

Employment Application

RPh on the Go is an equal opportunity employer and does not discriminate on the basis of race, religion, color, national origin, age, sex, gender, disability or any other characteristic protected by law.

PERSONAL INFORMATION (please print)

First Name: _____ MI: _____ Last: _____ Suffix: _____

How should your first name appear on your nametag? _____

Address: _____

City: _____ State: _____ Zip Code: _____

Social Security #: _____ Driver's License #: _____ State: _____

List any other names (including maiden names) or social security numbers you have used: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Email: _____

Emergency contact: _____

Relationship: _____ Telephone: _____

EDUCATIONAL AND PROFESSIONAL INFORMATION

Please include your resume, with your complete education and residency experience.

Pharmacy School Attended: _____

Degree(s): BS Pharmacy PharmD Other: _____

Please list all active and inactive pharmacist license(s). Please send a photocopy of all active licenses.

State	License Number	Expiration Date	Disciplinary Action <i>reprimand, probation, suspension, voluntary surrender, revocation</i>	
			Past Disciplinary Action	Current Disciplinary Action
			<input type="radio"/> No <input type="radio"/> Yes*	<input type="radio"/> No <input type="radio"/> Yes*
			<input type="radio"/> No <input type="radio"/> Yes*	<input type="radio"/> No <input type="radio"/> Yes*
			<input type="radio"/> No <input type="radio"/> Yes*	<input type="radio"/> No <input type="radio"/> Yes*
			<input type="radio"/> No <input type="radio"/> Yes*	<input type="radio"/> No <input type="radio"/> Yes*
			<input type="radio"/> No <input type="radio"/> Yes*	<input type="radio"/> No <input type="radio"/> Yes*
			<input type="radio"/> No <input type="radio"/> Yes*	<input type="radio"/> No <input type="radio"/> Yes*

If you have other active or inactive licenses, please attach an additional sheet with details.

* Year of Disciplinary Action: _____ Explanation of past or current license disciplinary actions

(attach a separate page if necessary): _____

Have you ever been convicted of a felony? No Yes If yes, please explain (attach a separate page if necessary):

Do you have liability/malpractice insurance? No Yes If yes:

Provider: _____ Policy Number: _____ Expiration Date _____

PHYSICAL RECORD

Do you need any special accommodations to perform the essential functions of your job? Yes No

If yes, please describe accommodations needed: _____

WORK EXPERIENCE

Please list your three most recent pharmacy-related positions. Please attach a copy of your current resume.

Current Employer: _____

Type of Business: Retail Long-term Care Hospital Out-Patient Hospital In-Patient Home Infusion Managed Care Other

Address: _____

City: _____ State: _____ Phone Number: _____

Position: _____ Salary: _____

Dates Employed: *from* _____ *to* _____ Reason for Leaving: _____

1) Supervisor or peer who can serve as a reference: _____

Title: _____ Work Phone: _____ Cell phone: _____

Email: _____ Dates worked together: _____

2) Supervisor or peer who can serve as a reference: _____

Title: _____ Work Phone: _____ Cell phone: _____

Email: _____ Dates worked together: _____

Please check if you do not wish for us to contact your current employer.

Employer: _____

Type of Business: Retail Long-term Care Hospital Out-Patient Hospital In-Patient Home Infusion Managed Care Other

Address: _____

City: _____ State: _____ Phone Number: _____

Position: _____ Salary: _____

Dates Employed: *from* _____ *to* _____ Reason for Leaving: _____

1) Supervisor or peer who can serve as a reference: _____

Title: _____ Work Phone: _____ Cell phone: _____

Email: _____ Dates worked together: _____

2) Supervisor or peer who can serve as a reference: _____

Title: _____ Work Phone: _____ Cell phone: _____

Email: _____ Dates worked together: _____

Employer: _____

Type of Business: Retail Long-term Care Hospital Out-Patient Hospital In-Patient Home Infusion Managed Care Other

Address: _____

City: _____ State: _____ Phone Number: _____

Position: _____ Salary: _____

Dates Employed: *from* _____ *to* _____ Reason for Leaving: _____

1) Supervisor or peer who can serve as a reference: _____

Title: _____ Work Phone: _____ Cell phone: _____

Email: _____ Dates worked together: _____

2) Supervisor or peer who can serve as a reference: _____

Title: _____ Work Phone: _____ Cell phone: _____

Email: _____ Dates worked together: _____

RPh on the Go Mandatory Training:

HEALTH INSURANCE PORTABILITY & ACCOUNTABILITY ACT OF 1996

Please read the following information about the Health Insurance Portability and Accountability Act of 1996. By signing the following page, you acknowledge that you are responsible for upholding the HIPAA guidelines and reviewing each client's procedures on protecting the patient's private health information.

What is the purpose of HIPAA?

- To provide health insurance portability from one employer to another
- To improve healthcare efficiency by standardizing the exchange of medical information
- To protect the patient's privacy against the misuse or improper disclosure of health records

Who is affected by HIPAA?

All employee pharmacists, relief pharmacists, owner pharmacists, consultant pharmacists, health care system pharmacists, interns, health care providers, health plan administrators, pharmacy technicians & support staff, who may have access to a patient's health information.

What is the definition of Personal Health Information (PHI)?

Any "individually identifiable" health information transmitted through conversation, computer, or paper. This includes conversations with a patient, physician, nurse, clinic, health insurance representative, or pharmacy technician. Identifiable information includes a patient's name, address, social security number, e-mail address, photograph, date of birth, gender, fax or phone number, driver's license, or relative's name. HIPAA does allow the use or disclosure of PHI to provide treatment, to collect payment, and to conduct health care operations. Treatment is defined as dispensing, DUR counseling, disease management, & refill reminders. Collecting payment is defined as verifying insurance coverage, reconciliation of claims, and third party billing. Operations are defined as malpractice insurance and hardware/software/database management. In addition, you may disclose PHI when required by law enforcement investigations, court orders, subpoenas, government benefit programs, State Boards of Pharmacy, the FDA for adverse events or product defects/recalls, or the Department of Health or CDC for disease or injury reporting.

How does HIPAA affect pharmacy operations?

When you counsel a patient (either in person or on the phone) regarding their medication, you should keep your voice low and attempt to do so in a discreet area, so others cannot eavesdrop. PHI should not be within open view of other patients, guests, customers, pharmaceutical sales reps, or delivery personnel. At the start of any assignment, it is imperative that you review each client's operations policies regarding documents and prescription vials containing PHI. Most pharmacies staple the prescription receipt on the outside of the bag for identification purposes. To protect the patient's privacy, the pharmacy may use a smaller type font, so this information is not so visible. At the register checkout, the pharmacy may place the receipt inside the bag or fold the receipt inside out and staple it to the outside of the bag. To discard paper documents containing PHI, either tear or shred the document. Either return the old vial to the customer or destroy the label before tossing any vial.

What is the Notice of Privacy Practices (NOPP)?

Effective with any prescriptions filled after 4-13-03, HIPAA requires that you post a copy of the Notice of Privacy Practices in the pharmacy and provide a copy to each patient. This notice describes the patient's privacy rights and explains how the pharmacy intends to use and disclose PHI. You must attempt to obtain the patient's written acknowledgement that he/she has received the pharmacy's privacy policy. If the patient refuses to sign, you are required to document your efforts to obtain a signature and the reason why the patient did not comply. A parent or guardian may sign for a child's prescription. If requested by the patient, you are required to provide a written accounting of disclosures of PHI and the pharmacy's prescription records for up to 6 years prior to the date of request (but not prior to HIPAA's effective date of 4-13-03). Patients may request additional restrictions on the use or disclosure of their PHI and the type of communications they prefer. Please familiarize yourself with and follow the client's procedures.

Complaint Procedures

If a patient feels the pharmacy has breached their privacy by inappropriately sharing their PHI, communicate that the pharmacy makes every attempt to respect their right to privacy. If the patient decides to pursue this further, provide the contact information as described in Notice of Privacy Practices. In addition, a formal complaint may be filed with the Secretary of Health & Human Services (listed on the NOPP).

How does HIPAA affect state laws?

HIPAA is a federal law that supercedes less stringent state laws, but not more stringent state laws. What are the legal consequences of non-compliance with HIPAA?


- Civil penalties up to \$25,000 per rule violation.
- Criminal penalties up to \$50,000 and one year in prison for knowingly and improperly obtaining or disclosing private health information.
- Up to \$250,000 fine and 10 years in prison for the sale, use, or transfer of private health information for personal gain or malicious harm.
- Sanctions apply to individual employees, not just the pharmacies.

Please keep this for your records.

Terms and Agreements

By signing below, I agree to the following list of terms and agreements:

- I certify that the facts contained in this application are true and complete to the best of my knowledge and understand that, if hired, falsified statements on this application can be grounds for dismissal.
- HIPAA: I have reviewed the training material regarding the implementation and legal consequences of HIPAA, Title II. I understand that I am responsible for reviewing each client's procedures on protecting the patient's private health information.
- BACKGROUND INVESTIGATION AND INFORMATION RELEASE: Prior to being hired and if applicable, during the course of your employment, the Company may obtain a background report and/or an investigative report about you. This Report may include, but is not limited to: current and former employers, academic records, professional and personal references, criminal conviction records, information regarding your character, experience, work habits, previous job performance, and the reasons for termination at previous places of employment. You expressly authorize, without reservation, the Company, the background reporting agency, all representatives, employees or agents to conduct a background check and/or to contact and obtain information from all references (personal and professional), employers, public agencies, licensing authorities and educational institutions and to otherwise verify the accuracy of all information provided by you in your application, resume and/or job interview. You also give permission to release information to the Company. You also agree that any information from the Report or information you have disclosed to the Company, may be disclosed by the Company to our client companies.
- DRUG SCREENS: We reserve the right to drug test applicants and employees.
- HEALTH SCREENS AND IMMUNIZATIONS: We reserve the right to require health screenings and/or immunization records as per contractual agreements with our clients. In compliance with state or regulatory requirements, records provided to RPh on the Go may be released to clients.
- PURPOSE: RPh on the Go was formed to provide licensed Registered Pharmacists in good standing with a source of temporary employment. By signing this Agreement, you represent that you are such a pharmacist and you agree to furnish pharmacy services performed by you to our Clients as an employee of our company. We will offer these assignments to you so that we mutually can fulfill our contractual obligations to these Clients.
- COMPLIANCE: Each assignment that you accept will be performed by you to its completion. You only need to service those assignments that you feel comfortable with and capable of performing at a maximum professional level. In providing these services, you agree to comply with all applicable State laws and pharmacy regulations in the states where you are working.
- WAGE AND TIMECARDS: We will pay you a base rate, negotiated at the time of agreement for each assignment. Additional compensation you might receive is reimbursement for distances traveled from your home, room and board (if overnight accommodations are necessary and approved), required "on call" time, appropriate pre-approved overtime work, and special rates for certain specific jobs. These "extras" will be agreed upon by us before any services are rendered by you. We will be fully responsible for these compensations once confirmed. When you provide pharmacy services to our Clients, you will provide us with signed time cards for the work once completed. You shall make no schedules or schedule changes without written confirmation by RPh on the Go.
- INSURANCE: If you drive a car to work, your responsibilities include maintaining current and adequate auto insurance. We recommend that you maintain professional liability insurance. Include proof of liability coverage with this application.
- DISCIPLINARY ACTIONS: If any disciplinary action has occurred that affects your ability to perform as a pharmacist in good standing, or you have been convicted of a felony, we must be immediately informed by telephone and in writing. These changes may affect any future assignments we can offer you.
- NON-COMPETE: During the term of an assignment and for twelve months following termination of an assignment, you agree that you will provide pharmacy services to our Clients only through our service. You agree that you will not provide pharmacy services to such Clients directly or indirectly (as an employee, independent contractor, etc) for that twelve-month period. Our contract with the Client prohibits the Client from hiring you without paying a permanent placement fee to our company. Therefore, if prior to the expiration of these twelve months a Client wants to hire you (as an employee or independent contractor, etc), you agree to immediately notify us. In our sole judgment, we may waive the twelve-month non-compete clauses provided we enter into a satisfactory compensation agreement with the Client or you.
- TERMS: This Agreement shall continue until (a) in our judgment, it is violated; or (b) thirty days written notice is given by either party to terminate this Agreement. In either event, you agree that the twelve month non-compete clause set forth above shall survive the termination of this Agreement. This Agreement describes the entire obligation of each party to the other and can only be changed in writing by both parties.

 **Pharmacist/Employee Signature:** _____

Print Name: _____ Date: _____

RPh on the Go USA, Inc. Signature: _____

Print Name: _____ Date: _____

Form W-4 (2008)

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

Exemption from withholding. If you are exempt, complete **only** lines 1, 2, 3, 4, and 7 and sign the form to validate it. Your exemption for 2008 expires February 16, 2009. See Pub. 505, Tax Withholding and Estimated Tax.

Note. You cannot claim exemption from withholding if (a) your income exceeds \$900 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. See Pub. 501, Exemptions, Standard Deduction, and Filing Information, for information.

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

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

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

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

Nonresident alien. If you are a nonresident alien, see 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 2008. 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:
 { • You are single and have only one job; or
 • You are married, have only one job, and your spouse does not work; or
 • Your wages from a second job or your spouse's wages (or the total of both) are \$1,500 or less. } **B** _____

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 \$58,000 (\$86,000 if married), enter "2" for each eligible child.
 • If your total income will be between \$58,000 and \$84,000 (\$86,000 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 W-4 <small>Department of the Treasury Internal Revenue Service</small>	Employee's Withholding Allowance Certificate ► 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.	OMB No. 1545-0074 2008
1 Type or print your first name and middle initial. Last name		2 Your social security number
Home address (number and street or rural route)		3 <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Married, but withhold at higher Single rate. <small>Note. If married, but legally separated, or spouse is a nonresident alien, check the "Single" box.</small>
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 2008, and I certify that I meet both of the following conditions for exemption. • Last year I had a right to a refund of all federal income tax withheld because I had no tax liability and • This year I expect a refund of all federal income tax withheld because I expect to have no tax liability. If you meet both conditions, write "Exempt" here ►		7 _____
Under penalties of perjury, I declare that I have examined this certificate and to the best of my knowledge and belief, it is true, correct, and complete.		
Employee's signature <small>(Form is not valid unless you sign it.)</small> ►		Date ►
8 Employer's name and address (Employer: Complete lines 8 and 10 only if sending to the IRS.)		9 Office code (optional) 10 Employer identification number (EIN)

Deductions and Adjustments Worksheet

Note. Use this worksheet *only* if you plan to itemize deductions, claim certain credits, or claim adjustments to income on your 2008 tax return.

- 1** Enter an estimate of your 2008 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 2008, you may have to reduce your itemized deductions if your income is over \$159,950 (\$79,975 if married filing separately). See *Worksheet 2* in Pub. 919 for details.) 1 \$ _____
- 2** Enter:

{	\$10,900 if married filing jointly or qualifying widow(er)	}	2	\$	
\$ 8,000 if head of household						
\$ 5,450 if single or married filing separately						
- 3** **Subtract** line 2 from line 1. If zero or less, enter “-0-” 3 \$ _____
- 4** Enter an estimate of your 2008 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 2008 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 \$3,500 and enter the result here. Drop any fraction 8 _____
- 9** Enter the number from the **Personal Allowances Worksheet**, line H, page 1 9 _____
- 10** **Add** lines 8 and 9 and enter the total here. If you plan to use the **Two-Earners/Multiple Jobs Worksheet**, also enter this total on line 1 below. Otherwise, **stop here** and enter this total on Form W-4, line 5, page 1 10 _____

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

Note. Use this worksheet *only* if the instructions under line H on page 1 direct you here.

- 1** Enter the number from line H, page 1 (or from line 10 above if you used the **Deductions and Adjustments Worksheet**) 1 _____
 - 2** Find the number in **Table 1** below that applies to the **LOWEST** paying job and enter it here. **However**, if you are married filing jointly and wages from the highest paying job are \$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 2008. For example, divide by 26 if you are paid every two weeks and you complete this form in December 2007. Enter the result here and on Form W-4, line 6, page 1. This is the additional amount to be withheld from each paycheck 9 \$ _____

Table 1

Table 2

Married Filing Jointly		All Others		Married Filing Jointly		All Others	
If wages from LOWEST paying job are—	Enter on line 2 above	If wages from LOWEST paying job are—	Enter on line 2 above	If wages from HIGHEST paying job are—	Enter on line 7 above	If wages from HIGHEST paying job are—	Enter on line 7 above
\$0 - \$4,500	0	\$0 - \$6,500	0	\$0 - \$65,000	\$530	\$0 - \$35,000	\$530
4,501 - 10,000	1	6,501 - 12,000	1	65,001 - 120,000	880	35,001 - 80,000	880
10,001 - 18,000	2	12,001 - 20,000	2	120,001 - 180,000	980	80,001 - 150,000	980
18,001 - 22,000	3	20,001 - 27,000	3	180,001 - 310,000	1,160	150,001 - 340,000	1,160
22,001 - 27,000	4	27,001 - 35,000	4	310,001 and over	1,230	340,001 and over	1,230
27,001 - 33,000	5	35,001 - 50,000	5				
33,001 - 40,000	6	50,001 - 65,000	6				
40,001 - 50,000	7	65,001 - 80,000	7				
50,001 - 55,000	8	80,001 - 95,000	8				
55,001 - 60,000	9	95,001 - 120,000	9				
60,001 - 65,000	10	120,001 and over	10				
65,001 - 75,000	11						
75,001 - 100,000	12						
100,001 - 110,000	13						
110,001 - 120,000	14						
120,001 and over	15						

Privacy Act and Paperwork Reduction Act Notice. We ask for the information on this form to carry out the Internal Revenue laws of the United States. The Internal Revenue Code requires this information under sections 3402(f)(2)(A) and 6109 and their regulations. Failure to provide a properly completed form will result in your being treated as a single person who claims no withholding allowances; providing fraudulent information may also subject you to penalties. Routine uses of this information include giving it to the Department of Justice for civil and criminal litigation, to cities, states, and the District of Columbia for use in administering their tax laws, and using it in the National Directory of New Hires. We may also disclose this information to other countries under a tax treaty, to federal and state agencies to enforce federal nontax criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism.

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

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

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

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 the documents presented have a future expiration date may also constitute illegal discrimination.

What Is the Purpose of This Form?

The purpose of this form is to document that each new employee (both citizen and non-citizen) hired after November 6, 1986 is authorized to work in the United States.

When Should the Form I-9 Be Used?

All employees, citizens and noncitizens, hired after November 6, 1986 and working in the United States must complete a Form I-9.

Filling Out the Form I-9

Section 1, Employee: This part of the form must be completed at the time of hire, which is the actual beginning of employment. Providing the Social Security number is voluntary, except for employees hired by employers participating in the USCIS Electronic Employment Eligibility Verification Program (E-Verify). **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" means all employers including 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 Form I-9. **However, employers are still responsible for completing and retaining the Form I-9.**

Section 3, Updating and Reverification: Employers must complete **Section 3** when updating and/or reverifying the Form 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.

- A. If an employee's name has changed at the time this form is being updated/reverified, complete Block A.
- B. 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.
- C. 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:

1. Examine any document that reflects that the employee is authorized to work in the U.S. (see List A **or** C);
2. Record the document title, document number and expiration date (if any) in Block C, and
3. Complete the signature block.

What Is the Filing Fee?

There is no associated filing fee for completing the Form I-9. This form is not filed with USCIS or any government agency. The Form I-9 must be retained by the employer and made available for inspection by U.S. Government officials as specified in the Privacy Act Notice below.

USCIS Forms and Information

To order USCIS forms, call our toll-free number at **1-800-870-3676**. Individuals can also get USCIS forms and information on immigration laws, regulations and procedures by telephoning our National Customer Service Center at **1-800-375-5283** or visiting our internet website at **www.uscis.gov**.

Photocopying and Retaining the Form I-9

A blank Form 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 Forms I-9 for three (3) years after the date of hire or one (1) year after the date employment ends, whichever is later.

The Form I-9 may be signed and retained electronically, as authorized in Department of Homeland Security regulations at 8 CFR § 274a.2.

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 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.

Paperwork Reduction Act

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, and completing the form, 9 minutes; **2)** assembling and filing (recordkeeping) the form, 3 minutes, for an average of 12 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., 3rd Floor, Suite 3008, Washington, DC 20529. OMB No. 1615-0047.

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

Form I-9, 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 the documents have 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 #

<p>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.</p>	<p>I attest, under penalty of perjury, that I am (check one of the following):</p> <p><input type="checkbox"/> A citizen or national of the United States</p> <p><input type="checkbox"/> A lawful permanent resident (Alien #) A _____</p> <p><input type="checkbox"/> An alien authorized to work until _____</p> <p>(Alien # or Admission #) _____</p>
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Employee's Signature	Date (month/day/year)
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Preparer and/or Translator Certification. (To be completed and signed if Section 1 is prepared by a person other than the employee.) I attest, under penalty of perjury, that I have assisted in the completion of this form and that to the best of my knowledge the information is true and correct.

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

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

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

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

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

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

A. New Name (if applicable)	B. Date of Rehire (month/day/year) (if applicable)
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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): _____
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I attest, under penalty of perjury, that to the best of my knowledge, this employee is eligible to work in the United States, and if the employee presented document(s), the document(s) I have examined appear to be genuine and to relate to the individual.

Signature of Employer or Authorized Representative	Date (month/day/year)
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LISTS OF ACCEPTABLE DOCUMENTS

LIST A Documents that Establish Both Identity and Employment Eligibility	LIST B Documents that Establish Identity	LIST C Documents that Establish Employment Eligibility
OR		AND
1. U.S. Passport (unexpired or expired)	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. U.S. Social Security card issued by the Social Security Administration <i>(other than a card stating it is not valid for employment)</i>
2. 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 Birth Abroad issued by the Department of State <i>(Form FS-545 or Form DS-1350)</i>
3. An unexpired foreign passport with a temporary I-551 stamp	3. School ID card with a photograph	3. Original or certified copy of a birth certificate issued by a state, county, municipal authority or outlying possession of the United States bearing an official seal
4. An unexpired Employment Authorization Document that contains a photograph <i>(Form I-766, I-688, I-688A, I-688B)</i>	4. Voter's registration card	4. Native American tribal document
5. An unexpired foreign passport with an unexpired Arrival-Departure Record, Form I-94, bearing the same name as the passport and containing an endorsement of the alien's nonimmigrant status, if that status authorizes the alien to work for the employer	5. U.S. Military card or draft record	5. U.S. Citizen ID Card <i>(Form I-197)</i>
	6. Military dependent's ID card	6. ID Card for use of Resident Citizen in the United States <i>(Form I-179)</i>
	7. U.S. Coast Guard Merchant Mariner Card	7. Unexpired employment authorization document issued by DHS <i>(other than those listed under List A)</i>
	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	

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