Instructions for Completing Forms

Employee Payroll Information	Complete all sections
Emergency Contact Information	Complete all sections
Form W-4 Federal Tax Withholding	Complete sections A-H & & 1-7. Sign & Date
Form G-4 State Tax Withholding	Complete sections 1-8. Sign & Date.
Form I-9 Employment Eligibility Verification*	Complete & sign "page 7 of 9." **Bring required documents.**
Forms MS 10-52 and 10-60 Medical & Phys. Examination Program	Complete all pages. Sign & Date.
Beneficiary Designation for Outstanding Wages/Other Monies	Complete applicable sections. Sign & Date.
Additional Employment Request	If you have an additional job, complete all sections OR if not applicable, mark N/A in all sections. Sign & Date.
Authorization for Release of Information	Complete, sign & date.
Motor Vehicle Use Program / Driver Acknowledgement	Complete sections. Sign & Date.
View Point Health (VPH) Transportation Safety / Standards of Employment	Print & sign name & date.
Policy and Procedure Acknowledgements	Initial all pages, sign & complete last page
Holidays	**Information to Keep**

*In compliance with the Georgia Security and Immigration Compliance Act of 2006, View Point Health verifies employment eligibility for new hires through the federal E-Verify program.

View Point Health
Employee Payroll Information

<table>
<tr><td colspan="3">*<u>Name must be the same as it appears on the Social Security card</u>*
Legal Name (Last Name,First Name Middle Initial, Jr./Sr.)</td><td>Social Security Number:</td></tr>
<tr><td colspan="3">Mailing Address</td><td>Apt/Room/Suite</td></tr>
<tr><td colspan="2">City, State</td><td>Zip Code</td><td>County of Residence</td></tr>
<tr><td colspan="4">Other Address (if different from mailing address)</td></tr>
<tr><td>Home Phone #</td><td>Cell Phone #</td><td>Sex: ___Male
___Female</td><td>Date of Birth (month/day/year)</td></tr>
<tr><td><u>Ethnic group</u>:
◯ None ◯ Amer. Indian
◯ Asian ◯ Black
◯ Hispanic ◯ Multi-race
◯ White</td><td><u>Military Status (check all that apply)</u>:
◯ Non-Veteran
◯ Active or Inactive Service Member
◯ Special Disabled Veteran
◯ Vietnam Era Veteran
◯ Other Veteran</td><td><u>U.S. Citizen</u>
___Yes ___ No

<u>Marital Status:</u></td><td>Signature of Employee

Date Signed</td></tr>
</table>

HR Office Use:

PeopleSoft ID#		Federal Tax Code	State Tax Code

Emergency Contact Information

(please print)

VIEW POINT Health
A Total Care Perspective

Employee's Name: _____
First Name Last Name Middle Name (Jr., III, etc.)

Address: _____
Street Number & Name, Post Office Box, Apt # (if applicable)

City: _____ State: _____ Zip Code: _____

County of Residence: _____ Home Phone#: _____

Cell Phone#: _____

Name of Emergency Contact: _____

Relationship: _____ Emergency Contact Phone#: _____

Other Emergency Contact Information if 1st Contact is Unavailable:

Additional Emergency Contact's Phone #: _____

Name: _____ Relationship: _____

Employee Signature: _____ Date: _____

(Please advise your supervisor & HR if this information changes)

Revised March 2018

Form W-4 (2019)

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

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. You may claim exemption from withholding for 2019 if **both** of the following apply.

- For 2018 you had a right to a refund of **all** federal income tax withheld because you had **no** tax liability, **and**
- For 2019 you expect a refund of **all** federal income tax withheld because you expect to have **no** tax liability.

If you're exempt, complete **only** lines 1, 2, 3, 4, and 7 and sign the form to validate it. Your exemption for 2019 expires February 17, 2020. See Pub. 505, Tax Withholding and Estimated Tax, to learn more about whether you qualify for exemption from withholding.

General Instructions

If you aren't exempt, follow the rest of these instructions to determine the number of withholding allowances you should claim for withholding for 2019 and any additional amount of tax to have withheld. For regular wages, withholding must be based on allowances you claimed and may not be a flat amount or percentage of wages.

You can also use the calculator at ***www.irs.gov/W4App*** to determine your tax withholding more accurately. Consider using this calculator if you have a more complicated tax situation, such as if you have a working spouse, more than one job, or a large amount of nonwage income not subject to withholding outside of your job. After your Form W-4 takes effect, you can also use this calculator to see how the amount of tax you're having withheld compares to your projected total tax for 2019. If you use the calculator, you don't need to complete any of the worksheets for Form W-4.

Note that if you have too much tax withheld, you will receive a refund when you file your tax return. If you have too little tax withheld, you will owe tax when you file your tax return, and you might owe a penalty.

Filers with multiple jobs or working spouses. If you have more than one job at a time, or if you're married filing jointly and your spouse is also working, read all of the instructions including the instructions for the Two-Earners/Multiple Jobs Worksheet before beginning.

Nonwage income. If you have a large amount of nonwage income not subject to withholding, such as interest or dividends, consider making estimated tax payments using Form 1040-ES, Estimated Tax for Individuals. Otherwise, you might owe additional tax. Or, you can use the Deductions, Adjustments, and Additional Income Worksheet on page 3 or the calculator at *www.irs.gov/W4App* to make sure you have enough tax withheld from your paycheck. If you have pension or annuity income, see Pub. 505 or use the calculator at *www.irs.gov/W4App* to find out if you should adjust your withholding on Form W-4 or W-4P.

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

Specific Instructions

Personal Allowances Worksheet

Complete this worksheet on page 3 first to determine the number of withholding allowances to claim.

Line C. *Head of household please note:* Generally, you may claim head of household filing status on your tax return only if you're unmarried and pay more than 50% of the costs of keeping up a home for yourself and a qualifying individual. See Pub. 501 for more information about filing status.

Line E. Child tax credit. When you file your tax return, you may be eligible to claim a child tax credit for each of your eligible children. To qualify, the child must be under age 17 as of December 31, must be your dependent who lives with you for more than half the year, and must have a valid social security number. To learn more about this credit, see Pub. 972, Child Tax Credit. To reduce the tax withheld from your pay by taking this credit into account, follow the instructions on line E of the worksheet. On the worksheet you will be asked about your total income. For this purpose, total income includes all of your wages and other income, including income earned by a spouse if you are filing a joint return.

Line F. Credit for other dependents. When you file your tax return, you may be eligible to claim a credit for other dependents for whom a child tax credit can't be claimed, such as a qualifying child who doesn't meet the age or social security number requirement for the child tax credit, or a qualifying relative. To learn more about this credit, see Pub. 972. To reduce the tax withheld from your pay by taking this credit into account, follow the instructions on line F of the worksheet. On the worksheet, you will be asked about your total income. For this purpose, total

---

Separate here and give Form W-4 to your employer. Keep the worksheet(s) for your records.

Form **W-4** — Department of the Treasury, Internal Revenue Service

Employee's Withholding Allowance Certificate

▶ **Whether you're 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.**

OMB No. 1545-0074

2019

1 Your first name and middle initial	Last name	2 Your social security number
Home address (number and street or rural route)	3 ☐ Single ☐ Married ☐ Married, but withhold at higher Single rate. **Note:** If married filing separately, check "Married, but withhold at higher Single rate."	
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 800-772-1213 for a replacement card.** ▶ ☐	

5	Total number of allowances you're claiming (from the applicable worksheet on the following pages)	5	
6	Additional amount, if any, you want withheld from each paycheck	6	$
7	I claim exemption from withholding for 2019, 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	

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 boxes 8 and 10 if sending to IRS and complete boxes 8, 9, and 10 if sending to State Directory of New Hires.)	9 First date of employment	10 Employer identification number (EIN)

income includes all of your wages and other income, including income earned by a spouse if you are filing a joint return.

Line G. Other credits. You may be able to reduce the tax withheld from your paycheck if you expect to claim other tax credits, such as tax credits for education (see Pub. 970). If you do so, your paycheck will be larger, but the amount of any refund that you receive when you file your tax return will be smaller. Follow the instructions for Worksheet 1-6 in Pub. 505 if you want to reduce your withholding to take these credits into account. Enter "-0-" on lines E and F if you use Worksheet 1-6.

Deductions, Adjustments, and Additional Income Worksheet

Complete this worksheet to determine if you're able to reduce the tax withheld from your paycheck to account for your itemized deductions and other adjustments to income, such as IRA contributions. If you do so, your refund at the end of the year will be smaller, but your paycheck will be larger. You're not required to complete this worksheet or reduce your withholding if you don't wish to do so.

You can also use this worksheet to figure out how much to increase the tax withheld from your paycheck if you have a large amount of nonwage income not subject to withholding, such as interest or dividends.

Another option is to take these items into account and make your withholding more accurate by using the calculator at *www.irs.gov/W4App*. If you use the calculator, you don't need to complete any of the worksheets for Form W-4.

Two-Earners/Multiple Jobs Worksheet

Complete this worksheet if you have more than one job at a time or are married filing jointly and have a working spouse. If you don't complete this worksheet, you might have too little tax withheld. If so, you will owe tax when you file your tax return and might be subject to a penalty.

Figure the total number of allowances you're entitled to claim and any additional amount of tax to withhold on all jobs using worksheets from only one Form W-4. Claim all allowances on the W-4 that you or your spouse file for the highest paying job in your family and claim zero allowances on Forms W-4 filed for all other jobs. For example, if you earn $60,000 per year and your spouse earns $20,000, you should complete the worksheets to determine what to enter on lines 5 and 6 of your Form W-4, and your spouse should enter zero ("-0-") on lines 5 and 6 of his or her Form W-4. See Pub. 505 for details.

Another option is to use the calculator at *www.irs.gov/W4App* to make your withholding more accurate.

Tip: If you have a working spouse and your incomes are similar, you can check the "Married, but withhold at higher Single rate" box instead of using this worksheet. If you choose this option, then each spouse should fill out the Personal Allowances Worksheet and check the "Married, but withhold at higher Single rate" box on Form W-4, but only one spouse should claim any allowances for credits or fill out the Deductions, Adjustments, and Additional Income Worksheet.

Instructions for Employer

Employees, do not complete box 8, 9, or 10. Your employer will complete these boxes if necessary.

New hire reporting. Employers are required by law to report new employees to a designated State Directory of New Hires. Employers may use Form W-4, boxes 8, 9, and 10 to comply with the new hire reporting requirement for a newly hired employee. A newly hired employee is an employee who hasn't previously been employed by the employer, or who was previously employed by the employer but has been separated from such prior employment for at least 60 consecutive days. Employers should contact the appropriate State Directory of New Hires to find out how to submit a copy of the completed Form W-4. For information and links to each designated State Directory of New Hires (including for U.S. territories), go to ***www.acf.hhs.gov/css/employers.***

If an employer is sending a copy of Form W-4 to a designated State Directory of New Hires to comply with the new hire reporting requirement for a newly hired employee, complete boxes 8, 9, and 10 as follows.

Box 8. Enter the employer's name and address. If the employer is sending a copy of this form to a State Directory of New Hires, enter the address where child support agencies should send income withholding orders.

Box 9. If the employer is sending a copy of this form to a State Directory of New Hires, enter the employee's first date of employment, which is the date services for payment were first performed by the employee. If the employer rehired the employee after the employee had been separated from the employer's service for at least 60 days, enter the rehire date.

Box 10. Enter the employer's employer identification number (EIN).

Personal Allowances Worksheet (Keep for your records.)

A	Enter "1" for yourself	A
B	Enter "1" if you will file as married filing jointly	B
C	Enter "1" if you will file as head of household	C
D	Enter "1" if: • You're single, or married filing separately, and have only one job; or • You're married filing jointly, have only one job, and your spouse doesn't work; or • Your wages from a second job or your spouse's wages (or the total of both) are $1,500 or less.	D
E	**Child tax credit.** See Pub. 972, Child Tax Credit, for more information. • If your total income will be less than $71,201 ($103,351 if married filing jointly), enter "4" for each eligible child. • If your total income will be from $71,201 to $179,050 ($103,351 to $345,850 if married filing jointly), enter "2" for each eligible child. • If your total income will be from $179,051 to $200,000 ($345,851 to $400,000 if married filing jointly), enter "1" for each eligible child. • If your total income will be higher than $200,000 ($400,000 if married filing jointly), enter "-0-"	E
F	**Credit for other dependents.** See Pub. 972, Child Tax Credit, for more information. • If your total income will be less than $71,201 ($103,351 if married filing jointly), enter "1" for each eligible dependent. • If your total income will be from $71,201 to $179,050 ($103,351 to $345,850 if married filing jointly), enter "1" for every two dependents (for example, "-0-" for one dependent, "1" if you have two or three dependents, and "2" if you have four dependents). • If your total income will be higher than $179,050 ($345,850 if married filing jointly), enter "-0-"	F
G	**Other credits.** If you have other credits, see Worksheet 1-6 of Pub. 505 and enter the amount from that worksheet here. If you use Worksheet 1-6, enter "-0-" on lines E and F	G
H	Add lines A through G and enter the total here ▶	H

For accuracy, complete all worksheets that apply.

- If you plan to **itemize** or **claim adjustments to income** and want to reduce your withholding, or if you have a large amount of nonwage income not subject to withholding and want to increase your withholding, see the **Deductions, Adjustments, and Additional Income Worksheet** below.
- If you **have more than one job at a time** or are **married filing jointly and you and your spouse both work,** and the combined earnings from all jobs exceed $53,000 ($24,450 if married filing jointly), see the **Two-Earners/Multiple Jobs Worksheet** on page 4 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 above.

Deductions, Adjustments, and Additional Income Worksheet

Note: Use this worksheet *only* if you plan to itemize deductions, claim certain adjustments to income, or have a large amount of nonwage income not subject to withholding.

1	Enter an estimate of your 2019 itemized deductions. These include qualifying home mortgage interest, charitable contributions, state and local taxes (up to $10,000), and medical expenses in excess of 10% of your income. See Pub. 505 for details	1 $
2	Enter: $24,400 if you're married filing jointly or qualifying widow(er); $18,350 if you're head of household; $12,200 if you're single or married filing separately	2 $
3	**Subtract** line 2 from line 1. If zero or less, enter "-0-"	3 $
4	Enter an estimate of your 2019 adjustments to income, qualified business income deduction, and any additional standard deduction for age or blindness (see Pub. 505 for information about these items)	4 $
5	**Add** lines 3 and 4 and enter the total	5 $
6	Enter an estimate of your 2019 nonwage income not subject to withholding (such as dividends or interest)	6 $
7	**Subtract** line 6 from line 5. If zero, enter "-0-". If less than zero, enter the amount in parentheses	7 $
8	**Divide** the amount on line 7 by $4,200 and enter the result here. If a negative amount, enter in parentheses. Drop any fraction	8
9	Enter the number from the **Personal Allowances Worksheet,** line H, above	9
10	**Add** lines 8 and 9 and enter the total here. If zero or less, enter "-0-". If you plan to use the **Two-Earners/ Multiple Jobs Worksheet,** also enter this total on line 1 of that worksheet on page 4. Otherwise, **stop here** and enter this total on Form W-4, line 5, page 1	10

Two-Earners/Multiple Jobs Worksheet

Note: Use this worksheet *only* if the instructions under line H from the **Personal Allowances Worksheet** direct you here.

1 Enter the number from the **Personal Allowances Worksheet**, line H, page 3 (or, if you used the **Deductions, Adjustments, and Additional Income Worksheet** on page 3, the number from line 10 of that worksheet) . . . . . 1 _____

2 Find the number in **Table 1** below that applies to the **LOWEST** paying job and enter it here. **However,** if you're married filing jointly and wages from the highest paying job are $75,000 or less and the combined wages for you and your spouse are $107,000 or less, don't 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 2019. For example, divide by 18 if you're paid every 2 weeks and you complete this form on a date in late April when there are 18 pay periods remaining in 2019. 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

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
$0 - $5,000	0	$0 - $7,000	0
5,001 - 9,500	1	7,001 - 13,000	1
9,501 - 19,500	2	13,001 - 27,500	2
19,501 - 35,000	3	27,501 - 32,000	3
35,001 - 40,000	4	32,001 - 40,000	4
40,001 - 46,000	5	40,001 - 60,000	5
46,001 - 55,000	6	60,001 - 75,000	6
55,001 - 60,000	7	75,001 - 85,000	7
60,001 - 70,000	8	85,001 - 95,000	8
70,001 - 75,000	9	95,001 - 100,000	9
75,001 - 85,000	10	100,001 - 110,000	10
85,001 - 95,000	11	110,001 - 115,000	11
95,001 - 125,000	12	115,001 - 125,000	12
125,001 - 155,000	13	125,001 - 135,000	13
155,001 - 165,000	14	135,001 - 145,000	14
165,001 - 175,000	15	145,001 - 160,000	15
175,001 - 180,000	16	160,001 - 180,000	16
180,001 - 195,000	17	180,001 and over	17
195,001 - 205,000	18		
205,001 and over	19		

Table 2

Married Filing Jointly		All Others	
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 - $24,900	$420	$0 - $7,200	$420
24,901 - 84,450	500	7,201 - 36,975	500
84,451 - 173,900	910	36,976 - 81,700	910
173,901 - 326,950	1,000	81,701 - 158,225	1,000
326,951 - 413,700	1,330	158,226 - 201,600	1,330
413,701 - 617,850	1,450	201,601 - 507,800	1,450
617,851 and over	1,540	507,801 and over	1,540

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 aren't required to provide the information requested on a form that's 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.

Form G-4 (Rev 02/15/19)

1811004012

STATE OF GEORGIA EMPLOYEE'S WITHHOLDING ALLOWANCE CERTIFICATE

1a YOUR FULL NAME	1b YOUR SOCIAL SECURITY NUMBER
2a HOME ADDRESS (Number, Street or Rural Route)	2b CITY, STATE AND ZIP CODE

PLEASE READ INSTRUCTIONS ON REVERSE SIDE BEFORE COMPLETING LINES 3 – 8

3. MARITAL STATUS

(If you do not wish to claim an allowance, enter "0" in the brackets beside your marital status.)

A. Single. Enter 0 or 1 ..... [ ]

B. Married Filing Joint, both spouses working. Enter 0 or 1 ..... [ ]

C. Married Filing Joint, one spouse working. Enter 0 or 1 or 2 ..... [ ]

D. Married Filing Separate. Enter 0 or 1 ..... [ ]

E. Head of Household. Enter 0 or 1 ..... [ ]

4. DEPENDENT ALLOWANCES [ ]

5. ADDITIONAL ALLOWANCES [ ]
(worksheet below must be completed)

6. ADDITIONAL WITHHOLDING $_____

WORKSHEET FOR CALCULATING ADDITIONAL ALLOWANCES
(Must be completed in order to enter an amount on step 5)

1. COMPLETE THIS LINE ONLY IF USING STANDARD DEDUCTION:
   Yourself ☐ Age 65 or over ☐ Blind
   Spouse ☐ Age 65 or over ☐ Blind Number of boxes checked _____ x 1300 ..... $_____
2. ADDITIONAL ALLOWANCES FOR DEDUCTIONS:
   A. Federal Estimated Itemized Deductions (If Itemizing Deductions) ..... $_____
   B. Georgia Standard Deduction (enter one) Single/Head of Household $4,600
      Each Spouse $3,000 $_____
   C. Subtract Line B from Line A (If zero or less, enter zero) ..... $_____
   D. Allowable Deductions to Federal Adjusted Gross Income ..... $_____
   E. Add the Amounts on Lines 1, 2C, and 2D ..... $_____
   F. Estimate of Taxable Income not Subject to Withholding ..... $_____
   G. Subtract Line F from Line E (if zero or less, stop here) ..... $_____
   H. Divide the Amount on Line G by $3,000. Enter total here and on Line 5 above ..... _____

(This is the maximum number of additional allowances you can claim. If the remainder is over $1,500 round up)

7. LETTER USED (Marital Status A, B, C, D, or E) _____ **TOTAL ALLOWANCES** (Total of Lines 3 - 5) _____
(Employer: The letter indicates the tax tables in Employer's Tax Guide)

8. EXEMPT: (Do not complete Lines 3 - 7 if claiming exempt) **Read the Line 8 instructions on page 2 before completing this section.**

a) I claim exemption from withholding because I incurred no Georgia income tax liability last year **and** I do not expect to have a Georgia income tax liability this year. **Check here** ☐

b) I certify that I am not subject to Georgia withholding because I meet the conditions set forth under the Servicemembers Civil Relief Act as provided on page 2. My state of residence is _____ My spouse's (servicemember) state of residence is _____. The states of residence must be the same to be exempt. **Check here** ☐

I certify under penalty of perjury that I am entitled to the number of withholding allowances or the exemption from withholding status claimed on this Form G-4. Also, I authorize my employer to deduct per pay period the additional amount listed above.

Employee's Signature_____ Date _____

Employer: Complete Line 9 and mail entire form only if the employee claims over 14 allowances or exempt from withholding.
If necessary, mail form to: Georgia Department of Revenue, Withholding Tax Unit, 1800 Century Blvd NE, Suite 8200, Atlanta, GA 30345

9. EMPLOYER'S NAME AND ADDRESS:

EMPLOYER'S FEIN:_____

EMPLOYER'S WH#:_____

Do not accept forms claiming additional allowances unless the worksheet has been completed. Do not accept forms claiming exempt if numbers are written on Lines 3 - 7.

INSTRUCTIONS FOR COMPLETING FORM G-4

Enter your full name, address and social security number in boxes 1a through 2b.

Line 3: Write the number of allowances you are claiming in the brackets beside your marital status.

A. Single – enter 1 if you are claiming yourself
B. Married Filing Joint, both spouses working – enter 1 if you claim yourself
C. Married Filing Joint, one spouse working – enter 1 if you claim yourself or 2 if you claim yourself and your spouse
D. Married Filing Separate – enter 1 if you claim yourself
E. Head of Household – enter 1 if you claim yourself

Line 4: Enter the number of dependent allowances you are entitled to claim.

Line 5: Complete the worksheet on Form G-4 if you claim additional allowances. Enter the number on Line H here. **Failure to complete and submit the worksheet will result in automatic denial on your claim.**

Line 6: Enter a specific dollar amount that you authorize your employer to withhold in addition to the tax withheld based on your marital status and number of allowances.

Line 7: Enter the letter of your marital status from Line 3. Enter total of the numbers on Lines 3-5.

Line 8:

a) Check the first box if you qualify to claim exempt from withholding. You can claim exempt if you filed a Georgia income tax return last year and the amount of Line 4 of Form 500EZ or Line 16 of Form 500 was zero, **and** you expect to file a Georgia tax return this year and will not have a tax liability. You cannot claim exempt if you did not file a Georgia income tax return for the previous tax year. **Receiving a refund in the previous tax year does not qualify you to claim exempt.**

EXAMPLES: Your employer withheld $500 of Georgia income tax from your wages. The amount on Line 4 of Form 500EZ (or Line 16 of Form 500) was $100. Your tax liability is the amount on Line 4 (or Line 16); therefore, you **do not qualify** to claim exempt.

Your employer withheld $500 of Georgia income tax from your wages. The amount on Line 4 of Form 500EZ (or Line 16 of Form 500) was $0 (zero). Your tax liability is the amount on Line 4 (or Line 16) and you filed a prior year income tax return; therefore you **qualify** to claim exempt.

b) Check the second box if you are not subject to Georgia withholding and meet the conditions set forth under the Servicemembers Civil Relief Act. Under the Act, a spouse of a servicemember may be exempt from Georgia income tax on income from services performed in Georgia if:

1. The servicemember is present in Georgia in compliance with military orders;
2. The spouse is in Georgia solely to be with the servicemember;
3. The servicemember maintains domicile in another state; and
4. The domicile of the spouse is the same as the domicile of the servicemember or the spouse of the servicemember has elected to use the same residence for purposes of taxation as the servicemember.

Additional information for employers regarding the Military Spouses Residency Relief Act:

1. On the W-2 the employer should not report any of the wages as Georgia wages.
2. If the spouse of a servicemember is entitled to the protection of the Military Spouses Residency Relief Act in another state and files a withholding exemption form in such other state, the spouse is required to submit a Georgia Form G-4 so that withholding will occur as is required by Georgia Law when a Georgia domiciliary works in another state and withholding is not required by such other state. If the spouse does not fill out the form, the employer shall withhold Georgia income tax as if the spouse is single with zero allowances.

Worksheet for calculating additional allowances. Enter the information as requested by each line. For Line 2D, enter items such as Retirement Income Exclusion, U.S. Obligations, and other allowable deductions per Georgia Law, see the IT-511 booklet for more information.

Do not complete Lines 3-7 if claiming exempt.

O.C.G.A. § 48-7-102 requires you to complete and submit Form G-4 to your employer in order to have tax withheld from your wages. By correctly completing this form, you can adjust the amount of tax withheld to meet your tax liability. Failure to submit a properly completed Form G-4 will result in your employer withholding tax as though you are single with zero allowances.

Employers are required to mail any Form G-4 claiming more than 14 allowances or exempt from withholding to the Georgia Department of Revenue for approval. Employers will honor the properly completed form as submitted pending notification from the Withholding Tax Unit. Upon approval, such forms remain in effect until changed or until February 15 of the following year. Employers who know that a G-4 is erroneous should not honor the form and should withhold as if the employee is single claiming zero allowances until a corrected form has been received.

Employment Eligibility Verification

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

USCIS
Form I-9
OMB No. 1615-0047
Expires 08/31/2019

▶ **START HERE:** Read instructions carefully before completing this form. The instructions must be available, either in paper or electronically, during completion of this form. Employers are liable for errors in the completion of this form.

ANTI-DISCRIMINATION NOTICE: It is illegal to discriminate against work-authorized individuals. Employers **CANNOT** specify which document(s) an employee may present to establish employment authorization and identity. The refusal to hire or continue to employ 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 Last 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	Employee's E-mail Address	Employee's 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 boxes):

☐ 1. A citizen of the United States

☐ 2. A noncitizen national of the United States *(See instructions)*

☐ 3. A lawful permanent resident (Alien Registration Number/USCIS Number): _____

☐ 4. An alien authorized to work until (expiration date, if applicable, mm/dd/yyyy): _____
Some aliens may write "N/A" in the expiration date field. *(See instructions)*

Aliens authorized to work must provide only one of the following document numbers to complete Form I-9: An Alien Registration Number/USCIS Number OR Form I-94 Admission Number OR Foreign Passport Number.

1. Alien Registration Number/USCIS Number: _____
OR
2. Form I-94 Admission Number: _____
OR
3. Foreign Passport Number: _____
Country of Issuance: _____

QR Code - Section 1
Do Not Write In This Space

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

Preparer and/or Translator Certification (check one):

☐ I did not use a preparer or translator. ☐ A preparer(s) and/or translator(s) assisted the employee in completing Section 1.
(Fields below must be completed and signed when preparers and/or translators assist an employee in completing Section 1.)

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

Signature of Preparer or Translator	Today's Date *(mm/dd/yyyy)*

Last Name *(Family Name)*	First Name *(Given Name)*

Address *(Street Number and Name)*	City or Town	State	ZIP Code

STOP *Employer Completes Next Page* STOP

Employment Eligibility Verification

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

USCIS
Form I-9
OMB No. 1615-0047
Expires 08/31/2019

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 a combination of one document from List B and one document from List C as listed on the "Lists of Acceptable Documents.")

Employee Info from Section 1	Last Name *(Family Name)*	First Name *(Given Name)*	M.I.	Citizenship/Immigration Status

List A Identity and Employment Authorization	OR	List B Identity	AND	List C Employment Authorization
Document Title		Document Title		Document Title
Issuing Authority		Issuing Authority		Issuing Authority
Document Number		Document Number		Document Number
Expiration Date *(if any)(mm/dd/yyyy)*		Expiration Date *(if any)(mm/dd/yyyy)*		Expiration Date *(if any)(mm/dd/yyyy)*
Document Title				
Issuing Authority				
Document Number				
Expiration Date *(if any)(mm/dd/yyyy)*				
Document Title				
Issuing Authority				
Document Number				
Expiration Date *(if any)(mm/dd/yyyy)*				

Additional Information

QR Code - Sections 2 & 3
Do Not Write In This Space

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)***

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

Last Name of Employer or Authorized Representative	First Name of Employer or Authorized Representative	Employer's Business or Organization Name
		View Point Health

Employer's Business or Organization Address (Street Number and Name)	City or Town	State	ZIP Code
175 Gwinnett Drive	Lawrenceville	GA	30046

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

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

C. If the employee's previous grant of employment authorization has expired, provide the information for the document or receipt that establishes continuing 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	Today's Date *(mm/dd/yyyy)*	Name of Employer or Authorized Representative

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.

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

Examples of many of these documents appear in Part 13 of the Handbook for Employers (M-274).

Refer to the instructions for more information about acceptable receipts.

GENERAL INFORMATION
MAPEP 10-50

MEDICAL AND PHYSICAL EXAMINATION PROGRAM (MAPEP)

Inquiry Authority/Use Statement

The collection of this information is authorized by O.C.G.A. 45-2-40. This information will be used to determine fitness for duty and to provide protection to employees from potential harmful effects associated with this employment. Unless otherwise stated, this information may be disclosed to the hiring agency, State agencies responsible for State benefits and workers' compensation programs, and, where pertinent, to an appropriate law enforcement agency for investigation for prosecutive purposes or in a legal proceeding to which the hiring agency is a party. As provided by the Americans With Disabilities Act of 1990 (Public Law 101-336), this information is to be filed separately from other personnel records and is to be used only for legitimate, non-discriminatory hiring and placement purposes with reasonable accommodation, where appropriate. Completion of this form is voluntary; however, if this information is not provided, the individual may not receive the requested benefits or employment.

Completed by Applicant/Employee

(Print in Ink)

Employee Name: _____
Last First Middle

_____-_____-_____
Social Security Number

Gender: ☐ Female ☐ Male

Date of Birth _____

1. Have you been provided detailed information on the duties of this position? ☐ Yes ☐ No

2. Do you understand the functional requirements and environmental factors of this position? ☐ Yes ☐ No

3. Are you capable of performing the duties and responsibilities of this position (with reasonable accommodations, if necessary ☐ Yes ☐ No

For the following questions, explain a "Yes" answer in the space provided below

4. Have you ever been employed by the State of Georgia or another Community Service Board? ☐ Yes ☐ No

5. Have you had a physical examination for employment with the State of Georgia or Community Service Board within the past twelve months period? ☐ Yes ☐ No

6. Is there anything in your past medical history, of which you have knowledge, that would prevent your being able to perform the duties of this position? ☐ Yes ☐ No

Explanation of items 4-6 checked "Yes." Enter item number before each comment

_____

_____

_____

_____

_____

_____

I certify that all information given by me in connection with this medical assessment is true to the best of my knowledge and belief. I agree and understand that any misstatements of material facts may cause forfeiture on my part of all right to employment in the service of the State of Georgia; may result in dismissal after appointment; or may result in loss of entitlement to disability retirement benefits. My signature also indicates that I understand all of the questions on this form.

_____ _____
Signature of Employee Date

MEDICAL AND PHYSICAL EXAMINATION PROGRAM (MAPEP)

Health Information Checklist

This checklist contains questions regarding your medical history and health. The primary use of this information will be to alert the employer and applicant of conditions that could negatively impact the health of customers or co-workers. This information may be used to determine fitness to perform job duties. This information will be handled in a confidential manner. It is essential that you answer all questions truthfully and completely. False or incomplete information may result in disqualification or termination if hired.

Completed by Applicant/Employee

(Type or Print in Ink)

Date: _____

Employee Name: (Last, First, Middle): _____

Employing Agency: View Point Health

Date Employed: _____

Have you now, or ever had the following?

	Yes	No
1. Loss of sight of both eyes. Loss of uncorrected (without glasses or contact lens) vision of more than 75% bilaterally (vision of 20/160 or J* or worse using both eyes).		
2. Diabetes		
3. Tuberculosis		
4. Epilepsy (convulsions, seizures or fits)		
5. Ankylosis (immobility) of major weight bearing joints (ankles, knee, hip)		
6. Any permanent condition which causes 20% (or more) impairment of a foot, leg, hand, arm, back, or the body as a whole		
7. Arthritis which is a hindrance to employment		
9. Amputated (loss of) foot, leg, arm, or hand		
10. Parkinson's disease (Paralysis Agitans)		
11. Cerebral palsy		
12. Multiple sclerosis		
13. Mental retardation (intelligence quotient within the lowest two percent of the general population)		

	Yes	No
14. Psychoneurotic disability following confinement for treatment in a recognized medical/mental hospital for a period in excess of 6 months.		
15. Hemophilia		
16. Sickle cell anemia		
17. Cardiovascular (heart or blood vessel) disease		
18. Total loss of hearing (loss of over half of hearing in each ear)		
19. Compressed air sequelae (damage to lungs, ruptured ear drum, etc due to air concussion, blasting, explosion, etc.)		
20. Muscular dystrophy		
21 Hyperinsulinism (hypoglycemia)		
22. Residual disability from poliomyelitis (Disability due to polio)		
23. Ruptured intervertebral (back) disc		
23. Chronic osteomyelitis (bone infection)		
24. Hepatitis		

REMARKS: _____

_____

_____ _____

Signature of Employee **Date**

STATE OF GEORGIA
MEDICAL AND PHYSICAL EXAMINATION PROGRAM
MEDICAL HISTORY REPORT 10-52

Name_____ Soc. Sec. No. _____-_____-_____

Job Title _____ Department _____

The purpose of these questions is to gather information concerning your health and physical condition, both now and in the past. This information will be used only to determine whether you can safely perform the duties of the job for which you are being considered. Please answer all of the following questions as fully and completely as you can. If you don't understand a question, or are unsure of how to answer it, leave it blank and request assistance.

I certify under penalty of perjury, that the information given by me is true to the best of my knowledge and belief. I agree and understand that any misstatements of material facts may cause forfeiture on my part of all right to employment in the service of the State of Georgia, may result in dismissal after appointment; or may result in loss of entitlement to disability retirement benefits. My signature also indicates that I understand all of the questions on this medical history form.

_____ _____
EMPLOYEE SIGNATURE **DATE**

Individual History – To Be Completed By Applicant/Employee (Use Ink)

A. **MEDICAL CONDITIONS.** *Check every item. Do you have or have you ever had any of the following: (If "Yes," give date of most recent occurrence and explain on page 3.)*

Health Condition	Yes	Year	No
HEAD, NOSE, MOUTH AND THROAT			
1. Persistent or severe headaches			
2. Frequent nose bleeds			
3. Frequent nasal congestion			
4. Persistent or severe sinus condition			
5. Bleeding gums			
6. Persistent or severe dental condition			
7. Hoarse when don't have cold			
8. Difficulty swallowing			
9. Persistent sore throat			
10. Loss of taste or smell			
11. Head injury			
12. Other head, nose, mouth or throat conditions:			
EARS AND HEARING			
13. Hearing difficulties			
14. Use hearing aid			
15. Ringing in ears (tinnitus)			
16. Perforated ear drum			
17. Persistent or severe ear infection			
18. Other ear or hearing conditions			
EYES AND VISION			
19. Glaucoma			
20. Cataract			
21. Eye irritations (itching or burning)			
22. Eye infection			
23. Defective vision			
24. Color blindness			
25. Injury to eye			
26. Eye surgery			
27. Double vision			

Health Condition	Yes	Year	No
28. Glasses			
29. Contact lenses			
RESPIRATORY SYSTEM (lungs & breathing)			
30. Persistent or severe colds			
31. Persistent or severe cough			
32. Coughing blood			
33. Asthma or breathing difficulty			
34. Emphysema			
35. Pneumonia			
36. Tuberculosis			
37. Other lung or breathing condition:			
CARDIOVASCULAR SYSTEM (heart & blood vessels)			
39. Heart attack			
39. Hardening of the arteries (Arteriosclerosis)			
40. High or low blood pressure			
41. Heart murmur			
42. Palpitations or irregular heart beat			
43. Episodes of chest pains, tightness, discomfort			
44. Shortness of breath			
45. Varicose veins			
46. Swelling of ankles, feet or legs (edema)			
47. Leg pains, cramps			
48. Other cardiac conditions:			
GASTROINTESTINAL SYSTEM (stomach & intestines)			
49. Persistent or severe nausea or indigestion			
50. Persistent or severe stomach pain			
51. Vomiting blood			
52. Persistent or severe vomiting			
53. Hernia (rupture)			
54. Stomach or duodenal ulcer			

Health Condition	Yes	Year	No
55. Colitis			
56. Hemorrhoids or piles			
57. Change in bowel habits			
58. Black stool or blood in stool			
59. Persistent or severe constipation			
60. Persistent or severe diarrhea			
61. Pancreatitis			
62. Appendicitis			
63. Other conditions of stomach or intestines			
LIVER, SPLEEN & GALLBLADDER			
64. Cirrhosis			
65. Hepatitis			
66. Yellow jaundice			
67. Gallstones			
68. Other conditions of liver, spleen or gallbladder			
KIDNEYS & URINARY TRACT			
69. Kidney stones			
70. Kidney infection			
71. Blood or pus in urine			
72. Pain or burning when urinating			
73. Frequent urination			
74. Albumen or protein in urine			
75. Prostate condition			
76. Burning discharge from penis			
77. Other conditions of kidneys or urinary tract			
REPRODUCTIVE SYSTEM (FEMALES ONLY)			
78. Pregnant at present			
NEUROLOGICAL (Nervous) SYSTEM			
79. Epilepsy, convulsions, seizures			
80. Periods of blackouts/loss of consciousness			
81. Fainting spells			
82. Dizzy spells (vertigo)			
83. Memory difficulty			
84. Tremor of the hands or head			
85. Paralysis of any type			
86. Stroke			
87. Severe numbness, tingling or weakness			
88. Dyslexia/learning difficulty			
89. Other conditions of neurological (nervous) system:			
MUSCULOSKELETAL SYSTEM			
90. Arthritis			
91. Bursitis/tendonitis			
92. Swollen or painful joints			
93. Dislocations			
94. Painful or trick shoulder			
95. Elbow problems			
96. Wrist or hand problems			
97. Back pain			
98. Back surgery			

Health Condition	Yes	Year	No
99. Trick or locked knee			
100. Knee surgery			
101. Foot problems			
102. Bone infection			
103. Broken or fractured bone			
104. Persistent or severe muscle aches or pains			
105. Other Musculoskeletal conditions			
ENDOCRINE/METABOLIC SYSTEM			
106. Diabetes			
107. Thyroid condition or disease			
108. Hypoglycemia			
109. Unexplained weight gain or loss			
110. Unusual loss or growth of body hair			
111. Gout			
112. Osteoporosis or other bone disease			
SKIN			
113. Rash			
114. Hives			
115. Moles that bleed or get larger			
116. Change in color of skin (other than suntan)			
117. Frequent boils/abscesses			
118. Trouble with fingernails			
119. Small itching blisters on the side of fingers or palms			
120. Sores that do not heal			
121. Other skin conditions			
BLOOD/LYMPH (hematologic) SYSTEMS			
122. Anemia			
123. Bleeding disorder			
124 Sickle cell disease or trait			
125. Phlebitis/blood clot			
126. Blood transfusion			
127. Chills, fever, night sweats			
128. Lymph node or glandular swelling that persists			
129. Other conditions of blood or lymph:			
CANCER			
130. Surgery			
131. Radiation therapy			
132. Chemotherapy			
133. Immunotherapy			
134. Hormone therapy			
135. Breast			
136. Bone			
137. Skin			
138. Other			
PSYCHOLOGICAL/MOOD			
139. mental problem requiring hospitalization			
140. Suicidal/attempted suicide			
141. Active psychosis			
142. Drug, narcotic or alcohol			

Health Condition	Yes	Year	No	Health Condition	Yes	Year	No
143. Persistent or severe depression/worry				ALLERGIES (caused by)			
144. Other psychological conditions.				152. Medication			
INFECTIOUS OR CHILDHOOD DISEASES				147. Rheumatic fever			
Meningitis/encephalitis				153. Food			
146. Polio				154. Soaps or detergents			
148. Mumps				155. Pollen			
149. Measels				156. Insect bites/scales			
150. Venereal Disease				157. Other:			
151. Other:							

Explanation of items checked "Yes." Enter item number (1-157) before each comment.

_____

_____

_____

_____

B. CURRENT MEDICATIONS and EXPLANATION FOR TAKING

_____

_____

C. SURGICAL HISTORY

Have you ever had surgery? ☐ **Yes** ☐ **No** *[If "Yes, complete the following information about each surgery]*

TYPE OF SURGERY — DATE (Mo/Yr)

1. _____ _____
2. _____ _____
3. _____ _____

D. HOSPITALIZATION HISTORY

Have you ever been hospitalized? ☐ **Yes** ☐ **No** *[If "Yes, complete the following information about each]hospitalization.]*

REASON FOR HOSPITALIZATION — DATE (Mo/Yr)

1. _____ _____
2. _____ _____
3. _____ _____

HR OFFICE TO COMPLETE:

Job Category (check one) ☐ **1** ☐ **2** ☐ **3** ☐ **4** ☐ **5**

JOB CATEGORIES

Category 1: Primarily sedentary, light, physical work with limited to no unusual working conditions (e.g., Office Worker, Manager, Administrator)
Category 2: Moderate to heavy physical activity and/or moderate to high interface w/working conditions of potential concern for certain health conditions
Category 3: Positions involving food preparation or the handling of raw consumable animal products
Category 4: Health-related positions involving direct contact with or exposure to air-borne pathogens (e.g., TB), blood-borne pathogens (e.g., HIV, viral hepatitis), human body parts or products, or hazardous chemicals (e.g., Nurse, Physician, Health Service Technician,
Category 5: Strenuous physical activity and/or extreme or potentially life-threatening working conditions requiring a high level of physical capability (e.g., Correctional Officer, Ranger)

View Point Health
OUTSTANDING WAGES/OTHER MONIES DUE UPON DEATH
BENEFICIARY DESIGNATION

_____ _____
Print your name **Your Social Security Number**

About your Beneficiary Designation
Official Code of Georgia Annotated Section 34-7-4 provides that, in the event of an employee's death, all outstanding wages or other monies owed to the employee be paid to any beneficiary so designated in writing, provided that the specified beneficiary is not legally prohibited* from receiving such sums or legally incapacitated.**

A beneficiary may be an organization or an individual and does not have to be related to you. In the event that a beneficiary has been designated in writing and such beneficiary is under legal incapacity**, then all wages and monies will be made payable to the duly qualified guardian.

***Legally prohibited:** An individual excluded by law from receiving payment upon your death (e.g. individual who intentionally causes your death to receive a profit as beneficiary).
****Legally incapacitated:** Individual proclaimed by law or judicial order as not being mentally capable of handling his/her own affairs.

Please complete the following, if you wish to designate a beneficiary:

In the event of my death, any wages or other monies due me from View Point Health shall be paid to the following individual that I hereby designate as my beneficiary for this purpose. This designation supersedes all prior designations that I have made to receive these wages and monies.

Primary Beneficiary

_____ _____
Print FULL name **Social Security Number**

_____
Print full address of primary beneficiary: Street address, City, State, Zip Code

Contingent Beneficiary

_____ _____
Print FULL name **Social Security Number**

_____
Print full address of contingent beneficiary: Street address, City, State, Zip Code

I understand that if no beneficiary is designated, the law provides that the outstanding wages and any other monies are payable upon death as follows: (1) first, to the surviving spouse and (2) second, in the absence of a surviving spouse, to the duly qualified guardian of surviving minor child or children.

_____ _____
Employee Signature **Date Signed**

Revised November , 2011

VIEW POINT HEALTH
Additional Employment Request

I, _____, request approval for employment outside of View Point Health. I am: ☐ current VPH employee ☐ applicant for VPH employment

☐ new hire for:_____
name of program or worksite

My current/proposed VPH position title is: _____

My current/proposed employment with View Point Health is: ☐ fulltime ☐ part-time

Usual/proposed work schedule at VHP:_____

Work schedule for additional employer:_____

_____

Name/address of additional employer: _____

_____Phone #:_____

Type of business:_____

Describe work you will perform for additional employer:_____

_____

Will your position with the additional employer require/allow you to refer its clients and/or their families for additional services of a type that VPH also provides? ☐ Yes ☐ No

If answering "yes" above, does the additional employer provide its services in areas served by View Point Health? ☐ No ☐ Yes:_____
(List counties)

I understand the VPH Policy on Additional Employment. I acknowledge that my View Point Health Employment has priority over any outside employment and that permission for outside employment may be withdrawn at any time. It is my responsibility to notify VPH if the conditions/duties of my additional employment change at any time in the future.

_____ _____ _____
Employee signature Date Print Employee Name

I recommend approval of the employee's request.

_____ _____ _____ _____
Signature of supervisor/ date Signature of program manager/date

☐ Additional employer checked against Region 2 and 3 Provider List for conflict of interest

☐ Approved ☐ Disapproved _____
Signature of Executive Director or Designee/Date

Authorization for Release of Information

My signature below evidences my understanding that upon my selection to fill the position of _____ at View Point Health and periodically thereafter as regulations require, a criminal employment history investigation and/or background or motor vehicle record investigation may also be conducted with regard to me. I further understand that information obtained during the investigation(s) may be used as a basis for the denial of initial employment, denial of reemployment, as well as for termination of employment. I understand that refusal to sign this release will result in termination of employment.

All information released to View Point Health with this authorization must be held strictly confidential and cannot be released by the recipient without my written consent. I understand that this authorization will remain in effect for the duration of my employment with View Point Health. I understand that unless otherwise limited by state or federal regulation and except to the extent that action has been taken which was based on my consent, I may withdraw this consent at any time.

_____

Signature of Employee/Applicant

_____

(Daytime phone #)

_____

(Date)

MOTOR VEHICLE USE PROGRAM
DRIVER ACKNOWLEDGEMENT

Before operating a vehicle for state of Georgia or View Point Health, employees must use this form to certify that they are qualified to safely operate the vehicle. Employees who drive on state/VPH business, regardless of the frequency, must use this form to recertify every 12 months.

By signing this form, I authorize the retrieval of my driving history and also certify that I am qualified to safely operate a vehicle for state business.

I specifically certify the following: (Please initial on each line.)

_____ I have a valid license for operating the vehicle.

_____ I do not currently have more than 10 points on my driver's license.

_____ I agree to use vision correction measures while operating the vehicle, if required by my driver's license.

_____ I agree to report any ticket or warning that I receive while operating the vehicle on state/View Point Health business.

_____ I do not have pending charges, or a conviction within the past 6 months, for any of the following offenses, and I agree to immediately notify my supervisor using the Driver Notification form should I be charged with one or more of these offenses:

- Driving Under the Influence,
- Leaving the Scene of an Accident,
- Refusal to take a Chemical Test for intoxication,
- Aggressive Driving, * or
- Exceeding the speed limit by more than 19 miles per hour*.

_____ I agree to notify my supervisor of any changes involving the above initialed items before I operate a vehicle for state/View Point Health business.

_____ I agree to notify my supervisor using the Driver Notification form immediately upon License Suspension, Revocation, or Expiration.

_____ I have reviewed and understand the Driver Safety Tips provided.

*Only if conviction would result in more than 10 points accumulated on the driving record.

Driver's License Information (please print)					
First Name	Middle Name	Last Name	Date of Birth	License #	State

_____ _____

Signature Date

Original to Risk Management Manager, Copy to Employee

View Point Health
Transportation Safety
Standards of Employment

I understand that if I drive a vehicle in the course of my job duties, or if my job requires me to transport clients either in my personal vehicle, a rented vehicle or in a View Point Health (VPH) vehicle, I must adhere to the View Point Health policy on Transportation Safety.

I agree that I will adhere to the following expectations:

1. Maintain a valid Georgia driver's license; provide a copy to the VPH Transportation Office. I authorize VPH to periodically process a motor vehicle report.

2. Maintain a motor vehicle record with no more than two chargeable accidents, moving violations or DUI's in any three-year period with the last five (5) years of the seven (7) year MVR period.

3. Report to my supervisor the next working day any convictions for motor vehicle violations or revocations, or suspensions of driver's license that I receive during the course of my employment with View Point Health.

4. I understand that if my license has been suspended, canceled or revoked during the past three (3) years, I am prohibited from driving a VPH vehicle, and I am prohibited from transporting consumers in my personal vehicle, a rented vehicle or in a VPH vehicle.

5. I understand that if I transport clients I agree to maintain current certification in First Aid, CPR, Driver Improvement and Passenger Assistance Safety and Sensitivity.

I understand that violation of this policy may result in disciplinary action up to and including dismissal.

_____ _____

Date Print Name

_____

Signature

Revised 09/14/2011

POLICY AND PROCEDURE ACKNOWLEDGMENTS

View Point Health

- **Read** each policy/procedure.
- **Initial** the bottom right corner of each page as you read.
- **Make note** of any questions you have about each section. Policies and procedures will be discussed during the enrollment session.
- **Initial and sign** the last page acknowledging that you have received, read and agreed to the policies and procedures presented. A complete list of the contents appears on the acknowledgement page.

ACKNOWLEDGMENT OF MANDATORY INITIAL TRAINING REQUIREMENTS

View Point Health requires all new employees who will have contact with consumers to complete an 8-hour course called "CPI" **prior to reporting to the work site.** Course materials teach verbal, behavioral and physical intervention methods for handling types of client behavior which occasionally may be encountered during employment. Participants must demonstrate satisfactory mastery of intervention techniques before performing any duties that involve client contact.

New employees are also required to attend four hours of training in the afternoon following enrollment and a one-day new employee orientation session, typically held on the day following the CPI course.

I agree to complete the Crisis Prevention Intervention (CPI) course, the post-enrollment training, and new employee orientation.

Some positions also require that incumbents pass courses in CPR and First Aid or present acceptable proof of current training. CPR and First Aid courses are presented on the fourth day of enrollment and training. Employees in those positions are required as a condition of employment to complete CPR and First Aid courses and maintain recertification.

Clinical positions must pass a course on Clinical Documentation, which is taught monthly.

ACKNOWLEGEMENT OF POSITION STATUS

I hereby acknowledge that the position I have accepted with View Point Health is in the unclassified service. I understand that as an employee in the unclassified service, my employment is "at will" and may be terminated at any time without notice or statement of reasons.

STANDARDS OF EMPLOYMENT

Employees of the View Point Health are expected to adhere to high moral and ethical standards. Employees are expected to abide by the following guidelines while employed with the agency.

- Employees must recognize that client welfare comes first. The client is the reason for the employee's job. The individual dignity of each client shall be respected at all times and upon all occasions.

- Employees' off-duty conduct should be such that it does not bring discredit upon the VPH.

- Employees who have outside financial interests which could be affected by state or community service board plans or activities should report the situation to the appropriate supervisor immediately.

_____

Employee Initials

- Each employee should be aware of and comply with VPH policies and state rules and regulations. Failure to comply with policies of View Point Health may result in disciplinary action up to and including dismissal.

- Employees should not engage in business other than regular duties during work hours.

- Telephones are for business purposes. Employee's use of the telephone for personal use should be limited to emergencies and should be brief. All other personal calls can be made during off duty hours.

- Employees are expected to conduct themselves in a professional and courteous manner with all contacts. All employees are responsible for the welfare of the clients. Employees are not to borrow or lend money to clients nor have any business dealings with clients.

- Employees should not give clients gifts, nor should they take gifts from clients. These circumstances should be discussed with employee's supervisor.

- Employees are expected to follow appropriate lines of supervision beginning with their immediate supervisor.

- Employees are required to arrive at work at assigned times and work the required number of hours.

- Employees are required to adhere to the Federal Drug-Free Work Place Act.

- Employees are required to work in areas as assigned by their supervisor. Employees acknowledge that management has the responsibility to accomplish the mission of View Point Health and may relocate or reassign staff including shift to accomplish that mission.

- Employees are required to protect the rights of clients (confidentiality, civil rights, etc.).

- Employees are expected to request the use of leave time. Leave time is granted at the discretion of the supervisor.

- Employees are required to maintain with the supervisor and the Human Resources office their current and correct address and telephone number at which they may be reached.

- Employees are required to recognize that there is a designated spokesperson to whom all questions from the news media should be directed. All requests for public releases should be channeled through the employee's supervisor who will get approval from the Executive Director or his designee.

_____

Employee Initials

VIEW POINT HEALTH DRUG-FREE WORKPLACE POLICY
EMPLOYEES SUBJECT TO DRUG/ALCOHOL SCREENING NOTICE

As a part of the basic terms and conditions of employment, employees are to be free of all illegal drugs and alcohol while performing assigned duties. All employees are prohibited from using or being under the influence of alcohol or illegal drugs while on duty. Employees are also prohibited from abusive use of legal drugs or other substances which, when abused, have the potential for significant risk or harm to the employee, other employees, clients, or the general public.

It is very important that you fully understand the requirements of the Federal Drug- Free Work Force Act, the VPH Drug-free Workplace Policy and the consequences that might result from violation of these policies. You are encouraged to thoroughly review these policies. Questions should be referred to your supervisor or to the Director of Human Resources.

These policies mandate that any employee who refuses to take a drug/alcohol screening test, or whose test indicates the use of non-prescribed drugs, illegal drugs or alcohol, will be subject to disciplinary action up to and including dismissal. Any employee who is terminated for violation of these policies may also be subject to disqualification from further state employment.

All employees of View Point Health, regardless of employment status, are subject to alcohol/drug screening. The Executive Director may direct any employee to submit to screening for the presence of non-prescribed drugs, illegal drugs or alcohol, if the appointing authority has reasonable suspicion that the employee has used non-prescribed drugs, illegal drugs, alcohol, or other substances while on duty. Employees are strictly prohibited from possessing or consuming (non-prescribed drugs), illegal drugs, or alcohol on property owned, leased, or otherwise operated by View Point Health.

I have read, or had read to me, the above notice and I understand that I may be required to submit to a drug/alcohol screening. My signature on this notice only acknowledges that the information in the notice has been presented to me, and does not indicate that I agree or disagree with the contents of the notice.

As an employee of View Point Health, I hereby certify that I have been notified concerning this agency's policy to maintain a drug-free workplace. I understand that the unlawful manufacture, distribution, dispensation, possession or use of a controlled substance is prohibited and violation of this policy can result in disciplinary action up to and including dismissal from employment. I understand that I must abide by the terms of this policy as a condition of employment and will notify my supervisor of any criminal drug arrest or conviction no later than five (5) days after such event occurs. I further realize that federal law may mandate that my employer communicate conviction information to a federal agency and I hereby waive any and all claims that may arise from conveying this information to a federal agency.

_____

Employee Initials

PRE-EMPLOYMENT DRUG TESTING POLICY

Some positions within VPH are required to submit to pre-employment drug testing. I understand that as a condition of employment with View Point Health, I must take and pass a drug test to determine the presence of illegal drugs, if it is required by law (O.C.G.A . 4520-110) for my position.

I am willing to take the drug test as directed and I understand that the cost of this drug test will be paid by the employer.

I understand that if I refuse to take the drug test or fail to appear at the testing location by the specified date, I will be disqualified from employment with any State employer for a period of two years.

I understand that should my drug test results indicate the presence of illegal drugs and such presence is not found by the Medical Review Officer to be authorized by state or federal law, I will be disqualified from any employment with any State employer for a period of two (2) years from the date that the test was administered.

I acknowledge that withholding or falsifying any of the requested information will result in immediate termination of my employment with View Pont Health. I acknowledge that if I refuse to sign this form, I am forfeiting any further consideration for employment at View Point Health.

RANDOM DRUG TESTING POLICY

Some positions within VPH are required to submit to random drug testing. Any employee who as a condition of employment is subject to random drug testing and who refuses to submit to drug testing or who fails to appear for drug testing after being directed to so appear shall be dismissed from employment. Any employee whose drug test under the random testing requirement indicates the illegal use of drugs shall be dismissed from employment. An employee dismissed for any of these reasons will not be recommended for re-employment with VPH for a minimum of two (2) years from the date of dismissal.

DEFENSIVE DRIVING COURSE REQUIREMENT

All VPH employees who transport consumers in their personal vehicles or in agency vehicles as a part of the job are required to attend a defensive driving course during the first 90 days of employment. This course is offered during working hours. Dates and times are publicized at work sites. I acknowledge that if I am required to transport consumers as a part of my job, it is my responsibility to register for and attend a defensive driving session during the next 90 days. I understand that attendance at a defensive driving training session during the first 90 days of my employment is required as a condition of continuing employment with View Point Health.

_____

Employee Initials

ADDITIONAL EMPLOYMENT POLICY

All VPH employees who have other employment must report this additional employment for approval by the Executive Director. I agree to abide by the VPH policies and procedures related to additional employment. A complete copy of all VPH policies and procedures related to additional employment.

WORKERS COMPENSATION POLICY

Workers Compensation is an accident insurance program which provides medical and income benefits to employees who are injured on the job. It also provides benefits to dependents if an employee dies as a result of a job-related injury.

I understand that if I am involved in an on-the-job injury and emergency treatment is NOT necessary, I must accept the services of a physician from the panel of physicians in the Managed Care Organization (MCO) designated by View Point Health. Physician's panel information is posted at all work sites. If I desire to obtain medical service from a physician not listed on the VPH panel, I may do so; however, I will be liable for any medical expenses. The physician selected may arrange for appropriate consultations, referrals, and other specialized medical services as the nature of the injury requires. If I am dissatisfied with the physician selected, I may make one change without permission of the VPH HR Director, the State Department of Administrative Services Risk Management Services, or the State Board of Workers Compensation.

In the case of an emergency, I should be taken to the nearest emergency room. However, all follow up care must, thereafter, be rendered by a physician from the panel (or a panel physician's referral).

I further understand that I must notify my supervisor and the Human Resources office as soon as an injury occurs regardless of the extent of the injury. Delay in notification can result in denial of payment for medical services rendered.

If my claim is accepted as compensable and I am receiving weekly indemnity benefits (or it has been no longer than sixty (60) days since I last received indemnity benefits), I understand I am entitled to **one** independent medical examination by a physician of my choice. Should I exercise this right, I will notify Department of Administrative Services **in writing in advance** of the examination. The cost will be paid by DOAS but no diagnostic procedures performed since my on-the-job injury and costing in excess of $250.00 will be repeated by my independent physician. If this cost does exceed $250.00, I understand I may be expected to pay for such procedures.

_____

Employee Initials

ACKNOWLEDGMENT OF RESPONSIBILITY TO MAINTAIN CURRENT LICENSURE, CERTIFICATE, OR REGISTRATION

Some positions within VPH require that incumbents maintain a current license, certificate or registration. If my position has such a requirement, I understand that it is my responsibility to maintain a current license, certificate or registration, and to renew such license, certificate, or registration when necessary. I understand that I am to advise my supervisor of any barriers encountered in renewing my license, certificate, or registration. I further understand that failure to maintain a current license, certificate or registration when required will result in termination of employment at the expiration of said license, certificate, or registration.

REQUIREMENTS FOR QUALIFIED DRIVERS

Some positions within VPH require the transport of clients either in agency-owned vehicles or personal vehicles. Persons in those positions are required to maintain status as a VPH Qualified Driver and to comply with the VPH policy on Transportation Safety. A Qualified Driver must have a current Georgia drivers' license with no more than two moving violations or driver fault accidents in any three-year period AND have current certifications in CPR, First Aid and Defensive Driving. I understand that if my position requires transport of clients as a condition of employment, my failure to maintain status as a qualified driver may result in disciplinary action up to and including dismissal. I also acknowledge my responsibility to report to my supervisor any citations for moving violations or driver fault accidents and to comply with the VPH policy on Transportation safety.

TRAINING REQUIREMENTS FOR UNLICENSED STAFF

Some positions within VPH provide statue-funded or Medicaid reimbursable services but persons in these positions are not required to be professionally licensed or to have any of a number of other recognized credentials. Persons in these unlicensed positions are required by the State to complete a "Standard Training Requirement for Paraprofessionals" with 90 days of hire. The training is provided via online courses which are made available during the regular course of employment. I understand that if I am unlicensed, I must complete within the first 90 days of my employment the on-line courses and requisite post-tests as a condition of continuing employment with View Point Health.

_____

Employee Initials

I hereby acknowledge that I have received, read and agreed to adhere to the following Policies and Procedures of View Point Health. (Please initial the space beside each entry and sign below):

_____Mandatory Initial Training Requirements

_____Acknowledgement of Position Status

_____Standards of Employment

_____VPH Drug-Free Workplace Policy

_____Employees Subject to Drug/Alcohol Screening Notice

_____Pre-employment Drug Testing Policy

_____Random Drug Testing Policy

_____Defensive Driving Course Requirement

_____Additional Employment Policy

_____Workers Compensation Policy

_____Responsibility to Maintain Current Licensure, Certificate, or Registration

_____Requirements for Qualified Drivers

_____Training Requirements for Unlicensed Staff

_____ Date_____

Employee Signature

_____

PRINT Full Name

HOLIDAYS

View Point Health recognizes those days designated as holidays by the State of Georgia with three exceptions. The following are the holidays normally observed by View Point Health:

January 1..... New Year's Day
Third Monday in January.....Martin Luther King, Jr.'s Birthday
January 19..... State Holiday (observed on the day after Thanksgiving)*
Last Monday in February..... Washington's Birthday (observed around Christmas)*
Last Monday in May..... National Memorial Day
July 4..... Independence Day
First Monday in September..... Labor Day
Fourth Thursday in November.....Thanksgiving
December 25.....Christmas

On the following holidays, ALL OUTPATIENT CENTERS will be closed and emergency services will be available. Twenty-four hour staffed facilities will still be open and employees may be required to work:

January 1..... New Year's Day
Third Monday in January.....Martin Luther King's Birthday
Last Monday in May.....National Memorial Day
July 4..... Independence Day
First Monday in September.....Labor Day
Fourth Thursday in November.....Thanksgiving
Fourth Friday in November.....State Holiday
December 25..... Christmas Day
Day before OR day after Christmas...Washington's Birthday observed

The following State of Georgia holidays are not observed by VPH. These holidays shall be observed only by classified employees and employees in the Employees' Retirement System. ALL CENTERS will be open for the full range of services:

April 26.....State Holiday
Second Monday in October.....Columbus Day
November 11.....Veterans Day

*Holidays occurring while the General Assembly is in session are customarily observed later in the year as specified in the Governor's proclamation.