Convergence Employee Leasing, Inc.
9393-1 Mill Springs Drive, Jacksonville, FL 32257
Phone: (904) 731-9014
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Employee Enrollment Packet

** CONFIDENTIAL **

FOR GEORGIA EMPLOYEES ONLY

Convergence Employee Leasing, Inc. is a co-employer of employees working for its Client Company. As a co-employer, Convergence is the employer of record for payroll, tax reporting, workers' compensation insurance, claims management and other administrative functions. The work-site employer is responsible for the day-to-day work of the employees as noted in the Convergence Client Service Agreement signed by the Client Company.

Instructions for completion of this packet

These 9 Items are Required:

- ☐ Section 1: Employee Information
- ☐ Section 2: Employee Set-Up Information
- ☐ Section 3: Pre-Hire Employee Statement
- ☐ W-4 Form
- ☐ Convergence Employee Agreement
- ☐ General Safety Rules
- ☐ Notice of Drug & Alcohol Testing and Release
- ☐ Government Issued Photo ID (Drivers License, State ID Card, i.e.)
- ☐ G-4 Form - Georgia Withholding

Note: This enrollment packet should not be completed until a potential employee has received a conditional offer of employment from the client company. Submit completed packet to Convergence ***BEFORE*** employee begins working. The above constitutes the mandatory paperwork that must be received and accepted by Convergence Employee Leasing, Inc. in order to become an eligible employee of Convergence Employee Leasing, Inc. If you have any questions about this employment application, please call Convergence immediately, (904) 731-9014.

Post Offer Medical Questionnaire: *This questionnaire should not be answered unless the applicant has accepted a conditional offer of employment and has not commenced employment with the client company*.

Form I-9:
On-site employer/client company must retain Form I-9 for their records. Convergence does not receive or maintain I-9 Forms.

Form 1210-014:
The attached document is being provided as a convenience to you. Note: Convergence Employee Leasing, Inc. and its affiliated entities is NOT responsible for health insurance and/or health insurance benefits for you and/or your family.

Please visit our website for Form Direct Deposit, State Withholding & other supplemental forms.

Section 1: Employee Information *(To be completed by the employee/applicant)*

Client Company: _____ Location: _____

Last Name: _____ First Name: _____ MI: _____ SSN: _____

Address: _____ City: _____ State: _____ Zip: _____

Date of Birth: _____ Contact #: _____ Email: _____

Gender: _____ Job Duties: _____

Emergency Contact Name: _____ Relationship: _____ Emergency Contact Phone #: _____

Section 2: Employee Set-Up Information *(To be completed by the on-site client)*

Workers' Comp. Code(s): _____ Job Description: _____ Department: _____

☐ New Employee ☐ Rehire, Rehire Date: _____, Original Hire Date w/Client _____

Method & Rate of Pay (*Must comply with FLSA Guidelines*): ☐ Full-Time ☐ Part-Time ☐ Permanent ☐ Seasonal

☐ Hourly $ _____ ☐ Annual Salary $ _____ ☐ Commission _____ ☐ Piece Work _____ ☐ Tips

Mandatory Garnishment? (If yes, please attach court order) ☐ Yes ☐ No

Signature of Client Company Representative **Print Name** **Date**

_____ _____ _____

Section 3: Pre-Hire Employee Statement *(To be completed by the employee/applicant)*

This form confirms your understanding of the nature of the PEO relationship between Convergence and _____ (hereinafter Client). This letter serves as your acknowledgement and understanding of that relationship and the limitations of that relationship. Please read each question carefully and fill in the banks as requested. Please initial at the end of each question to confirm that you have read and understand the question. In that regard you acknowledge:

1. I agree that the rate of pay listed above is the rate of pay which I have been promised. x _____

2. That you acknowledge that if you are hired by Convergence you will only be paid by check from Convergence for work that you perform for the Client. x _____

3. That you understand that if you are hired by Convergence and you accept any W-2 wage payments from Client that you may be engaged in workers' compensation fraud as well as tax and/or child support fraud. x _____

4. That you are not an independent contractor or subcontractor. x _____

5. That you acknowledge and agree that if you are hurt on the job for Convergence then the only wages and earnings that will be calculated for any workers' compensation benefits that you receive are the wages paid through the check or direct deposit from Convergence. x _____

6. That if you are injured while working for Convergence and Client has not reported or has underreported your hours or wages then your workers' compensation claim may be denied. x _____

7. That if you are hired by Convergence and are injured while working on a job for someone other than Convergence and Client, you will not be considered as a covered leased co-employee for workers' compensation purposes. x _____

8. That you understand that if you do not receive a weekly pay check from Convergence you are not considered a Convergence employee even if you have gotten a check from Convergence in the past. x _____

I attest that my signature or mark signifies my confirmation that my statements above are true and accurate and are given by me freely and without duress.

Printed Name _____ **Signature**: _____ **Date**: _____

CONVERGENCE EMPLOYEE AGREEMENT

I, the undersigned employee, in consideration of my hiring by Convergence Employee Leasing, Inc. ("CEL") as an at-will leased employee of CEL, acknowledge and agree to the following:

At-Will Employment: I have been hired as an at-will employee of CEL which is an employee leasing company, there is no contract of employment which exists between me and the client to which I have been assigned, nor between CEL and me and CEL has no liability with regard to any employment agreement. I understand and agree that either CEL or I can terminate our employment relationship at any time as I am an at-will employee of CEL. I further understand and agree that continued employment with the client to which I have been assigned is an essential requirement for employment with CEL and that if my employment with the client to which I have been assigned ends, my employment with CEL will also immediately end at that time.

Co-Employment: I understand and agree CEL does not have actual control over my workplace and as such, is not in a position to end or remediate any discrimination, harassment, or retaliation which may be occurring. The responsibility to resolve and/or end such inappropriate conduct rests with the client company, however, CEL will attempt to facilitate a resolution.

Benefits: I also agree that while I am a leased employee of CEL, if CEL does not receive payment from client for services which I perform as a leased employee, CEL will still pay me the applicable minimum wage (or the legally required minimum salary) for any such pay period, and I agree to this method of compensation. I understand and agree that CEL has no obligation to pay me any other compensation or benefit unless CEL has specifically, in a written agreement with me, adopted the client's obligation to pay me such compensation or benefit. I understand that the client to which I am assigned at all times remains obligated to pay me my regular hourly rate of pay if I am a non-exempt employee and to pay me my full salary if I am an exempt employee even if CEL is not paid by the client to which I am assigned. I understand and agree that CEL does not assume responsibility for payment of bonuses, commissions, severance pay, deferred compensation, profit sharing, vacation, sick, or other paid time off pay, or for any other payment, where payment for such items has not been received by CEL from the client to which I am assigned.

Unemployment: I have been informed and I agree that if my assignment with any CEL client to which I am assigned ends for any reason, I must report back to CEL within **seventy-two (72) hours** for possible reassignment and that unemployment benefits may be denied me if I fail to do so.

Workers' Compensation: In recognition of the fact that any work related injuries which might be sustained by me are covered by state workers' compensation statutes, and to avoid the circumvention of such state statutes which may result from suits against the customers or clients of CEL or against CEL based on the same injury or injuries, and to the extent permitted by law, I hereby waive and forever release any rights I might have to make claims or bring suit against any client or customer of CEL or against CEL for damages based upon injuries which are covered under such workers' compensation statutes. **I also agree to notify CEL within 24 hours of any job-related injury I receive and comply with any drug testing policy which CEL may adopt, and I specifically agree to post-accident drug testing within 24 hours in any situation where it is allowed by law. I understand and agree that if I am accepted as a leased employee of CEL, I am expressly prohibited from performing any work outside the state of Florida for client during my status as a leased employee except as is allowed pursuant to the workers' compensation policy provided to me by CEL or except as may be allowed in writing by CEL and CEL's workers' compensation carrier.** If I work outside the state of Florida for client without first securing this approval, I understand that, I will not be a leased employee of CEL and may not be provided workers' compensation benefits through CEL or CEL's workers' compensation carrier. My leased employment with CEL will be considered immediately terminated upon commencement of my trip outside the state of Florida to perform work for client where prior approval has not been received as set forth herein. I further understand that any unauthorized treatment for an alleged injury will not be reimbursed under any conditions unless the alleged injuries are life threatening. I further understand and agree that I will submit to a drug and alcohol test if I cause or contribute to an on-the-job injury, which results in the injury to others or me. I also understand that my refusal to subject to a drug and alcohol test under these stated conditions may result in my immediate termination.

Discrimination and Harassment: In addition, I also agree that if at any time during my employment I am subjected to any type of discrimination, including discrimination because of race, sex, age, genetic information, religion, color, retaliation, national origin, handicap, disability, or marital status, or if I am subjected to any type of harassment including sexual harassment, I will immediately contact an appropriate person of the client company to which I have been assigned. In most instances, this appropriate person will be the president of the client company. Should I choose not to contact the client company for any reason, I may contact CEL's human resources director at (904) 731- 9014 in order to obtain assistance in the resolution of such matters.

Print Applicant's Name: _____ **SSN:**_____

Applicant's Signature: _____ **Date**:_____

GENERAL SAFETY RULES

1. Job safety is the responsibility of each individual employee. Job safety is often applying common sense to a situation. Use good common sense and stay alert on the job at all times.
2. **All injuries, no matter how slight, must be reported to your supervisor immediately. A drug test will be required within 24 hours of all work-related injuries. If you test positive for illegal drugs, you will be terminated and may lose your worker's compensation benefits.**
3. If an injury occurs, use only company approved medical facilities. Any other medical treatment will be at your own expense.
4. Employees under the influence of drugs or alcohol on-the-job will be subject to immediate discharge. Employees taking prescribed medications should advise the supervisor prior to the start of the shift.
5. If when reporting for work you feel ill or are emotionally upset due to personal problems, discuss them with your foreman/supervisor before starting work.
6. Report any unsafe condition to your supervisor immediately, regardless if the unsafe condition directly affects you.
7. If at any time you are not sure of how to perform the job you have been instructed to do: STOP AND CHECK WITH YOUR SUPERVISOR. This is for your safety and for that of your fellow workers.
8. Do not start or operate any equipment without the proper authority and safety instruction. Never operate a piece of equipment when guards or other safety devices are not in place.
9. Do not attempt to repair or tamper with equipment not working properly. Report the condition to your supervisor immediately.
10. Any employee who is furnished safety equipment will be required to use such equipment while doing the work for which the equipment was furnished.
11. Good housekeeping practices should be followed at all times. This means clean tools, dry floors, neat work areas and properly arranged materials.
12, Use the correct method of lifting objects. Lift with your legs, not your back. If a load is too heavy or awkward, ask for assistance.
13. All electrical power tools and cords must have an operational third wire positive ground. Electrical tools and cords without positive grounding should not be used. Double insulated tools must be so marked.
14. Do not use flammable liquids, toxic materials, chemicals or acids unless authorized and instructed in the proper procedures.
15. Do not smoke in areas which are not specifically designed as smoking areas.
16. All employees who drive or are passengers while on company business must wear their seatbelts at all times.
17. Obey all safety and warning signs at all times.
18. Submitting false or fraudulent information when reporting injury is a third-degree felony and will be cause for dismissal and denial of medical wage loss benefits.

I have read these rules (or I have had them read to me), and understand them and will obey them for my own benefit.

Print Applicant's Name: _____ **SSN:** _____

Applicant's Signature: _____ **Date:** _____

Supervisor's Signature: _____ **Date:** _____

Where injury is caused by the willful refusal of the employee to use safety equipment or obey safety rules, the compensation benefits can be reduced by 25% (Florida Statute 44.09.(4))

NOTICE OF DRUG & ALCOHOL TESTING & RELEASE

The illegal use of drugs and the abuse of alcohol are problems that invade the workplace, endangering the health and safety of the abusers and those who work around them. This Company (Convergence Employee Leasing) is committed to creating and maintaining a workplace free of substance abuse without jeopardizing valued utilized individuals' job security. To address this problem, our Company has developed a policy regarding the illegal use of drugs and the abuse of alcohol that we believe best serves the interests of all utilized individuals. Refer to your "on-site" employer for a copy of this policy. Our policy formally and clearly states that the illegal use of drugs or abuse of alcohol or prescription drugs will not be tolerated. As a means of maintaining our policy, we retain and reserve the right to require pre-employment and active utilized individual drug testing and we require post-accident drug testing. This policy was designed with two basic objectives in mind:

1. Utilized individuals deserve a work environment that is free from the effects of drugs and the problems associated with their use, and
2. This Company has a responsibility to maintain a healthy and safe workplace.

To assist us in maintaining a safe and healthful workplace, we have created an Employee Assistance Program (EAP). The EAP provides utilized individuals and their families confidential assessment, referral, and follow-up for personal or health problems.

To assist us in providing a safe and healthy workplace, we maintain a resource file of information on various means of employee assistance in our community, including but not limited to drug and alcohol abuse programs, utilized individuals are encouraged to use this resource file, which is located [_____insert where]. In addition, we will distribute this information to utilized individuals for their confidential use. A utilized individual whose conduct violates this Company's Substance Abuse Policy (*and who does not accept the help we offer under the EAP) will be disciplined up to and including termination. We believe it is important that we all work together to make this Company a drug-free workplace and a safe, rewarding place to work.

DRUG & ALCOHOL TESTING RELEASE

I hereby consent to submit to testing for drugs and/or alcohol the necessity of which shall be determined by Convergence Employee Leasing, Inc. and affiliated companies for fitness for duty (Including random drug testing), post-accident testing and the selection process of applicants for employment for the purpose of determining the presence of drug and/or alcohol content thereof.

I agree that Convergence will assign a designated clinic or physician that may collect these specimens for these tests and may test them, if qualified, or forward them to a licensed or certified laboratory designated by the company for analysis. I further agree to and hereby authorize the release of said test results to the Convergence Employee Leasing, Inc.

I understand that my current use of illegal drugs may prohibit me from being employed at this Company.

I further agree that a reproduced copy of this pre-employment consent and release form shall have the same force and effect as the original. I have carefully read the foregoing and fully understand its contents. I acknowledge that my signing of this consent and release form is a voluntary act on my part and that I have not been coerced into signing this document by anyone.

Print Applicant's Name: _____ **SSN:** _____

Applicant's Signature: _____ **Date:** _____

Supervisor's Signature: _____ **Date:** _____

Voluntary Post Offer Medical Questionnaire: *Check the appropriate box & complete the appropriate*

If the applicant agrees to complete this questionnaire, please have them complete <u>after</u> the applicant has accepted a conditional offer of employment and has not commenced employment with said client company. By completing this form, the applicant is verifying that the company listed below has already presented a conditional job offer.

1. Have you ever had a job-related injury OR filed a workers' compensation claim in the past?

☐ No (If no, skip to #2) ☐ Yes (If yes, please list all job-related injuries below or attached a separate piece of paper)

Part(s) of the body affected: _____ Date of injury: _____ Status of Claim: ☐ Open ☐ Closed

Job Restrictions: ☐ No ☐ Yes If yes, list restrictions: _____

2. Have You Ever Had or been treated for?

☐ Yes ☐ No Asthma

☐ Yes ☐ No Hay Fever

☐ Yes ☐ No Migraine Headaches

☐ Yes ☐ No Diabetes

☐ Yes ☐ No A head injury

☐ Yes ☐ No Color Blindness

☐ Yes ☐ No A fear of heights

☐ Yes ☐ No An amputated foot, arm, leg, or hand

☐ Yes ☐ No Heart trouble

☐ Yes ☐ No Loss of sight of one or both eyes

☐ Yes ☐ No Fainting spells or dizziness

☐ Yes ☐ No Cerebral Palsy

☐ Yes ☐ No Swelling of the legs or ankles

☐ Yes ☐ No Multiple sclerosis

☐ Yes ☐ No Skin rashes or Eczema

☐ Yes ☐ No Parkinson's disease

☐ Yes ☐ No Kidney Problems

☐ Yes ☐ No Depression

☐ Yes ☐ No Knee problems

☐ Yes ☐ No Hyperinsulinism (hypoglycemia)

☐ Yes ☐ No Pulmonary Disease (lung)

☐ Yes ☐ No Joint Pains or Arthritis

☐ Yes ☐ No Cardiovascular disorder

☐ Yes ☐ No Epilepsy

☐ Yes ☐ No Tuberculosis

☐ Yes ☐ No Cancer

☐ Yes ☐ No Mental retardation

☐ Yes ☐ No Varicose veins

☐ Yes ☐ No Hemophilia

☐ Yes ☐ No Sickle cell anemia

☐ Yes ☐ No Chronic infection of bone

☐ Yes ☐ No Tendonitis

☐ Yes ☐ No Muscular dystrophy

☐ Yes ☐ No Repetitive Motion Disorder

☐ Yes ☐ No Ruptured disc

☐ Yes ☐ No Stiffness of major weight-bearing joints

☐ Yes ☐ No Nervous trouble or treatment

☐ Yes ☐ No Back pain

☐ Yes ☐ No Neck pain

☐ Yes ☐ No Hand pain

☐ Yes ☐ No Mental conditions

☐ Yes ☐ No Do you have partial loss of hearing?

☐ Yes ☐ No Do you need glasses to read or for distance?

☐ Yes ☐ No Any serious wrist problems including Carpal Tunnel Syndrome?

☐ Yes ☐ No Ankylosis (immobility) of major weight bearing joints (ankles, knee, hip)

☐ Yes ☐ No Compressed air sequelae (damage to lungs, ruptured ear drum, etc. due to explosion, air concussion, etc.

☐ Yes ☐ No Have you ever had an audiogram (hearing test)? If yes, results _____

☐ Yes ☐ No Any broken bones? Which bones? _____ When? _____

☐ Yes ☐ No High blood pressure? If yes, do you take medicine to control high blood pressure? ☐ Yes ☐ No

☐ Yes ☐ No Any serious injuries? Month _____ Year _____ Nature of the injury _____

☐ Yes ☐ No A hernia or rupture? Month _____ Year _____

☐ Yes ☐ No Any neck pain or problems? Month _____ Year _____

☐ Yes ☐ No Injured back? Month _____ Year _____

☐ Yes ☐ No Surgery? Month _____ Year _____ Type? _____

☐ Yes ☐ No Ever-refused surgery? If yes, why? _____

☐ Yes ☐ No An allergic reaction to any drugs? Which drugs? _____

☐ Yes ☐ No Partial loss of uncorrected vision of more than 75 percent bilaterally?

☐ Yes ☐ No Psychoneurotic disability following confinement for treatment in a recognized medical or mental institution for a period in excess of six months?

☐ Yes ☐ No Permanent condition that constitutes 20% impairment of a foot, leg, hand, or arm, or of the body as a whole?

☐ Yes ☐ No Do you or have you within the past year participated in recreational drug use?

☐ Yes ☐ No Have you ever participated in a drug abuse treatment program? Where? _____

☐ Yes ☐ No Do you currently take any prescription medications? If so, what? _____

☐ Yes ☐ No Do you have any condition or have you sustained any injury that would have an effect on your capacity to perform the duties of this position without reasonable accommodations?

Have You Ever Been Refused Employment or Unable to Hold a Job Because of?

☐ Yes ☐ No Sensitivity to dust

☐ Yes ☐ No Inability to perform certain motions

☐ Yes ☐ No Inability to assume certain positions

☐ Yes ☐ No Other medical reasons? _____

☐ Yes ☐ No Estimate the number of workdays you have lost in each of the past two years. _____

Please list the name of any doctors you have seen during the past two years. List your family doctor first.

_____

Our workers' compensation insurance carrier may check for previous claims by name and social security number. If you had a previous claim or injury, and fail to make us aware of it, you may be legally denied benefits in the event of a new injury by operation of the Landmark Rycroft Ruling. For your own protections and appropriate medical care, please make us aware of any previous injuries.

Employee's Printed Name: _____ **SSN:** _____

Date of Birth _____/_____/_____**Height** _____ **Weight** _____

Employee's Signature: _____ **Date:** _____

Supervisor's Signature: _____ **Date:** _____

Company Name: _____

Form **W-4**

Department of the Treasury
Internal Revenue Service

Employee's Withholding Certificate

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

OMB No. 1545-0074

2025

Step 1: Enter Personal Information

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

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

TIP: Consider using the estimator at *www.irs.gov/W4App* to determine the most accurate withholding for the rest of the year if: you are completing this form after the beginning of the year; expect to work only part of the year; or have changes during the year in your marital status, number of jobs for you (and/or your spouse if married filing jointly), dependents, other income (not from jobs), deductions, or credits. Have your most recent pay stub(s) from this year available when using the estimator. At the beginning of next year, use the estimator again to recheck your withholding.

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

Step 2: Multiple Jobs or Spouse Works

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

Do **only one** of the following.

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

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

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

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

Step 3: Claim Dependent and Other Credits

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

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

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

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

Step 4 (optional): Other Adjustments

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

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

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

Step 5: Sign Here

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

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

Employers Only

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

Form G-4 (Rev. 04/19/24)

2411004014

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
Enter letter below on Line 7.

A. Single
B. Married Filing Separate or Married Filing Joint, both spouses working
C. Married Filing Joint, one spouse working
D. Head of Household

4. DEPENDENT ALLOWANCES [ ]

5. GEORGIA ADJUSTMENTS ALLOWANCE [ ]
(See instructions for details. Worksheet below must be completed)

6. ADDITIONAL WITHHOLDING $_____

WORKSHEET FOR CALCULATING ADDITIONAL ALLOWANCES
(Must be completed for step 5)

A. Federal Estimated Itemized Deductions (If Itemizing Deductions)..... $_____
B. Georgia Standard Deduction (enter one): $_____
Single/Head of Household $12,000
Married Filing Joint $24,000
Married Filing Separate $12,000
C. Subtract Line B from Line A (If zero or less, enter zero) .....$_____
D. Allowable Georgia Adjustments to Federal Adjusted Gross Income .....$_____
E. Add the Amounts on Lines C and D .....$_____
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 $4,000. Enter total here and on Line 5 above .....
(This is the number of Georgia Adjustments Allowances you can claim. If the remainder is over $1,500 round up)

7. LETTER USED (Marital Status A, B, C or D) _____ **TOTAL ALLOWANCES** (Total of Lines 4 - 5) _____
(Employer: The letter indicates the tax tables in Employer's Tax Guide)

8. EXEMPT: (Do not complete Lines 4 - 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, Taxpayer Services Division, P.O. Box 105499, Atlanta, GA 30359

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 4 - 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 letter on Line 7 according to your marital status.

A. Single
B. Married Filing Separate or Married Filing Joint, both spouses working
C. Married Filing Joint, one spouse working
D. Head of Household

Line 4: Enter the number of dependent allowances you are entitled to claim. The term "dependent" shall have the same meaning as in the Internal Revenue Code of 1986; provided, however, that any unborn child with a detectable human heartbeat, as such terms are defined in Code Section 1-2-1, shall qualify as a dependent minor.

Line 5: Complete the worksheet on Form G-4 if you claim Georgia adjustments Allowances. Enter the number from 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 4-5.

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 D, 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 4-7 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. Employers should honor the properly completed form as submitted unless otherwise notified by the Department. 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 07/31/2026

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Additional Information

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

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

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

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

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

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

LISTS OF ACCEPTABLE DOCUMENTS

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

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

Acceptable Receipts

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Supplement B,
Reverification and Rehire (formerly Section 3)

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

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

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

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

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

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

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

I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented documentation, the documentation I examined appears to be genuine and to relate to the individual who presented it.

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

Additional Information (Initial and date each notation.)

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

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

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

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

I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented documentation, the documentation I examined appears to be genuine and to relate to the individual who presented it.

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

Additional Information (Initial and date each notation.)

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

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

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

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

I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented documentation, the documentation I examined appears to be genuine and to relate to the individual who presented it.

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

Additional Information (Initial and date each notation.)

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