim Veteran's Preference? ☐ Yes ☐ No

POSITION APPLYING FOR: _____

Type of Position Desired ☐ Full Time ☐ Part Time ☐ Temporary

Salary Expected: _____ Date Available: _____

REFERENCE INFORMATION

List three references other than relatives who have knowledge of your skills or experience

	Name	Telephone	Email	How do you know this reference?
1				
2				
3				

EMPLOYMENT RECORD

List your most recent position first

1 Company Name:

Address

Street _____ City _____ State _____ Zip Code _____

Immediate Supervisor: _____ Supervisor's Job Title: _____

Supervisor Email: _____ Supervisor Phone Number: ( ) _____

Job Title: _____ Full-time ☐ Part-time ☐

Primary Duties:

Reason for Leaving:

_____ May we contact your current employer? ☐ Yes ☐ No

Start Date _____ End Date _____ Starting Salary _____ Ending Salary _____

2 Company Name:

Address: Street _____ City _____ State _____ Zip Code _____

Immediate Supervisor: _____ Supervisor's Job Title: _____

Supervisor Email: _____ Supervisor Phone Number: ( ) _____

Job Title: _____ Full-time ☐ Part-time ☐

Primary Duties:

Reason for Leaving: _____

Start Date _____ End Date _____ Starting Salary _____ Ending Salary _____

3 Company Name: _____

Address: Street _____ City _____ State _____ Zip Code _____

Immediate Supervisor: _____ Supervisor's Job Title: _____

Supervisor Email: _____ Supervisor Phone Number: ( ) _____

Job Title: _____ Full-time ☐ Part-time ☐

Primary Duties:

Reason for Leaving: _____

Start Date _____ End Date _____ Starting Salary _____ Ending Salary _____

EDUCATIONAL BACKGROUND

	Name/Location of School	Grade/Credit Hours Completed	Major Subjects Studied	Degree, Certification, or Diploma Received
1				
2				
3				
4				

PROFESSIONAL LICENSES AND CERTIFICATIONS

	Type	State	ID Number	Expiration Date
1				
2				
3				
4				

Please read the following carefully before signing this application:

I attest to the accuracy and truthfulness of the information provided, and I understand that falsification or omission of any information on this application could result in my disqualification from further consideration in the selection process, or if hired, termination of my employment. I understand that consideration for employment is conditioned upon the results of a background check, and I authorize the Board of Trustees of the Nebraska Sate Colleges, the College and its agents or assigns to investigate all statements made by me on this application, to conduct a thorough investigation of my background and activities, and I agree to cooperate in such investigation and to release the Board of Trustees and its agents and assigns from all liability or responsibility and of all persons and corporations requesting or supplying such information. I authorize the Board of Trustees of the Nebraska State Colleges, the College and its agents and assigns to contact my cited references and any developed uncited references to make inquiries concerning my current and past employment. This authorization will expire six months from the date it is signed. A facsimile copy or electronic version of this document shall be considered as effective and valid as the original.

Applicant Signature _____ Date: _____

The Nebraska State Colleges are equal opportunity institutions and do not discriminate against any student, employee, or applicant on the basis of race, color, national origin, sex, sexual orientation, gender identity, disability, religion, or age in employment and education opportunities. Each College has designated an individual to coordinate the Colleges' non-discrimination efforts to comply with regulations implementing Title II of the Americans with Disabilities Act, Titles VI and VII of the Civil Rights Act, Title IX of the Education Amendments of 1972, the Age Discrimination Act of 1975, and Section 504 of the Rehabilitation Act. Inquiries regarding non-discrimination policies and practices may be directed to the Compliance Coordinators assigned at each College and identified on each College website.

Amee Diers
Director of Human Resources
Chadron State College
Chadron, NE 69337
Telephone: 308-432-6224
Email: adiers@csc.edu

RESET PRINT

NEBRASKA
Good Life. Great Service.
DEPARTMENT OF REVENUE

Employee's Nebraska Withholding Allowance Certificate

- **Whether you are entitled to claim a certain number of allowances or exemption from withholding is subject to review by the Nebraska Department of Revenue (DOR). Your employer may be required to send a copy of this form to DOR.**

FORM **W-4N**

Your First Name and Initial	Last Name	Your Social Security Number

Current Mailing Address (Number and Street or PO Box)

City | State | Zip Code

☐ Single ☐ Married

Note: If married, but legally separated, or spouse is a nonresident alien, check the "Single" box. Individuals filing income tax returns with a "Head of Household" status check the "Single" box.

1 Total number of allowances you are claiming (from line 4g on the worksheet below)	**1**	
2 Additional amount, if any, you want withheld from each paycheck for Nebraska income tax withheld	**2**	
3 I claim exemption from withholding and I can provide satisfactory evidence to my employer that I meet **both** of the following conditions for exemption. • Last year I had a right to a refund of all Nebraska income tax withheld because I had no tax liability, and • This year I expect a refund of all Nebraska income tax withheld because I expect to have no tax liability. If you can provide evidence that you can meet both conditions, write "Exempt" here	**3**	

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

sign here ▶ Employee's Signature _____ Date _____

Employer's Name and Address (Employer: Complete employer information if sending to DOR)	Nebraska ID Number

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

Personal Allowances Worksheet

• Keep for your records.

Allowances approximate tax deductions that may reduce your tax liability. The number of allowances is determined by many factors including, but not limited to, filing status, how many jobs you have, tax credits, and how many children or dependents that you claim on your tax return.

Allowances claimed on the Form W-4N are used by your employer to determine the Nebraska state income tax withheld from your wages to meet your Nebraska state income tax obligation.

4 a Enter "1" for **yourself** if no one else can claim you as a dependent	**4a**	
b Enter "1" if: • You are single and have only one job; or • You are married, have only one job, and your spouse does not work; or • Your wages from a second job or your spouse's wages (or the total of both for the year) are $1,500 or less	**4b**	
c Enter "1" for your **spouse**. But, you may choose to enter "-0-" if you are married and have either a working spouse or more than one job. (Entering "-0-" may help you avoid having too little tax withheld)	**4c**	
d Enter number of Nebraska personal exemptions (other than your spouse or yourself) you will claim on your Nebraska tax return. This is the number of children and dependents you will list on your Nebraska return that qualify for either the child or dependent tax credit on the federal return	**4d**	
e Enter "1" if you will file as **head of household** on your tax return	**4e**	
f Enter "1" if you have at least $2,000 of **child or dependent care expenses** for which you plan to claim a credit	**4f**	
g Enter total of lines a through f here and on line 1 above. (Note: This may be different from the number of exemptions you claim on your Nebraska tax return)	**4g**	

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.

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

APPLICANT DISCLOSURE AND AUTHORIZATION FORM

[IMPORTANT -- PLEASE READ CAREFULLY BEFORE SIGNING AUTHORIZATION]

DISCLOSURE REGARDING BACKGROUND INVESTIGATION

[Employer] ("The Company") may obtain information about you from a consumer reporting agency for employment purposes. Thus, you may be the subject of a "consumer report" and/or an "investigative consumer report" which may include information about your character, general reputation, personal characteristics, and/or mode of living, which can involve personal interviews with sources such as your neighbors, friends, or associates. These reports may contain information regarding your credit history, criminal history, social security verification, motor vehicle records ("driving records"), verification of your education or employment history including current position, worker's compensation injuries, or other background checks. You have the right, upon written request made within a reasonable time after receipt of this notice, to request disclosure of the nature and scope of any investigative consumer report conducted by [**One Source The Background Check Company, PO Box 24148, Omaha, NE 68124, 1.800.608.3645, www.onesourcebackground.com**]. The scope of this notice and authorization is allowing the Company to obtain from any outside organization all manners of consumer reports and investigative consumer reports now and throughout the course of your employment to the extent permitted by law.

ACKNOWLEDGMENT AND AUTHORIZATION

I acknowledge receipt of the DISCLOSURE REGARDING BACKGROUND INVESTIGATION and A SUMMARY OF YOUR RIGHTS UNDER THE FAIR CREDIT REPORTING ACT and certify that I have read and understand both of those documents. I hereby authorize the obtaining of "consumer reports" and/or "investigative consumer reports" by the Company at any time after receipt of this authorization and throughout my employment, if applicable. I agree that a facsimile ("fax"), electronic or photographic copy of this Authorization shall be as valid as the original.

PLEASE PRINT LEGIBLY

This information will be used for background screening purposes only and will not be used for any other purpose

Last Name: _____ First Name: _____ Middle: _____

Other Names/Alias: _____

Social Security #: _____ Date of Birth (MM/DD/YYYY): _____

Driver's License #: _____ State of Driver's License: _____

Present Address: _____ Phone: _____

City: _____ State: _____ Zip: _____

Email Address: _____

All Previous Addresses in the Last Seven (7) Years

_____

_____

_____

_____

_____

_____

_____

Signature: _____ Date: _____

STATE LAW NOTICES AND DISCLOSURES – BACKGROUND INVESTIGATION

Pursuant to state law, the following disclosures are provided to state residents.

CALIFORNIA applicants or employees only: By signing below, you also acknowledge receipt of the NOTICE REGARDING BACKGROUND INVESTIGATION PURSUANT TO CALIFORNIA LAW. Please check the box if you would like to receive a copy of the investigative consumer report or consumer credit report at no charge if one is obtained by the Company. Check box to receive report. ☐
NEW YORK applicants or employees only: You have the right to inspect and receive a copy of any investigative consumer report requested by the Company by contacting One Source The Background Check Company, PO Box 24148, Omaha, NE 68124, 1.800.608.3645, www.onesourcebackground.com.
NEW YORK applicants or employees only: By signing below, you also acknowledge receipt of a copy of Article 23-A of the New York Correction Law.
WASHINGTON applicants or employees only: You have the right to request from One Source The Background Check Company, PO Box 24148, Omaha, NE 68124, 1.800.608.3645, www.onesourcebackground.com a written summary of your rights and remedies under the Washington Fair Credit Reporting Act.
MASSACHUSETTS, MINNESOTA and OKLAHOMA applicants or employees only: Please check the box if you would like to receive a copy of your consumer report, free of charge, if one is obtained by the Company. Check box to receive report.

☐

Signature: _____

Print Name: _____

Date:_____

Para información en español, visite www.consumerfinance.gov/learnmore o escribe a la Consumer Financial Protection Bureau, 1700 G Street NW, Washington, DC 20552.

A SUMMARY OF YOUR RIGHTS UNDER THE FAIR CREDIT REPORTING ACT

The federal Fair Credit Reporting Act (FCRA) promotes the accuracy, fairness, and privacy of information in the files of consumer reporting agencies. There are many types of consumer reporting agencies, including credit bureaus and specialty agencies (such as agencies that sell information about check writing histories, medical records, and rental history records). Here is a summary of your major rights under FCRA. **For more information, including information about additional rights, go to** www.consumerfinance.gov/learnmore **or write to: Consumer Financial Protection Bureau, 1700 G Street NW, Washington, DC 20552.**

- **You must be told if information in your file has been used against you.** Anyone who uses a credit report or another type of consumer report to deny your application for credit, insurance, or employment – or to take another adverse action against you – must tell you, and must give you the name, address, and phone number of the agency that provided the information.
- **You have the right to know what is in your file.** You may request and obtain all the information about you in the files of a consumer reporting agency (your "file disclosure"). You will be required to provide proper identification, which may include your Social Security number. In many cases, the disclosure will be free. You are entitled to a free file disclosure if:
  - a person has taken adverse action against you because of information in your credit report;
  - you are the victim of identity theft and place a fraud alert in your file;
  - your file contains inaccurate information as a result of fraud;
  - you are on public assistance;
  - you are unemployed but expect to apply for employment within 60 days.

  In addition, all consumers are entitled to one free disclosure every 12 months upon request from each nationwide credit bureau and from nationwide specialty consumer reporting agencies. See www.consumerfinance.gov/learnmore for additional information.
- **You have the right to ask for a credit score.** Credit scores are numerical summaries of your credit-worthiness based on information from credit bureaus. You may request a credit score from consumer reporting agencies that create scores or distribute scores used in residential real property loans, but you will have to pay for it. In some mortgage transactions, you will receive credit score information for free from the mortgage lender.
- **You have the right to dispute incomplete or inaccurate information.** If you identify information in your file that is incomplete or inaccurate, and report it to the consumer reporting agency, the agency must investigate unless your dispute is frivolous. See www.consumerfinance.gov/learnmore for an explanation of dispute procedures.
- **Consumer reporting agencies must correct or delete inaccurate, incomplete, or unverifiable information.** Inaccurate, incomplete, or unverifiable information must be removed or corrected, usually within 30 days. However, a consumer reporting agency may continue to report information it has verified as accurate.
- **Consumer reporting agencies may not report outdated negative information.** In most cases, a consumer reporting agency may not report negative information that is more than seven years old, or bankruptcies that are more than 10 years old.
- **Access to your file is limited.** A consumer reporting agency may provide information about you only to people with a valid need – usually to consider an application with a creditor, insurer, employer, landlord, or other business. The FCRA specifies those with a valid need for access.
- **You must give your consent for reports to be provided to employers.** A consumer reporting agency may not give out information about you to your employer, or a potential employer, without your written consent given to the employer. Written consent generally is not required in the trucking industry. For more information, go to www.consumerfinance.gov/learnmore.

- **You may limit "prescreened" offers of credit and insurance you get based on information in your credit report.** Unsolicited "prescreened" offers for credit and insurance must include a toll-free phone number you can call if you choose to remove your name and address from the lists these offers are based on. You may opt out with the nationwide credit bureaus at 1-888-567-8688.
- The following FCRA right applies with respect to nationwide consumer reporting agencies:

  CONSUMERS HAVE THE RIGHT TO OBTAIN A SECURITY FREEZE

  You have a right to place a "security freeze" on your credit report, which will prohibit a consumer reporting agency from releasing information in your credit report without your express authorization. The security freeze is designed to prevent credit, loans, and services from being approved in your name without your consent.
  However, you should be aware that using a security freeze to take control over who gets access to the personal and financial information in your credit report may delay, interfere with, or prohibit the timely approval of any subsequent request or application you make regarding a new loan, credit, mortgage, or any other account involving the extension of credit.

  As an alternative to a security freeze, you have the right to place an initial or extended fraud alert on your credit file at no cost. An initial fraud alert is a 1-year alert that is placed on a consumer's credit file. Upon seeing a fraud alert display on a consumer's credit file, a business is required to take steps to verify the consumer's identity before extending new credit. If you are a victim of identity theft, you are entitled to an extended fraud alert, which is a fraud alert lasting 7 years.

  A security freeze does not apply to a person or entity, or its affiliates, or collection agencies acting on behalf of the person or entity, with which you have an existing account that requests information in your credit report for the purposes of reviewing or collecting the account. Reviewing the account includes activities related to account maintenance, monitoring, credit line increases, and account upgrades and enhancements.

  - **You may seek damages from violators.** If a consumer reporting agency, or, in some cases, a user of consumer reports or a furnisher of information to a consumer reporting agency violates the FCRA, you may be able to sue in state or federal court.
  - **Identity theft victims and active duty military personnel have additional rights.** For more information, visit www.consumerfinance.gov/learnmore.

States may enforce the FCRA, and many states have their own consumer reporting laws. In some cases, you may have more rights under state law. For more information, contact your state or local consumer protection agency or your state Attorney General. For information about your federal rights, contact:

TYPE OF BUSINESS:	CONTACT:
1.a. Banks, savings associations, and credit unions with total assets of over $10 billion and their affiliates	a. Consumer Financial Protection Bureau 1700 G Street NW Washington, DC 20552
b. Such affiliates that are not banks, savings associations, or credit unions also should list, in addition to the CFPB:	b. Federal Trade Commission Consumer Response Center 600 Pennsylvania Avenue NW Washington, DC 20580 (877) 382-4357
2. To the extent not included in item 1 above: a.National banks, federal savings associations, and federal branches and federal agencies of foreign banks	a. Office of the Comptroller of the Currency Customer Assistance Group P.O. Box 53570 Houston, TX 77052
b. State member banks, branches and agencies of foreign banks (other than federal branches, federal agencies, and Insured State Branches of Foreign Banks), commercial lending companies owned or controlled by foreign banks, and organizations operating under section 25 or 25A of the Federal Reserve Act.	b. Federal Reserve Consumer Help Center P.O. Box 1200 Minneapolis, MN 55480
c. Nonmember Insured Banks, Insured State Branches of Foreign Banks, and insured state savings associations	c. Division of Depositor and Consumer Protection National Center for Consumer and Depositor Assistance Federal Deposit Insurance Corporation 1100 Walnut Street, Box #11 Kansas City, MO 64106
d. Federal Credit Unions	d. National Credit Union Administration Office of Consumer Financial Protection 1775 Duke Street Alexandria, VA 22314
3. Air carriers	Assistant General Counsel for Office of Aviation Consumer Protection Department of Transportation 1200 New Jersey Avenue SE Washington, DC 20590
4. Creditors Subject to the Surface Transportation Board	Office of Public Assistance, Governmental Affairs, and Compliance Surface Transportation Board 395 E Street SW Washington, DC 20423
5. Creditors Subject to the Packers and Stockyards Act, 1921	Nearest Packers and Stockyards Division Regional Office
6. Small Business Investment Companies	Associate Administrator, Office of Capital Access United States Small Business Administration 409 Third Street SW, Suite 8200 Washington, DC 20416
7. Brokers and Dealers	Securities and Exchange Commission 100 F Street NE Washington, DC 20549
8. Institutions that are members of the Farm Credit System	Farm Credit Administration 1501 Farm Credit Drive McLean, VA 22102-5090
9. Retailers, Finance Companies, and All Other Creditors Not Listed Above	Federal Trade Commission Consumer Response Center 600 Pennsylvania Avenue NW Washington, DC 20580 (877) 382-4357

Drug and Alcohol Counseling Resources

Student Health Services located in Crites Hall (432-6232) offers resources for a variety of alcohol and other drug abuse prevention and education services for students. The Alternative Student Choice (TASC) group also can provide information to students regarding the use and effects of drugs, tobacco and alcohol. Contact Residence Life at (432-6403).

Alcoholics Anonymous (AA) – 432-2626

Al-Anon Meetings – 432-8446; Hotline – 1-800-344-2666

Alcohol & Drug Referral Hotline – 1-800-252-6465 (24 hr) Drug

Abuse Information and Referral Hotline – 1-800-662-4357

Panhandle Mental Health Center – 308-635-3171 or 1-877-492-7001

NIDA NATIONAL INSTITUTE ON DRUG ABUSE

Commonly Abused Drugs

Visit NIDA at www.drugabuse.gov

National Institutes of Health
U.S. Department of Health and Human Services

Substances: Category and Name	Examples of *Commercial* and Street Names	DEA Schedule*/ How Administered**	*Acute Effects*/Health Risks
Tobacco			*Increased blood pressure and heart rate/chronic lung disease; cardiovascular disease; stroke; cancers of the mouth, pharynx, larynx, esophagus, stomach, pancreas, cervix, kidney, bladder, and acute myeloid leukemia; adverse pregnancy outcomes; addiction*
Nicotine	Found in cigarettes, cigars, bidis, and smokeless tobacco (snuff, spit tobacco, chew)	Not scheduled/smoked, snorted, chewed	
Alcohol			*In low doses, euphoria, mild stimulation, relaxation, lowered inhibitions; in higher doses, drowsiness, slurred speech, nausea, emotional volatility, loss of coordination, visual distortions, impaired memory, sexual dysfunction, loss of consciousness/increased risk of injuries, violence, fetal damage (in pregnant women); depression; neurologic deficits; hypertension; liver and heart disease; addiction; fatal overdose*
Alcohol (ethyl alcohol)	Found in liquor, beer, and wine	Not scheduled/swallowed	
Cannabinoids			*Euphoria; relaxation; slowed reaction time; distorted sensory perception; impaired balance and coordination; increased heart rate and appetite; impaired learning, memory; anxiety; panic attacks; psychosis/cough; frequent respiratory infections; possible mental health decline; addiction*
Marijuana	Blunt, dope, ganja, grass, herb, joint, bud, Mary Jane, pot, reefer, green, trees, smoke, sinsemilla, skunk, weed	I/smoked, swallowed	
Hashish	Boom, gangster, hash, hash oil, hemp	I/smoked, swallowed	
Opioids			*Euphoria; drowsiness; impaired coordination; dizziness; confusion; nausea; sedation; feeling of heaviness in the body; slowed or arrested breathing/constipation; endocarditis; hepatitis; HIV; addiction; fatal overdose*
Heroin	*Diacetylmorphine:* smack, horse, brown sugar, dope, H, junk, skag, skunk, white horse, China white; cheese (with OTC cold medicine and antihistamine)	I/injected, smoked, snorted	
Opium	*Laudanum, paregoric:* big O, black stuff, block, gum, hop	II, III, V/swallowed, smoked	
Stimulants			*Increased heart rate, blood pressure, body temperature, metabolism; feelings of exhilaration; increased energy, mental alertness; tremors; reduced appetite; irritability; anxiety; panic; paranoia; violent behavior; psychosis/weight loss; insomnia; cardiac or cardiovascular complications; stroke; seizures; addiction* **Also, for cocaine**—nasal damage from snorting **Also, for methamphetamine**—severe dental problems
Cocaine	*Cocaine hydrochloride:* blow, bump, C, candy, Charlie, coke, crack, flake, rock, snow, toot	II/snorted, smoked, injected	
Amphetamine	*Biphetamine, Dexedrine:* bennies, black beauties, crosses, hearts, LA turnaround, speed, truck drivers, uppers	II/swallowed, snorted, smoked, injected	
Methamphetamine	*Desoxyn:* meth, ice, crank, chalk, crystal, fire, glass, go fast, speed	II/swallowed, snorted, smoked, injected	
Club Drugs			***MDMA**—mild hallucinogenic effects; increased tactile sensitivity, empathic feelings; lowered inhibition; anxiety; chills; sweating; teeth clenching; muscle cramping/* sleep disturbances; depression; impaired memory; hyperthermia; addiction ***Flunitrazepam**—sedation; muscle relaxation; confusion; memory loss; dizziness; impaired coordination/*addiction ***GHB**—drowsiness; nausea; headache; disorientation; loss of coordination; memory loss/* unconsciousness; seizures; coma
MDMA (methylenedioxymethamphetamine)	Ecstasy, Adam, clarity, Eve, lover's speed, peace, uppers	I/swallowed, snorted, injected	
Flunitrazepam***	*Rohypnol:* forget-me pill, Mexican Valium, R2, roach, Roche, roofies, roofinol, rope, rophies	IV/swallowed, snorted	
GHB***	*Gamma-hydroxybutyrate:* G, Georgia home boy, grievous bodily harm, liquid ecstasy, soap, scoop, goop, liquid X	I/swallowed	
Dissociative Drugs			*Feelings of being separate from one's body and environment; impaired motor function/anxiety; tremors; numbness; memory loss; nausea* ***Also, for ketamine**—analgesia; impaired memory; delirium; respiratory depression and arrest; death* ***Also, for PCP and analogs**—analgesia; psychosis; aggression; violence; slurred speech; loss of coordination; hallucinations* ***Also, for DXM**—euphoria; slurred speech; confusion; dizziness; distorted visual perceptions*
Ketamine	*Ketalar SV:* cat Valium, K, Special K, vitamin K	III/injected, snorted, smoked	
PCP and analogs	*Phencyclidine:* angel dust, boat, hog, love boat, peace pill	I, II/swallowed, smoked, injected	
Salvia divinorum	Salvia, Shepherdess's Herb, Maria Pastora, magic mint, Sally-D	Not scheduled/chewed, swallowed, smoked	
Dextromethorphan (DXM)	Found in some cough and cold medications: Robotripping, Robo, Triple C	Not scheduled/swallowed	
Hallucinogens			*Altered states of perception and feeling; hallucinations; nausea* ***Also, for LSD and mescaline**—increased body temperature, heart rate, blood pressure; loss of appetite; sweating; sleeplessness; numbness; dizziness; weakness; tremors; impulsive behavior; rapid shifts in emotion* ***Also, for LSD**—Flashbacks, Hallucinogen Persisting Perception Disorder* ***Also, for psilocybin**—nervousness; paranoia; panic*
LSD	*Lysergic acid diethylamide:* acid, blotter, cubes, microdot, yellow sunshine, blue heaven	I/swallowed, absorbed through mouth tissues	
Mescaline	Buttons, cactus, mesc, peyote	I/swallowed, smoked	
Psilocybin	Magic mushrooms, purple passion, shrooms, little smoke	I/swallowed	
Other Compounds			***Steroids**—no intoxication effects/*hypertension; blood clotting and cholesterol changes; liver cysts; hostility and aggression; acne; in adolescents—premature stoppage of growth; in males—prostate cancer, reduced sperm production, shrunken testicles, breast enlargement; in females—menstrual irregularities, development of beard and other masculine characteristics ***Inhalants** (varies by chemical)—stimulation; loss of inhibition; headache; nausea or vomiting; slurred speech; loss of motor coordination; wheezing/*cramps; muscle weakness; depression; memory impairment; damage to cardiovascular and nervous systems; unconsciousness; sudden death
Anabolic steroids	*Anadrol, Oxandrin, Durabolin, Depo-Testosterone, Equipoise:* roids, juice, gym candy, pumpers	III/injected, swallowed, applied to skin	
Inhalants	*Solvents (paint thinners, gasoline, glues); gases (butane, propane, aerosol propellants, nitrous oxide); nitrites (isoamyl, isobutyl, cyclohexyl):* laughing gas, poppers, snappers, whippets	Not scheduled/inhaled through nose or mouth	

Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 12-31-2026)

PART A: General Information

Even if you are offered health coverage through your employment, you may have other coverage options through the Health Insurance Marketplace ("Marketplace"). To assist you as you evaluate options for you and your family, this notice provides some basic information about the Health Insurance Marketplace and health coverage offered through your employment.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options in your geographic area.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium and other out-of-pocket costs, but only if your employer does not offer coverage, or offers coverage that is not considered affordable for you and doesn't meet certain minimum value standards (discussed below). The savings that you're eligible for depends on your household income. You may also be eligible for a tax credit that lowers your costs.

Does Employment-Based Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that is considered affordable for you and meets certain minimum value standards, you will not be eligible for a tax credit, or advance payment of the tax credit, for your Marketplace coverage and may wish to enroll in your employment-based health plan. However, you may be eligible for a tax credit, and advance payments of the credit that lowers your monthly premium, or a reduction in certain cost-sharing, if your employer does not offer coverage to you at all or does not offer coverage that is considered affordable for you or meet minimum value standards. If your share of the premium cost of all plans offered to you through your employment is more than 9.12%[1] of your annual household income, or if the coverage through your employment does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit, and advance payment of the credit, if you do not enroll in the employment-based health coverage. For family members of the employee, coverage is considered affordable if the employee's cost of premiums for the lowest-cost plan that would cover all family members does not exceed 9.12% of the employee's household income.[1,2]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered through your employment, then you may lose access to whatever the employer contributes to the employment-based coverage. Also, this employer contribution -as well as your employee contribution to employment-based coverage- is generally excluded from income for federal and state income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis. In addition, note that if the health coverage offered through your employment does not meet the affordability or minimum value standards, but you accept that coverage anyway, you will not be eligible for a tax credit. You should consider all of these factors in determining whether to purchase a health plan through the Marketplace.

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[1] Indexed annually; see https://www.irs.gov/pub/irs-drop/rp-22-34.pdf for 2023.

[2] An employer-sponsored or other employment-based health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs. For purposes of eligibility for the premium tax credit, to meet the "minimum value standard," the health plan must also provide substantial coverage of both inpatient hospital services and physician services.

When Can I Enroll in Health Insurance Coverage through the Marketplace?

You can enroll in a Marketplace health insurance plan during the annual Marketplace Open Enrollment Period. Open Enrollment varies by state but generally starts November 1 and continues through at least December 15.

Outside the annual Open Enrollment Period, you can sign up for health insurance if you qualify for a Special Enrollment Period. In general, you qualify for a Special Enrollment Period if you've had certain qualifying life events, such as getting married, having a baby, adopting a child, or losing eligibility for other health coverage. Depending on your Special Enrollment Period type, you may have 60 days before or 60 days following the qualifying life event to enroll in a Marketplace plan.

There is also a Marketplace Special Enrollment Period for individuals and their families who lose eligibility for Medicaid or Children's Health Insurance Program (CHIP) coverage on or after March 31, 2023, through July 31, 2024. Since the onset of the nationwide COVID-19 public health emergency, state Medicaid and CHIP agencies generally have not terminated the enrollment of any Medicaid or CHIP beneficiary who was enrolled on or after March 18, 2020, through March 31, 2023. As state Medicaid and CHIP agencies resume regular eligibility and enrollment practices, many individuals may no longer be eligible for Medicaid or CHIP coverage starting as early as March 31, 2023. The U.S. Department of Health and Human Services **is offering a temporary Marketplace Special Enrollment period to allow these individuals to enroll in Marketplace coverage.**

Marketplace-eligible individuals who live in states served by HealthCare.gov and either- submit a new application or update an existing application on HealthCare.gov between March 31, 2023 and July 31, 2024, and attest to a termination date of Medicaid or CHIP coverage within the same time period, are eligible for a 60-day Special Enrollment Period. **That means that if you lose Medicaid or CHIP coverage between March 31, 2023, and July 31, 2024, you may be able to enroll in Marketplace coverage within 60 days of when you lost Medicaid or CHIP coverage.** In addition, if you or your family members are enrolled in Medicaid or CHIP coverage, it is important to make sure that your contact information is up to date to make sure you get any information about changes to your eligibility. To learn more, visit HealthCare.gov or call the Marketplace Call Center at 1-800-318-2596. TTY users can call 1-855-889-4325.

What about Alternatives to Marketplace Health Insurance Coverage?

If you or your family are eligible for coverage in an employment-based health plan (such as an employer-sponsored health plan), you or your family may also be eligible for a Special Enrollment Period to enroll in that health plan in certain circumstances, including if you or your dependents were enrolled in Medicaid or CHIP coverage and lost that coverage. Generally, you have 60 days after the loss of Medicaid or CHIP coverage to enroll in an employment-based health plan, but if you and your family lost eligibility for Medicaid or CHIP coverage between March 31, 2023 and July 10, 2023, you can request this special enrollment in the employment-based health plan through September 8, 2023. Confirm the deadline with your employer or your employment-based health plan.

Alternatively, you can enroll in Medicaid or CHIP coverage at any time by filling out an application through the Marketplace or applying directly through your state Medicaid agency. Visit https://www.healthcare.gov/medicaid-chip/getting-medicaid-chip/ for more details.

How Can I Get More Information?

For more information about your coverage offered through your employment, please check your health plan's summary plan description or contact

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The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit **HealthCare.gov** for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer name		4. Employer Identification Number (EIN)
5. Employer address		6. Employer phone number
7. City	8. State	9. ZIP code
10. Who can we contact about employee health coverage at this job?		
11. Phone number (if different from above)	12. Email address	

Here is some basic information about health coverage offered by this employer:

- As your employer, we offer a health plan to:
  - ☐ All employees. Eligible employees are:
  - ☐ Some employees. Eligible employees are:
- With respect to dependents:
  - ☐ We do offer coverage. Eligible dependents are:
  - ☐ We do not offer coverage.

☐ If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, **HealthCare.gov** will guide you through the process. Here's the employer information you'll enter when you visit **HealthCare.gov** to find out if you can get a tax credit to lower your monthly premiums.

The information below corresponds to the Marketplace Employer Coverage Tool. Completing this section is optional for employers, but will help ensure employees understand their coverage choices.

13. **Is the employee currently eligible for coverage offered by this employer, or will the employee be eligible in the next 3 months?**

☐ **Yes** (Continue)
13a. If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage? _____ (mm/dd/yyyy) (Continue)
☐ **No** (STOP and return this form to employee)

14. Does the employer offer a health plan that meets the minimum value standard*?
☐ Yes (Go to question 15) ☐ No (STOP and return form to employee)

15. For the lowest-cost plan that meets the minimum value standard* **offered only to the employee** (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/ she received the maximum discount for any tobacco cessation programs, and didn't receive any other discounts based on wellness programs.
a. How much would the employee have to pay in premiums for this plan? $_____
b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

If the plan year will end soon and you know that the health plans offered will change, go to question 16. If you don't know, STOP and return form to employee.

16. What change will the employer make for the new plan year?_____
☐ Employer won't offer health coverage
☐ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)
a. How much would the employee have to pay in premiums for this plan? $_____
b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

• An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)