The Screening Process

Section 1

- This section is to validate that the candidate is able to perform the work to be assigned by signing off on a Job Description of Essential Functions.
- Obtain signature on Job Description form.
- Obtain and review for completeness an application for employment.
- Obtain signatures on background check forms.
- If you wish to consider further for the position, conduct an interview go to Section 2.
**Why Screen Prospective Employee’s?**

A recent study* reported the following benefits of pre-employment screening:

- **Improved Quality of Personnel** 70%
- **Reduced Turnover** 56%
- **Increase productivity** 26%
- **Improved safety performance** 19%

*Human Capital magazine

**Screening Process (Suggested)**

1) **Develop Written Job Descriptions for all Positions.** Under the ADA, employees must be qualified to perform the **essential functions** outlined in the job description. This can be your first question of a prospective candidate. If they cannot perform the essential functions of the job description, management must determine if a **reasonable accommodation** can be made so the employee can perform the essential functions. If a reasonable accommodation can be made it is suggested that management make the effort to do so, as otherwise may violate the federal rights of the candidate. If reasonable accommodation can not be made, the employee may be deemed unqualified and not considered for the position.

2) If qualified, obtain completed Application for employment on candidates

3) Check references to validate work history and education- gaps in employment may be a signs an unmotivated worker.

4) Interview candidate and look for problem indicators

5) **Require a functional capacity evaluation** to verify that the candidate is physically fit to perform the job described in the job description. This can be a condition of employment after a job offer is made to the candidate.

6) **If you have a Drug Free Workplace,** make conditional offer based on negative drug test.

7) **If offer is accepted,** complete **New Worker Orientation Form.**

6) **After hire,** have new worker complete the enclosed Medical Health Questionnaire. Explain its intention and the downside of lying.

9) Show the new worker the work area, reviewing work rules.
# Screening and Hiring Process Checklist

## Information Gathering:
- [ ] Application for employment completed
- [ ] Job Description signed
- [ ] Fair Credit Reporting Act signed
- [ ] Drug Test Consent Form
- [ ] Part Time Acknowledgement, if applicable
- [ ] Drug Test Policy Form signed
- [ ] Motor Vehicle Record Check Form signed
- [ ] Social Security number obtained

## Background Check Process:
- [ ] Previous Employment Verified
- [ ] Previous Education/Credentials Verified
- [ ] Social Security # verified
- [ ] References Checked
- [ ] Criminal history checked

## Interview Process:
- [ ] Interview conducted and documented
- [ ] Conditional Job Offer made
- [ ] After conditional offer send for Physical and Drug Test

## Employment Process:
- [ ] Employee Information Sheet
- [ ] Post offer Medical Health Questionnaire complete/reviewed
- [ ] Workers Comp History ordered and reviewed against MHQ
- [ ] New Worker Orientation conducted
- [ ] Benefits forms completed
- [ ] W-4 forms completed
- [ ] State Tax forms completed
- [ ] Federal I-9 form completed
- [ ] Offer characteristics form
- [ ] Company absentee Policy Signed
- [ ] Injury Management Protocol signed
- [ ] General Safety Rules signed
- [ ] Applicant voluntary questionnaire presented
- [ ] Employee handbook presented
Applicant Information

Out of respect for your valuable time and our desire to attract quality applicants we want to advise you of our Screening and Hiring Process so that you will know up front what we expect of you to be considered for employment.

We require the following actions of all applicants for further consideration of employment:

º Completed Application – this means every blank filled out in ink
º Read, understand and sign all forms that request a signature
º Read, understand and sign the Job Description form
º We will check all of your references
º We will conduct a background check based on what you have provided
º We will require a drug screen and a negative result is required
º We will require a post offer physical to validate you are fit for duty
º We will conduct a workers’ compensation claims history check
º We will require that you complete a New Worker Orientation program

We are looking for team members that can work together with others and offer new ideas to enhance our products and services.

We seek to have a long-term business relationship with our employees yet employment is “at will” and if hired, you may quit at any time and we may separate you at any time for any reason.

Please sign below that you understand these Applicant requirements.

Printed Name: _____________________________

Signed: _________________________________

Date: ______________
Job Description

Position: Crew Member

Job Description Statement:
To ensure that you are Fit-For-Duty and can perform the Essential Functions and Physical Demands of the position that you are applying for, please read the below Job Description and sign that you can safety and consistent perform such task.

Job Description:
The overall purpose and objective of the crew is to perform in a safe, efficient, reliable and environmentally compliant manner. The worker may assist other crews as needed to reach the overall goals of the company in a timely manner.

Essential Functions of the Job:
Employee must demonstrate the ability to move the head, spine, upper and lower extremities through adequate range of motion to allow the employee to safely operate equipment, climb on ladders and stairs.

Employee must be able to bend, stoop, squat, crouch, and kneel to reach low lying areas such as the bottom of equipment.

Employee may walk on unleveled terrain, must flex and twist the trunk, assume other awkward postures and positions to perform work tasks. Reaching, grasping, and pulling actions are required to complete work tasks.

Minimum Job Qualification Requirements:
º High School or General Education Diploma
º Business or Trade School or Professional School recommended.
º Valid driver's license with the state of Louisiana with an acceptable driving record
º Pass a drug test with a negative result for illegal substances

Legend: 
º O = Occasional  F = Frequent  C = Continuous  N = Never

<table>
<thead>
<tr>
<th>Description</th>
<th>O</th>
<th>F</th>
<th>C</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Physical Activity</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Climbing Stairs</td>
<td></td>
<td></td>
<td></td>
<td>x</td>
</tr>
<tr>
<td>Balancing</td>
<td></td>
<td></td>
<td>x</td>
<td></td>
</tr>
<tr>
<td>Walking</td>
<td>x</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Environmental Exposures</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sitting</td>
<td></td>
<td>x</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Extreme Cold-Below 30 F</td>
<td></td>
<td></td>
<td>x</td>
<td></td>
</tr>
<tr>
<td>Stooping</td>
<td>x</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Extreme Heat-Above 100 F</td>
<td></td>
<td></td>
<td>x</td>
<td></td>
</tr>
<tr>
<td>Kneeling</td>
<td>x</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wetness</td>
<td></td>
<td></td>
<td>x</td>
<td></td>
</tr>
<tr>
<td>Squatting</td>
<td>x</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Humidity-Above 90%</td>
<td></td>
<td></td>
<td>x</td>
<td></td>
</tr>
<tr>
<td>Body Twisting</td>
<td>x</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Noise-Over 85 Decibels</td>
<td></td>
<td></td>
<td>x</td>
<td></td>
</tr>
<tr>
<td>Crawling</td>
<td>x</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Respirator- Breathing</td>
<td></td>
<td></td>
<td>x</td>
<td></td>
</tr>
</tbody>
</table>
Sense of Touch  x  Confined/Cramped Spaces  x
Manual Dexterity  x  Elevated Heights  x
Speaking Clearly  x  Working With People  x
Reaching, High and Low  x  Working Alone  x
Lifting  x
Carrying  x
Pushing  x
Pulling  x
Climbing Ladders  x

**Environmental Exposures include:** summer heat and humidity, winter cold, rain, dust and other chemicals.

**Physical Demand Characteristics (PDC) of Work:** Meets the definition of **Heavy.**

<table>
<thead>
<tr>
<th>Physical Demand Level</th>
<th>Occasional 0-33% of the workday</th>
<th>Frequent 34-66% of the workday</th>
<th>Constant 67-100% of the workday</th>
<th>Typical Energy Required</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sedentary</td>
<td>10 lbs</td>
<td>Negligible</td>
<td>Negligible</td>
<td>1.5-2.1M ETS</td>
</tr>
<tr>
<td>Light</td>
<td>20 lbs</td>
<td>10 lbs.</td>
<td>Negligible</td>
<td>2.2-3.5M ETS</td>
</tr>
<tr>
<td>Light-Medium</td>
<td>35 lbs</td>
<td>20 lbs.</td>
<td>5 lbs.</td>
<td>3.6-4.5M ETS</td>
</tr>
<tr>
<td>Medium</td>
<td>20 to 50 lbs</td>
<td>10 to 25 lbs.</td>
<td>10 lbs.</td>
<td>3.6-6.3M ETS</td>
</tr>
<tr>
<td>Medium-Heavy</td>
<td>75 lbs</td>
<td>35 lbs.</td>
<td>15 lbs.</td>
<td>6.4-7.0M ETS</td>
</tr>
<tr>
<td><strong>Heavy</strong></td>
<td><strong>50 to 100 lbs</strong></td>
<td><strong>25 to 50 lbs.</strong></td>
<td><strong>10 to 20 lbs.</strong></td>
<td><strong>6.4-7.5M ETS</strong></td>
</tr>
<tr>
<td>Very Heavy</td>
<td>Over 100 lbs</td>
<td>Over 50 lbs.</td>
<td>Over 20 lbs.</td>
<td>Over 7.5M ETS</td>
</tr>
</tbody>
</table>

The heaviest weight lifted is a 50 lbs. The following table contains a summary of the minimal requirements of the job and should not be viewed as an exhaustive list.

<table>
<thead>
<tr>
<th>Lifting</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Up to 5 lbs</td>
<td>Occasional</td>
</tr>
<tr>
<td>6-10 lbs</td>
<td>Occasional</td>
</tr>
<tr>
<td>11-20 lbs</td>
<td>Occasional</td>
</tr>
<tr>
<td>21-25 lbs</td>
<td>Occasional</td>
</tr>
<tr>
<td>26-50 lbs</td>
<td>Occasional</td>
</tr>
<tr>
<td>51-75 lbs</td>
<td>Occasional</td>
</tr>
<tr>
<td>76-82 lbs</td>
<td>Frequent</td>
</tr>
<tr>
<td>Over 100 lbs</td>
<td>Frequent</td>
</tr>
</tbody>
</table>
Job Qualifications

° Material Handling: The worker lifts and carries items to complete assigned task.

° Dexterity: Employee must have good dexterity to operate levers, hold hoses, control equipment, and perform related task.

° Cardio respiratory Demand: Employee must demonstrate the aerobic capacity to stand, walk and carry items on a frequent basis.

Work Rate:
Job demands can be expressed in metabolic equivalents, related to a person’s resting oxygen consumption, and compared to the worker’s performance on a comparable aerobic capacity test.

- Stand 75%-90% of the workday Constant
- Walk 75%-90% of the workday Constant
- Sit 0%-33% of the workday Occasional

Validation of the Functional Job Description
Physical demands may exceed those listed in this functional job description with deviations in routine work practices. Employees are required to follow company and plant safety and security policies and seek assistance to perform any job task, which they may feel exceeds their current safe work capacity. This position meets the criterion of the Heavy strength grade.

My signature below indicates that I understand the job requirements of this position and that I can consistently and safely perform the listed job functions.

Printed Name: ___________________________
Signature: ______________________________
Date: _______________
Employment Application

This Company is an equal employment opportunity employer. We adhere to a policy of making employment decisions without regard to race, color, religion, sex, sexual orientation, national origin, citizenship, age or disability. Your opportunity for employment depends solely on your qualifications.

Please print all information except for signature. All applicants will be tested for illegal drugs.

Name: ____________________________________________ Date: ________________

last first middle

Address: _____________________________________________ How long at this address? ______

number street city state zip code

Telephone #: _____________ Mobile #: _____________ Social Security #: _______-_____-________

Are you a United States Citizen: ______. If no, are you authorized to work in the U.S? ___________

Position applied for: ______ Salary desired: $________ per week. Hours you can work: ______

Full time:_____ Part time:____ Do you have a valid driver license: ______ State of issue: ______

DL #: ________________ Do you have a CDL License: ______ Operator: ______ Chauffer ______

Expiration date: ______ How will you get to and from work: ______ Any moving violations in the last 3 years: _______, if yes for what _____________________________________________

Education: Please list all schools that you attended.

<table>
<thead>
<tr>
<th>Type of School</th>
<th>Name of School</th>
<th>Location of School</th>
<th>Years Completed</th>
<th>Degree Earned</th>
</tr>
</thead>
<tbody>
<tr>
<td>High School</td>
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<tr>
<td>College</td>
<td></td>
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<tr>
<td>Trade School</td>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

Experience:

<table>
<thead>
<tr>
<th>Former Employer</th>
<th>Supervisor Name</th>
<th>Dates To/From</th>
<th>Reason for Leaving</th>
<th>Title</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>

May we contact your past and present employers? □ Yes □ No If not, why ____________________

Are you a member of the National Guard: ______ U.S. Armed Forces:______ Discharge Date:_______
### References:

<table>
<thead>
<tr>
<th>Name</th>
<th>Address</th>
<th>Phone</th>
<th>Relationship to You</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

Have you ever been convicted of a crime: _________  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. ___________________________________________________

Did you complete this application yourself   Yes   No  If not, who did _______________________

We welcome any additional information that you would like to provide for consideration of employment.

**In exchange for the consideration of my job application by this Company I agree that:**

Neither the acceptance of this application nor the subsequent entry into any type of employment relationship, either in the position applied for or any other position, and regardless of the contents of employee handbooks, personnel manuals, benefit plans, policy statements, and the like as they may exist from time to time, or other Company practices, shall serve to create an actual or implied contract of employment, or to confer any right to remain an employee of this Company, or otherwise to change in any respect the employment-at-will relationship between it and the undersigned, and that relationship cannot be altered except by a written instrument signed by the President/General Manager of the Company. Both the undersigned and this Company may end the employment relationship at any time, without specified notice or reason. If employed, I understand that the Company may unilaterally change or revise their benefits, policies and procedures and such changes may include reduction in benefits. I authorize investigation of all statements contained in this application. I understand that the misrepresentation or omission of facts called for is cause for dismissal at any time without any previous notice. I hereby give the Company permission to contact schools, previous employers (unless otherwise indicated), references, and others, and hereby release the Company from any liability as a result of such contact. I also understand that (1) the Company has a drug and alcohol policy that provides for pre-employment testing as well as testing after employment; (2) consent to and compliance with such policy is a condition of my employment; and (3) continued employment is based on the successful passing of testing under such policy. I further understand that continued employment may be based on the successful passing of job-related physical examinations. I understand that, in connection with the routine processing of your employment application, the Company may request from a consumer reporting agency an investigative consumer report including information as to my credit records, character, general reputation, personal characteristics, and mode of living. Upon written request from me, the Company, will provide me with additional information concerning the nature and scope of any such report requested by it, as required by the Fair Credit Reporting Act. I further understand that my employment with the Company shall be probationary for a period of sixty (60) days, and further that at any time during the probationary period or thereafter, my employment relation with the Company is terminable at will for any reason by either party.

I agree to release all medical information as requested by employer regarding my medical history. I authorize all physicians or hospitals who have delivered medical services to me to furnish a full report of my medical condition and allow review and copies of medical records and reports.

Print Name: ___________________ Date: ___________ Signature: ___________________________
Authorization and Consent for Release of Information

This company, hereinafter referred to as Company, requires as a condition of employment and/or continued employment, or promotion, all applicants consent to and authorize a verification of their background, including but not limited to, information submitted on their application or résumé. I, the undersigned applicant, do hereby certify that the information provided by me for the purpose of employment is true and complete to the best of my knowledge. I understand that if I am employed, any false statements will be considered as cause for possible dismissal.

This release and authorization acknowledges that the Company may now, or at any time while I am employed, conduct a verification of my education, previous employment and work history, credit history, motor vehicle records, contact personal references, require that I provide a urine specimen to be tested for the presence of drugs or alcohol, investigate workers’ compensation claims and obtain any criminal or civil history record information pertaining to me which may be in the files of any Federal, State or local criminal justice agency in any state or province or any information as deemed necessary to fulfill the job requirements. I authorize this Company and any of its agents/designated personnel, to disclose orally and in writing the results of this verification process and/or interview to the designated authorized representative of the Company. I have read and understand this release and consent, and I authorize the background verification. I authorize persons, schools, current and former employers and other organizations and Agencies to provide this Company with all information that may be requested, and I hereby release all of the persons and Agencies providing such information from any and all claims and damages connected with their release of any requested information. I agree that a signed copy of this document is as valid as the original. I do hereby agree to forever release and discharge the Company, its agent and their associates to the full extent permitted by law from claims, damages, costs, and expenses, for any errors, omissions or any other charge or complaint filed with any agency arising from the retrieving and reporting of information.

______________________________   ______________________________
SS#:_________--_______--__________
Signature

______________________________________________   ____________________
Name Printed  (First, Middle, Last)                  Date

______________________________           ______________________________
Street Address             City                         State                            Zip Code

______________________________
License Number

Date of Birth-used to verify criminal and civil records and not for a hiring decision.
Authorization for Use and/or Disclosure of Protected Health Information

As required by the Health Information Portability and Accountability Act of 1996, our facility may not use or disclose your health information except as provided in Notice of Privacy Practices without your authorization. Your signature on this form indicates that you are giving permission for the “uses/disclosures/uses and disclosures” described herein.

I, _________________________________________________ (print name) hereby authorize the “use/disclosure/use and “disclosure” of the following health information that pertains to me involving the following:

1. Pre-Placement Assessment
2. Work Related Injuries
3. Wellness Evaluation
4. Rehabilitation and Treatment
5. Urgent Care

I authorize the following persons to make the disclosures of my health information:

1. Physicians and Staff

I authorize the following persons to receive these disclosures of my health information:

1. Business Associate and/or designated named and authorized personnel. Business Associate shall mean entity-requesting services provided by us. Business Associate agrees to abide by the assurances, terms and conditions contained in the performance of its obligations.

I understand that information disclosed pursuant to this authorization may be re-disclosed to additional parties.

Printed Name: _____________________________

Signature: _________________________________

Date:___________________
Drug Test Consent and Release Form

I hereby consent to submit to urinalysis and/or other tests as shall be determined thereof by the Company as a condition of employment and for the purpose of determining specific drug content.

I further agree to have these results reviewed by a Medical Review Officer. I hereby release to the Company, the results of the test(s) to which I have consented. I further authorize the Company to discuss the results with medical/personnel collecting the Specimen, the testing facility, it’s directors, officers, agents, and employees responsible for administering the aforementioned test(s) or evaluating the results thereof and any of them herein and to use the test results in conjunction with employment actions, professional licensing procedures, and as a defense to any legal action to which I am party.

I further release any testing facility or any physicians who have tested me from any liability arising from a release of any and all results, written reports, medical reports, and data concerning my test(s) to the appropriate Company officials or government agencies.

I further agree that a reproduced copy of this consent and release form shall have the same force and effect as the original.

I have carefully read the foregoing and fully understand its contents. I acknowledge that my signing of this consent and release form is a voluntary act on my part and that I have not been coerced into signing this document by anyone.

Printed Name: _____________________________

Signature: _________________________________

Date: _______________
Part-Time Acknowledgement

I understand that this application is not a contract of employment, expressed or implied, between the Company and me. I further understand that if the Company extends an offer of employment, it is solely on an at-will basis, that it is entered into voluntarily, and that I am free to resign at any time, for any reason, with or without notice. I understand that similarly, the Company is free to conclude my employment at any time, for any reason not prohibited by law, with or without notice.

I further understand that if the Company extends an offer of employment, a condition of employment is the understanding that such employment customarily provides less than forty hours per week and is considered “part time” as a result. A forty-hour week is not guaranteed. The amount of hours worked is solely dependent upon work availability. Any provisions in the application concerning the applicant’s preference to the number of hours willing to work or the availability to work are only a request for information by the Company. The Company reserves the right to modify, amend or terminate any provisions herein at any time, with or without notice.

Printed Name: _____________________________________

Signed Name: ______________________________________

Date: _____________________
Medical Exam & Drug Test Policy

In accordance with LSA R.S. 23:897, K., it is the stated policy of that this company has a right of reimbursement from an employee or an applicant who becomes an employee, provided the employee is compensated at a rate equivalent to not less than one dollar above the existing federal minimum wage and is not a part-time or seasonal employee as defined in R.S. 23:1021, for the costs of such employee's or applicant's pre-employment medical examination and/or drug test, if the employee voluntarily terminates the employment relationship sooner than ninety working days after his first day of work or never reports to work, unless such voluntary termination is attributable to a substantial change made to the employment by the employer as applied in Louisiana Employment Security Law.

A n employee who, without prior approval, fails to report to work as scheduled for 3 consecutive days shall be deemed to have voluntarily terminated his/her employment by abandonment of his/her position.

In accordance with LSA R.S. 23:634, B. and the terms of the above-stated policy, I hereby agree that the costs of my pre-employment medical examination and/or drug test, may be withheld from my wages if I voluntarily resign within ninety working days from my first day of work.

Printed Name: _______________________________

Signature: _________________________________

Date: _______________
Motor Vehicle Record Review Consent Form

I understand that I am required to maintain a valid driver’s license. Additionally, I grant this Company the right to review my motor vehicle driving record at anytime.

My current drivers’ license is issued from the state of ___________ and is # __________

If involved in an accident, the police report will be used to determine who was at fault. I understand that I am responsible for obtaining a copy of the police report. If the police report is not obtained, I will be considered at fault.

I am required to report any license revocation, suspension or traffic citation to the Safety Director regardless of whether the change resulted from operating a Company vehicle or private vehicle, no later than 24 hours after the event occurs.

I understand that I can be terminated if I knowingly operate a Company vehicle while my drivers’ license is suspended or revoked.

In accordance with the Company’s MVR review program, a review of my motor vehicle record may result in the following action:

- I may be required to attend an 8-hour defensive driving training class prior to being allowed to drive a Company vehicle. The class must be completed within 30 days of being put in a non-driving status. It will be completed during off duty time and at my expense.
- I may be put in a non-driving status for a year pending the next annual review.
- I may be terminated if a non-driving position is not available.

Printed Name: ________________________________

Signed Name: ________________________________

Date: ______________
Social Security Number Verification

By affixing my signature below, I ______________________________ do hereby certify that my U.S. Social Security number is __________________________ and that I have legal authority to work in the United States. I also certify that I am fluent in the English language and understand all information requested above.

Printed Name: ______________________________

Signe Name: ______________________________

Date: _______________
The Background Checking Process

Section 2

- It is critical to review all completed documents for completeness. If not have applicant review documents to ensure all questions are responded to.

- It is important to check the background of workers to validate that what they have stated is accurate. If the background checks are acceptable proceed to an interview.

- Conduct and interview with the prospective candidate and document responses.

- After the interview process, if a decision is made to extend an offer of employment it should be a “conditional” offer of employment based on a negative drug screen and/or passing a Fit For Duty Physical.
Employment Verification Request

To Whom It May Concern:

The applicant named below is being considered for employment with our Company and has listed your organization as a former place of employment. In accordance with the release signed by the applicant on our Employment Application please provide the information requested and return this form to us by fax to: _______________________.

Thank You, Human Resources

Applicant: ______________________________________

Record of Employment:

Date Hired: __________________

Date Separated: ________________

Position(s) Held: ______________________________________________________

Reason Employment Ended: _____________________________________________

Job Performance: Please rate the Applicant in each of the following areas:

<table>
<thead>
<tr>
<th>Job Skill</th>
<th>Excellent</th>
<th>Good</th>
<th>Average</th>
<th>Poor</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initiative</td>
<td>Excellent</td>
<td>Good</td>
<td>Average</td>
<td>Poor</td>
</tr>
<tr>
<td>Attendance</td>
<td>Excellent</td>
<td>Good</td>
<td>Average</td>
<td>Poor</td>
</tr>
<tr>
<td>Conduct</td>
<td>Excellent</td>
<td>Good</td>
<td>Average</td>
<td>Poor</td>
</tr>
</tbody>
</table>

Would you rehire the Applicant? _______Yes _______No

Signature: ________________________

Title: ___________________________

Date: ____________
Documentation of Interview

Applicant: _______________________________ Date: _______________

On time for appointment: __________
Dressed appropriately: ____________

Qualities:
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________

Concerns:
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________

Drawbacks:
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________

Decision to Hire:
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________

Conditional offer of Employment will be extended:  Yes ☐  No ☐

________ Offer is condition upon received a negative drug screen result
________ Offer is conditional on being declared Fit-For-Duty by a Physician as measured to
the Job Description for the position.
Off-Limits Interview Questions

1. Are you married? Divorced?
2. If you’re single, are you living with anyone?
3. How old are you?
4. Do you have children? If so, how many and how old are they?
5. Do you own or rent your home?
6. What church do you attend?
7. Do you have any debts?
8. Do you belong to any social or political groups?
9. How much and what kinds of insurance do you have?

The following questions could result in an American with Disabilities Act lawsuit:

10. Do you suffer from an illness or disability?
11. Have you ever had or been treated for any of these conditions or diseases? (followed by a checklist)
12. Have you ever been hospitalized? What for?
13. Have you ever been treated by a psychiatrist or psychologist?
14. Have you had a major illness recently?
15. How many days of work did you miss last year because of illness?
16. Do you have any disabilities or impairments that might affect your performance in this job?
17. Are you taking any prescribed drugs?
18. Have you ever been treated for drug addiction or alcoholism?

Many companies ask female applicants questions they don’t ask males. Not smart. Here are some questions to avoid with female applicants:

19. Do you plan to get married?
20. Do you intend to start a family?
21. What are your day care plans?
22. Are you comfortable supervising men?
23. What would you do if your husband were transferred?
24. Do you think you could perform the job as well as man?
25. Are you likely to take time off under the Family and Medical Leave Act?

Final point: If a job candidate reveals information that you’re not allowed to ask, don’t pursue the topic further. The “she brought it up” excuse won’t fly in court, so change the subject right away.
Take this interviewing quiz to better understand what questions are acceptable.

1. What is your religious denomination, your religious affiliation, your church or the name of your pastor? No.
2. What religious holidays do you observe? No.
3. What is your lineage, ancestry, national origin, descent, parentage, nationality or birthplace? No.
4. What is your marital status? No.
5. If you have children, what are their ages?
6. How old are you? What was the date of your birth? No.
7. Do you have any impairment, mental or physical, which would interfere with your ability to perform the job for which you have applied? Yes.
8. How will you get to work? No.
9. If your original name has been changed by court order or otherwise, what was your original name? No.
10. Have you ever worked for this Company under a different name? Yes.
11. What is your place of residence? Yes.
12. What part of town is that? No.
13. How long have you resided in this city or state? Yes,
14. Do you own or rent? No.
15. Did you receive an honorable discharge from the military? No.
16. Have you ever been arrested? If so, for what? No.

#1. A better way to ask: Is there any reason you may not be able to come to work on time?

#15. Better to ask, “Were you in the military? What type of discharge did you receive?”

#16 Being arrested is not necessarily being convicted. It’s OK to ask if an applicant has ever been convicted of a crime.
Request for Medical Services

To Whom It May Concern:

This is to authorize the following test(s) on: ________________________________ .

_____ Non- DOT 5 Panel Drug Screen
_____ DOT 5 Panel Drug Screen
_____ DOT-CDL Physical Examination
_____ Breath Alcohol Test
_____ Saliva Alcohol
_____ Hearing Baseline
_____ Lumbar Spine X-ray
_____ Physical Examination
_____ Respirator Fit Testing
_____ Pulmonary Function Testing
_____ Chest X-Ray
_____ Basic Medical Evaluation

Please forward results to my attention:

Printed Name: ________________________________

Signature: ________________________________

Fax # or E-Mail: ________________________________
Interviewer Completion Form

Applicant: ________________________________ Date: _________________

Please enter a date in each space or list as N/A
Conditional Offer of Employment made: ___________________

Offer of Employment Rescinded due to: ________________

Applicant Hired: _____________ Rate of Pay $___________ Start Date: ______________

Employee File Created: ________________

Background Checks completed and acceptable: ________________

Date of Drug Test: ________________

Date of Alcohol Test: ________________

New Hire Packet Given: ________________

Driver’s License Copy: ________________

MVR Checked and meets criteria: Clear or Other ________________

Uniform issued ________________

Workers Compensation Check Conducted: ________________

Post Offer Medical Health Questionnaire completed: ________________

Child Support, if any: ________________

I-9 Completed ________________

Employee Contact Information Completed: ________________

State tax forms completed: ________________

Picture taken the Employee file; ________________

Injury Management Protocol Signed: ________________
Post Hire Information

Section 3

- Obtain signatures on all New Hire forms
- Provide New Worker safety orientation
**Employee General Information**

Employee Name: _____________________________
Employee Address: ____________________________________________________
Employee Phone # ________________________   Mobile # ____________________
Employee e-mail address: ____________________________________________
Date of Hire: ___________
Birth Date: ____________
Height ___________ Weight ___________
Title: __________________________
Salary: $ ____________
Full Time or Part Time: ______________________
Exempt or non- Exempt: ______________________
Marital Status: ___________
Spouse Name (If any) ___________________________
Spouses Occupation: _______________________ Phone # ________________________

**Emergency Contact Information:**

<table>
<thead>
<tr>
<th>Name</th>
<th>Phone Number</th>
<th>Relationship</th>
</tr>
</thead>
<tbody>
<tr>
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</tr>
</tbody>
</table>

**Dependents:**

<table>
<thead>
<tr>
<th>Name</th>
<th>Age</th>
<th>Relationship</th>
</tr>
</thead>
<tbody>
<tr>
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</tr>
</tbody>
</table>

25
Form W-4 (2013)

Purpose. Complete Form W-4 so that your employer can withheld the correct federal income tax from your pay. Consider completing a new Form W-4 each year and when your personal or financial situations change.

Exemption from withholding. If you are exempt, complete only lines 1, 2, 3, 4, and 7 and sign the form. If you are entitled to claiming exemption, complete the Personal Allowances Worksheet below. Enter your total number of allowances on line 5 and sign the form. If you are exempt from withholding if your income exceeds $1,000 and includes more than $300 of unearned income (for example, interest and dividends).

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

Complete all worksheets that apply. However, if you may claim spouse (no zero) allowances. For regular withholding, this must be based on allowances claimed on Form W-4 for the year preceding your tax return only if you are married, and pay more than 25% of the cost of keeping up a home for yourself and your dependent(s) or other qualifying individuals. See Pub. 502, Form W-4, and Pub. 13, Standard Deduction, and Filing Information, for information.

Tax credits. You can take a credit for income tax credits in account in determining your allowable number of withholding allowances. Credits for child or dependent care expenses and the child credit may be claimed using the Personal Allowances Worksheet below. See Pub. 502 for information on converting your other credits into withholding allowances.

Nonwage income. If you have a large amount of nonwage income, such as interest or dividends, consider making estimated tax payments using Form 1040 ES, Estimated Tax for Individuals. Otherwise, you may owe additional tax. If you have pensions or annuity income, see Pub. 505 to find out if you should report your annuity income on Form W-4 or W-4P.

Two earners or multiple jobs. If you have a working spouse or more than one job, figure the total number of allowances you are entitled to claim on all jobs using worksheets from only one Form W-4. Your withholding usually will be more accurate when all allowances are claimed on the form W-4 for the highest paying job and zero allowances are claimed on the others. See Pub. 595 for details.

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

Check your withholding. After you complete your Form W-4, take it to your employer to have it revised and sign. Use Pub. 505 to see how the amount you are having withheld compares to your projected total tax for 2013. See Pub. 505, especially if your earnings exceed $35,000 (single), or $62,000 (married). Future developments. Information about any future developments affecting Form W-4, such as legislative enactments after this release, is posted at www.irs.gov/w4.

---

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

| A | Enter “1” for yourself if no one else can claim you as a dependent. |
| B | Enter “1” if: |
| | a. You are single and have only one job; or |
| | b. You are married, have only one job, and your spouse does not work; or |
| | c. Your wages from a second job or your spouse’s wages (or the total of both) are $1,500 or less. |

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

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

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

**F** Enter “1” if you have at least $1,900 of child or dependent care expenses which you will claim a credit.

(For example, you have children, other individuals on whom you can claim dependency exemption, etc.)

**G** Child Tax Credit (including additional child tax credit). See Pub. 972, Child Tax Credit, for more information.

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

---

**For accuracy, complete all worksheets that apply.**

| If you plan to itemize your deductions and claims to income and want to reduce your withholding, see the DEDUCTIONS AND ADJUSTMENTS WORKSHEET on page 2. |
| If you are single and have more than one job and are married and you file jointly, check the “Single” box. |
| If you have two or more eligible children, check the “Single” box. |
| If you file jointly, check the “Joint” box. |

---

**Employee’s Withholding Allowance Certificate**

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

<table>
<thead>
<tr>
<th>Your first name and initial</th>
<th>Social security number</th>
</tr>
</thead>
<tbody>
<tr>
<td>First name</td>
<td>Initial</td>
</tr>
<tr>
<td>Home address, street, and ZIP code</td>
<td>City or town, state, and ZIP code</td>
</tr>
</tbody>
</table>

---

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

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

**7** I claim exemption from withholding for 2013, and certify that I meet both of the following conditions for exemption:

- 2013 I had a right to a refund of all federal income tax withheld because I had no tax liability, and
- 2013 I claim exemption from withholding for 2013, and I certify that I meet both of the following conditions for exemption:

- Last year I had a right to a refund of all federal income tax withheld because I had no tax liability, and
- This year I expect a refund of all federal income tax withheld because I expect to have no tax liability. If you meet both conditions, write “Exempt” here.

---

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

**Employee’s signature**

(This form is not valid unless you sign it.)

Date:

**Office code (if applicable)**

**Employee identification number (if any)**

---

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

<table>
<thead>
<tr>
<th>Github</th>
<th>100/2002</th>
</tr>
</thead>
</table>

---

Form W-4 (2013)
Deductions and Adjustments Worksheet

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

1. Enter an estimate of your 2013 itemized deductions. These include qualifying home mortgage interest, charitable contributions, state and local taxes, medical expenses in excess of 10% (7.5% if either you or your spouse was born before January 2, 1984) of your income, and miscellaneous deductions. For 2013, you may have to reduce your itemized deductions if your income is over $500,000 and you are married filing jointly or if you are a qualifying widow(er); $77,750 if you are head of household; $125,000 if you are single and not head of household or a qualifying widow(er); or $150,000 if you are married filing separately. See Pub. 505 for details. $12,200

2. Enter:

- $8,950 if head of household
- $6,100 if single or married filing separately

3. Subtract line 2 from line 1. If zero or less, enter "0" $3

4. Enter an estimate of your 2013 adjustments to income and any additional standard deduction (see Pub. 505) $4

5. Add lines 3 and 4 and enter the total. (Include any amount for credits from the Credit for Child and Dependent Care Expenses, and any other credits.) $6

6. Enter an estimate of your 2013 nonwage income (such as dividends or interest) $6

7. Subtract $3

8. Add $7

9. Enter the number from the Personal Allowances Worksheet, line H, page 1 $9

10. Add lines 8 and 9 and enter the total here. If you plan to use the Two-Earners/Multiple Jobs Worksheet, also enter this total on line 1 below. Otherwise, stop here and enter this total on Form W-4, line 5, page 1 $9

Two-Earners/Multiple Jobs Worksheet (See Two earners or multiple jobs on page 1.)

Note. Use this worksheet only if the instructions under line H on page 1 direct you here.

1. Enter the number from line H, page 1 (or from line 10 above if you used the Deductions and Adjustments Worksheet) $1

2. Find the number in Table 1 below that applies to the LOWEST paying job and enter it here. However, if you are married filing jointly and wages from the highest paying job are $65,000 or less, do not enter more than $3 $2

3. If line 1 is more than or equal to line 2, subtract line 2 from line 1. Enter the result here (if zero, enter "0") and on Form W-4, line 5, page 1. Do not use the rest of this worksheet. $3

4. Enter the number from line 2 of this worksheet $4

5. Enter the number from line 1 of this worksheet $5

6. Subtract line 5 from line 4 $6

7. Find the amount in Table 2 below that applies to the HIGHEST paying job and enter it here $7

8. Multiply line 7 by line 6 and enter the result here. This is the additional annual withholding needed $8

9. Divide line 8 by the number of pay periods applies to the HIGHEST paying job and enter it here $9

10. Enter the result here and on Form W-4, line 6, page 1. This is the additional amount to be withheld from each paycheck $9

<table>
<thead>
<tr>
<th>Married Filing Jointly</th>
<th>All Others</th>
</tr>
</thead>
<tbody>
<tr>
<td>If wages from LOWEST paying job are—</td>
<td>Enter on line 2 above</td>
</tr>
<tr>
<td>$0 - $30,000</td>
<td>0</td>
</tr>
<tr>
<td>31,001 - 43,000</td>
<td>1</td>
</tr>
<tr>
<td>44,001 - 53,000</td>
<td>2</td>
</tr>
<tr>
<td>54,001 - 63,000</td>
<td>3</td>
</tr>
<tr>
<td>64,001 - 73,000</td>
<td>4</td>
</tr>
<tr>
<td>74,001 - 83,000</td>
<td>5</td>
</tr>
<tr>
<td>84,001 - 93,000</td>
<td>6</td>
</tr>
<tr>
<td>94,001 - 103,000</td>
<td>7</td>
</tr>
<tr>
<td>114,001 - 123,000</td>
<td>8</td>
</tr>
<tr>
<td>124,001 - 133,000</td>
<td>9</td>
</tr>
<tr>
<td>134,001 - 143,000</td>
<td>10</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Married Filing Jointly</th>
<th>All Others</th>
</tr>
</thead>
<tbody>
<tr>
<td>If wages from HIGHEST paying job are—</td>
<td>Enter on line 7 above</td>
</tr>
<tr>
<td>$0 - $27,700</td>
<td>0</td>
</tr>
<tr>
<td>28,001 - 33,000</td>
<td>1</td>
</tr>
<tr>
<td>34,001 - 40,000</td>
<td>2</td>
</tr>
<tr>
<td>41,001 - 47,000</td>
<td>3</td>
</tr>
<tr>
<td>48,001 - 54,000</td>
<td>4</td>
</tr>
<tr>
<td>55,001 - 57,000</td>
<td>5</td>
</tr>
<tr>
<td>58,001 - 62,000</td>
<td>6</td>
</tr>
<tr>
<td>63,001 - 67,000</td>
<td>7</td>
</tr>
<tr>
<td>68,001 - 72,000</td>
<td>8</td>
</tr>
<tr>
<td>73,001 - 77,000</td>
<td>9</td>
</tr>
<tr>
<td>78,001 - 82,000</td>
<td>10</td>
</tr>
<tr>
<td>83,001 and over</td>
<td>11</td>
</tr>
<tr>
<td>84,001 and over</td>
<td>12</td>
</tr>
<tr>
<td>85,001 and over</td>
<td>13</td>
</tr>
<tr>
<td>86,001 and over</td>
<td>14</td>
</tr>
<tr>
<td>87,001 and over</td>
<td>15</td>
</tr>
</tbody>
</table>

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 6102, 6109, and 6110 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 taxed as a single person who claims no withholding allowances; providing insufficient information may subject you to penalties. Routine uses of this information include giving it to the Department of Justice for civil or criminal litigation; to other states, the District of Columbia, and U.S. commonwealths and possessions for use in administering their tax laws; and to the Department of Health and Human Services for use in the National Directory of New Hires. We may also disclose this information to other countries under a tax treaty, to federal and state agencies to enforce federal non-tax criminal laws, or to federal law enforcement 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. Records 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 6109.

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. Please see the instructions for your income tax return.
State of Louisiana
Department of Revenue

Employee Withholding Exemption Certificate
(L-4)

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

Basic Instructions: Employees who are subject to state withholding should complete the personal allowances worksheet below. Do not claim more than your correct withholding personal exemptions and the correct number of withholding dependency credits. Do not claim additional withholding exemptions if you qualify as head of household. In such cases, only the withholding personal exemption applicable to single individuals is allowable. You must file a new certificate within 10 days if the number of your exemptions decreases, except where the change occurs as the result of death of a spouse or a dependent. You may file a new certificate at any time the number of your exemptions increases. Penalties are imposed for willfully supplying false information or willful failure to supply information that would reduce the withholding exemptions. This form must be filed with your employer. Otherwise, he must withhold Louisiana income tax from your wages without exemption.

Note to Employer: Keep this certificate with your records. If the employee is believed to have claimed too many exemptions or dependency credits, the Secretary of Revenue should be so advised by forwarding a copy of the employee’s signed L-4 form to the Department.

Personal Allowances Worksheet

A. In Block A, enter "0" if you claim neither yourself nor your spouse, or
   In Block A, enter "1" if you claim yourself, provided you do not claim this exemption in connection with other employment or your spouse has not claimed your exemption, or
   In Block A, enter "2" if you claim yourself and your spouse. You may choose to enter "0" if you are married, and have either a working spouse, or more than one job. (This may help you avoid having too little tax withheld.)

B. In Block B, enter the number of dependents (other than your spouse or yourself) whom you will claim on your tax return. If no credits are claimed, enter "0".

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

Employee’s Withholding Allowance Certificate

Louisiana Department of Revenue

1. Type or print first name and middle initial
   Last name

2. Social Security Number

☐ No exemptions or dependents claimed
☐ Single
☐ Married

4. Home address (number and street or rural route)

5. City, State, ZIP

6. Total number of exemptions you are claiming (from Block A above)

7. Total number of dependents you are claiming (from Block B above)

8. Additional amount, if any, you want withheld each pay period

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

Employee’s signature

Date

The following is to be completed by employer.

9. Employer’s name and address

10. Employer’s state withholding account number
## INSTRUCTIONS

### Who may claim exemption from withholding of income tax:

You may be entitled to claim exemption from withholding Louisiana income tax if you incurred no liability for Louisiana income tax for the prior year and you anticipate that you will incur no liability for such income tax for the current year. For this purpose, your federal tax liability if your joint or separate return shows tax before the allowance of any credit for income tax withheld. If you claim this exemption, your employer will not withhold Louisiana income tax from your wages.

**When to claim exemption:**

File this certificate with your employer as soon as you determine you are entitled to claim this exemption. You must file a certificate each year if you wish to continue to claim the exemption.

For assistance, call the Department of Revenue at (225) 219-0102

### Multiple employers:

If you are employed by more than one employer, you may claim the exemption from withholding with each employer, provided that the total of your anticipated income will not cause you to incur any liability for Louisiana income tax for the current year and you incurred no liability for Louisiana income tax for the previous year.

**When you must revoke this exemption:**

You must revoke this exemption certificate:

- (1) within 10 days from the day you anticipate you will incur Louisiana income tax liability for the current year, or
- (2) if you anticipate you will incur Louisiana income tax liability for the following year (if a fiscal year taxpayer, within 10 days after you so anticipate, or by the first day of the last month of your current taxable year, whichever is later.) If you want to discontinue, or are required to revoke this exemption, you must file a new Employee’s Withholding Exemption Certificate (Form L-4) with your employer.
Employment Eligibility Verification
Department of Homeland Security
U.S. Citizenship and Immigration Services

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

ANTI-Discrimination NOTICE: It is illegal to discriminate against work-authorized individuals. Employers CANNOT specify which document(s) they will accept from an employee. The refusal to hire an individual because the documentation presented has a future expiration date may also constitute illegal discrimination.

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

Last Name (Family Name) First Name (Given Name) Middle Initial Other Names Used (if any)
Address (Street Number and Name) Apt. Number City or Town State Zip Code
Date of Birth (mm/dd/yyyy) U.S. Social Security Number E-mail Address Telephone Number

I am aware that federal law provides for imprisonment and/or fines for false statements or use of false documents in connection with the completion of this form.

I attest, under penalty of perjury, that I am (check one of the following):

☐ A citizen of the United States
☐ A noncitizen national of the United States (See instructions)
☐ A lawful permanent resident (Alien Registration Number/USCIS Number):

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

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

1. Alien Registration Number/USCIS Number:

OR

2. Form I-94 Admission Number:

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

Foreign Passport Number: Country of Issuance:

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

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

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

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

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

Employer Completes Next Page
### Section 2. Employer or Authorized Representative Review and Verification

Employers or their authorized representative must complete and sign Section 2 within 3 business days of the employee's first day of employment. You must physically examine one document from List A OR examine a combination of one document from List B and one document from List C as listed on the "Lists of Acceptable Documents" on the next page of this form. For each document you review, record the following information: document title, issuing authority, document number, and expiration date, if any.

<table>
<thead>
<tr>
<th>Employee Last Name, First Name and Middle Initial from Section 1:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>List A</strong> Identity and Employment Authorization <strong>OR</strong> <strong>List B</strong> Identity <strong>AND</strong> <strong>List C</strong> Employment Authorization</td>
</tr>
<tr>
<td>Document Title:</td>
</tr>
<tr>
<td>Issuing Authority:</td>
</tr>
<tr>
<td>Document Number:</td>
</tr>
<tr>
<td>Expiration Date (if any)(mm/dd/yyyy):</td>
</tr>
<tr>
<td><strong>3-D Barcode</strong></td>
</tr>
</tbody>
</table>

**Certification**

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

The employee's first day of employment (mm/dd/yyyy): ___

(See instructions for exemptions.)

<table>
<thead>
<tr>
<th>Signature of Employer or Authorized Representative</th>
<th>Date (mm/dd/yyyy)</th>
<th>Title of Employer or Authorized Representative</th>
</tr>
</thead>
<tbody>
<tr>
<td>Last Name (Family Name)</td>
<td>First Name (Given Name)</td>
<td>Employer's Business or Organization Name</td>
</tr>
</tbody>
</table>

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

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

A. New Name (if applicable) Last Name (Family Name) First Name (Given Name) Middle Initial

B. Date of Rehire (if applicable) (mm/dd/yyyy):

C. If employee’s previous grant of employment authorization has expired, provide the information for the document from List A or List C the employee presented that establishes current employment authorization in the space provided below.

| Document Title: | Document Number: | Expiration Date (if any)(mm/dd/yyyy): |

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

| Signature of Employer or Authorized Representative: | Date (mm/dd/yyyy): | Print Name of Employer or Authorized Representative: |

31
LISTS OF ACCEPTABLE DOCUMENTS
All documents must be UNEXPIRED

Employees may present one selection from List A
or a combination of one selection from List B and one selection from List C.

<table>
<thead>
<tr>
<th>LIST A</th>
<th>LIST B</th>
<th>LIST C</th>
</tr>
</thead>
<tbody>
<tr>
<td>Documents that Establish Both Identity and Employment Authorization</td>
<td>Documents that Establish Identity</td>
<td>Documents that Establish Employment Authorization</td>
</tr>
<tr>
<td>1. U.S. Passport or U.S. Passport Card</td>
<td>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</td>
<td>1. A Social Security Account Number card, unless the card includes one of the following restrictions: (1) NOT VALID FOR EMPLOYMENT</td>
</tr>
<tr>
<td>2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551)</td>
<td>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</td>
<td>(2) VALID FOR WORK ONLY WITH INS AUTHORIZATION</td>
</tr>
<tr>
<td>3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa</td>
<td>3. School ID card with a photograph</td>
<td>(3) VALID FOR WORK ONLY WITH DHS AUTHORIZATION</td>
</tr>
<tr>
<td>4. Employment Authorization Document that contains a photograph (Form I-766)</td>
<td>4. Voter's registration card</td>
<td>2. Certification of Birth Abroad issued by the Department of State (Form FS-545)</td>
</tr>
<tr>
<td>5. For a nonimmigrant alien authorized to work for a specific employer because of his or her status:</td>
<td>5. U.S. Military card or draft record</td>
<td>3. Certification of Report of Birth issued by the Department of State (Form DS-1350)</td>
</tr>
<tr>
<td>a. Foreign passport; and</td>
<td>6. Military dependent's ID card</td>
<td>4. Original or certified copy of birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal</td>
</tr>
<tr>
<td>b. Form I-94 or Form I-94A that has the following:</td>
<td>7. U.S. Coast Guard Merchant Mariner Card</td>
<td>5. Native American tribal document</td>
</tr>
<tr>
<td>(1) The same name as the passport; and</td>
<td>8. Native American tribal document</td>
<td>6. U.S. Citizen ID Card (Form I-197)</td>
</tr>
<tr>
<td>(2) An endorsement of the alien's nonimmigrant status as long as that period of endorsement has not yet expired and the proposed employment is not in conflict with any restrictions or limitations identified on the form.</td>
<td>9. Driver's license issued by a Canadian government authority</td>
<td>7. Identification Card for Use of Resident Citizen in the United States (Form I-179)</td>
</tr>
<tr>
<td>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</td>
<td>For persons under age 18 who are unable to present a document listed above:</td>
<td>8. Employment authorization document issued by the Department of Homeland Security</td>
</tr>
<tr>
<td></td>
<td>10. School record or report card</td>
<td></td>
</tr>
<tr>
<td></td>
<td>11. Clinic, doctor, or hospital record</td>
<td></td>
</tr>
<tr>
<td></td>
<td>12. Day-care or nursery school record</td>
<td></td>
</tr>
</tbody>
</table>

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

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

This Company is sometimes required by State and Federal Regulations to provide information on applicants for security clearances onto jobsites and/or to compile statistical data and maintain records of certain characteristics of job applications. To enable us to meet these requirements, we request your voluntary cooperation in completing this form. This information will be used for the specific purposes stated above and will be kept separate from your application. None of the information will be used to discriminate against or give preference to any individual.

Printed Name: __________________________ SS #: ________________________

A. Date of Birth: ___/___/_______  B. Age _______

C. Sex:  Male  i
To: New Hires

From: Human Resources Manager

Reference: Medical Questionnaire

The enclosed form will be completed by all employees.

This information will be kept strictly confidential and will only be released to our Workers’ Compensation insurance company in the event you have a job related injury.

This information is being collected to allow our insurance company to potentially lower the cost of our Workers’ Compensation claims, if we have any.

If you have a previous injury or medical condition you must list it on the attached form. If the cost of an injury is increased due to this medical condition our insurance company can file with the state to get some of the claim paid by the Second Injury Fund.

It is important to understand that your statements are regarded as material representations and any misrepresentation may result in forfeiture of Workers’ Compensation benefits.

Please let us know of any questions.

Thank You.
Procedure For Requesting Office of Workers Compensation Records:

All requests for information from OWCA closed disputed files must be made in writing. State who you are, who you represent, whether or not you were a party to the original case, name and social security number of the claimant, and specify the type of information needed. The Louisiana statute governing the confidentiality of the records does not allow the injured worker to authorize the release of non-public records to third parties. Reporting forms are not considered public record and are not subject to subpoena.

Only companies doing pre-employment screening or other investigative services may use the Workers’ compensation Claims Research Request form. Otherwise, do not use this form.

All closed disputed cases have a portion of the file that is considered public record. A public record is an order, decision or award that has been signed by an OWCA judge in a disputed case. If you were a party to the original case or if you are now representing someone in an ongoing OWCA disputed case, you may obtain non-public records.

Mail your request to the Office of Workers’ compensation Administration, P.O. Box 94040, Baton Rouge, Louisiana 70804, attention Records Management.

Copies are twenty-five cents per page plus one dollar per page for certified copies. Please do not send payment with your request, you will be notified if payment is required. Payment must be made by check or money order. Credit cards are not accepted.

For certification or further information regarding records request please call 1-800-201-3457 or 225-342-2031.

The following is an explanation of the different responses provided on the Workers’ Compensation claims Search Request form.

1) No closed disputed claim on file for the social security number submitted. The OWCA does have reporting forms on file. However, reporting forms or information from reporting forms are not considered public information and are not subject to Subpoena.

2) The OWCA does not have any information for the social security number submitted.

3) The OWCA does have a closed disputed claim on file containing orders, decisions or awards signed by an OWCA judge. However, the file is in transit.

4) The OWCA is sending you the information requested.

5) The public information available is enclosed. (orders, decisions or awards signed by an OWCA judge in a closed disputed case)

6) The OWCA must have a social security number in order to process a claim search.

7) Payment is required.
WORKERS’ COMPENSATION CLAIMS SEARCH REQUEST FORM
(Complete top portion only and fax to 225-342-7582 or mail to the P.O. Box listed at bottom of page)

COMPANY NAME:
COMPANY ADDRESS:
FAX NUMBER:
PHONE NUMBER:
EMAIL:
APPLICANT NAME:
SOCIAL SECURITY NUMBER:

OWCA CLAIMS SEARCH RESPONSE

1) ☐ The Office of Workers’ Compensation Administration does not have a public record for the social security number provided.

2) ☐ The information requested is enclosed.

3) ☐ The public information available is enclosed.

4) ☐ Please provide a social security number for your request.

5) ☐ Copies are twenty-five cents per page. This request totals _____ pages. Please remit $ _____ by check or money order made payable to the Office of Workers’ Compensation Administrative Fund. Mail to the address listed below.

6) ☐ See attached invoice.

PLEASE RETURN A COPY OF THIS REQUEST IF PAYMENT IS REQUIRED

_______________________________________    __________________________
Name         Date

Revised: 11-19-08
New Worker Orientation Letter

Welcome to our family of employee’s. We are glad you decided to join us and look forward to your employment with us for many years. I am writing this letter to you to convey a very important message. We need your services and want to do everything in our power to make sure you do not get hurt at work. We will provide you with training on how to avoid injuries. But we can’t train you on everything to keep you safe, So, I am asking you to work with us to protect your health and safety by doing the following:

1) If you see a hazard, which is any condition that can cause injury, correct the hazard or notify your Supervisor immediately.

2) If you have an idea to help you and your fellow employees work safer, suggest it to your Supervisor so it can be looked into. There may be a cash reward for you.

3) If you have an injury or witness an injury, report it to your Supervisor immediately. If injured, you will be taken to our Company doctor and we will provide you light-duty-modified duty work, if prescribed.

You see, we need you healthy and safe and so does your family. So work with us to keep you, your fellow workers and our customers safe.

Please signal your understanding of these items and your agreement to work safely by signing below.

Best Wishes for gainful and happy employment with your new work Team.

Printed Name: ________________________________

Signature: ____________________________________

Date:___________________
Check List of New Worker Training and Orientation

Supervisors have the responsibility of obtaining all necessary signatures and educating workers on the company Safety and Claims Management program.

New Employee: ____________________________

Date Hired: ________________

Date Trained: ________________

Department: ________________

Supervisor: ________________

Documentation of New Worker Training:

  Indoctrination and Orientation performed
  ; Employee Safety Responsibility Statement signed
  ; Educate Employees on Immediate Reporting of accidents and injuries
  ; Educated on Procedure to visit Company Doctor
  ; Educated on Transitional Duty, if required by a Doctor
  ; Educated on the required use of Personal Protection Equipment
  ; Educated on Safety Mission Statement
  ; Review and explain General Safety Rules

This is to certify that I have had Basic Safety Orientation on the following topics:

<table>
<thead>
<tr>
<th>Hazard Communications</th>
<th>Confined Space</th>
</tr>
</thead>
<tbody>
<tr>
<td>Respirators</td>
<td>Fire/Fire Extinguishers</td>
</tr>
<tr>
<td>Personal Protective Equipment (PPE)</td>
<td>Basic First Aid (not certified training)</td>
</tr>
<tr>
<td>Hearing Conservation</td>
<td>Blood Borne Pathogens</td>
</tr>
<tr>
<td>Fall Protection</td>
<td>Heat/Cold Stress</td>
</tr>
<tr>
<td>Lockout Tagout</td>
<td>Good Safety Practices</td>
</tr>
</tbody>
</table>

I, certify that I have completed all items listed in the New Worker Training.

Printed Name: ____________________________
Signed Name: ____________________________
Employee Pledge Statement of Safety Responsibility

I understand that this Company takes the safety of its workers very seriously. Therefore, I understand it is my duty and responsibility to:

1) Report all unsafe conditions to my Supervisor **immediately.**
2) Report all incidents and injuries to my Supervisor **immediately.**
3) Use all precautions in my daily work to protect my well being and health
4) Follow all Safety Rules, spoken and written.
5) Ask for training and information if I am unfamiliar with a task.

I understand that if Injured, my Supervisor will take me to Doctor or apply First Aid. Also, I understand that light-duty work is available if assigned by the doctor.

This organization used care in selecting me and now ask me to use care to protect myself and the assets of the organization.

I pledge to conduct myself in a professional matter by wearing the personal protection equipment (PPE) provided by my employer.

I understand the need for a safe workplace and agree to do my best to be a safe worker.

Employee Signature: __________________________________________

Printed Name: ______________________________________________

Date: ____________
General Safety Rules

The following rules are General Safety Rules that apply to all personnel at all times. In addition to these Rules, other rules and exposure specific training will be provided to protect the health and well being of our workforce. You have a duty and responsibility to obey these and all rules issued by this Company. Failure to do so will result in disciplinary action up to and including termination.

1) No Horseplay or fighting allowed.
2) No firearms or weapons of any kind allowed on Company property
3) Report all unsafe conditions to your supervisor immediately.
4) Wear seatbelts at all times.
5) Keep work areas clean and free of debris.
6) No alcohol or drugs will be used or allowed on Company property.
7) Report all injuries Immediately to your Supervisor.
8) Ask for training if unfamiliar with any task.
9) Use lifting equipment or get help for loads over 35 lbs.
10) Do not remove or bypass any guard on any piece of machinery.
11) Use appropriate Personal Protection Equipment (PPE) as needed.
12) Any spill of food or liquid must be cleaned up immediately.

I have read and understand these General Safety Rules. I understand that I may at any time ask my Supervisor for more information. I will obey these Safety Rules and others as distributed.

Date: ____________

Employee: ___________________ Printed Name: ___________________

Supervisor: ___________________ Printed Name: ___________________
Safety Rule Violation Disciplinary Policy

As you know, the management takes very seriously the safety and health our most valuable asset, you, our employees. We strive to provide an environment that fosters safety which protects you from injury. With that in mind, effective immediately, we have instituted a Policy of Reinforcement of the Safety Program. Therefore, if you are observed by your supervisor disobeying a Safety Rule or creating or not correcting an unsafe condition the policy is as follows:

1st offense - Written reprimand, copy placed in personnel file.

2nd offense - Second written reprimand with required Re-Training.

3rd offense - Termination for cause from the Company

Notice of Safety Rules Violation

To: _________________________________ Date _____________________

From: Supervisor

This shall serve to give you formal notice that you have violated a Company safety rule.

The safety rule(s) that was violated is ______________________________________________________
______________________________________________________________________________________.

In accordance with our Company Safety Policy this Notice will be placed in your personnel file. If another violation of the same or another safety rule should occur you will be given re-training.

However, if such re-training does not improve your performance your employment will be terminated. It is our continuing pursuit to maintain a safe workplace.

Employee comments:
______________________________________________________________________________________
______________________________________________________________________________________
______________________________________________________________________________________

Cc: Employee Personnel File
Injury Management Policy

We require that, as a condition of employment, you report any and all workplace or customer injuries and property damage, no matter how minor, immediately to your Supervisor.

Once the incident is reported we will:

→ provide prompt medical care, if needed.
→ collect a post accident drug screen (for employee injuries)
→ assist in all manner to return you to work quickly (employee injuries)
→ perform an accident investigation to determine the facts of the incident (all injuries)
→ report the incident to the appropriate insurance Company, if warranted

If you are injured in the course and scope of your employment you need to know:

• Reporting an incident or injury to a co-worker is not acceptable.
• Provide all necessary details to explain the incident.

If the doctor authorizes you to be off work:

• By state law you are not entitled to lost wage benefits for the first seven (7) calendar days. If available you may use sick time accrued or vacation time accrued.

• You will receive only 66 2/3% of your wage tax free.

• We will work to return-you-to work in an accommodating position.

We invite any questions you may have.

Name Printed: _______________________________________
Name Signed:_______________________________________
Date: ___________
**Company Absentee Policy**

When this company bids jobs and schedules work we plan on having a certain crew to be able to perform the work. We need our crews to show up as planned so we can complete the construction projects on time and on budget. As you know, we hired you to work here and perform certain task. We expect you to come to work as scheduled, unimpaired and ready to work.

This is your notice that we now have in place an Absentee Policy in place.

This policy requires you to show up for work on your regularly scheduled times and designated jobsite every workday.

If for some reason you cannot make it into work that day you have to call the main office by 8AM so we can make other arrangements for someone to take your place on the job.

If you fail to call in 2 times you will be terminated for violation of this policy.

Furthermore, you will only be granted a total of 2 unscheduled absences.

I have read and understand the Absentee Policy stated above.

Printed Name: ________________________________

Signed: ____________________________________

Date: _________________
Out of State Motor Vehicles

The State of Louisiana requires employers to notify employees that:

A. Any person who is a resident of a state which requires registration of the motor vehicle or motor vehicles of a person who is employed in that state within thirty days of such employment, and who is employed in and maintains a residence in Louisiana and who operate one or more vehicles on the public streets and roads in Louisiana shall apply for a certificate of registration for each of those vehicles within thirty days of the date on which the person was employed in Louisiana, except active members of the armed forces.

Smoking Policy

State of Louisiana law § 1300.24 Smoking regulated in the office workplace:

It is the policy of this company to provide reasonable accommodations in so far as possible between the preferences of smoking and non smoking employees.

- Please be a courteous smoker and understand that others may not enjoy the smoke that smoking emits.
- Please limit smoking to the designated area.
- Please be sure to extinguish the cigarette completely.
- Please understand that lit cigarettes are an ignition source and should be kept away from flammables and combustibles.
- You have the right to smoke and we respect that.
# Louisiana New Hire/Rehire Form

Effective October 1, 1997 Act 97 of the 1997 LA Legislative Session requires all Louisiana Employers, both public and private, to report all newly hired or rehired employees to the State of Louisiana within 20 days of hire. Information about new hire reporting and online reporting is available on our website: [www.LA-nowhire.com](http://www.LA-nowhire.com).

To ensure the highest level of accuracy, please print neatly in capital letters and avoid contact with the edges of the boxes. The following will serve as an example:

```
ABCDEFGHIJKLMNOPQRSTUVWXYZ123
```

## Employer Information

<table>
<thead>
<tr>
<th>Federal Employer ID Number (FEIN):</th>
<th>State ID Number (required if available):</th>
</tr>
</thead>
<tbody>
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<table>
<thead>
<tr>
<th>Employer Name:</th>
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</table>

<table>
<thead>
<tr>
<th>Employer Address:</th>
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</table>

<table>
<thead>
<tr>
<th>Employer City:</th>
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</table>

<table>
<thead>
<tr>
<th>Employer State:</th>
<th>Zip Code (5 digit):</th>
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<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Employer Phone (optional):</th>
<th>Extension:</th>
<th>Employer Fax (optional):</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Email (optional):</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

## Employee Information

<table>
<thead>
<tr>
<th>Employee Social Security Number (SSN):</th>
<th>Date of Hire (First day employee works for pay)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Employee First Name:</th>
<th>Middle Name:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Employee Last Name:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Employee Address:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Employee City:</th>
<th>Employee State:</th>
<th>Zip Code (5 digit):</th>
</tr>
</thead>
<tbody>
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<td></td>
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<td></td>
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</table>

<table>
<thead>
<tr>
<th>Occupation (required if available):</th>
<th>Date of Birth (optional):</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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*Reports will not be processed if required information is missing.*

Questions? Call us toll-free (888) 223-1461
The Separation/Termination Process

Section 4

- Exit form from Louisiana Department of Labor (Form LDOL 77). This may be filed online at www.laworks.net and should be done within 72 hours after separation.

- Instructions to Worker and Employee (Employee should receive a copy of the form with the instructions to Employee).
INSTRUCTIONS TO EMPLOYER FOR PREPARATION OF SEPARATION NOTICE ALLEGING DISQUALIFICATION

A Separation Notice Alleging Disqualification should be made out in triplicate for each worker who leaves your employ without good cause connected with his work, is discharged for misconduct connected with his work, or is unemployed because of a labor dispute.

Mail an original to the Administrator, Louisiana Department of Labor, Post Office Box 94094, Baton Rouge, Louisiana 70804 within 72 hours after employee has been separated from work.

Give a duplicate copy to the worker along with the "Instructions To The Worker" and the Worker's Claim Information, Form LDOL 87W, or if delivery is impossible, mail to his last known address within 72 hours.

Keep a triplicate in your files for reference.

Enter here the worker's full name as it appears on your records. If it is different from that on the Social Security card, report both names.

Enter worker's Social Security Number. If it is known to you that he has more than one number, enter all numbers.

Enter the date the worker was separated from your employ.

Enter the date the worker was hired.

Enter the date the worker last worked.

Enter the date the worker was separated from your employ.

Check the reason for separation and explain in detail in space provided.

: give the detailed reason for leaving so that it can be determined whether or not a disqualification for leaving without good cause attributable to a substantial change with the employment should be assessed.

: give the detailed reason for discharge so that the information can be used in determining whether or not a disqualification should be assessed for misconduct connected with the work.

: give complete details as to the reason for the leave and the time period involved.

: give all details known to you relative to the worker's illness or injury.

: give complete information relative to reason for the separation and whether or not the worker had a contract or a reasonable assurance of returning.

: give detailed information relative to the new work offered, such as, salary, hours, job conditions, location, etc.

: give details of labor dispute so that the information can be used in determining whether or not the worker is disqualified for benefits due to participation in the dispute.

: give the detailed reason for retirement, whether voluntary or compulsory, exact amount of pension before deductions, and whether Company contributed, employee contributed or a combination of employer/employee contributions.

: enter here any other reason not enumerated above which might disqualify the worker. Give full explanation.

Complete as indicated on the form. Report gross dollar amounts.

This notice should be signed by an officer or employee authorized to assume responsibility for the information and his title or position. This notice should be dated as of the date it is handed or mailed to the worker and mailed to the Administrator, Louisiana Department of Labor, Post Office Box 94094,
INSTRUCTIONS TO THE WORKER

Having become unemployed, you should go to an office of the Louisiana Department of Labor most convenient to you and register for work. If you intend to file a claim for benefits, you may do so at the same time. Under the Louisiana Employment Security Law, you may be disqualified for benefits, if it is determined that:

- You left your work without good cause attributable to a substantial change with your employment, or
- You were discharged for misconduct connected with your work, or
- You failed to accept suitable work when offered or to apply for available suitable work, when so directed by the Administrator or the employment office, or
- You were taking part in a labor dispute in the establishment in which you were employed, or
- You were seeking unemployment compensation benefits under any other State or Federal Law.

It is important for you to register for work immediately even though you may be temporarily disqualified for benefits.

In deciding whether you are disqualified, the Louisiana Department of Labor will consider the statements made by your employer on Form LDOL 77, Separation Notice, concerning the reason for your separation and the statements you make when you file your claim for benefits at the office of the Louisiana Department of Labor. If you do not agree with the reasons for leaving your job as given on the Form LDOL 77, Separation Notice, state reason for leaving your job to the representative at the office of the Louisiana Department of Labor.

: It is not necessary to EMPLOY any one to help you collect benefits. Any representative of the Louisiana Department of Labor will advise you and help you with your claim.

at once at the most convenient office of the Louisiana Department of Labor.
SEPARATION NOTICE ALLEGING DISQUALIFICATION

1. NAME ______________________________________ 2. SS NO. __________________________________________
3. DATE OF SEPARATION ____________ 4. DATE HIRED____________ 5. DATE LAST WORKED ____________

PLEASE PROVIDE DETAILED EXPLANATION for item checked below. Should this individual file a claim for unemployment insurance benefits, complete facts will enable this agency to make an equitable decision.

6. REASON FOR LEAVING:
   01 ( ) Voluntary Leaving (Quit)
   02 ( ) Discharge (Fired)
   03 ( ) Lack of Work (R.I.F.)
   04 ( ) Leave of Absence
   05 ( ) Not Physically Able to Work
   06 ( ) School Employee Contract
   07 ( ) Refused Other Suitable Work
   08 ( ) Labor Dispute
   09 ( ) Retirement, Pension
   10 ( ) Other (Please Explain)

7. VACATION, SEVERANCE, DISMISSAL, BONUS, HOLIDAY PAY INFORMATION
   The employee received or will receive:
   ( ) Vacation $ __________ week(s) ______
   ( ) Severance/Dismissal $ __________ week(s) ______
   ( ) Bonus $ __________ week(s) ______
   ( ) Holiday Pay $ __________ week(s) ______
   LUMP SUM ( ) Vacation ( ) Accrued Leave
   ( ) Severance/Dismissal Pay ( ) Bonus
   ( ) Holiday Pay ( ) Other Remuneration

EXPLANATION:
______________________________________________________________________________________________________
______________________________________________________________________________________________________
______________________________________________________________________________________________________
______________________________________________________________________________________________________
______________________________________________________________________________________________________

I certify that the worker whose name and social security number appear above has been separated from work and that the above information is true and correct. I further certify that the individual has been handed or mailed a copy of this notice.

8. ___________________________ 9. ___________________________ 10. __________________________
   Employer Name                Phone - Area Code & No.         Employer Acct. No.
11. ___________________________ 12. ___________________________
    Address Street/Box           City                        State
13. ___________________________ 14. ___________________________ 15. __________________________
    Signature                  Title                        Date

FILL OUT IN TRIPlicate. MAIL ORIGINAL TO - Administrator, Louisiana Department of Labor, Post Office Box 94094, Baton Rouge, LA, 70804-9094 WITHIN 72 HOURS after separation. Give a copy of this form and a copy of the “Instructions to the Worker” to the employee within 72 hours, and retain a copy for your files.

Failure to submit this notice within the specified time limits may forfeit your right to appeal. It must be submitted within 72 hours after the worker’s separation from employer.
Employee Separation From Employment Documentation

Printed Name: ________________________     SSN: _______- _____-_______

Separation Date: ____________________   Last Date Worked: __________________

Reason for Separation:

___ Voluntary Quit
___ Discharge for Cause (state reason below)
___ Lack of Work: Reduction in Force
___ Leave of Absence
___ Violation of Absentee Policy
___ Not Physically Able to Work
___ School Employee Contract
___ Refused Other Suitable Work
___ Retirement
___ Violation of Safety Rules
___ Violation of Drug Free Workplace Policy
___ Misconduct
___ Other

Comments: ____________________________________________________________
______________________________________________________________________
______________________________________________________________________
________________________________________________________________________
I understand that I have been separated from employment with this company. I have not sustained an injury that has not been reported during my employment.

______________________________________________________________________
Previous Employee Signed Name