INNOVATIVE
HIRING
TECHNOLOGY INC.

EMPLOYMENT APPLICATION

Application date: ________

Interviewer: ________

Last Name ________ First Name ________ Middle Name ________ SS# ________

Address ________ Apt.# or P.O. Box ________ Drivers License # / State ________

City ________ State ________ Zip ________

( ) ________ Home Phone ( ) ________ Mobile Phone ________ Emergency Contact ( ) ________ Phone

Other names prior employment or education records would be shown under (i.e. Maiden Name)

Position applied for 1. ________ 2. ________ Date available: ________

How did you hear about us? ________ Referred By: ________ ❑ * Smoker ❑ * Non-Smoker

Geographic preference: ________ Workshift available: DAYS: ________ HOURS: ________

Salary desired: (Min.) $ ________ per ________ Available: ❑ Temp ❑ Perm ❑ Either ❑ Part Time ❑ Full Time

* How long have you been a local resident? ________ * Rent? ____ * Own? ____

* Spouse's Name? ________ * Spouse's Employer? ________

Have you been convicted of a crime within the past seven years? ❑ Yes ❑ No (A conviction will not necessarily preclude employment.)

If YES, list offense(s): ________

Date: ________ State: ________ Explain: ________

Have you ever been bonded? ❑ Yes ❑ No Have you ever had a fidelity bond cancelled or denied? ❑ Yes ❑ No

Have you ever been discharged by an employer? ❑ Yes ❑ No If yes, give details: ________

Education:

High School: ________ Years: ____ City: ________ Diploma: ________

College: ________ Years: ____ City: ________ Degree: ________

Other: ________ Years: ____ City: ________ Degree: ________

Most Recent Employer:

Company: ________ Type of Business: ________

Address: ________ Phone: ________

City / State / Zip ________

Dates: Immediate Supervisor: ________ Phone / Ext. ________

Position Held: Salary From: $ ________ per ________ To: $ ________ per ________

From: ________ Mo./Yr. Detailed Job Responsibilities: ________

To: ________ Mo./Yr. Reason for Leaving: ________

May we contact: ❑ Yes ❑ No If No, why? ________

Previous Employer:

Company: ________ Type of Business: ________

Address: ________ Phone: ________

City / State / Zip ________

Dates: Immediate Supervisor: ________ Phone / Ext. ________

Position Held: Salary From: $ ________ per ________ To: $ ________ per ________

From: ________ Mo./Yr. Detailed Job Responsibilities: ________

To: ________ Mo./Yr. Reason for Leaving: ________

May we contact: ❑ Yes ❑ No If No, why? ________

Previous Employer:

Company: ________ Type of Business: ________

Address: ________ Phone: ________

City / State / Zip ________

Dates: Immediate Supervisor: ________ Phone / Ext. ________

Position Held: Salary From: $ ________ per ________ To: $ ________ per ________

From: ________ Mo./Yr. Detailed Job Responsibilities: ________

To: ________ Mo./Yr. Reason for Leaving: ________

May we contact: ❑ Yes ❑ No If No, why? ________

For Office Use Only

IHT Staffing Skill Sheet

Applicant Name: ______________________________

PLEASE SELECT SKILLS THAT YOU HAVE EXPERIENCE IN

INDUSTRIAL

- [ ] Assembly
- [ ] Carpentry
- [ ] CNC Operator
- [ ] Construction
- [ ] Forklift
- [ ] General Labor
- [ ] HVAC
- [ ] Industrial Maint.
- [ ] Injection Molding
- [ ] Inspection
- [ ] Inventory
- [ ] Landscaper
- [ ] Loading/Unloading
- [ ] Machine Operator
- [ ] Material Handling
- [ ] Order Puller
- [ ] Packaging
- [ ] Painter
- [ ] Plumber
- [ ] Quality Control
- [ ] Security
- [ ] Seamstress/Sewer
- [ ] Stocking
- [ ] Shipping & Receiving
- [ ] Soldering
- [ ] Warehouse
- [ ] Welder

HOTEL/PROP MGMT

- [ ] Building Maint.
- [ ] Groundskeeper
- [ ] Hotel/Resort Maint.
- [ ] Housekeeping
- [ ] Laundry

MECHANICS

- [ ] Auto Detailer
- [ ] Auto Mechanic
- [ ] Diesel Mechanic

HEAVY EQUIPMENT

- [ ] Backhoe
- [ ] Bobcat
- [ ] Bulldozer
- [ ] CDL Class A
- [ ] CDL Class B
- [ ] Hazmat Endorsement
- [ ] Heavy Equip. Operator
- [ ] Non-CDL Driver

FOOD SERVICE

- [ ] Banquet Server
- [ ] Bartender
- [ ] Breakfast Cook
- [ ] Busser
- [ ] Prep Cook
- [ ] Dishwasher

SHIFT

- [ ] First
- [ ] Second
- [ ] Third
- [ ] Weekends

TRANSPORTATION

- [ ] Bike/Moped
- [ ] Car
- [ ] Public
- [ ] Ride
- [ ] Walk

OFFICE SKILLS

- [ ] Data Entry
- [ ] Dictaphone
- [ ] Dispatcher
- [ ] Filing
- [ ] Legal Terminology
- [ ] Shorthand
- [ ] Speed Writing
- [ ] Typing WPM _____

ADMIN/OFFICE

- [ ] Admin. Assistant
- [ ] Call Center
- [ ] Customer Service
- [ ] Executive Assistant
- [ ] General Office
- [ ] Human Resources
- [ ] Legal Assistant
- [ ] Mail Clerk
- [ ] Office Manager
- [ ] Paralegal
- [ ] Property Manager
- [ ] Receptionist
- [ ] Retail
- [ ] Sales
- [ ] Switchboard Operator

MEDICAL

- [ ] Insurance Verification
- [ ] Medical Assistant
- [ ] Medical Billing
- [ ] Medical Receptionist
- [ ] Medical Terminology
- [ ] Scheduler

SOFTWARE

- [ ] Access
- [ ] Email/Internet
- [ ] Excel
- [ ] Google Shared Sheets
- [ ] Iqware
- [ ] Microsoft Publisher
- [ ] Office Suites
- [ ] Outlook
- [ ] Photoshop
- [ ] Power Point
- [ ] Word
- [ ] Word Perfect

ACCOUNTING

- [ ] Accounting Clerk
- [ ] Accounts Payable
- [ ] Accounts Receivable
- [ ] AS400
- [ ] Bookkeeping
- [ ] Cashier
- [ ] Cost Accounting
- [ ] Credit Collections
- [ ] Payroll
- [ ] Peachtree
- [ ] Quickbooks

OTHER SKILLS NOT LISTED

- [ ] ______________
- [ ] ______________
- [ ] ______________
- [ ] ______________
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IHT STAFFING
2105-A CROMLEY CIRCLE
MYRTLE BEACH, SC 29577

Personal Health History Questionnaire

Applicable state and federal laws prohibit discrimination based on disability or prior filing of claim for workers' compensation or taking medical leave to which you were entitled. This personal health history questionnaire will be maintained in a file separate from your employment file. Any false statements, misrepresentations, or concealments to secure employment are sufficient grounds for dismissal.

Circle YES or NO if you now have, or if you are being treated now by a health care provider, OR if you have had in the past, or have been treated in the past by a health care provider, for any of the following. Please provide the details of any "YES" answer, including the duration of the condition, dates of treatment, work restrictions or impairment level (if any), and outcome. Please use additional sheets of paper if necessary to fully answer each question.

YES	__ NO	1.	Carpel Tunnel diagnosis or surgery	DETAILS:
YES	NO	2.	Heart Disease or Attack	DETAILS:
__ YES	NO	3.	Bone or Joint problems, ie. Knee/shoulder/wrist, etc.	DETAILS:
YES	NO	4.	Dizziness, fainting spells or frequent headaches	DETAILS:
YES	NO	5.	Depression/Nervous Disorder/Mental Illness	DETAILS:
YES	NO	6.	Back or neck condition/injury?	DETAILS:
YES	NO	7.	Have you ever had surgery?	DETAILS:
YES	NO	8.	Do you have any physical limitations that limit or reduce your ability to perform any work related duties?	DETAILS:
YES	NO	9.	Have you ever had a workers' compensation claim due to an on-the-job injury or illness?	DETAILS:
YES	NO	10.	Have you had any medical condition, illness, or disease that resulted in your absence from work or inability to perform the essential functions of your job for more than 7 consecutive work days?	DETAILS:

Have you ever had or been treated for any of the following conditions or diseases?

Repetitive Stress Trauma: ___ No ___ Yes

Back or neck problems or injury: ___ No ___ Yes

Knee injury: ___ No ___ Yes

Major illness in the past five years: ___ No ___ Yes

Diabetes: ___ No ___ Yes

Alcoholism: ___ No ___ Yes

Drug Addiction: ___ No ___ Yes

____

Employee Signature   Date

____

Print Name   Social Security Number (SSN)

____

Witnessed by   Date

IHT STAFFING

PERMANENT & TEMPORARY SERVICES

CRIMINAL BACKGROUND AND DRUG TESTING REIMBURSEMENT

______________________, I agree to have my criminal background checked for a possible position with IHT. I also agree to a drug test to be conducted.

By signing this form, applicant is agreeing to reimburse IHT for the cost of this criminal background check/drug test from their 1st paycheck in the amount of $20.00.

Applicant Signature: ______________________

Date: ______________________

IHT Coordinator: ______________________

Worker's Compensation Policy

All worker's compensation claims must be reported to IHT Staffing immediately for any accidents or injuries while working or while on any work site. All claims must be submitted within 8 hours of happening, whether major or minor. You must contact IHT Staffing (843-626-7970, during business hours and after hours). After reporting your injury, you must report to our office to fill out necessary paperwork. From there you will be sent to an approved Doctor's Care or Emergency Room depending on your medical needs. If an accident happens after hours or on the weekend, a report must be made and you must report to our office at 8a on the following Monday morning to complete paperwork. You must bring all medical documentation with you.

Failure to report an injury in the 8 hours could mean that your claim could be delayed. If you seek medical attention on your own, you ARE RESPONSIBLE for that medical bill.

If you have a minor injury and decide not to file a WC claim, you will need to fill out a Refusal of Treatment. This must also be done within the 8-hour period.

After each medical visit, you must bring in all documentation given to you to IHT Staffing after your visit.

I have read the Workers' Compensation Policy and understand all procedures.

____

Date:

____

IHT STAFFING POLICIES AND PROCEDURES

Please initial each line after you have read and completely understand each statement.

_____ I understand that I am expected to complete any job assignment that I work unless the work is unsafe. If I consider the job unsafe, I will call IHT Staffing immediately. A 24-hour answering service is available seven days a week for your convenience, 843-626-7970. All job details will be given to the employee upon acceptance of assignments.

_____ If for some unexpected reason such as an emergency or illness I cannot make an assignment or if I will be arriving late. I will contact IHT Staffing as soon as possible so that a replacement can be scheduled in my place. I also agree to give IHT Staffing 48-hour notice if I need time off for a doctor's visit, car repairs, etc. My failure to do so will be grounds for IHT Staffing to assume that I have voluntarily quit. Non-compliance with this availability policy is regarded as voluntarily quit and you may be ineligible for unemployment benefits. Also, it states on the back of the IHT Staffing timecard when signed, you agree to the terms and conditions. An employer may not hire an IHT Staffing employee before the hours are completed without IHT Staffing being paid a fee.

_____ Full-time is defined as 40 hours per week.

_____ IHT Staffing has a very strict SUBSTANCE ABUSE POLICY and by signing this form I consent to submit to pre-employment (as required) and random drug testing. I understand that failure to comply with this my assignment will be grounds for my immediate termination.

_____ IHT Staffing is not liable for drug screening and background checks. The employee will pay for the required pre-employment screenings upfront when applicable.

_____ Timecards are the responsibility of the employee. They can be picked up at the office during business hours, printed off the IHT Staffing website (ihtstaffing.com) or found in the mailbox beside the front door. I understand that IHT Staffing will not recognize or pay for any hours worked by me WITHOUT a timecard SIGNED by the client. As an employee of the IHT Staffing, it is my responsibility to fill out a timecard properly and make sure that it is turned into IHT Staffing office by 9 am every Monday morning. If the timecard is faxed, it is my responsibility to follow up and confirm that my timecard has been received. Failure to turn in a signed timecard could result in not being paid on time. Pay checks are available for pick-up every Friday from 7:30 am to 5:00 pm. IHT Staffing offers direct deposit and pay cards in addition to regular paychecks.

By signing below, you agree to IHT Staffing's policies and procedures.

Employee Signature: ______________________ Date: ________________

IMPORTANT TO ALL EMPLOYEES

- NO EATING OR DRINKING ANYWHERE WHILE AT WORK, EXCEPT IN DESIGNATED AREAS AND ONLY PERMITTED FOOD WHETHER BROUGHT OR GIVEN BY MANAGEMENT

- NO CELL PHONE USE WHILE WORKING

- NO SMOKING EXCEPT IN DESIGNATED AREAS AND ONLY AT BREAK TIMES

- NO ILLEGAL DRUGS OR WEAPONS ARE PERMITTED, INCLUDING IN VEHICLES AND IN PARKING LOTS.

- NO VISITORS AT WORK

- NO DRINKING ALCOHOLIC BEVERAGES AT WORK

- HOSPITALITY/WEEKEND WORKERS: WEEKENDS ARE MANDATORY!

- IF UNIFORMS ARE REQUIRED, YOU MUST WEAR THEM (INCLUDING NAME TAGS AND TIES)

- IF UNIFORMS, KEYS AND SUPPLIES ARE ISSUED AND YOU ARE NO LONGER WORKING THERE, YOU ARE REQUIRED TO TURN THEM IN TO THE OFFICE AT IHT STAFFING BEFORE RECEIVING YOUR PAY. IF YOU ARE ON DIRECT DEPOSIT, YOU WILL RECEIVE A PAPER CHECK ONCE THE MATERIALS ARE TURNED IN.

SIGNATURE: ____________________ DATE: ____________________

EMPLOYEE ACKNOWLEDGEMENT FORM

The Coastal Group (and all affiliated companies) is firmly committed to your safety. We will do everything possible to prevent workplace accidents and are committed to providing a safe working environment for you and all employees.

You are encouraged to report any unsafe work practices or safety hazards encountered on the job. All accidents/incidents (no matter how slight) are to be reported immediately to the supervisor on duty.

A key factor in implementing this policy will be strict compliance to all applicable federal, state, local, and The Coastal Groups policies and procedures. Failure to comply with these policies may result in disciplinary actions.

Additionally, The Coastal Group (and all affiliates) subscribes to these principles:

1. All accidents are preventable through implementation of effective Safety and Health Control policies and programs.
2. Safety and Health controls are a major part of our work week every day.
3. Accident prevention is good business. It minimizes human suffering, promotes better working conditions for everyone, holds The Coastal Group in higher regard with customers, and increases productivity.
4. Management is responsible for providing the safest possible workplace for Employees. Consequently, management is committed to allocating and providing the resources needed to promote and effectively implement this safety policy.
5. Employees are responsible for following safe work practices, company rules, and for preventing accidents and injuries.
6. Our safety program applies to all employees and persons affected or associated in any way by the scope of this business.

By signing this document, I confirm receipt of The Coastal Group's Employee Safety Handbook and acknowledge that I have read and understood all polices, programs, and actions as described and agree to comply with these policies.

____

Employee Name (printed)

____

Employee Signature **DATE**

IHT STAFFING
2105 Cromley Circle UN-A
Myrtle Beach, SC 29577

EEO IDENTIFICATION

Various agencies of the United States Government require employers to maintain information on applicants pertaining to factors such as race, sex, and type of position for which an individual applies. The information requested on this sheet is for compliance with certain record keeping requirements. Waterfront Staffing Inc believe all persons are entitled to equal employment opportunities and do not discriminate against its employees or applicants for employment because of race, color, sex, religion, national origin, disability, veteran status, age, marital status, or any other protected group status.

Name: ______________________________ Date: ____/____/______

Position applied for: ______________________________

Social Security Number (SSN): ______________ Date of Birth: ____/____/____ Gender: ☐ Male ☐ Female

Race/Ethnic Data:

☐ White (Non-Hispanic)
Origins of Europe, North Africa, or Middle East

☐ Asian (Non-Hispanic)
Origins of Far East, Southeast Asia, or the Indian subcontinent

☐ Native Hawaiian or Other Pacific Islander
Origins of Hawaii, Guam, Samoa, or other Pacific Islands

☐ Black or African American (Non-Hispanic)
Origins in any of the black Racial groups of Africa

☐ Hispanic or Latino
Mexican, Cuban, Puerto Rican, South or Central American, or Other Spanish culture or origin regardless of race

☐ American Indian or Alaskan Native
Origins of North and South America (including Central America), who maintain tribal affiliation or community attachment

☐ Two or more races (Non-Hispanic)
All persons who identify with more than one of the above races

Regulations issued by the U.S. Department of Labor with respect to disabled individuals, disabled veteran and Vietnam Era veterans require that federal contractors provide an opportunity for self-identification to candidates seeking employment. Such self-identification is submitted on a voluntary basis, for use one in accordance with regulations, and without subjecting the individual to adverse treatment.

Disabled/Veteran Classification(s):

☐ Special Disabled Veteran (30% or more disability)

☐ Vietnam Era Veteran

☐ Other Eligible Veteran

☐ Disabled Individual

To be Completed by the Worksite Employer

☐ If the employee elected not to complete this form, the Worksite Employer has completed it through visual identification as required by law.

From the EEO job classification listed below, which one best describes the position filled?

☐ 1.1 – Executive/Senior Level Officials and Managers
☐ 1.2 – First/Mid Level Officials & Managers
☐ 2 – Professionals
☐ 3 – Technicians
☐ 4 – Sales
☐ 5 – Office and Clerical
☐ 6 – Craft Workers (skilled)
☐ 7 – Operative (semi-skilled)
☐ 8 – Laborers (unskilled)
☐ 9 – Service Workers

employers HR

Employers HR
EMPLOYEE DATA FORM
(PLEASE FILL OUT COMPLETELY & ACCURATELY)

Company Name: IHT Staffing

Location: Myrtle Beach, SC

SECTION 1

Employee: ______________________ ________________________ SS#: ___________________

Address: ____ Apt.: _____ Phone: _________________

City: _____________________ County: __________________ State: ___________ Zip: _______

Hire Date with Client: ____________________ Hire Date with Employers HR: ___________________

IN CASE OF EMERGENCY, PLEASE CONTACT

Name: ____ Relationship: ____________________

Address: ____ Apt.: _____ Phone: _________________

City: _____________________ County: __________________ State: ___________ Zip: _______

SECTION 2

Date of Birth: ________________________ Sex: ____ Male _____ Female

Please check the appropriate box below:

___ Hispanic or Latino ___White ___ Black or African American ___ Native Hawaiian or Other Pacific Islander
___ Asian ___ American Indian or Alaska Native ___ Two or more Races

Employee Signature: ___________________________________ Date: ________________________

This Section Must be Completed by Your Supervisor

Supervisor's Name: ___________________________ Hire Date: ____________________________

Type of Hire: ___ New Hire ___ Re-hire ___ Employers HR/Client Transaction

Job Title: _______________________________ Employees #____________ Badge #___________

Division: ______________ Department_____________ Location__________ Region____________

Employee: ___ Full Time ___ Part Time ___Exempt ___ Non-exempt Workers Compensation Class Code

Pay Cycle: ___ Weekly ___ Bi-Weekly ___ Semi-Monthly___ Monthly ______________________

Pay type and Rate: Hourly Rate $_________Salary (Per Pay Cycle) $ _______Commissions/Other $_________

Insurance Eligibility: ____ YES ___ NO Date Eligible _____________ Benefit Group_____________

Employers HR is an Equal Opportunity Employer. The above information is used only to submit to the EEO report to the Federal Government each year. Employers HR is subject to certain governmental recordkeeping and reporting requirements for the administration of civil rights laws and regulations. In order to comply with these laws, the employer invites employees to voluntarily self-identify their race, ethnicity and gender. Submission of this information is voluntary and refusal to provide it will not subject you to any adverse treatment. The information will be kept confidential and separate from personnel files. It will only be used in accordance with the provisions of applicable laws, executive orders and regulations: including those that require the information to be summarized and reported to the federal government for civil rights enforcement. When reported, data will not identify any specific individual.

I, the undersigned employee, in consideration of my hiring by Employers HR as an at-will leased employee, of Employer HR, acknowledge and agree to the following. I have been hired as an at will employee of Employers HR which s an employee leasing company and there is no contract of employment which exist between me and the client to which I have been assigned, not between Employers HR and Me. I understand and agree that either Employers HR or I can terminate our employment relationship at any time, as I am an at will employee. I also agree that I may be assigned to an affiliated Employers HR company and employed by such company at any time at the sole and complete discretion of Employers HR and without my consent or agreement. I also agree that while I am a leased employee of Employers HR, if Employers HR does not receive payment from client for services which I perform as a leased employee, Employers HR will still pay me the applicable minimum wage (or the legally required minimum salary or overtime pay) for any such pay period, and I agree to this method of compensation. 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 non-exempt employee and to pay me my full salary if am an exempt employee even if Employers HR is not paid by the client to which I am assigned. I have been informed and I agree that if my assignment with any Employers HR client to which I am assigned ends for any reason, I must report back to Employers with in seventy-two (72) hours for possible reassignment and that unemployment benefits may be denied to me if I fail to do so. In recognition of the fact that any work injuries which might be sustained by me are covered by state workers compensation statutes, and to avoid the circumvention of such statutes which might result from suits against the customers or clients of Employers HR or against Employers HR 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 Employers HR or against Employers HR for damages based upon injuries which are covered under such workers compensation statutes. I also agree to comply with any drug testing policy, which Employers HR may adopt, and I specifically agree to post-accident drug testing in any situation where it is allowed by law. 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, religion, color, veteran status, 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 Employers HR Human Resources Direction at888-796-8398 in order to obtain assistance in the resolution of such matters.

Employee Signature: ______________________________________ Date: ________________

________________:PAYCARD (CHECK IF YOU WOULD LIKE A PAYCARD)

By providing the information requested above and signing below, I hereby elect and consent to receive my wages, including but not limited to off cycle age payments and wage payments upon discharge by electronic transfer of wages to a paycard.

EmployeeSignature:________________________________Date:________________

PAYCARD NUMBER:____

DEPOSIT AMOUNT:________________________OR ALL:________________________

PRINT FULL NAME:____

ADDRESS:____

BIRTHDATE:____________________________

SS NUMBER:____________________________

EMPLOYEE DIRECT DEPOSIT AUTHORIZATION FORM

In order to have your paystubs emailed to you weekly from our payroll system, please provide an email address:______________________________

IMPORTANT: Direct Deposit will not be processed until a voided check or direct deposit form from your bank is provided to us.

In order to receive Automatic Deposits, please complete the following information. For new enrollees and employees changing accounts, you must attach a voided personal check; if a savings deposit, please provide the proper routing number. Print clearly using a pen

Financial Institution (Bank) Information (For Direct Deposit Accounts Only) Please verify the ABA Routing Number, with your financial institution, for your Checking Account(s) (first 9 digits on your check) and for all other accounts. The employee is responsible for the accuracy of ABA Routing Number. Please allow 14 business days before receiving your first direct deposit.

Employer Information:	Company Name			Date of Hire
Employee Information:	Employee Name		Soc. Sec. #	Birth Date
	Street Address			Daytime Phone Number
	City	State	Zip Code	Home Phone Number
Check One	☐ New Enrollment	☐ Change Institution	☐ Cancel Participation	
Financial Institution Information:	Financial Institution Name			Type of Account ☐ Checking ☐ Savings
	Street Address			Bank Phone Number
	City	State	Zip Code	Deposit Amount $______
	Direct Deposit Routing/Transit No.		Account Number	______%
Financial Institution Information: (Use reverse side for additional institutions)	Financial Institution Name			Type of Account ☐ Checking ☐ Savings
	Street Address			Bank Phone Number
	City	State	Zip Code	Deposit Amount $______
	Direct Deposit Routing/Transit No.		Account Number	______%

Permission to Deduct

FOR NEW ENROLLMENTS AND CHANGES, A VOIDED CHECK OR SAVINGS DEPOSIT SLIP MUST BE ATTACHED TO THIS FORM. (TO VERIFY OF ROUTING/TRANSIT NUMBERS)

I (we) hereby authorize Employers HR, to initiate credit entries and to initiate, if necessary, debit entries and adjustments for any credit entries in error to my (our) checking and/or savings account indicated below and the Financial Institution named below to credit and/or debit the same to such account. If I become subject to any attachment, garnishment, or levies, my participation in Direct Deposit may be terminated, and I will receive a check for my pay. In the event of an employee termination, the final pay may be a physical check. In order to cancel, you MUST provide written notice to Employers HR prior to payroll run with your name, SSN, and signature with the request to cancel. Employers HR will send Direct Deposits to arrive on your check date. Employers HR assumes no responsibility for when your banking institution credits funds to your account and reserves the right to override this authorization in accordance with your work site agreement.

____________________________ ____________
Employee Signature Date

www.employershr.net

2420 ENTERPRISE ROAD | SUITE 103 | CLEARWATER, FL 33763 | PHONE: 888.796.8398

Employment Eligibility Verification

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

	List A	OR	List B	AND	List C
Document Title 1					
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					
Document Title 2 (if any)			**Additional Information**		
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)			☐ 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)
BARNHART, LINDA SUE PAYROLL	Linda Sue Barnhart	

Employer's Business or Organization Name	Employer's Business or Organization Address, City or Town, State, ZIP Code
IHT STAFFING	2105 CROMLEY CIRCLE UNIT-A, MYRTLE BEACH, SC 29577

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

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)

Print Form | Reset Form

1350

dor.sc.gov

STATE OF SOUTH CAROLINA
DEPARTMENT OF REVENUE

SOUTH CAROLINA EMPLOYEE'S WITHHOLDING ALLOWANCE CERTIFICATE

SC W-4
(Rev. 11/21/24)
3527
2025

Give this form to your employer. Keep the worksheets for your records. The SCDOR may review any allowances and exemptions claimed. Your employer may be required to send a copy of this form to the SCDOR.

Part I: Employee Information

1 First name and middle initial	Last name	2 Social Security Number
Address		3 ☐ Single ☐ Married ☐ Married, but withhold at higher Single rate* *Check if married but filing separately.
City / State / ZIP		4 Check if **your last name is different** on your Social Security card. ☐ For a replacement card, contact the Social Security Admin at 1-800-772-1213.

5 Total number of allowances (from the applicable worksheet on page 3) 5

6 Additional amount, if any, to withhold from each paycheck .... 6 $

7 I claim exemption from withholding for 2025. Check the box for the exemption reason and write **Exempt** on line 7. 7

☐ For tax year 2024, I had a right to a refund of **all** South Carolina Income Tax withheld because I had **no** tax liability, **and** for tax year 2025 I expect a refund of **all** South Carolina Income Tax withheld because I expect to have **no** tax liability.

☐ For tax year 2025. I am a military servicemember or the spouse of a military servicemember and elect to use another state as my state of domicile. See instructions. State of domicile: ______________________

Under penalty of law, I certify that this information is correct, true, and complete to the best of my knowledge.

Employee's signature (required) ______________________________ **Date** ____________

Part II: Employer Information

Complete box 8 and box 10 if sending to the SCDOR. Complete box 8, box 9, and box 10 if sending to the State Directory of New Hires.

8 Employer's name and address	9 First date of employment	10 FEIN

INSTRUCTIONS

Employee instructions

Complete the SC W-4 so your employer can withhold the correct South Carolina Income Tax from your pay. If you have too much tax withheld, you will receive a refund when you file your South Carolina Individual Income 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.

Determine the number of withholding allowances you should claim for withholding for 2025 and any additional amount of tax to be withheld. For regular wages, withholding must be based on allowances you claimed and may not be a flat amount or percentage of wages.

Consider completing a new SC W-4 each year and when your personal or financial situation changes. This keeps your withholding accurate and helps you avoid surprises when you file your South Carolina Individual Income Tax return.

For the latest information about South Carolina Withholding Tax and the SC W-4, visit **dor.sc.gov/withholding**.

Exemptions: You may claim exemption from South Carolina withholding for 2025 for one of the following reasons:

- For tax year 2024, you had a right to a refund of **all** South Carolina Income Tax withheld because you had **no** tax liability, **and** for tax year 2025 you expect a refund of **all** South Carolina Income Tax withheld because you expect to have **no** tax liability.
- Under the provisions of the Veterans Auto and Education Improvement Act, you are a military servicemember or a military servicemember's spouse who is electing for tax purposes to use the domicile state of the servicemember, the domicile state of the spouse, or the permanent duty station of the servicemember as your state of domicile. Enter the name of the state on the line provided. Refer to SC Revenue Ruling #24-5, available at **dor.sc.gov/policy**, for more information.

If you are exempt, complete **only** line 1 through line 4 and line 7. Check the box for the reason you are claiming an exemption and write **Exempt** on line 7. Your exemption from withholding expires on December 31, 2025, unless a new SC W-4 is submitted to the employer.

If the state of domicile changes during the year, the servicemember and/or spouse should provide the employer with an updated SC W-4 to ensure the employer withholds the correct amount of Income Taxes for the remainder of the tax year.

Filers with multiple jobs or working spouses: You will need to file an SC W-4 for each employer. If you have more than one job, or if you are married filing jointly and your spouse is also working, you may want to consider only claiming allowances on the SC W-4 for the highest earning job and/or adding additional withholding on line 6 to ensure you are having enough withheld.

VSI **3122501-BSD1** OFFICE USE ONLY LOCATION ________ New Hire ☐ Rehire ☐ Date __/__/____

ENROLLMENT FORM

ESC/MEC 4NAW P1M v25.1

A. REQUIRED EMPLOYEE INFORMATION

PRINT USING BLACK or BLUE INK (Must Be Filled Out)

Name	Phone	
Social Security #	Date of Birth / /	Gender M F
Address		Apt. #
City	Zip	State

B. MEDICARE INFORMATION

Do you or any of your dependents receive Medicare Benefits?

☐ Yes ☐ No. If Yes:

Medicare Health Insurance Claim Number (HICN)

Medicare Effective Date

Name of Covered Person(s):
1. 2.

C. LIMITED BENEFIT PLAN SELECTION

Payroll Deducted Weekly Rates

You **MUST** enroll in the **Fixed Indemnity Medical Insurance Plan** before adding any additional benefits in Section C. Your coverage level for the additional benefits in Section C will be identical to your Fixed Indemnity Medical Plan selection. These plans are underwritten by BCS Insurance Company and 4 Ever Life Insurance Company.

	FIXED INDEMNITY MEDICAL [1]	DENTAL [1]	VISION [1]	TERM LIFE [1]	SHORT-TERM DISABILITY [1,2]
Employee Only	☐ **$19.98**	**$5.40**	**$2.42**	**$0.60**	**$4.20**
Employee + Child(ren)	☐ **$33.17**	**$14.58**	**$6.54**	**$0.90**	
Employee + Spouse	☐ **$37.96**	**$10.80**	**$4.84**	**$0.90**	
Employee + Family	☐ **$50.55**	**$20.52**	**$9.20**	**$1.80**	
	☐ **NO** to ALL Benefits	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

[1] This coverage is not available to residents of **NH, HI,** or **PR.** [2] STD is not available to persons who reside in **CA, HI, NH, NJ, NY,** or **RI.**

For Term Life / Accidental Death & Dismemberment please write in your beneficiary information. Accidental Death & Dismemberment is part of the Term Life Benefit.

Name Relationship

D. REQUIRED DEPENDENT INFORMATION

Name	Social Security #	Date of Birth	Gender	Relationship
Name	Social Security #	/ /	M F	☐ Spouse ☐ Child ☐ Domestic Partner
Name	Social Security #	/ /	M F	☐ Spouse ☐ Child ☐ Domestic Partner
Name	Social Security #	/ /	M F	☐ Spouse ☐ Child ☐ Domestic Partner

E. OPTIONAL MEC WELLNESS/PREVENTIVE BENEFIT SELECTION [1]

83122501-M-BSD1 **Payroll Deducted Weekly Rates**

Enrolling in the **Optional MEC Wellness/Preventive Benefit** may **DISQUALIFY** you from receiving a subsidy from the health insurance exchange. The MEC Wellness/Preventive Benefit is **NOT** underwritten by BCS Insurance Company. It is a benefit offered and provided by your employer. Note: The Patient Protection and Affordable Care Act (PPACA) individual mandate no longer imposes a penalty at the federal level; however, please check with your state for any state specific individual mandate requirements or penalties. Rates for the MEC Wellness/Preventive Benefit are billed weekly.

☐ **$13.42** Employee Only ☐ **$15.18** Employee + Child(ren) ☐ **$16.38** Employee + Spouse ☐ **$18.66** Employee + Family

☐ **NO** to MEC Wellness/Preventive

[1] This coverage is not available to residents of HI, or PR

F. REQUIRED SIGNATURE

YOU MUST SIGN AND DATE EVEN IF YOU DECLINE COVERAGE

By signing below, I confirm I have read the Benefits Summary and the Limitations and Exclusions for the recommended benefit plans; I've been offered self-funded ACA compliant coverage (MEC Wellness/Preventive) and open enrollment is only available for a limited time. I also understand that making no benefit selection is a declination of benefit coverage and benefit coverage is only available to employees who are over the age of 18 with a valid SSN.

DATE __/__/____ ▶ **SIGNATURE**