



## PHOENIX HEALTH CARE

218 ROUTE 17 NORTH, ROCHELLE PARK, NJ 07662 201-567-4364 FAX 201-567-7232 WWW.PHOENIXHEALTHCARENJ.COM

Dear

Thank you for your interest in applying for work with Phoenix Health Care, Inc.. Enclosed is an application for you to complete. As soon as you receive this application, contact us to set up an interview at your earliest convenience.

As you are probably aware, both the Health Department and JCAHO require evidence of the following items annually:

### Current Nursing License

BCLS/ACLS.....	ACLS is required of all ER personnel
Malpractice.....	1-2 or 1-3 million.
Physical.....	Must include a PPD/Mantoux and Rubella Titre
Fire, Safety, and Infection Control.	

In addition, any of the following certifications that you may have are extremely helpful:

IV Certification

ICU/CCU Certification

Chemotherapy administration

Operating Room

CV or Resume

We currently have work available in the following areas:

ICU/CCU/OH	MED/SURG
ER/ERH	TELEMETRY
PACU	LONG TERM CARE/SUB ACUTE
OR/RR/PACU	PRIVATE DUTY
NICU/PICU	ONCOLOGY IN-PATIENT/OUT-PATIENT
PSYCH	

If you have any questions, please do not hesitate to telephone us at any time.

Thank you in advance.

Lynn Ziegler RN  
Nurse Recruiter



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### APPLICATION FOR EMPLOYMENT

Name: \_\_\_\_\_ SS No.: \_\_\_\_\_  
Last First

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

County: \_\_\_\_\_

Home Telephone No.: \_\_\_\_\_ Work Telephone No.: \_\_\_\_\_

Email: \_\_\_\_\_ Beeper #: \_\_\_\_\_ Cell #: \_\_\_\_\_

NJ RN License No.: \_\_\_\_\_ Expiration Date: \_\_\_\_\_

Area of Expertise: \_\_\_\_\_

Hospitals: \_\_\_\_\_

Shifts: \_\_\_\_\_

### MALPRACTICE INSURANCE INFORMATION

Company: \_\_\_\_\_ Expiration Date: \_\_\_\_\_

Policy No.: \_\_\_\_\_ Coverage Limits: \_\_\_\_\_

### EDUCATION

	Institution	From/To	Degree or Certificate
School Nursing/Undergraduate:			
Graduate:			
College:			

-Over-

# APPLICATION FOR EMPLOYMENT

Page 2

## PROFESSIONAL HISTORY (Start with most recent)

Facility & Address: \_\_\_\_\_  
From/To: \_\_\_\_\_ Unit(s) Worked: \_\_\_\_\_  
Supervisor: \_\_\_\_\_ Phone No.: \_\_\_\_\_

Facility & Address: \_\_\_\_\_  
From/To: \_\_\_\_\_ Unit(s) Worked: \_\_\_\_\_  
Supervisor: \_\_\_\_\_ Phone No.: \_\_\_\_\_

## CERTIFICATIONS

B.C.L.S.: \_\_\_\_\_ Expiration Date: \_\_\_\_\_ A.C.L.S.: \_\_\_\_\_ Expiration Date: \_\_\_\_\_  
I.V. Certification Date: \_\_\_\_\_ Institution: \_\_\_\_\_  
CCRN Date: \_\_\_\_\_ CCRN #: \_\_\_\_\_ Expiration: \_\_\_\_\_  
CEN Date: \_\_\_\_\_ CEN #: \_\_\_\_\_ Expiration: \_\_\_\_\_

Please check areas in which you are clinically competent and willing to work (must have 1 yr. current experience in the area checked):

<input type="checkbox"/>	Medical ICU	<input type="checkbox"/>	Emergency/ERH	<input type="checkbox"/>	Private Duty
<input type="checkbox"/>	Coronary ICU	<input type="checkbox"/>	PACU	<input type="checkbox"/>	Well Baby
<input type="checkbox"/>	Surgical ICU	<input type="checkbox"/>	L&D/P.P	<input type="checkbox"/>	CNA
<input type="checkbox"/>	Open Heart	<input type="checkbox"/>	General Peds	<input type="checkbox"/>	Telemetry
<input type="checkbox"/>	Operating Room	<input type="checkbox"/>	Utilization Review	<input type="checkbox"/>	Sub Acute
<input type="checkbox"/>	Neonatal ICU	<input type="checkbox"/>	Oncology	<input type="checkbox"/>	LTC
<input type="checkbox"/>	Pediatrics ICU	<input type="checkbox"/>	Med/Surg	<input type="checkbox"/>	Case Management- D/C Planning

Please list pertinent continuing education / critical care courses completed.  
Include ICU Certification, seminars and in-service programs:

Course: \_\_\_\_\_ Location: \_\_\_\_\_ Date: \_\_\_\_\_  
Course: \_\_\_\_\_ Location: \_\_\_\_\_ Date: \_\_\_\_\_  
Course: \_\_\_\_\_ Location: \_\_\_\_\_ Date: \_\_\_\_\_

I certify the above information to be true and accurate.

Applicant's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Interviewer's Signature: \_\_\_\_\_

Comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**PHOENIX HEALTH CARE  
CRIMINAL BACKGROUND CHECK  
SEARCH REQUEST FORM**

**To Be Completed By Applicant:** (Please type or print legibly)

Individual's Name: \_\_\_\_\_

Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

Phone #: \_\_\_\_\_ Social Security No: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Driver's License No: \_\_\_\_\_ DL State: \_\_\_\_\_

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**APPLICANT CONSENT FOR BACKGROUND  
INVESTIGATION**

I hereby authorize Phoenix Health Care and its affiliates, or its agents to investigate me, my former employment and professional reputation.

I hereby authorize all persons, firms, companies, government agencies, courts, credit agencies, associations or institutions having control of any documents, records or other information to furnish said documents to the above requestor.

I understand that the above information is specifically related to the background investigation process, and that in no way will it be used as a basis for the employment decision.

I hereby release to Phoenix Health Care and its affiliate, or its agents from any and all liability resulting from such investigation.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_



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I HAVE READ AND UNDERSTAND THE INFECTION CONTROL, FIRE AND ELECTRICAL SAFETY, AND HIPPA GUIDELINES IN ACCORDANCE WITH THE STATE AND JCAHO REGULATION.

Print Name \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

Authorized Signature \_\_\_\_\_ Date \_\_\_\_\_



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### PHYSICIAN'S STATEMENT

RE: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**DATE OF PHYSICAL EXAM:** \_\_\_\_\_

**DATE AND RESULTS OF TWO STEP MANTOUX:** \_\_\_\_\_

(one time requirement)

**DATE AND RESULTS OF PPD:** \_\_\_\_\_

(yearly requirement)

**IF PPD IS/HAS BEEN POSITIVE, A CHEST X-RAY IS REQUIRED. ANY SYMPTOMS?**

\_\_\_\_\_

**DATE OF POSITIVE PPD:** \_\_\_\_\_

**DATE AND RESULTS OF CHEST X-RAY:** \_\_\_\_\_

**DATE OF MEASLES, MUMPS & RUBELLA (MMR) VACCINATION:** \_\_\_\_\_

**DATE AND RESULTS OF RUBELLA TITER:** \_\_\_\_\_

**DATE AND RESULTS OF RUBEOLA TITER:** \_\_\_\_\_

**DATE OF VARICELLA TITER:** \_\_\_\_\_

**DATE OF HEP B VACCINE** \_\_\_\_\_

**OR, IF YOU HAVE DECLINED THE HEPATITIS B VACCINE PLEASE SIGN HERE:**

**NURSES SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

Please sign below, stating that you have examined the above named individual and found her/him to be free from health conditions which would be of potential risk to patients or which might interfere with the performance of the person's duties as a healthcare worker, including, but not limited to the habituation or addiction to substances which may alter the individual's behavior.

**PHYSICIAN'S SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

**PHYSICIAN'S NAME (PRINT):** \_\_\_\_\_

**ADDRESS:** \_\_\_\_\_

**EMPLOYEE'S SIGNATURE** \_\_\_\_\_ **DATE** \_\_\_\_\_



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### DRUG SCREEN

This is to ensure that \_\_\_\_\_ is free from any health impairment that is of potential risk to patients or might interfere with the performance of the work of such person including but not limited to, the habituation of addiction to Depressants, Stimulants, Narcotics, Alcohol or other drugs or substances that might alter the behavior of the nurse.

Physician's signature \_\_\_\_\_

Physician's Name \_\_\_\_\_  
(print)

Address \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Date \_\_\_\_\_



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As a condition of my association with Phoenix Health Care , I understand that the information that I will access through my employment at Phoenix Health Care will include sensitive and confidential patient information. I understand that it is my responsibility to maintain confidentiality of all information, both clinical or financial, that is entrusted to me. This obligation shall exist while I am under contract or associated with Phoenix Health Care and shall continue after my association, contract expiration, or termination regardless of the reason.

I specifically understand that information regarding patients, employees and individuals affiliated with Phoenix Health Care or any of their accounts is to be shared with only those individuals who have an authorized need to know.

If issued a computer password, I agree not to release it to anyone else. I will not post, share or otherwise distribute my password. I will contact the Information Systems Department immediately if I have reason to believe the confidentiality of my password has been broken.

By signing below, I acknowledge that I have read the above and accept the responsibilities associated with these statements. I understand that I will be subject to disciplinary action, suspension and possible immediate termination if I violate any of the above agreed upon statements.

---

Name (print)

---

Signature

---

Date



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Dear

The applicant listed below has applied for assignments through PHOENIX HEALTH CARE, INC. We ask that you verify and complete this form at your earliest convenience. It is understood that any information provided by you will be kept confidential. Thank you for your cooperation in the completion of this form.

\_\_\_\_\_  
Phoenix Health Care

I authorize the above named employer to furnish Phoenix Health Care, Inc. with the information requested on this form.

\_\_\_\_\_  
Applicant Signature

PLEASE PRINT:

Name of Applicant \_\_\_\_\_

Social Security Number \_\_\_\_\_ Position \_\_\_\_\_

Dates Employed \_\_\_\_\_ to \_\_\_\_\_ Clinical Area \_\_\_\_\_

Please Evaluate Application	Acceptable	Unacceptable	Comments
Knowledge of Medication Principles			
Knowledge of Primary Nursing			
Ability to Work Independently			
Cooperation			
Attendance & Punctuality			
Personal Appearance			

Additional Comments \_\_\_\_\_

If no longer employed:  
Reason for leaving: \_\_\_\_\_

Eligible for re-employment  Yes  No If not please explain:

Does applicant have any physical disability? \_\_\_\_\_

Has applicant ever received compensation for injuries?  Yes  No

Signature \_\_\_\_\_ Date \_\_\_\_\_

Title \_\_\_\_\_



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Applicant Signature

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Name of Applicant \_\_\_\_\_

Social Security Number \_\_\_\_\_ Position \_\_\_\_\_

Dates Employed \_\_\_\_\_ to \_\_\_\_\_ Clinical Area \_\_\_\_\_

Please Evaluate Application	Acceptable	Unacceptable	Comments
Knowledge of Medication Principles			
Knowledge of Primary Nursing			
Ability to Work Independently			
Cooperation			
Attendance & Punctuality			
Personal Appearance			

Additional Comments \_\_\_\_\_

If no longer employed:

Reason for leaving: \_\_\_\_\_

Eligible for re-employment  Yes  No If not please explain:

Does applicant have any physical disability? \_\_\_\_\_

Has applicant ever received compensation for injuries?  Yes  No

Signature \_\_\_\_\_ Date \_\_\_\_\_

Title \_\_\_\_\_



**INSTRUCTIONS**

PLEASE READ ALL INSTRUCTIONS CAREFULLY BEFORE COMPLETING THIS FORM.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

**EMPLOYERS MUST RETAIN COMPLETED FORM I-9  
PLEASE DO NOT MAIL COMPLETED FORM I-9 TO ICE OR USCIS**

# Employment Eligibility Verification

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

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

Print Name: Last	First	Middle Initial	Maiden Name
Address (Street Name and Number)		Apt. #	Date of Birth (month/day/year)
City	State	Zip Code	Social Security #
<b>I am aware that federal law provides for imprisonment and/or fines for false statements or use of false documents in connection with the completion of this form.</b>		I attest, under penalty of perjury, that I am (check one of the following): <input type="checkbox"/> A citizen or national of the United States <input type="checkbox"/> A Lawful Permanent Resident (Alien #) A _____ <input type="checkbox"/> An alien authorized to work until _____ (Alien # or Admission #) _____	
		Employee's Signature	
			Date (month/day/year)

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

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

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

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

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

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

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

A. New Name (if applicable)	B. Date of Rehire (month/day/year) (if applicable)
C. If employee's previous grant of work authorization has expired, provide the information below for the document that establishes current employment eligibility.	
Document Title: _____	Document #: _____
Expiration Date (if any): _____	
<b>I attest, under penalty of perjury, that to the best of my knowledge, this employee is eligible to work in the United States, and if the employee presented document(s), the document(s) I have examined appear to be genuine and to relate to the individual.</b>	
Signature of Employer or Authorized Representative	Date (month/day/year)

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

## LISTS OF ACCEPTABLE DOCUMENTS

LIST A	LIST B	LIST C		
Documents that Establish Both Identity and Employment Eligibility	Documents that Establish Identity	Documents that Establish Employment Eligibility		
<ol style="list-style-type: none"> <li>1. U.S. Passport (unexpired or expired)</li> <li>2. Certificate of U.S. Citizenship (Form N-560 or N-561)</li> <li>3. Certificate of Naturalization (Form N-550 or N-570)</li> <li>4. Unexpired foreign passport, with I-551 stamp or attached Form I-94 indicating unexpired employment authorization</li> <li>5. Permanent Resident Card or Alien Registration Receipt Card with photograph (Form I-151 or I-551)</li> <li>6. Unexpired Temporary Resident Card (Form I-688)</li> <li>7. Unexpired Employment Authorization Card (Form I-688A)</li> <li>8. Unexpired Reentry Permit (Form I-327)</li> <li>9. Unexpired Refugee Travel Document (Form I-571)</li> <li>10. Unexpired Employment Authorization Document issued by DHS that contains a photograph (Form I-688B)</li> </ol>	OR	<ol style="list-style-type: none"> <li>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</li> <li>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</li> <li>3. School ID card with a photograph</li> <li>4. Voter's registration card</li> <li>5. U.S. Military card or draft record</li> <li>6. Military dependent's ID card</li> <li>7. U.S. Coast Guard Merchant Mariner Card</li> <li>8. Native American tribal document</li> <li>9. Driver's license issued by a Canadian government authority</li> </ol> <p style="text-align: center; margin: 5px 0;"><b>For persons under age 18 who are unable to present a document listed above:</b></p> <ol style="list-style-type: none"> <li>10. School record or report card</li> <li>11. Clinic, doctor or hospital record</li> <li>12. Day-care or nursery school record</li> </ol>	AND	<ol style="list-style-type: none"> <li>1. U.S. social security card issued by the Social Security Administration (other than a card stating it is not valid for employment)</li> <li>2. Certification of Birth Abroad issued by the Department of State (Form FS-545 or Form DS-1350)</li> <li>3. Original or certified copy of a birth certificate issued by a state, county, municipal authority or outlying possession of the United States bearing an official seal</li> <li>4. Native American tribal document</li> <li>5. U.S. Citizen ID Card (Form I-197)</li> <li>6. ID Card for use of Resident Citizen in the United States (Form I-179)</li> <li>7. Unexpired employment authorization document issued by DHS (other than those listed under List A)</li> </ol>

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

# Form W-4 (2007)

**Purpose.** Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay. Because your tax situation may change, you may want to refigure your withholding each year.

**Exemption from withholding.** If you are exempt, complete only lines 1, 2, 3, 4, and 7 and sign the form to validate it. Your exemption for 2007 expires February 16, 2008. See Pub. 505, Tax Withholding and Estimated Tax.

**Note.** You cannot claim exemption from withholding if (a) your income exceeds \$850 and includes more than \$300 of unearned income (for example, interest and dividends) and (b) another person can claim you as a dependent on their tax return.

**Basic instructions.** If you are not exempt, complete the **Personal Allowances Worksheet** below. The worksheets on page 2 adjust your withholding allowances based on

itemized deductions, certain credits, adjustments to income, or two-earner/multiple job situations. Complete all worksheets that apply. However, you may claim fewer (or zero) allowances.

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

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

**Nonwage income.** If you have a large amount of nonwage income, such as interest or dividends, consider making estimated tax payments using Form 1040-ES, Estimated Tax

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

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

**Nonresident alien.** If you are a nonresident alien, see the instructions for Form 8233 before completing this Form W-4.

**Check your withholding.** After your Form W-4 takes effect, use Pub. 919 to see how the dollar amount you are having withheld compares to your projected total tax for 2007. See Pub. 919, especially if your earnings exceed \$130,000 (Single) or \$180,000 (Married).

## Personal Allowances Worksheet (Keep for your records.)

**A** Enter "1" for yourself if no one else can claim you as a dependent. A \_\_\_\_\_

**B** Enter "1" if: B \_\_\_\_\_

- You are single and have only one job; or
- You are married, have only one job, and your spouse does not work; or
- Your wages from a second job or your spouse's wages (or the total of both) are \$1,000 or less.

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

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

**E** Enter "1" if you will file as head of household on your tax return (see conditions under Head of household above) E \_\_\_\_\_

**F** Enter "1" if you have at least \$1,500 of child or dependent care expenses for which you plan to claim a credit F \_\_\_\_\_

(Note. Do not include child support payments. See Pub. 503, Child and Dependent Care Expenses, for details.)

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

- If your total income will be less than \$57,000 (\$85,000 if married), enter "2" for each eligible child.
- If your total income will be between \$57,000 and \$84,000 (\$85,000 and \$119,000 if married), enter "1" for each eligible child plus "1" additional if you have 4 or more eligible children. G \_\_\_\_\_

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

For accuracy, complete all worksheets that apply.

- If you plan to itemize or claim adjustments to income and want to reduce your withholding, see the **Deductions and Adjustments Worksheet** on page 2.
- If you have more than one job or are married and you and your spouse both work and the combined earnings from all jobs exceed \$40,000 (\$25,000 if married) see the **Two-Earners/Multiple Jobs Worksheet** on page 2 to avoid having too little tax withheld.
- If neither of the above situations applies, stop here and enter the number from line H on line 5 of Form W-4 below.

Cut here and give Form W-4 to your employer. Keep the top part for your records.

Form <b>W-4</b> Department of the Treasury Internal Revenue Service	<h2 style="margin: 0;">Employee's Withholding Allowance Certificate</h2> <p style="font-size: small; margin: 0;">▶ Whether you are entitled to claim a certain number of allowances or exemption from withholding is subject to review by the IRS. Your employer may be required to send a copy of this form to the IRS.</p>	OMB No. 1545-0074 <div style="font-size: 2em; font-weight: bold; margin: 5px 0;">2007</div>
1 Type or print your first name and middle initial. <span style="float: right;">Last name</span>		2 Your social security number
Home address (number and street or rural route)		3 <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Married, but withhold at higher Single rate. Note. If married, but legally separated, or spouse is a nonresident alien, check the "Single" box.
City or town, state, and ZIP code		4 If your last name differs from that shown on your social security card, check here. You must call 1-800-772-1213 for a replacement card. ▶ <input type="checkbox"/>
5 Total number of allowances you are claiming (from line H above or from the applicable worksheet on page 2)		5 _____
6 Additional amount, if any, you want withheld from each paycheck		6 \$ _____
7 I claim exemption from withholding for 2007, and I certify that I meet both of the following conditions for exemption. <ul style="list-style-type: none"> <li>• Last year I had a right to a refund of all federal income tax withheld because I had no tax liability and</li> <li>• This year I expect a refund of all federal income tax withheld because I expect to have no tax liability.</li> </ul> If you meet both conditions, write "Exempt" here <span style="float: right;">▶ 7 _____</span>		
Under penalties of perjury, I declare that I have examined this certificate and to the best of my knowledge and belief, it is true, correct, and complete.		
Employee's signature (Form is not valid unless you sign it.) ▶		
8 Employer's name and address (Employer: Complete lines 8 and 10 only if sending to the IRS.)		9 Office code (optional)
		10 Employer identification number (EIN)

**Deductions and Adjustments Worksheet**

- Note.** Use this worksheet *only* if you plan to itemize deductions, claim certain credits, or claim adjustments to income on your 2007 tax return.
- 1 Enter an estimate of your 2007 itemized deductions. These include qualifying home mortgage interest, charitable contributions, state and local taxes, medical expenses in excess of 7.5% of your income, and miscellaneous deductions. (For 2007, you may have to reduce your itemized deductions if your income is over \$156,400 (\$78,200 if married filing separately). See *Worksheet 2* in Pub. 919 for details.) 1 \$ \_\_\_\_\_
  - 2 Enter:  $\left\{ \begin{array}{l} \$10,700 \text{ if married filing jointly or qualifying widow(er)} \\ \$7,850 \text{ if head of household} \\ \$5,350 \text{ if single or married filing separately} \end{array} \right\}$  2 \$ \_\_\_\_\_
  - 3 Subtract line 2 from line 1. If zero or less, enter "-0-" 3 \$ \_\_\_\_\_
  - 4 Enter an estimate of your 2007 adjustments to income, including alimony, deductible IRA contributions, and student loan interest 4 \$ \_\_\_\_\_
  - 5 Add lines 3 and 4 and enter the total. (Include any amount for credits from *Worksheet 8* in Pub. 919) 5 \$ \_\_\_\_\_
  - 6 Enter an estimate of your 2007 nonwage income (such as dividends or interest) 6 \$ \_\_\_\_\_
  - 7 Subtract line 6 from line 5. If zero or less, enter "-0-" 7 \$ \_\_\_\_\_
  - 8 Divide the amount on line 7 by \$3,400 and enter the result here. Drop any fraction 8 \_\_\_\_\_
  - 9 Enter the number from the **Personal Allowances Worksheet**, line H, page 1 9 \_\_\_\_\_
  - 10 Add lines 8 and 9 and enter the total here. If you plan to use the **Two-Earners/Multiple Jobs Worksheet**, also enter this total on line 1 below. Otherwise, stop here and enter this total on Form W-4, line 5, page 1 10 \_\_\_\_\_

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

- Note.** Use this worksheet *only* if the instructions under line H on page 1 direct you here.
- 1 Enter the number from line H, page 1 (or from line 10 above if you used the **Deductions and Adjustments Worksheet**) 1 \_\_\_\_\_
  - 2 Find the number in **Table 1** below that applies to the **LOWEST** paying job and enter it here. However, if you are married filing jointly and wages from the highest paying job are \$50,000 or less, do not enter more than "3." 2 \_\_\_\_\_
  - 3 If line 1 is more than or equal to line 2, subtract line 2 from line 1. Enter the result here (if zero, enter "-0-") and on Form W-4, line 5, page 1. Do not use the rest of this worksheet 3 \_\_\_\_\_
- Note.** If line 1 is less than line 2, enter "-0-" on Form W-4, line 5, page 1. Complete lines 4-9 below to calculate the additional withholding amount necessary to avoid a year-end tax bill.
- 4 Enter the number from line 2 of this worksheet 4 \_\_\_\_\_
  - 5 Enter the number from line 1 of this worksheet 5 \_\_\_\_\_
  - 6 Subtract line 5 from line 4 6 \_\_\_\_\_
  - 7 Find the amount in **Table 2** below that applies to the **HIGHEST** paying job and enter it here 7 \$ \_\_\_\_\_
  - 8 Multiply line 7 by line 6 and enter the result here. This is the additional annual withholding needed 8 \$ \_\_\_\_\_
  - 9 Divide line 8 by the number of pay periods remaining in 2007. For example, divide by 26 if you are paid every two weeks and you complete this form in December 2006. Enter the result here and on Form W-4, line 6, page 1. This is the additional amount to be withheld from each paycheck 9 \$ \_\_\_\_\_

**Table 1**

**Table 2**

Married Filing Jointly		All Others		Married Filing Jointly		All Others	
If wages from <b>LOWEST</b> paying job are—	Enter on line 2 above	If wages from <b>LOWEST</b> paying job are—	Enter on line 2 above	If wages from <b>HIGHEST</b> paying job are—	Enter on line 7 above	If wages from <b>HIGHEST</b> paying job are—	Enter on line 7 above
\$0 - \$4,500	0	\$0 - \$6,000	0	\$0 - \$65,000	\$510	\$0 - \$35,000	\$510
4,501 - 9,000	1	6,001 - 12,000	1	65,001 - 120,000	850	35,001 - 80,000	850
9,001 - 18,000	2	12,001 - 19,000	2	120,001 - 170,000	950	80,001 - 150,000	950
18,001 - 22,000	3	19,001 - 26,000	3	170,001 - 300,000	1,120	150,001 - 340,000	1,120
22,001 - 26,000	4	26,001 - 35,000	4	300,001 and over	1,190	340,001 and over	1,190
26,001 - 32,000	5	35,001 - 50,000	5				
32,001 - 38,000	6	50,001 - 65,000	6				
38,001 - 46,000	7	65,001 - 80,000	7				
46,001 - 55,000	8	80,001 - 90,000	8				
55,001 - 60,000	9	90,001 - 120,000	9				
60,001 - 65,000	10	120,001 and over	10				
65,001 - 75,000	11						
75,001 - 95,000	12						
95,001 - 105,000	13						
105,001 - 120,000	14						
120,001 and over	15						

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

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