

Form W-4 (2011)

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

Exemption from withholding. If you are exempt, complete **only** lines 1, 2, 3, 4, and 7 and sign the form to validate it. Your exemption for 2011 expires February 16, 2012. See Pub. 505, Tax Withholding and Estimated Tax.

Note. If another person can claim you as a dependent on his or her tax return, you cannot claim exemption from withholding if your income exceeds \$950 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 jobs situations.

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

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

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

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

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

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

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

Check your withholding. After your Form W-4 takes effect, use Pub. 919 to see how the amount you are having withheld compares to your projected total tax for 2011. See Pub. 919, especially if your earnings exceed \$130,000 (Single) or \$180,000 (Married).

Personal Allowances Worksheet (Keep for your records.)

A	Enter "1" for yourself if no one else can claim you as a dependent	A	<u> </u>			
B	Enter "1" if: <table style="display: inline-table; vertical-align: middle;"> <tr> <td style="font-size: 3em; vertical-align: middle;">{</td> <td style="padding: 0 10px;"> <ul style="list-style-type: none"> • You are single and have only one job; or • You are married, have only one job, and your spouse does not work; or • Your wages from a second job or your spouse's wages (or the total of both) are \$1,500 or less. </td> <td style="font-size: 3em; vertical-align: middle;">}</td> </tr> </table>	{	<ul style="list-style-type: none"> • You are single and have only one job; or • You are married, have only one job, and your spouse does not work; or • Your wages from a second job or your spouse's wages (or the total of both) are \$1,500 or less. 	}	B	<u> </u>
{	<ul style="list-style-type: none"> • You are single and have only one job; or • You are married, have only one job, and your spouse does not work; or • Your wages from a second job or your spouse's wages (or the total of both) are \$1,500 or less. 	}				
C	Enter "1" for your spouse . But, you may choose to enter "-0-" if you are married and have either a working spouse or more than one job. (Entering "-0-" may help you avoid having too little tax withheld.)	C	<u> </u>			
D	Enter number of dependents (other than your spouse or yourself) you will claim on your tax return	D	<u> </u>			
E	Enter "1" if you will file as head of household on your tax return (see conditions under Head of household above)	E	<u> </u>			
F	Enter "1" if you have at least \$1,900 of child or dependent care expenses for which you plan to claim a credit (Note. Do not include child support payments. See Pub. 503, Child and Dependent Care Expenses, for details.)	F	<u> </u>			
G	Child Tax Credit (including additional child tax credit). See Pub. 972, Child Tax Credit, for more information. • If your total income will be less than \$61,000 (\$90,000 if married), enter "2" for each eligible child; then less "1" if you have three or more eligible children. • If your total income will be between \$61,000 and \$84,000 (\$90,000 and \$119,000 if married), enter "1" for each eligible child plus "1" additional if you have six or more eligible children	G	<u> </u>			
H	Add lines A through G and enter total here. (Note. This may be different from the number of exemptions you claim on your tax return.) ▶	H	<u> </u>			
	For accuracy, complete all worksheets that apply. <table style="display: inline-table; vertical-align: middle;"> <tr> <td style="font-size: 3em; vertical-align: middle;">{</td> <td style="padding: 0 10px;"> <ul style="list-style-type: none"> • If you plan to itemize or claim adjustments to income and want to reduce your withholding, see the Deductions and Adjustments Worksheet on page 2. • If you have more than one job or are married and you and your spouse both work and the combined earnings from all jobs exceed \$40,000 (\$10,000 if married), see the Two-Earners/Multiple Jobs Worksheet on page 2 to avoid having too little tax withheld. • If neither of the above situations applies, stop here and enter the number from line H on line 5 of Form W-4 below. </td> <td style="font-size: 3em; vertical-align: middle;">}</td> </tr> </table>	{	<ul style="list-style-type: none"> • If you plan to itemize or claim adjustments to income and want to reduce your withholding, see the Deductions and Adjustments Worksheet on page 2. • If you have more than one job or are married and you and your spouse both work and the combined earnings from all jobs exceed \$40,000 (\$10,000 if married), see the Two-Earners/Multiple Jobs Worksheet on page 2 to avoid having too little tax withheld. • If neither of the above situations applies, stop here and enter the number from line H on line 5 of Form W-4 below. 	}		
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----- Cut here and give Form W-4 to your employer. Keep the top part for your records. -----

Form W-4 Department of the Treasury Internal Revenue Service	<h2 style="margin: 0;">Employee's Withholding Allowance Certificate</h2> <p style="margin: 0;">▶ Whether you are entitled to claim a certain number of allowances or exemption from withholding is subject to review by the IRS. Your employer may be required to send a copy of this form to the IRS.</p>	OMB No. 1545-0074 2011
1 Type or print your first name and middle initial.	Last name	2 Your social security number
Home address (number and street or rural route)		3 <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Married, but withhold at higher Single rate. Note. If married, but legally separated, or spouse is a nonresident alien, check the "Single" box.
City or town, state, and ZIP code		4 If your last name differs from that shown on your social security card, check here. You must call 1-800-772-1213 for a replacement card. ▶ <input type="checkbox"/>
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	5 <u> </u> 6 \$ <u> </u>
7 I claim exemption from withholding for 2011, and I certify that I meet both of the following conditions for exemption. • Last year I had a right to a refund of all federal income tax withheld because I had no tax liability and • This year I expect a refund of all federal income tax withheld because I expect to have no tax liability. If you meet both conditions, write "Exempt" here ▶		7 <u> </u>
Under penalties of perjury, I declare that I have examined this certificate and to the best of my knowledge and belief, it is true, correct, and complete.		
Employee's signature (This form is not valid unless you sign it.) ▶		Date ▶
8 Employer's name and address (Employer: Complete lines 8 and 10 only if sending to the IRS.)	9 Office code (optional)	10 Employer identification number (EIN)

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 2011 itemized deductions. These include qualifying home mortgage interest, charitable contributions, state and local taxes, medical expenses in excess of 7.5% of your income, and miscellaneous deductions	1	\$ _____
2	Enter: $\left\{ \begin{array}{l} \$11,600 \text{ if married filing jointly or qualifying widow(er)} \\ \$8,500 \text{ if head of household} \\ \$5,800 \text{ if single or married filing separately} \end{array} \right\}$	2	\$ _____
3	Subtract line 2 from line 1. If zero or less, enter “-0-”	3	\$ _____
4	Enter an estimate of your 2011 adjustments to income and any additional standard deduction (see Pub. 919)	4	\$ _____
5	Add lines 3 and 4 and enter the total. (Include any amount for credits from the <i>Converting Credits to Withholding Allowances for 2011 Form W-4 Worksheet</i> in Pub. 919.)	5	\$ _____
6	Enter an estimate of your 2011 nonwage income (such as dividends or interest)	6	\$ _____
7	Subtract line 6 from line 5. If zero or less, enter “-0-”	7	\$ _____
8	Divide the amount on line 7 by \$3,700 and enter the result here. Drop any fraction	8	_____
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	10	_____

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	_____
Note. If line 1 is less than line 2, enter “-0-” on Form W-4, line 5, page 1. Complete lines 4 through 9 below to figure the additional withholding amount necessary to avoid a year-end tax bill.			
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 remaining in 2011. For example, divide by 26 if you are paid every two weeks and you complete this form in December 2010. 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 1

Table 2

Married Filing Jointly		All Others		Married Filing Jointly		All Others	
If wages from LOWEST paying job are—	Enter on line 2 above	If wages from LOWEST paying job are—	Enter on line 2 above	If wages from HIGHEST paying job are—	Enter on line 7 above	If wages from HIGHEST paying job are—	Enter on line 7 above
\$0 - \$5,000 -	0	\$0 - \$8,000 -	0	\$0 - \$65,000	\$560	\$0 - \$35,000	\$560
5,001 - 12,000 -	1	8,001 - 15,000 -	1	65,001 - 125,000	930	35,001 - 90,000	930
12,001 - 22,000 -	2	15,001 - 25,000 -	2	125,001 - 185,000	1,040	90,001 - 165,000	1,040
22,001 - 25,000 -	3	25,001 - 30,000 -	3	185,001 - 335,000	1,220	165,001 - 370,000	1,220
25,001 - 30,000 -	4	30,001 - 40,000 -	4	335,001 and over	1,300	370,001 and over	1,300
30,001 - 40,000 -	5	40,001 - 50,000 -	5				
40,001 - 48,000 -	6	50,001 - 65,000 -	6				
48,001 - 55,000 -	7	65,001 - 80,000 -	7				
55,001 - 65,000 -	8	80,001 - 95,000 -	8				
65,001 - 72,000 -	9	95,001 -120,000 -	9				
72,001 - 85,000 -	10	120,001 and over	10				
85,001 - 97,000 -	11						
97,001 -110,000 -	12						
110,001 -120,000 -	13						
120,001 -135,000 -	14						
135,001 and over	15						

Privacy Act and Paperwork Reduction Act Notice. We ask for the information on this form to carry out the Internal Revenue laws of the United States. Internal Revenue Code sections 3402(f)(2) and 6109 and their regulations require you to provide this information; your employer uses it to determine your federal income tax withholding. Failure to provide a properly completed form will result in your being treated as a single person who claims no withholding allowances; providing fraudulent information may subject you to penalties. Routine uses of this information include giving it to the Department of Justice for civil and criminal litigation, to cities, states, the District of Columbia, and U.S. commonwealths and 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 nontax criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism.

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

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

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

EMPLOYEE AUTHORIZATION AGREEMENT FOR DIRECT DEPOSIT

Please print legibly - It's your payroll check!!

1.

Employee Name _____

Social Security No. _____

1	Enter your name and Social Security Number.
2	Complete direct deposit information for one account. If you are depositing to more than one account complete form DD-4.
3	Sign and return to your employer. Keep a copy for your records.

I would like my net payroll directly deposited to the following bank account:

This authorization supersedes all previous authorizations.

2.

BANK ACCOUNT

Checking Savings

New Change Delete

Account Number _____

Bank Name _____

Bank ABA# _____

Please attach one of the following (check one):

Voided check

Bank letter or specification sheet

EMPLOYEE AUTHORIZATION

3.

I authorize my employer to deposit funds representing my net pay each payday directly into the above account, and to initiate (if necessary) adjustments for any credit made in error to my account. This authority will remain in effect until I have given written notice to my employer to terminate this service.

Employee Signature _____

Date _____

Return this form and attachments to your employer

EMPLOYER AUTHORIZATION

I / We authorize Rand Payroll Services to initiate debit and credit electronic transactions as necessary to pay this employee, all related taxes and all related fees.

Company _____

Employer Authorization _____

Date _____

Submit this form and attachments before the next payroll

Form DD-1

TAPE VOIDED CHECK HERE

INSTRUCTIONS

PLEASE READ ALL INSTRUCTIONS CAREFULLY BEFORE COMPLETING THIS FORM.

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

Section 1 - Employee. All employees, citizens and noncitizens, hired after November 6, 1986, must complete Section 1 of this form at the time of hire, which is the actual beginning of employment. **The employer is responsible for ensuring that Section 1 is timely and properly completed.**

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

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

Employers must complete Section 2 by examining evidence of identity and employment eligibility within three (3) business days of the date employment begins. If employees are authorized to work, but are unable to present the required document(s) within three business days, they must present a receipt for the application of the document(s) within three business days and the actual document(s) within ninety (90) days. However, if employers hire individuals for a duration of less than three business days, Section 2 must be completed at the time employment begins. **Employers must record: 1) document title; 2) issuing authority; 3) document number, 4) expiration date, if any; and 5) the date employment begins.** Employers must sign and date the certification. Employees must present original documents. Employers may, but are not required to, photocopy the document(s) presented. These photocopies may only be used for the verification process and must be retained with the I-9. **However, employers are still responsible for completing the I-9.**

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

- If an employee's name has changed at the time this form is being updated/reverified, complete Block A.
- If an employee is rehired within three (3) years of the date this form was originally completed and the employee is still eligible to be employed on the same basis as previously indicated on this form (updating), complete Block B and the signature block.
- If an employee is rehired within three (3) years of the date this form was originally completed and the employee's work authorization has expired or if a current employee's work authorization is about to expire (reverification), complete Block B and:

- examine any document that reflects that the employee is authorized to work in the U.S. (see List A or C),
- record the document title, document number and expiration date (if any) in Block C, and
- complete the signature block.

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

For more detailed information, you may refer to the Department of Homeland Security (DHS) Handbook for Employers, (Form M-274). You may obtain the handbook at your local U.S. Citizenship and Immigration Services (USCIS) office.

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

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

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

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

Reporting Burden. We try to create forms and instructions that are accurate, can be easily understood and which impose the least possible burden on you to provide us with information. Often this is difficult because some immigration laws are very complex. Accordingly, the reporting burden for this collection of information is computed as follows: **1) learning about this form, 5 minutes; 2) completing the form, 5 minutes; and 3) assembling and filing (recordkeeping) the form, 5 minutes, for an average of 15 minutes per response.** If you have comments regarding the accuracy of this burden estimate, or suggestions for making this form simpler, you can write to U.S. Citizenship and Immigration Services, Regulatory Management Division, 111 Massachusetts Avenue, N.W., Washington, DC 20529. OMB No. 1615-0047.

NOTE: This is the 1991 edition of the Form I-9 that has been rebranded with a current printing date to reflect the recent transition from the INS to DHS and its components.

Employment Eligibility Verification

Please read instructions carefully before completing this form. The instructions must be available during completion of this form. ANTI-DISCRIMINATION NOTICE: It is illegal to discriminate against work eligible individuals. Employers CANNOT specify which document(s) they will accept from an employee. The refusal to hire an individual because of a future expiration date may also constitute illegal discrimination.

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

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

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):
	<input type="checkbox"/> A citizen or national of the United States
	<input type="checkbox"/> A Lawful Permanent Resident (Alien #) A _____ <input type="checkbox"/> An alien authorized to work until _____ (Alien # or Admission #) _____

Employee's Signature	Date (month/day/year)
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Preparer and/or Translator Certification. (To be completed and signed if Section 1 is prepared by a person other than the employee.) I attest, under penalty of perjury, that I have assisted in the completion of this form and that to the best of my knowledge the information is true and correct.

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

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

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

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

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

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

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

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

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

LISTS OF ACCEPTABLE DOCUMENTS

LIST A	LIST B	LIST C
Documents that Establish Both Identity and Employment Eligibility	Documents that Establish Identity	Documents that Establish Employment Eligibility
<ol style="list-style-type: none"> 1. U.S. Passport (unexpired or expired) 2. Certificate of U.S. Citizenship (<i>Form N-560 or N-561</i>) 3. Certificate of Naturalization (<i>Form N-550 or N-570</i>) 4. Unexpired foreign passport, with <i>I-551 stamp</i> or attached <i>Form I-94</i> indicating unexpired employment authorization 5. Permanent Resident Card or Alien Registration Receipt Card with photograph (<i>Form I-151 or I-551</i>) 6. Unexpired Temporary Resident Card (<i>Form I-688</i>) 7. Unexpired Employment Authorization Card (<i>Form I-688A</i>) 8. Unexpired Reentry Permit (<i>Form I-327</i>) 9. Unexpired Refugee Travel Document (<i>Form I-571</i>) 10. Unexpired Employment Authorization Document issued by DHS that contains a photograph (<i>Form I-688B</i>) 	OR	<ol style="list-style-type: none"> 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 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 3. School ID card with a photograph 4. Voter's registration card 5. U.S. Military card or draft record 6. Military dependent's ID card 7. U.S. Coast Guard Merchant Mariner Card 8. Native American tribal document 9. Driver's license issued by a Canadian government authority <p style="text-align: center; font-weight: bold;">For persons under age 18 who are unable to present a document listed above:</p> <ol style="list-style-type: none"> 10. School record or report card 11. Clinic, doctor or hospital record 12. Day-care or nursery school record
	AND	<ol style="list-style-type: none"> 1. U.S. social security card issued by the Social Security Administration (<i>other than a card stating it is not valid for employment</i>) 2. Certification of Birth Abroad issued by the Department of State (<i>Form FS-545 or Form DS-1350</i>) 3. Original or certified copy of a birth certificate issued by a state, county, municipal authority or outlying possession of the United States bearing an official seal 4. Native American tribal document 5. U.S. Citizen ID Card (<i>Form I-197</i>) 6. ID Card for use of Resident Citizen in the United States (<i>Form I-179</i>) 7. Unexpired employment authorization document issued by DHS (<i>other than those listed under List A</i>)

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



The Business Council of New York State, Inc. Insurance Fund

ENROLLMENT FORM

Group No. _____

Employer: _____

Employee Name: _____

Last

First

Middle

Social Security No. ____ / ____ / ____ Date of Birth: ____ / ____ / ____
Month Day Year

Sex: Male Female

Date Hired: ____ / ____ / ____
Month Day Year

Annual Salary: _____

Occupation: _____

Please check applicable box.

- Life/AD&D
 Dependent Life
 LTD
 DBL/STD

BENEFICIARY DESIGNATION

It is important that your beneficiary designation be clear so that there will be no question as to your meaning. It is also important that you name a primary and contingent beneficiary. When naming your beneficiary(ies) please indicate their full name, address, social security number, relationship and, if a minor, the age of that minor. If the beneficiary is not related either by blood or by marriage, insert the words, "Not Related." If you need assistance, contact Human Resources or your own legal counsel. Following are examples of the most common designations:

- Mary J. Doe, Wife (not Mrs. John Doe).
- Mary J. Doe, Wife, if living, otherwise to Joseph W. Doe, Son.
- Mary J. Doe, Wife, if living, otherwise to Jane Doe, Daughter, and Joseph W. Doe, Son, in equal shares or to the survivor.
- Estate of the Insured.

If you name more than one beneficiary with unequal shares, please show the amount of insurance to be paid to each beneficiary in fractional parts, for example "1/3 to Mary Jones, Mother, and 2/3 to Edith Jones, Wife."

	Full Name	Address	SSN	Relationship	D.O.B.
Primary					
Contingent					

The beneficiary for life insurance on the lives of your spouse and children will automatically be you, if surviving, otherwise the estate of the spouse and children, subject to policy provisions. A beneficiary for employees Life insurance may be changed upon written request.

DEPENDENT LIFE INSURANCE

Effective	Names of Eligible Dependents to be covered*	Relationship	D.O.B

* The term "dependent" is limited to the employee's spouse, unmarried children to age 19, and unmarried children from 19 to 25 who are registered full-time students, principally dependent upon the employee for maintenance and support, residing in the United States or Canada.

EMPLOYEE STATEMENT

I understand that on the effective date of my insurance coverage, I must meet each of the following conditions: (a) I must be actively at work and able to perform all duties of my occupation; (b) I must be regularly working on a full-time basis at my employer's business establishment or at some other location to which my employer's business requires me to travel, (c) I must not have lost time from work due to my own sickness or injury on the day preceding the effective date, and (d) I have completed any applicable waiting period.

I certify that I meet each of the above conditions and understand that I will not be covered otherwise. I authorize my employer to make deductions from my earnings, if contributions are required.

Employee's signature Date **Certified** _____
Employer's Representative Date

Please do not write below — for Business Council purposes only

Eff. Date: ____ / ____ / ____ Amount of Insurance: _____ Monthly Salary: _____ DBL/STD: _____
Month Day Year



OSPRA 101 (06/03)

Consent Form For Fingerprinting And Criminal History Records Search of Prospective Employees And Applicants For Certification

Office of School Personnel Review and Accountability

NYS Education Department
987 Education Building Annex
Albany, NY 12234

ph: (518) 473-2998
fax: (518) 473-8812

www.highered.nysed.gov/tcert/osptra
OSPRA@mail.nysed.gov

*For Fiscal Use Only
Leave Blank*

Instructions to Applicant:

- Please **completely** fill out sections 1, 2 and 5 on this form prior to submission.
- If you are seeking clearance for employment, have the prospective employer complete sections 3 and 4.
- Fill out the top portion of the fingerprint cards **completely** in accordance with the sample fingerprint card.
- Get a bank check, certified check, money order or employer check for \$99 (effective 7/1/03) payable to the New York State Education Department. **No personal checks accepted.**
- Take the completed OSPRA 101, the completed fingerprint cards and the \$99 fee to the fingerprint location to get fingerprinted. Get fingerprinted. Sign the fingerprint card.
- Mail the completed OSPRA 101, the completed fingerprint cards and the \$99 fee to OSPRA in the preaddressed stamped envelope.

Type or print all information. Inaccurate, incomplete or illegible information will delay processing.

SECTION 1

Social Security Number:		Name (Last, First, Middle Initial):					
Mailing Address:							
City:	State:	Zip:	Telephone number & area code:				
Date of Birth (00/00/0000):	State or Country of Birth:	Height:	Weight:	Sex:	Race:	Hair:	Eyes:

SECTION 2

Please choose (✓) one of the following (or both, if applicable):

- I am or will be applying for Teacher or Administrator Certification I am applying for Clearance for Employment

SECTION 3

(This section MUST be completed by the prospective employer if you are seeking clearance for employment)

<input type="checkbox"/> School District/ BOCES/Charter School	<i>Charter Schools: Please contact OSPRA if you do not know your BEDS #</i>		<input type="checkbox"/> Contract Service Provider
Prospective Employer Name:	First six digits of school BEDS #:	Federal Tax ID number:	
Rolling V Bus Corp	622002	223052888	
Employer Address:		Title of Position of Prospective Employee:	
5008 State Route 42, South Fallsburg, NY 12779		Bus Monitor	
Fingerprinting Contact Person:	Contact Phone #:	Identify who is paying the \$94.25 (effective 10/30/07) fingerprinting fee:	
Linda Kleingardner	845-434-0511	<input type="checkbox"/> Prospective Employee	<input checked="" type="checkbox"/> School/Employer
Signature of Employer Representative or Fingerprinting Contact Person: _____			

SECTION 4

(This section MUST be completed by the Contract Service Provider "CSP" if the prospective employer is a CSP)

Name of primary district in which the prospective employee will work; this district will receive the clearance for employment, not the CSP (a 102 must be completed for each additional district):	First six digits of BEDS code of Primary District
Ellenville Central School District	622002

SECTION 5

1. I have read "Fingerprinting Information and Instructions" (OSPRA 100) issued by the State Education Department and understand that the Commissioner of Education is required by law and regulation to request a fingerprint-supported criminal history record from the Division of Criminal Justice Services (DCJS) and the Federal Bureau of Investigation (FBI). The Commissioner is authorized to review such information for the purposes of issuing a clearance for employment or the certificate for which I have applied.
2. I have been informed of the procedures and my right to obtain, review, and challenge the accuracy and completeness, where appropriate, of my criminal history information pursuant to regulations and procedures established by DCJS and the FBI.
3. I understand that I have the right to withdraw my application for employment, without prejudice, any time before employment is offered or declined, regardless of whether a prospective employer or I have reviewed my criminal history information.
4. I understand that I may submit to the Commissioner any information that may be relevant to the consideration of my application including, where applicable, information in regard to good conduct and rehabilitation.
5. I have been advised that the criminal history record forwarded to the Commissioner by DCJS and the FBI shall be confidential pursuant to the applicable federal and state laws, rules and regulations and shall not be published or in any way disclosed to persons other than the Commissioner unless otherwise authorized by law. I understand, however, that certain information regarding subsequent arrest notifications received by the Commissioner shall be forwarded to my employing school district, charter school, or board of cooperative educational services.
6. I understand that the fee for DCJS and the FBI to conduct a fingerprint supported criminal history background check is established at \$99.00. I can apply for a "fee waiver" from my prospective employer if such fee would cause an unreasonable financial hardship. In order for the Commissioner to process my application, my prospective employer or I must enclose the \$99.00 fee by certified check, money order, or school check payable to the New York State Education Department.
7. I have been informed of my right to request that my fingerprints be destroyed when I am no longer employed at a school district, charter school or board of cooperative educational services. I also understand that in the event my employment is terminated and I have not become employed in the same or another school district, charter school or board of cooperative educational services within twelve months of such termination, the Commissioner shall notify DCJS of such termination and the record of my fingerprints for the purpose of employment shall be destroyed.
8. **I understand that no clearance for employment will be issued unless my prospective employer has completed Section 3.**
9. **If I am an applicant for certification, I understand that receipt of my certificate is the only documentation that I will receive indicating that my fingerprints have been cleared, unless I am also seeking clearance for employment and have had my prospective employer complete Section 3.**

I have read this consent form and hereby authorize and consent for the Commissioner of Education to use my fingerprints to secure my criminal history record from DCJS and the FBI. I declare and affirm that the fingerprints submitted are my own, and that the information I entered on the fingerprint cards and this consent form is true, complete and accurate. I do authorize NYSED to obtain and review criminal records, including arrests, and dispositions as part of their background investigation of my suitability for employment.

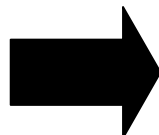
Applicant Signature: _____ Date: _____

SECTION 6

Name and Address of Agency Where Fingerprint Services Performed:	
------------------------------------------------------------------	--

SECTION 7

Mail completed packet to:
(consent form, fingerprint cards and a certified check, money order, or school check for \$99 payable to the New York State Education Department)



Fingerprint Processing
NYS Education Department
PO Box 7352
Albany, NY 12214-0349

Application for Employment

Date of Application _____ Position applied for _____

PERSONAL INFORMATION

Last Name	First Name	Middle Name	Jr/Sr.
Present Street Address	City	State	Zip Code
Home Phone	Social Security Number		
Have you ever used another name? <input type="checkbox"/> NO <input type="checkbox"/> YES if yes, list _____			
Drivers License Class _____		Drivers License Number _____	
Date of Birth _____			
Are you over the age of 18 years? <input type="checkbox"/> NO <input type="checkbox"/> YES			

EDUCATION

	Name and Address of School	Graduated?	Years attended	Degree earned
High School				
College				
Graduate				

GENERAL INFORMATION

Date available to start:	Full-time or Part-time?																								
Days and Hours Available to work	<table style="width: 100%; text-align: center;"> <tr> <td>Day</td> <td>Sun</td> <td>Mon</td> <td>Tues</td> <td>Wed</td> <td>Thur</td> <td>Fri</td> <td>Sat</td> </tr> <tr> <td>From</td> <td colspan="7">_____</td> </tr> <tr> <td>To</td> <td colspan="7">_____</td> </tr> </table>	Day	Sun	Mon	Tues	Wed	Thur	Fri	Sat	From	_____							To	_____						
Day	Sun	Mon	Tues	Wed	Thur	Fri	Sat																		
From	_____																								
To	_____																								
Do you have any medical history that would limit your ability to perform the job applied for without endangering the health or safety of yourself and others? <input type="checkbox"/> NO <input type="checkbox"/> YES																									
Have you ever been convicted of any crime? <input type="checkbox"/> NO <input type="checkbox"/> YES (note: a conviction is not an automatic bar to employment.) If yes, please explain and state the charge, the court, the date, and the disposition of the case: _____																									

Rolling V Bus Corp./Gershowitz Transportation Inc.

Are you currently out on bail or released on your own recognizance pending trial? NO YES

If yes, please explain _____

EMPLOYMENT/WORK EXPERIENCE (list last 7 years)

Company No. 1 (Present or most recent employer)		Phone Number	
Address	City	State	Zip
Employed from (month and Year)	Rate of Pay	Position Held	
From	To	Starting	Ending
Describe all of your significant job duties:			
Reason for Leaving:			
May we contact this employer? <input type="checkbox"/> YES <input type="checkbox"/> NO			
Company No. 2		Phone Number	
Address	City	State	Zip
Employed from (month and Year)	Rate of Pay	Position Held	
From	To	Starting	Ending
Describe all of your significant job duties:			
Reason for Leaving:			
May we contact this employer? <input type="checkbox"/> YES <input type="checkbox"/> NO			
Company No. 3		Phone Number	
Address	City	State	Zip
Employed from (month and Year)	Rate of Pay	Position Held	
From	To	Starting	Ending
Describe all of your significant job duties:			
Reason for Leaving:			
May we contact this employer? <input type="checkbox"/> YES <input type="checkbox"/> NO			
Company No. 4		Phone Number	
Address	City	State	Zip

Rolling V Bus Corp./Gershowitz Transportation Inc.

Employed from (month and Year)		Rate of Pay		Position Held
From	To	Starting	Ending	
Describe all of your significant job duties:				
Reason for Leaving:				
May we contact this employer? <input type="checkbox"/> YES <input type="checkbox"/> NO				

PERSONAL REFERENCES

List 3 references who are not friends or relatives				
Name	Address	Phone Number	How long have you known? (yrs)	Where did you meet?

I hereby certify that the information contained in this application is true and correct to the best of my knowledge and agree to have any of the statements checked, unless I have indicated to the contrary. Further, I release parties and persons from any and all liability for any damages that result from furnishing such information that they may have. I understand that any misrepresentations, falsification, or material omission of information on this application, regardless of the time elapsed after discovery, may result in my failure to receive an offer or, if I am hired, my immediate dismissal from employment.

I authorize the Company to inquire into my educational, professional and past employment history references as needed to research my qualifications for this position. I hereby give my consent to any former employer to provide employment-related information about me to the Company and will hold the Company, my former employers and professional references harmless from any claim made on the basis that such information about me was provided or that any employment decision was made on the basis of such information.

In consideration of my employment, I agree to conform to the rules and standards of this company. I further agree that my employment and compensation can be terminated at will, with or without cause, and with or without notice, at any time, either at my option or at the option of this company. I understand that no employee or representative of this company, other than its president, has the authority to enter into any agreement for employment for any specified period of time, or to make any agreement contrary to the foregoing. Further, the president may not alter the at-will nature of the employment relationship unless the president and I both sign a written agreement that clearly and expressly specifies the intent to do so. I agree that this constitutes an integrated agreement with respect to the at-will nature of my employment relationship that is final and fully binding, and that there are no oral or collateral agreements regarding this issue.

I also understand that all offers of employment are conditioned on the provisions of satisfactory proof of an applicant's identity and legal authority to work in the United States under Immigration Reform and Control Act (IRCA) of 1986. The document(s) provided will be used for completion of Form I-9.

I hereby acknowledge that I have read, understand and agree to the above statements.

Signature of Applicant

Date



Criminal History Record Check Consent Form

NYS Office For People With Developmental Disabilities
 Criminal Background Check Unit
 PO Box 3005
 Schenectady, NY 12303-0005

The purpose of this form is to verify that the applicant understands and consents to the criminal history record check process.

Instructions:

1. Applicant must complete all fields on this form. Please print legibly.
2. Submit to Agency/Registered Provider/DDSO to retain.

Last Name	First Name	MI
Date of Birth	Social Security Number	
Street Address or PO Box (applicant's)		
City	State	Zip

PLEASE READ EACH STATEMENT BEFORE SIGNING

By signing this consent form I am acknowledging that I understand and consent to the following statements:

1. I understand that _____(agency/DDSO/registered provider) is required/authorized by New York State Mental Hygiene Law 31.35 and Executive Law 845-b to request a check of my criminal history record.
2. Criminal history record checks are requested from the New York State Division of Criminal Justice Services (DCJS) and the Federal Bureau of Investigation (FBI). The OPWDD CBC Unit is authorized to receive the results of the criminal history record check and to develop a summary of the results. The summary will indicate:
 - whether I have a criminal history record, as maintained by DCJS and/or the FBI;
 - specific crimes for which I was convicted (felony or misdemeanor) or criminal charges which do not reflect a disposition;
 - the date of the criminal charge or conviction; and
 - the jurisdiction in which the charge or conviction took place.
3. I hereby consent to the OPWDD CBC Unit providing the summary of my criminal history record information, which includes information from both DCJS and the FBI, to the agency/DDSO listed above.
4. If I am an applicant for employment, I may withdraw my request without prejudice at any time before my application is accepted or declined regardless of whether my criminal history record information has been reviewed.
5. I have been informed that I have the right to obtain, review and seek correction of my criminal history record information under regulations and procedures established by the New York State Division of Criminal Justice Services and the Federal Bureau of Investigation.
6. I have been informed of the reason for the request for my criminal history record information and consent to having my fingerprints taken for the purpose of a criminal history record check by the New York State Division of Criminal Justice Services (DCJS) and the Federal Bureau of Investigation (FBI).

Signature _____ Date _____

Signature _____ Date _____

(of parent or legal guardian if applicant is under 18 years)



Request for Criminal History Record Check for Registered Providers

NYS Office For People For Developmental Disabilities
 Criminal Background Check Unit
 PO Box 3005
 Schenectady, NY 12303-0005

Form 106A is to be used **ONLY** by registered providers (supplying transportation or staff) that contract with OPWDD and voluntary agencies. The purpose of this form is to formally request a criminal history record check.

Instructions:

1. Complete all fields on the form. Please print legibly.
2. Authorized party must sign and date the form.
3. If Livescan prints are being taken, give completed form to applicant to bring to Livescan location.
4. If "ink and roll" is being used, mail the completed form along with fingerprint cards and Form OMR 107 to the CBC Unit at above address.

Registered Provider Name	Registered Provider ID

Applicant's Last Name	First Name	MI

Date of Birth	Social Security Number

Street Address or PO Box (applicant's)

City	State	Zip

<u>Program Type (check one)</u> <input type="checkbox"/> Transportation (0670) <input type="checkbox"/> Subcontract Service (0880)	<u>Position Type (check one)</u> <input type="checkbox"/> Support <input type="checkbox"/> Clinical <input type="checkbox"/> Direct Care
------------------------------------------------------------------------------------------------------------------------------------------	---------------------------------------------------------------------------------------------------------------------------------------------------

Status Type – N- Employees of vendors and contractors

The applicant will have regular and substantial unsupervised or unrestricted physical contact with individuals receiving services and is a subject party concerning whom a criminal history record check is required by law. The results of the criminal history record check will be used solely for purposes authorized by law. Informed consent has been given by the applicant and is on file.

Name of Authorized Party _____
OPWDD Secure Message ID _____
Signature of Authorized Party _____ Date _____

Before the Road Test

1. Partners in safety

800 North street
845-341-0515

Call and schedule an appointment for DOT Physical and
Drug screening

Directions:

Rt 17 east to exit 119 (Pine Bush)

Make a right at end of ramp

Make a left onto North Street (Rt 17M)

Partners in Safety is on right side

ALL REFERENCE LETTERS MUST INCLUDE:

- 1) NAME AND ADDRESS OF DRIVER/ATTENDANT.
- 2) NAME AND ADDRESS OF REFERENCE.
- 3) DATE.
- 4) STATEMENTS ON HOW INDIVIDUALS BECAME ACQUAINTED.
- 5) STATEMENTS THAT INDIVIDUALS ARE NOT RELATED BY BLOOD OR MARRIAGE.

REFERENCE LETTER

(DATE)

I _____

have known _____

who resides at _____
for the last _____ years, and during this time have found him/her to be of good moral character and a thoroughly reliable person. We became acquainted through (state how - friends, employment, etc.) and are not related either by blood or marriage.

ADDITIONAL COMMENTS:

Sincerely,

(NAME)

(ADDRESS)

(PHONE NUMBER)

ALL REFERENCE LETTERS MUST INCLUDE:

- 1) NAME AND ADDRESS OF DRIVER/ATTENDANT.
- 2) NAME AND ADDRESS OF REFERENCE.
- 3) DATE.
- 4) STATEMENTS ON HOW INDIVIDUALS BECAME ACQUAINTED.
- 5) STATEMENTS THAT INDIVIDUALS ARE NOT RELATED BY BLOOD OR MARRIAGE.

REFERENCE LETTER

(DATE)

I _____

have known _____

who resides at _____
for the last _____ years, and during this time have found him/her to be of good moral character and a thoroughly reliable person. We became acquainted through (state how - friends, employment, etc.) and are not related either by blood or marriage.

ADDITIONAL COMMENTS:

Sincerely,

(NAME)

(ADDRESS)

(PHONE NUMBER)

ALL REFERENCE LETTERS MUST INCLUDE:

- 1) NAME AND ADDRESS OF DRIVER/ATTENDANT.
- 2) NAME AND ADDRESS OF REFERENCE.
- 3) DATE.
- 4) STATEMENTS ON HOW INDIVIDUALS BECAME ACQUAINTED.
- 5) STATEMENTS THAT INDIVIDUALS ARE NOT RELATED BY BLOOD OR MARRIAGE.

REFERENCE LETTER

(DATE)

I _____
have known _____
who resides at _____
for the last _____ years, and during this time have found him/her to be of good
moral character and a thoroughly reliable person. We became acquainted through
(state how - friends, employment, etc.) and are not related either by blood or
marriage.

ADDITIONAL COMMENTS:

Sincerely,

(NAME)

(ADDRESS)

(PHONE NUMBER)

Monitor applicant hiring process and file checklist

FORM

1. Phone interview or personal interview
 - Use phone interview- checklist CDL 1
 - Use hiring criteria CDL 2
 - Evaluation form CDL 3
 - Employee Application needs to be filled out
 - Have them go for a physical and drug test
 - Have them fill out the form to be fingerprinted OSPRA 101
 - i. For most districts have them get printed at PD M2
 - ii. For Ellenville school follow procedures for live scan M2
 - iii. For ARC program – they should fill out ORMDD form OPWDD 105/106A
 - Sign them up for a Pre-service and PPT test
 - They should be given a packet of forms needed for hire
 - Their references should be called CDL 13
2. Once at the new terminal the following should happen
 - a terminal managers orientation
 - HR department should receive all payroll forms TMO 1
 - a veteran driver ride along containing the following information
 1. all information and handouts from VMRA script VDP 1

Procedure for Monitor Prints

Effective 12/1/10

Monitor should get print cards done at local PD as usual

They should fill out the OSPRA 101 form with their personal information

Using this information management should set up an account for this person at:

<http://www.highered.nysed.gov/tcert/ospra> and click the **TEACH** button

Recording the following information:

- Username (set up as 2 first letters of first name, and full last name – if possible)
- Security question – choose first 5 digits of favorite rewards card (make up a 5 digit code and record answer)
- Make up any password and record

Put email address in as mine, so I get any feedback on compliance issues

Once you have completed setting up an account, you will come to a page to log in

Log in using the username and password you made

You will come to a page where you will see under Fingerprinting

A fingerprint application

You need to fill out all the monitors personal information here and submit

Choose to have cards mailed to them – they will be spares, have em bring us to them

Then mail a check and prints to address on printed confirmation form

- remember monitors are supposed to be cleared before working, so this needs to be done soon after we hire them.

For Ellenville monitors ONLY!!!

You need to fill out all the monitors personal information here and submit

ONLINE :

They should fill out the OSPRA 101 form with their personal information

Using this information from form 101, management should set up an account for this person at:

<http://www.highered.nysed.gov/tcert/ospra> and click the **TEACH** button

Recording the following information:

- Username (set up as 2 first letters of first name, and full last name – if possible)
- Security question – choose first 5 digits of favorite rewards card (make up a 5 digit code and record answer)
- Make up any password and record

Put email address in as mine, so I get any feedback on compliance issues

Once you have completed setting up an account, you will come to a page to log in

Log in using the username and password you made

You will come to a page where you will see under Fingerprinting

A fingerprint application

You need to fill out all the monitors personal information here and submit

Then you will need to go to payment screen

Payment should be submitted with a credit card

Once payment is accepted, print out the payment coupon

The applicant should set up an appointment with Denise Avery at the Ellenville School

(phone # 647-0120), to get LIVE SCAN prints done

They must bring this payment coupon with them to the appointment

Date: _____

Applicant Name: _____

I hereby authorize Rolling V Bus Corp to seek information regarding my driving record and drug/alcohol history from the previous employers listed below.

Signed: _____



**ROLLING V
BUS CORPORATION**

MAIN OFFICE

ROLLING V BUS CORPORATION
P.O. Box 110
5008 ROUTE 42
SOUTH FALLSBURG, NY 12779
PHONE: 845-434-0511
800-999-6593
FAX: 845-434-0259
EMAIL: INFO@ROLLINGV.COM

LIBERTY OFFICE

GERSHOWITZ TRANSPORTATION
33 ADEN ROAD
LIBERTY, NY 12754
PHONE: 845-292-4485
800-999-6593
FAX: 845-292-0487

ELLENVILLE OFFICE

9 DEPOT STREET
ELLENVILLE, NY 12428
PHONE: 845-647-9187
FAX: 845-647-7495

LIVINGSTON MANOR OFFICE

68 SCHOOL STREET
LIVINGSTON MANOR, NY 12758
PHONE: 845-439-3713
FAX: 845-439-3823

NEVERSINK OFFICE

GERSHOWITZ TRANSPORTATION
7444 STATE ROUTE 55
NEVERSINK, NY 12765
PHONE: 845-985-2609
FAX: 845-985-0570

ROSCOE OFFICE

1 ATHLETIC FIELD RD
ROSCOE, NY 12776
PHONE: 607-498-5888
FAX: 607-498-4980

Previous Employer #1: _____ Phone#: _____

Address: _____

Date Contacted: _____

Notes: _____

Previous Employer #2: _____ Phone#: _____

Address: _____

Date Contacted: _____

Notes: _____

Previous Employer #3: _____ Phone#: _____

Address: _____

Date Contacted: _____

Notes: _____

ELLENVILLE CENTRAL SCHOOL DISTRICT

New Driver/Attendant/or Monitor Requirements and Qualifications for Employment in School District

Name of Driver/Aide/or Monitor _____
Print First Name Print Middle Initial Print Last Name

Operator _____
Date Scheduled for Employment

Position for Which Approval Is Requested _____

Requirements to Have Been Completed Satisfactorily Before Transporting Students:

_____ Application - Form DS-870 for drivers _____
Date of Application

_____ At Least 21 Years of Age (8 NYCRR 156.3 (h)) for drivers _____
At Least 19 Years of Age for attendants or monitors (8 NYCRR 156.3 c2) Date of Birth

_____ Appropriate License for drivers- CDL Class B or C with each having a _____
P (Passenger) and an S (School Bus) Endorsement License Class/Endorsement(s)

_____ Review of Abstract of Driving Record for drivers (15 NYCRR 6.8 a-b) - _____
Form DS-872 Date of Driving Record Review

_____ Background Check/3 References for drivers (8 NYCRR 156.3 e) _____
Date(s)

_____ Physical Examination for drivers no more than four weeks before onset _____
of employment (8 NYCRR 156.3 b3; Ed Law §3624 - Form DS-874 Date of Physical Examination

_____ Physical Examination of attendants and monitors no more than two _____
weeks prior to the beginning of school (8 NYCRR 156.3 c3i-ii) Date of Physical Examination

Note: Physical examinations for Attendants and Monitors are optional based upon the decision of the Chief School Administrator

_____ Physical Performance Test (8 NYCRR 156.3 c2 for drivers; _____

8 NYCRR 156.3 c3iii for attendants and monitors – Test Form PT-900 _____
Date of Test

_____ Fingerprinting (15 NYCRR 6.4a and 8 NYCRR 87.4; 8 NYCRR 87.2 h1 _____
for attendants and monitors) Date of Receipt of Submission

_____ Drug and Alcohol Test (Omnibus Transportation Employee _____
Testing Act of 1991 (49 C.F.R. 382)) Date of Drug/Alcohol Test

_____ SED 3-Hour Course Completed (8 NYCRR 156.3 d2 and d3 for drivers; _____
8 NYCRR 156.3 c5 for attendants and monitors) Date of Course

_____ CPR Training for attendants and monitors if this skill is required as part of _____
The IEP prepared for students (8 NYCRR 156.3 c4) Date of Course

Signature and Title of Operator’s Representative

Signature Title Date

Approved for Employment:

Superintendent of Schools in Compliance with Ed Law §3624 Date

SCRIPT

For New Employees hired after 6/4/12

Drivers and Monitors that are assigned to a regular route (including a standby route position), will get paid a MINIMUM 3 hour guarantee, at their hourly rate, for their primary route work. Any work beyond this route work will be paid at the following starting hourly rates:

\$15.00 for Route Big Bus Moves

\$12.50 for Route Van Moves

\$12.00 for any Charter Moves

\$10.00 for any required training time

\$8.00 for any monitor route or charter work

\$8.00 for other non-revenue work (bus moves, ect...)

\$0.80 per live mile for medical car work

Any actual work beyond 40 hours per week will be paid at time and $\frac{1}{2}$ of the average hourly rate for the week. Time spent on "interstate charters" (trips that go over state lines) is excluded from the overtime calculation.

Employees can usually expect increases in hourly route and charter rates from time to time, depending on the economic position of the company.

Employee should sign off that they have been given this information, and retained in their personnel file.

Employee Signature: _____ Date: _____

Manager signature: _____ Date: _____

Uniform and ID Implementation

Message: To raise the profile and level of professionalism displayed by our workforce, we are implementing a Uniform and ID policy, effective 9/1/12.

All employees will be required to wear an approved Shirt issued by the Company. All employees will receive 3 short and 3 long sleeve shirts, and a photo ID card.

Employees are required to:

- Wear clean issued garments at all times when on the job
- Keep items clean
- Turn in issued garments upon termination or voluntary departure from company.
- Wear company issued photo ID prominently.

Employees may not:

- Wear company issued garments off the job, where reasonably possible.
- Allow others to wear company issued garments.

Employees may:

- Turn in old, worn or excessively stained items from this new distribution for replacements – within reason.
- Wear previously issued Rolling V or Gershowitz attire as long as it is in good condition.

OTHER:

Employees reporting to work without company shirt will be issued one by TM for that day. The garment must be returned after washing by employee. Employees failing to return garment will be charged appropriate fee. These incidences will be monitored by TM and consistent failure to comply with policy will result in disciplinary action.

Please fill out this form to receive a set of uniform shirts

Name: _____

Terminal Assignment: _____

Shirt Size: _____

Instructions for Completing the Statewide Central Register Database Check Form

LDSS-3370

- **ALL** information on the form must be easily read so that data entry and results are accurate. Each SCR Database Check submitted should be reviewed for completeness and legibility by the program/agency liaison. If the form is incomplete or illegible, it will be returned to the agency for corrections.

THE PROPER WAY TO COMPLETE THE FORM:

AGENCY INFORMATION

TOP LINE OF FORM:

- The three-digit agency code must be placed in the top left-hand box, followed by the Resource I.D. (RID) in the next box to the right. (Contact the licensing agency if there are any questions about these.)
- Daycare providers must place their Child Care Facility System (CCFS) Number in the box next to Resource ID (RID), in lieu of Resource ID number. (Contact your licensing agency/Regional Office if you have any questions).
- Clearance Category letter code (see back of Form LDSS-3370) must be placed in the middle box.
- Phone number (with area code) enables the SCR to contact the agency liaison if this becomes necessary.
- The Request ID Box is for SCR use only.

AGENCY ADDRESS AREA:

- Agency Name: Please use full name, no abbreviations
- Agency Liaison is the contact person at the inquiring agency. (*The SCR response will be addressed to the liaison.) **The liaison cannot be the applicant or a relative of the applicant.**
- Agency Address: Must include street, city

APPLICANT INFORMATION

APPLICANT/HOUSEHOLD MEMBER AREA:

- **ALL HOUSEHOLD MEMBERS, ADULTS AND CHILDREN, WHETHER RELATED TO THE APPLICANT OR NOT, ARE TO BE LISTED IN THIS AREA OF THE FORM.**

- Remember to **write clearly** or **type** all information in order to assist in obtaining an accurate response. Record all names with the last name first, then the first name, and middle name.
- First line: Applicant's name. If there is more than one applicant place the additional name(s) on the lines below the maiden name line.
- Second line: Any maiden names, previous married names, or aliases by which the applicant is or has been known. Use additional lines if there is more than one maiden/married/alias name to be listed.
- Remaining lines: Names of all other household members. (Attach an additional page if needed.)
- If there are no other household members, indicate NONE on the line below "Maiden/Alias".**
- First column: indicate the relationship to the applicant of each person listed. (Spouse, son, daughter, mother, father, friend, etc.)
- Sex M/F column: fill in either M (Male) or F (Female) for every person listed.
- Date of Birth column: fill in complete date of birth (mm/dd/yy) for everyone listed on the form.

ADDRESS AREA:

The information required varies depending on the particular category:

- For Adoption, Foster Care and Family and Group Family Day Care (see back of form for categories), provide addresses for the applicant and any household member who is 18 and older. We need this information for the last 28 years. Attach supplemental pages if necessary, but **do not use** another LDSS-3370 form to list this additional information. Be sure to associate address histories with particular individuals (i.e., indicate which addresses are for which household members).
- For all other categories, only the applicant's address history is required – for the last 28 years.
- Complete addresses are required. Include street name and city/town/village. Also include street number and apartment number. **Post Office Box numbers are not acceptable.** If the applicant has lived abroad, indicate country and dates of residence. If the applicant has spent time in the military, list base names and locations along with dates. **Be sure that there are no periods of time unaccounted for.**
- The top line is for the current address. The previous address should be listed on the second line downward, and so on to the back of the form for the last 28 years. Staple the attached supplemental page to the form if more space is needed, but do not use another copy of the LDSS-3370 for this additional information.

SIGNATURE AREA:

Signatures required depend upon the particular category:

- For Adoption, Foster Care and Family and Group Family Day Care (see back of form for category), signatures are needed from the applicant and any household member who is 18 or older.
- For all other categories, only the applicant's signature is required.
- All signatures must correspond to the names recorded in the Applicant/Household Member Area-for example; Mary Smith should not sign Mary Ann Smith. Victoria Smith should not sign Vicki.
- Applicants must sign in the boxes marked "Applicant's Signature", household members over 18 who are not applicants must sign in the boxes at the extreme bottom of the page marked "Signature".
- All signatures must be dated (mm/dd/yy). The SCR will not accept a form with a signature date more than 6 months old.

If you have questions regarding proper completion of this form, **please call the SCR at 518-474-5297.**

MAIL YOUR COMPLETED LDSS-3370 FORM TO:

**STATEWIDE CENTRAL REGISTER
P.O. BOX 4480
ALBANY, N.Y. 12204-0480**

TO ORDER A SUPPLY OF LDSS-3370 FORMS:

Please access the (OCFS-4627) **Request for Forms and Publications**, from the Intranet: <http://ocfs.state.nyenet/admin/forms/SCR/>
Internet: <http://www.ocfs.state.ny.us/main/forms/cps/> and mail the completed OCFS-4627 Request for Forms and Publications, to:
THE OFFICE OF CHILDREN AND FAMILY SERVICES, RESOURCE DISTRIBUTION CENTER, 11 FOURTH AVE, RENSSELAER, NY 12144.

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES
STATEWIDE CENTRAL REGISTER DATABASE CHECK
Agency Use Only

SCR USE ONLY
REQUEST I.D.:

ALL INFORMATION MUST BE COMPLETE. PLEASE PRINT OR TYPE

AGENCY CODE: E51	RESOURCE I.D. (RID) 20099864	CHILD CARE FACILITY SYSTEM (CCFS) NUMBER:	CATEGORY USE ALPHA CODE:	PHONE NUMBER (Area Code): (845) 434 - 0511
PRINT BELOW THE ADDRESS ASSOCIATED WITH YOUR RID/CCFS NUMBER: AGENCY NAME: ROLLING V BUS CORP AGENCY LIAISON: Linda Kleingardner STREET ADDRESS: PO Box 110, 5008 Route 42 CITY: So. Fallsburg STATE: NY ZIP CODE: 12779			The particular classifications of persons who must or may be screened are set forth on the reverse side of this document. The alpha codes to complete the "Category" box above are also on the reverse side of this form FOR ALL CATEGORIES: Complete the following for yourself, your spouse, your children and any other person(s) in your home at the present time. MAKE SURE YOU COMPLETE ALL MAIDEN NAME/ALIAS SECTIONS THAT APPLY. IF NONE, STATE "NONE" List RELATIONSHIP in the fields below (see reverse side for instructions) Attach additional page if necessary.	

The purpose of collecting the demographic data on *other persons in your household* who are not screened pursuant to Section 424-a of the Social Services Law is to enable the N.Y.S. Office of Children and Family Services to identify with the greatest degree of certainty whether the person(s) being screened is the subject of an indicated child abuse or maltreatment report. The utilization of this information in a discriminatory manner is contrary to the Human Rights Law.

APPLICANT/HOUSEHOLD MEMBER AREA

***PLEASE TYPE OR PRINT CLEARLY**

RELATIONSHIP TO APPLICANT	LAST NAME	FIRST NAME	SEX M/F	DATE OF BIRTH
APPLICANT				
MAIDEN/ALIAS				

Please provide your current address and any other addresses at which you have resided for the last 28 years, including street, city and state. For Adoption, Foster Care, Family and Group Family Day Care, also include the same address history for household members 18 of age and older.

CURRENT STREET ADDRESS	APT #	CITY	STATE	ZIP	FROM	TO
PREVIOUS STREET ADDRESS	APT #	CITY	STATE	ZIP	FROM	TO
PREVIOUS STREET ADDRESS	APT #	CITY	STATE	ZIP	FROM	TO
PREVIOUS STREET ADDRESS	APT #	CITY	STATE	ZIP	FROM	TO
PREVIOUS STREET ADDRESS	APT #	CITY	STATE	ZIP	FROM	TO

I affirm that all the information provided on this form is true to the best of my knowledge. I understand that if I knowingly give false statements, such action could be grounds for denial or dismissal from employment or denial or revocation of a license, certificate, permit, registration or approval.

APPLICANT'S SIGNATURE	DATE	APPLICANT'S SIGNATURE	DATE
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EIGHTEEN YEARS OLD OR OVER:

I understand that as a person eighteen years of age or over in a home of an applicant to become an Adoptive or a Foster Parent or a Family or Group Family Day Care provider, the information I have provided will be used to inquire of the Statewide Central Register to determine if I am the subject of an indicated report of child abuse or maltreatment.

SIGNATURE	DATE	SIGNATURE	DATE
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AGENCY LIAISON INSTRUCTIONS

Please verify that each form is completed. Incomplete forms will be returned to the sender. For ADOPTION, FOSTER CARE, and FAMILY and GROUP FAMILY DAY CARE, if both spouses are applicants, both are to sign. Persons eighteen years old and over residing in the home of applicants for ADOPTION, FOSTER CARE and FAMILY AND GROUP FAMILY DAY CARE also must sign the form.

AGENCY CODE

Record your 3-digit agency code. **NOTE:** Day Care, Family and Group Family Day Care and Camps must provide the agency code of the agency or office which issues your license or certificate. Verify your Alpha or Alpha/Numeric 3 digit code with your licensing agency.

DAYCARE PROVIDERS

Must place their Child Care Facility System (CCFS) Number in the box next to Resource ID (RID), in lieu of Resource ID (RID) number. (Contact your licensing agency/Regional Office if you have any questions).

RESOURCE I.D. (RID)

Record your RESOURCE I.D. (RID) in this field. OCFS, OMH, OMRDD, DOH, OASAS and SED licensed agencies and programs, and Local Departments of Social Services, have RID'S as of 9/01. Verify your RID with your licensing agency. If you need assistance, email: ocfs.sm.conn_app@ocfs.state.ny.us

CLEARANCE CATEGORIES

Record the appropriate category.

- F - Prospective/new employee other than day care employees. (fee required - see below)*
- D - Prospective employee (Local DSS district - bill against reimbursement)**
- Y - Prospective Day Care employee (fee required - see below)*
- S - Provider of goods/services
- Y - Applying to be a group family day care assistant. (fee required - see below)*
- Q - Applying to be group family day care provider. (fee required - see below)*
- Z - Prospective volunteer/consultant.
- X - Applying to be adoptive parents pursuant to an application pending before the inquiring agency.
- W - Applying to be foster parents or family care home providers.
- R - Applying to be kinship foster parents.
- P - Applying to be family day care provider. (fee required - see below)*
- N - Applying for a license to operate a day care center. (To be submitted by authorized licensing agency only.) (fee required - see below)*
- M - Director of a summer camp, overnight camp, day camp or traveling day camp.
- E - Current employee.

AGENCY LIAISON

Record the name of the person to whom the response should be sent (**cannot be the same as applicant or related to the applicant**).

APPLICANT/HOUSEHOLD MEMBER AREA INSTRUCTIONS- This information is to be provided by the applicant/employee/provider. See front of form.

APPLICANT (S) (at least one person must be so designated)-USE FIRST LINE

MAIDEN NAME/ALTERNATIVE/AKA: must be completed for every applicant. Record **ALL** previous names used. Start with second line. Use as many lines as needed (One last name per line)

OTHER HOUSEHOLD MEMBERS: describe relationship to applicant, e.g., son, daughter, father, mother, friend, etc. on remaining lines (ATTACH ADDITIONAL PAGE IF NECESSARY)

IF NO OTHER HOUSEHOLD MEMBERS, record NONE on line below MAIDEN/ALIAS.

*Social Service Law 424-a requires the collection of a \$25.00 fee for certain categories. A certified check, postal or bank money order, teller's check, cashier's check or agency check made payable to "New York State Office of Children and Family Services" in the amount of twenty-five dollars, is to accompany the form. The check also is to include the applicant's name and the agency code.

N.B.: **a separate check must accompany each form.**

**Social Service Law 424-a, allows local DSS to bill against their reimbursement the charge collected for screening prospective employees.

If you have questions regarding proper completion of this form, please call the SCR at 518-474-5297.

MAIL YOUR COMPLETED LDSS-3370 FORM TO:

**STATEWIDE CENTRAL REGISTER
P.O. BOX 4480, Attention: Service Center Unit
ALBANY, N.Y. 12204-0480**

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THE OFFICE OF CHILDREN AND FAMILY SERVICES, RESOURCE DISTRIBUTION CENTER, 11 FOURTH AVE, RENSSELAER, NY 12144. If you have difficulty accessing a form on either site, you can call the automated forms hotline at 518-473-0971.

