MERCY
MEDICAL CENTER
A Ministry of the Sisters of Charity Health System

New Employee Packet

Welcome to Mercy Medical Center and congratulations on your new position!
The enclosed packet will guide you through our new hire process.

Human Resources Appointment

Human Resources is located in Mercy Hall (map enclosed):

- As you turn into the main Mercy Medical Center entrance, make a left
- Drive past the visitor's parking deck, towards the employee parking lot C. Follow the road as it curves to the right and you will see the Human Resource sign above the entrance.
- Turn right where you see the Human Resources sign and park in the designated HR parking area on the right, next to the building
- Come in the glass doors and report to the front desk

For your Human Resources appointment, you will need:

- ❑ Completed enclosed New Employee Packet ***(please print one-sided)***
- ❑ Acceptable forms of identification as stated in the directions for the I-9 form
- ❑ Social Security card for payroll purposes
- ❑ Highest level of education obtained (transcript, diploma or degree)
- ❑ Professional licensures and/or certifications (BLS, ACLS, PALS, etc.)
- ❑ Voided check for the direct deposit form (or a deposit slip if direct deposit to savings account)
- ❑ Vehicle registration information (year, make, model, plate number)
- ❑ After your Human Resources appointment you will be directed to Security off the main lobby to have your picture taken for your identification badge and to register your vehicle for parking (form is included in this packet). You will receive your badge in General Orientation.
- ❑ **Fingerprinting Requirement**: If you are a Pharmacy employee you are also required to complete fingerprinting background check as part of your employment (FBI and Ohio BCI), per Emily's Law. There is no charge to you for this requirement. Please contact the Stark County Sheriff's Office at (330) 430-3800 or (330) 451-1383 within 24 hours to schedule your appointment. They are located at 4500 Atlantic Boulevard, Canton (off Route 62). You will need your driver's license for this appointment.

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Employee Health Services
HEALTH HISTORY RECORD

In order to comply with Title II of the Genetic Information Nondiscrimination Act (GINA) which prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of employees or their family members, we are asking that you not provide any genetic information when responding to this request for medical information. `Genetic information,' as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

Name: _____ Telephone Number: _____
last first

Address: _____

Social Security Number: _____ Birthdate: _____

In Emergency Notify: _____
name relationship telephone no.

Are you allergic to any medication(s)? ☐ No ☐ Yes What? _____

Are you allergic to any other items? ☐ No ☐ Yes What? _____

Did you have any of these diseases? *(Circle answer. Y = Yes, N= No)*

Chicken Pox—Y N Mumps—Y N Measles *(9-day)* 20____ German Measles/Rubella *(3-day)*—Y N

What year were you immunized for the following?

Tetanus/TDap 20____ Mumps 20____ Measles (9-day) 20____ German Measles/Rubella (3-day) 20____

When was your last TB *(tuberculin)* skin test? 20____ Result? Negative____ Positive____

If positive, year of last chest x-ray 20____

Have you received the Hepatitis B vaccine series? *(Cirlce answer.)* Y N

If yes, what year did you complete the series? _____

List past hospitalizations, including, both inpatient and outpatient:

DATE	REASON	PHYSICIAN'S NAME

Have you ever had, or do you now have, any of the following?

	Yes	No	When		Yes	No	When
1. Amputation of Foot, Arm, etc.				20. Heart Problems			
2. Anemia				21. Hernia(s)			
3. Arteriosclerosis				22. High/Low Blood Pressure			
4. Arthritis				23. Low Blood Sugar			
5. Blood Problem *(hemophilia)*				24. Severe Infections *(bone, blood, brain)*			
6. Bone Problem *(ankylosis, osteoporosis)*				25. Kidney Problems *(stones)*			
7. Back Problem/Injury				26. Liver Problems *(jaundice, hepatitis)*			
8. Cancer				27. Lung Problems *(asthma, emphysema, silicosis)*			
9. Cerebral Palsy							
10. Convulsions *(epilepsy)*				28. Muscle Problems *(MS, MD)*			
11. Diabetes *(sugar)*				29. Nerve Problems *(stress)*			
12. Ear Problems				30. Phlebitis *(blood clot)*			
13. Eye Disease/Condition				31. Stroke			
14. Fainting/Dizzy Spells				32. Sinus/Throat Problems			
15. Frequent Nosebleeds				33. Thyroid Problem			
16. Frequent/Severe Headaches				34. Tuberculosis *(TB)*			
17. Gallbladder Disease				35. Varicose Veins			
18. Gastrointestinal Problems *(ulcer, colitis)*				36. Viral Disease *(polio, mono, herpes)*			
19. Hearing Difficulties							

37. Has your work ever been limited or restricted because of your health? ☐ No ☐ Yes
38. Do you have any physical complaint, impairment, or disability at present? ☐ No ☐ Yes

Please comment on all "Yes" answers (1-38): _____

_____

_____

HEALTH APPRAISAL:

Do you currently take any medications? ☐ No ☐ Yes What? _____
Do you limit your caffeine intake *(coffee, tea, chocolate)?* ☐ No ☐ Yes
Do you use tobacco products? ☐ No ☐ Yes If yes, what and how much?
Cigarettes _____ Pipe _____
Cigars _____ Smokeless _____
Do you engage in any hobby, sport, etc., to reduce stress? ☐ No ☐ Yes
Do you have trouble sleeping? ☐ No ☐ Yes
Do you drink alcohol? ☐ No ☐ Yes If yes, how many alcoholic beverages per week? _____
Are you safety conscious both at work and at home? ☐ No ☐ Yes

HEALTH CARE:

1. Do you have a family doctor? ☐ No ☐ Yes Who? _____
2. Do you have other doctors whom you see at least yearly? ☐ No ☐ Yes Who? _____

_____

3. Do you have your blood pressure checked at least once a year? ☐ No ☐ Yes
4. Do you have your eyes examined at least every 2 years? ☐ No ☐ Yes
5. Estimate your present state of health: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

R.N./M.D. Comments: _____

Mercy Medical Center does not discriminate in hiring or employment on the basis of physical or mental impairment which may constitute a handicap. Your employment status will not be affected by the existence of these conditions; however, willful falsification or failure to give full and complete information is grounds for immediate termination of employment.

I hereby attest that the information given above is true to the best of my knowledge.

Date_____/_____/_____ Employee's Signature _____

Date_____/_____/_____ Nurse's Signature _____ R.N.

Date_____/_____/_____ Physician's Signature _____ M.D.

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MANDATORY RESPIRATOR MEDICAL EVAULATION QUESTIONNAIRE

ALL APPROPRIATE QUESTIONS MUST BE ANSWERED OR THE QUESTIONNAIRE CAN NOT BE EVALUATED, AND WILL BE RETURNED FOR COMPLETION.

Please use blue or black ink only:

Name:	SSN:
Company Name:	Job Title:
Date: Age:	Sex: ☐ Male ☐ Female
Height: _____ Ft. _____ In.	Weight: _____ Lbs.
Department:	Supervisor:

Check the type of respirator you will use (you can check more than one category):

a. ☐ N, R, or P disposable respirator (filter-mask, non-cartridge type only).

b. ☐ Other type (for example, half-or-full face piece type, powered-air purifying, supplied-air, self-contained breathing apparatus)

PART A

YES	NO	Please check yes or no
☐	☐	1. Can you read?
☐	☐	2. Has your employer told you how to contact the health care professional who will review this questionnaire?
☐	☐	3. Have you worn a respirator?
☐	☐	4. Do you *currently* smoke tobacco, or have you smoked tobacco in the last month?
		5. Have you ever had any of the following conditions?
☐	☐	a. Seizures (fits)
☐	☐	b. Diabetes (sugar disease)
☐	☐	c. Allergic reactions that interfere with your breathing.
		If yes, please explain: _____
☐	☐	d. Claustrophobia (fear of closed-in places)
☐	☐	Have you been fit-tested before?
☐	☐	e. Trouble smelling odors
		6. Have you ever had any of the following pulmonary or lung problems?
☐	☐	a. Asbestosis
☐	☐	b. Asthma
☐	☐	c. Chronic Bronchitis
☐	☐	d. Emphysema

PART A

YES	NO	Please check yes or no
☐	☐	e. Pneumonia
☐	☐	f. Tuberculosis
☐	☐	g. Silicosis
☐	☐	h. Pneumonothorax (collapsed lung)
☐	☐	i. Lung Cancer
☐	☐	j. Broken Ribs
☐	☐	k. Any chest injuries or surgeries
☐	☐	l. Any other lung problem that you've been told about
		7. Do you *currently* have any of the following symptoms of pulmonary or lung illness?
☐	☐	a. Shortness of breath
☐	☐	b. Shortness of breath when walking fast on level ground or walking up a slight hill or incline
☐	☐	c. Shortness of breath when walking with other people
☐	☐	d. Have to stop for breath when walking at your own pace on level ground
☐	☐	e. Shortness of breath when washing or dressing yourself
☐	☐	f. Shortness of breath that interferes with your job
☐	☐	g. Coughing that produces a phlegm (thick sputum)
☐	☐	h. Coughing that wakes you early in the morning
☐	☐	i. Coughing that occurs mostly when you are laying down
☐	☐	j. Coughing up blood in the last month
☐	☐	k. Wheezing
☐	☐	l. Wheezing that interferes with your job
☐	☐	m. Chest pain when you breathe deeply
☐	☐	n. Any other symptoms that you think may be related to lung problems
		8. Have you ever had any of the following cardiovascular or heart symptoms?
☐	☐	a. Frequent pain or tightness in your chest
☐	☐	b. Pain or tightness in your chest during physical activity
☐	☐	c. Pain or tightness in your chest that interferes with your job
☐	☐	d. In the past two years, have you noticed your heart skipping or missing a beat
☐	☐	e. Heartburn or indigestion that is not related to eating
☐	☐	f. Any other symptoms that you think may be related to heart or circulation problems
		9. Do you *currently* take medication for any of the following problems
☐	☐	a. Heart trouble
☐	☐	b. Breathing or lung problems
☐	☐	c. Blood pressure
☐	☐	d. Seizures (fits)

PART A

YES	NO	Please check yes or no
		10. If you've used a respirator, have you ever had any of the following problems? (if you've never used a respirator, check the following space and go to Question #11) ☐
☐	☐	a. Eye irritation
☐	☐	b. Skin allergies or rashes
☐	☐	c. Anxiety
☐	☐	d. General weakness or fatigue
☐	☐	e. Any other problem that interferes with your use of a respirator
☐	☐	11. Would you like to talk to the health care professional, who will review this questionnaire, about your answers to this questionnaire?

Complete questions #12 through #17 only if you are expected to use a full-face or SCBA respirator.

YES	NO	Please check yes or no		
☐	☐	12.	Have you ever lost vision in either eye (temporarily or permanently)	
		13.	Do you *currently* have any of the following vision problems?	
☐	☐		a.	Wear contact lenses
☐	☐		b.	Wear glasses
☐	☐		c.	Color blindness
☐	☐		d.	Any other eye or vision problems
☐	☐	14.	Have you ever had an injury to your ears, including a broken ear drum?	
		15.	Do you *currently* have any of the following hearing problems?	
☐	☐		a.	Difficulty hearing
☐	☐		b.	Wear a hearing aid
☐	☐		c.	Any other hearing or ear problem
☐	☐	16.	Have you ever had a back injury?	
		17.	Do you *currently* have any of the following musculoskeletal problems?	
☐	☐		a.	Weakness in any of your hands, arms, legs, or feet
☐	☐		b.	Back pain
☐	☐		c.	Difficulty fully moving your arms and legs
☐	☐		d.	Pain or stiffness when you lean forward or backward at the waist
☐	☐		e.	Difficulty fully moving you head up and down
☐	☐		f.	Difficulty moving your head side to side
☐	☐		g.	Difficulty bending at your knees
☐	☐		h.	Difficulty squatting to the ground
☐	☐		i.	Climbing a flight of stairs or a ladder carrying more that 25 lbs.
☐	☐		j.	Any other muscle or skeletal problem that interferes with using a respirator

PART B

YES	NO	Please check yes or no
☐	☐	1. In your present job, are you working at high altitudes (5,000 feet) or in a place that has lower than normal amounts of oxygen?
		If "yes", do you have feelings of dizziness, shortness of breath, pounding in your chest or other symptoms when you're working under these conditions?
☐	☐	2. At work or at home, have you ever been exposed to hazardous solvents, hazardous airborne chemicals (e.g. gases, fumes, or dust), or have you come into skin contact with hazardous chemicals?
		If "yes", name the chemicals if you know them: _____
☐	☐	3. Have you ever worked with any of the materials, or under any of the conditions listed below?
☐	☐	a. Asbestos
☐	☐	b. Silica (e.g., in sandblasting)
☐	☐	c. Tungsten/cobalt (e.g., grinding or welding this material)
☐	☐	d. Coal (for example, mining)
☐	☐	e. Iron
☐	☐	f. Tin
☐	☐	g. Dusty environments
☐	☐	h. Beryllium
☐	☐	i. Aluminum
☐	☐	j. Any other hazardous exposures
		If "yes", describe these exposures: _____
☐	☐	4. List any second jobs or side businesses you have: _____
☐	☐	5. List your previous occupations: _____
☐	☐	6. List your current and previous hobbies: _____
☐	☐	7. Have you been in the military services?
		If "yes", were you exposed to biological or chemical agents (either in training or combat)? _____
☐	☐	8. Have you ever worked on a HAZMAT team?
☐	☐	9. Other than medications for breathing and lung problems, heart trouble, blood pressure and seizures mentioned earlier in this questionnaire, are you taking any other medications for any reason (including over-the-counter medications).
		If "yes", name the medications if you know them: _____

PART B

YES	NO	Please check yes or no
☐	☐	10. Will you be using any of the following items with your respirator(s)?
☐	☐	a. HEPA Filters
☐	☐	b. Canisters (for example, gas masks)
☐	☐	c. Cartridges
☐	☐	11. How often are you expected to use the respirator(s)
☐	☐	a. Escape only (no rescue)
☐	☐	b. Emergency rescue only
☐	☐	c. 1 to 4 hours per day
☐	☐	d. 4 to 8 hours per day
☐	☐	e. Other _____

I ACKNOWLEDGE THAT THE ABOVE INFORMATION IS CORRECT.

Date: _____ Employee Signature: _____

Reviewed by: _____ Date: _____

Recommendations:

Physician's Recommendations (if appropriate):

Physician's Signature: _____

ADMINISTRATIVE POLICY MANUAL

Title/Description:	**CONFIDENTIALITY OF INFORMATION**	Policy Manual # **111.158**
		Corresponding Policy

Effective Date: **12/1/98** Revised Date:	Authorized by:

PURPOSE:

The Medical Center recognizes the need for confidentiality of all information produced by examination, treatment, observation, consultation, conversation or review of medical records and computerized data. This policy recognizes the inherent right of privacy for any individual, patient and family employee and physician.

POLICY:

1. Any necessary exchange of confidential information shall be conducted in a manner which promotes privacy and prevents unauthorized disclosure. All discussion of confidential information in public places is prohibited. Employees' relationship and familiarity with a patient do not justify unauthorized access to information, such as unauthorized visits to hospitalized workers, review of medical records of employees, families or friends and discussion of this information. Such action is strictly prohibited.

2. Any unauthorized access, release, use or possession of confidential information by any Medical Center employee will result in corrective action up to and including termination of employment.

3. Unauthorized access by the Medical Staff will result in action in accordance with procedures established in the Medical Staff Bylaws.

4. Confidential information shall be stored in a manner which promotes privacy and prevents unauthorized disclosure.

CONFIDENTIALITY STATEMENT

I have read and understand the Medical Center's Administrative Policy "Confidentiality of Information #111.158."

_____ _____

Signature Date

_____ _____

Mercy Representative Date

THIS STATEMENT WILL BE KEPT IN YOUR FILE IN THE HUMAN RESOURCES DEPARTMENT!

MERCY
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HOSPITAL INFORMATION SYSTEMS

CODE OF ETHICS

F-4482-NS 916 0699

SOFTWARE

This code of ethics states the Hospital policy concerning software duplication. Unless otherwise provided in the license, any unauthorized duplication of copyrighted software, except for backup and archival purposes, is a violation of the law and is contrary to the Hospitals' policies. The following points are to be followed to comply with software license agreements:

1. Hospital employees/students are not permitted to make unauthorized copies of any software under any circumstances.
2. The Hospital will not tolerate the use of any unauthorized copies of software. Any employee/student illegally reproducing software can be subject to civil and criminal penalties, including fines and imprisonment. The Hospital does not condone illegal copying of software under any circumstances.
3. Hospital employees/students are not permitted to give software to any outsiders, including clients, customers and others.
4. All software used by the Hospital on company computers will be properly purchased through appropriate procedures.

E-MAIL

1.
   - All employees will use the E-mail system in accordance with the E-mail Code of Ethics.
   - E-mail should not be used to relay patient clinical and occurrence information.
   - Use of profanity, racial slurs, sexual innuendoes, and threatening verbiage is prohibited and will not be tolerated.
   - The E-mail system shall not be used for personal communications, such as after-work appointments or gossip. E-mail is hospital property and must be used for work purposes only. Information contained in E-mail is hospital property and may be accessed and disclosed as part of a legal process.
   - Using the system to solicit outside business ventures; to access confidential patient information without authorization or for personal; political or religious causes is prohibited.
   - It is the sole responsibility of the user to minimize the number of old E-mail messages retained, in order to conserve resources.
2. All E-mail users are required to read and sign the Hospital Information Systems Code of Ethics and return the signed form to Information Services. Any user violating the Code of Ethics may be subject to progressive corrective action.

PASSWORD ASSIGNMENT

By accepting a Signon/Password on the Hospital System(s), I understand:

1. I have a legal obligation to keep confidential all information concerning patients that I may have access to and will only discuss information with employees/students who have a need to know the information in order to perform their job.
2. I will not intentionally attempt to gain access to areas that are not needed for the performance of my job.
3. The signon/password that is assigned is unique to me and is not transferrable.
4. I am solely and fully accountable for any information entered into the system or information accessed by any person under my signon/password. I will notify my supervisor and/or the System Manager (or designee) immediately, if I suspect that someone has gained unauthorized access to my signon/password.
5. I understand that according to the Hospital policy on confidentiality of information, any unauthorized access, release, use or possession of confidential information by an employee/student will result in progressive corrective action up to and including termination of employment.
6. I have read and understand the E-mail Code of Ethics.

MY SIGNATURE BELOW ACKNOWLEDGES THAT I HAVE READ AND UNDERSTOOD THE CODE OF ETHICS FOR MERCY MEDICAL CENTER UNDER WHICH A SIGNON/PASSWORD HAS BEEN ASSIGNED TO ME.

I UNDERSTAND THAT FAILURE TO COMPLY WITH THE ABOVE POLICIES WILL RESULT IN FORMAL DISCIPLINARY ACTION, UP TO AND POSSIBLY INCLUDING TERMINATION FROM THE COMPANY IN THE CASE OF EMPLOYEES AND THE TERMINATION OR CANCELLATION OF AGREEMENTS IN THE CASE OF PHYSICIANS, CONSULTANTS, OR VENDORS.

_____ _____
Employee/Student Signature Date

_____ _____
Manager/Instructor Date

FORWARD TO SECURITY ADMINISTRATOR, INFORMATION SERVICES DEPARTMENT. THANK YOU.

INFORMATION SECURITY AGREEMENT

Computerized information systems are one of the Company's most valuable assets. Our success and the privacy of our patients depend on the protection of this information against theft, destruction or disclosure to outside interests.

Employees, physicians, consultants and vendors may at some time be required to operate computer equipment or have access to software systems as part of their performance or duties for Mercy Medical Center. Those charged with this responsibility must understand information security policies in effect throughout the Company.

Therefore, I agree to the following provisions:

- Not to operate or attempt to operate computer equipment without specific authorization from supervisors.
- Not to demonstrate the operation of computer equipment to anyone without specific authorization.
- To maintain assigned passwords that allow access to computer systems and equipment in strictest confidence and not disclose a password with anyone, at any time, for any reason.
- To access only computer systems, equipment and functions as required for the performance of my responsibilities.
- To contact my supervisor or Security Coordinator/Designee immediately and request a new password(s) if mine is (are) accidentally revealed.
- Not to record passwords in any manner, as this increases the possibility of accidental disclosure.
- Not to disclose any portion of the Company's computerized system with any unauthorized individuals. This includes, but is not limited to, the design, programming techniques, flow charts, source code, screens and documentation created by Company employees or outside sources.
- Not to disclose any portion of a patient's record except to a recipient designated by the patient or to a recipient authorized by the Company who has a need-to-know in order to provide for the continuing care of the patient or to discharge one's employment or other service obligation to the Company.
- To report activity that is contrary to the provisions of this agreement to my supervisor or Security Coordinator.

I understand that failure to comply with the above policies will result in formal disciplinary action, up to and possibly including termination from the Company in the case of employees and the termination or cancellation of agreements in the case of physicians, consultants, or vendors.

Employee/Physician/Consultant/Vendor Signature	Cost Center	Date

_____Print Name

MERCY
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DIRECT DEPOSIT AUTHORIZATION

(Changes may also be made in Employee Self-Service in Lawson)

NAME **(Please Print)**:_____DATE:_____

LAWSON #_____

DEPOSIT INFORMATION

Primary Account

BANK NAME _____**ROUTING NO**._____

ACCOUNT NO._____ **ACOUNT TYPE**_____

(SAVINGS OR CHECKINGS)

Default Account: Remaining amount of pay, after any secondary account deposits, will go into this account.

DEPOSIT INFORMATION

Secondary Account

BANK NAME _____**ROUTING NO**._____

ACCOUNT NO._____ **ACOUNT TYPE**_____

(SAVINGS OR CHECKINGS)

AMOUNT TO BE DEPOSITED:_____

(PERCENTAGE (%) OR SPECIFY DOLLAR AMOUNT)

☐ **NEW ACCOUNT(S)** **OR** ☐ **CHANGING ACCOUNT(S)**

I hereby authorize Mercy Medical Center to initiate entries to my account as indicated above and for the Financial Organization indicated to credit the same to such account(s). Charges to said account(s) may only be made to reverse credit amounts erroneously posted. This termination in such time and in such manner as to afford a reasonable opportunity to act upon it.

DATE_____ **EMPLOYEE SIGNATURE**_____

******IMPORTANT*****

PLEASE ATTACH A VOIDED CHECK OR STATEMENT FOR YOUR ACCOUNT TO THIS FORM AND RETURN TO HUMAN RESOURCES DEPARTMENT. ONCE THE COMPLETED FORM IS RECEIVED, IT MAY TAKE UP TO TWO OR THREE PAY CYCLES BEFORE AN INITIAL TRANSACTION /CHANGE TO THE DIRECT DEPOSIT CAN TAKE EFFECT.

ENTIRE FORM MUST BE COMPLETE PRIOR TO SUBMISSION TO HUMAN RESOURCES.

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Emergency Notification Information

Employee Name:_____

Lawson #: _____

In case of emergency, please notify:

Name:_____

Relationship:_____

Address:_____

City, State, Zip: _____

Phone: _____

Cell Phone: _____

Work Phone:_____

MERCY MEDICAL CENTER

DRUG, ALCOHOL, AND/OR NICOTINE TESTING CONSENT and AUTHORIZATION FORM

I hereby agree, upon a request made under the drug/alcohol testing and the post ï offer/pre-employment evaluation policies of Mercy Medical Center to submit to a drug, alcohol or nicotine test. I understand and agree that if I at any time refuse to submit to a drug, alcohol, or nicotine test under company policy, or if I otherwise fail to cooperate with the testing procedures, I will be subject to immediate termination. I further authorize and give full permission to have the hospital and/or its company physician release any and all documentation relating to such test to the hospital and/or its representatives or appropriate licensing agencies.

I authorize the disclosure of my drug, alcohol, and/or nicotine test results to be released to appropriate parties with the Medical Center for the purpose of conforming to the Medical Centerôs drug/alcohol and post-offer/pre-employment evaluation screening policies.

I understand that I have the right to revoke this authorization at any time by sending a written revocation to Mercy Medical Center Health Information, 1320 Mercy Drive, NW, Canton, OH 44708. I understand that the revocation will not apply to information that has already been released in response to this authorization. Unless otherwise revoked, this authorization will expire within 60 days.

I understand that the Medical Center will not condition the provision of treatment or payment to me on the signing of this authorization. I understand that authorizing the disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by Federal confidentiality rules.

I understand that only duly-authorized Medical Center officers, employees, and agents will have access to information furnished or obtained in connection with the test; that they will maintain and protect the confidentiality of such information to the greatest extent possible; and that they will share such information only to the extent necessary to make employment decisions and to respond to inquiries or notices from government entities, including but not limited to licensing agencies.

I will hold harmless the Medical Center, its company physician, officers, employees, and representatives, and any testing laboratory the hospital might use, meaning that I will not sue or hold responsible such parties for any alleged harm to me that might result from such testing, including loss of employment or any other kind of adverse job action that might arise as a result of the drug, alcohol, or nicotine test, even if a hospital or laboratory representative makes an error in the administration or analysis of the test or the reporting of the results. I will further hold harmless the Medical Center, its physicians, officers, employees, and representatives, and any testing laboratory the hospital might use for any alleged harm to me that might result from the release or use of information or documentation relating to the drug, alcohol, or nicotine test, as long as the release or use of the information is within the scope of this policy and the procedures as explained in the paragraph above.

_____ _____

Signature of Employee Date

_____

Employee's Name - Printed

_____ _____

Signature of Witness Date

_____

Witness Name - Printed

New Hire Self-Identification Data Sheet

Please complete this New Hire Self-Identification Data Sheet. It will supply us with information we need for federal reporting obligations. Please be advised that this information will be used and kept confidential, in accordance with applicable laws and regulations. This information will not be used as the basis for any employment decision.

Name _____
Last First Middle

Social Security # (last 4 digits) _____

Self-Identification

We are subject to certain government recordkeeping and reporting requirements for the administration of civil rights laws and regulations. To comply with these laws, we invite you to voluntarily self-identify your race or ethnicity. **Submission of this information is voluntary and refusal to provide it will not subject you to any adverse treatment**. The information obtained will be kept confidential and separate from personnel files. It may only be used in accordance with the provisions of applicable laws, executive orders, and regulations, including those requiring information to be summarized and reported to the federal government for civil rights enforcement. When reported, data will not identify any specific individual.

Please check the EEO Identification Group that <u>best</u> applies to you:

☐ **Hispanic or Latino (HISP):** *A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race.*

- OR -

☐ **White (WHT):** *A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.*

☐ **Black or African American (BLK):** *A person having origins in any of the black racial groups of Africa.*

☐ **Native Hawaiian or Other Pacific Islander (HAW):** *A person having origins in any of the peoples of Hawaii, Guam, Samoa, or other Pacific Islands.*

☐ **Asian (ASIA):** *A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian Subcontinent, including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.*

☐ **American Indian or Alaska Native (NATV):** *A person having origins in any of the original peoples of North and South America (including Central America), and who maintain tribal affiliation or community attachment.*

☐ **Two or More Races (TWO):** *All persons who identify with more than one of the above races, excluding those who identify themselves as Hispanic or Latino.*

New Hire Self-Identification Data Sheet (page 2)

Gender: ☐ Male ☐ Female

Please check the Veteran status that <u>best</u> applies to you, if applicable:

☐ ***Protected Veteran (C)*** – means a veteran who is protected under the nondiscrimination and affirmative action provisions of the Vietnam Veterans' Readjustment Assistance Act, 38 U.S.C. 4212; specifically a veteran who may be classified as an active duty wartime or campaign badge veteran, disabled veteran, Armed Forces service medal veteran, or recently separated veteran.

☐ ***Active duty wartime or campaign badge Veteran (1)*** – means a veteran who served on active duty in the U.S. military, ground, naval or air service during a war or in a campaign or expedition for which a campaign badge has been authorized under the laws administered by the Department of Defense.

☐ ***Armed Forces Service Medal Veteran (7)*** – means any veteran who, while serving on active duty in the U.S. military, ground, naval or air service, participated in a United States military operation for which an Armed Forces service medal was awarded pursuant to Executive Order 12985 (61 FR 1209, 3 CFR, 1996 Comp., p. 159).

☐ ***Disabled Veteran (2)*** – means (1) A veteran of the U.S. military, ground, naval or air service who is entitled to compensation (or who but for the receipt of military retired pay would be entitled to compensation) under laws administered by the Secretary of Veterans Affairs, or (2) A person who was discharged or released from active duty because of a service-connected disability.

☐ ***Recently Separated Veteran (8)*** – means a veteran during the three-year period beginning on the date of such veteran's discharge or release from active duty in the U.S. military, ground, naval or air service.

☐ ***I am not a Veteran (N)***

Please check the disability status that <u>best</u> applies to you, if applicable:

You are considered to have a disability if you have a physical or mental impairment or medical condition that substantially limits a major life activity, or if you have a history or record of such an impairment or medical condition. Disabilities include, but are not limited to:

- *Blindness*
- *Deafness*
- *Cancer*
- *Diabetes*
- *Epilepsy*
- *Autism*
- *Cerebral palsy*
- *HIV/AIDS*
- *Schizophrenia*
- *Muscular dystrophy*
- *Bipolar disorder*
- *Major depression*
- *Multiple sclerosis*
- *Missing limbs or partially missing limbs*
- *Post-traumatic stress disorder*
- *Obsessive compulsive disorder*
- *Impairments requiring the use of a wheelchair*
- *Intellectual disability*

Please check one of the boxes below:

☐ Yes, I have a disability ☐ No, I do not have a disability ☐ I do not wish to answer

_____ _____

Signature **Date**

Security Access Control

Employee Vehicle Registration Form

Employee Information

Last Name_____First Name_____MI_____

Cost Center_____ Lawson Number_____ Kronos Number_____

Job Title: _____ Department: _____

Institute: _____ Credentials: _____

Vehicle Information (register up to 3 vehicles)

License Plate Number: _____ Color_____

Year _____Make_____Model_____

License Plate Number: _____ Color_____

Year _____Make_____ Model_____

License Plate Number: _____ Color_____

Year _____Make_____ Model_____

Employment Eligibility Verification

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

USCIS
Form I-9
OMB No. 1615-0047
Expires 10/31/2022

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

ANTI-DISCRIMINATION NOTICE: It is illegal to discriminate against work-authorized individuals. Employers **CANNOT** specify which document(s) an employee may present to establish employment authorization and identity. The refusal to hire or continue to employ an individual because the documentation presented has a future expiration date may also constitute illegal discrimination.

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

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

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

Date of Birth *(mm/dd/yyyy)*	U.S. Social Security Number	Employee's E-mail Address	Employee's Telephone Number
	☐☐☐ - ☐☐ - ☐☐☐☐		

I am aware that federal law provides for imprisonment and/or fines for false statements or use of false documents in connection with the completion of this form.

I attest, under penalty of perjury, that I am (check one of the following boxes):

☐ 1. A citizen of the United States

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

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

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

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

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

QR Code - Section 1
Do Not Write In This Space

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

Preparer and/or Translator Certification (check one):

☐ I did not use a preparer or translator. ☐ A preparer(s) and/or translator(s) assisted the employee in completing Section 1.

(Fields below must be completed and signed when preparers and/or translators assist an employee in completing Section 1.)

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

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

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

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

STOP *Employer Completes Next Page* STOP

Employment Eligibility Verification

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

USCIS
Form I-9
OMB No. 1615-0047
Expires 10/31/2022

Section 2. Employer or Authorized Representative Review and Verification

(Employers or their authorized representative must complete and sign Section 2 within 3 business days of the employee's first day of employment. You must physically examine one document from List A OR a combination of one document from List B and one document from List C as listed on the "Lists of Acceptable Documents.")

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

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

Additional Information

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

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

The employee's first day of employment *(mm/dd/yyyy)*: _____ ***(See instructions for exemptions)***

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

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

Employer's Business or Organization Address (*Street Number and Name*)	City or Town	State	ZIP Code

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

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

C. If the employee's previous grant of employment authorization has expired, provide the information for the document or receipt that establishes continuing employment authorization in the space provided below.

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

I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented document(s), the document(s) I have examined appear to be genuine and to relate to the individual.

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

LISTS OF ACCEPTABLE DOCUMENTS
All documents must be UNEXPIRED

Employees may present one selection from List A
or a combination of one selection from List B and one selection from List C.

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

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

Refer to the instructions for more information about acceptable receipts.

MERCY
MEDICAL CENTER
A Ministry of the Sisters of Charity Health System

Fair Credit Reporting Act
Disclosure And Authorization To Applicant

When considering your application for employment and when making a decision about whether to offer you employment, Mercy Medical Center may wish to obtain and use a "consumer report" from a "consumer reporting agency". The definitions of these terms, from the Fair Credit Reporting Act ("FCRA"), are stated below. As an applicant for employment at Mercy Medical Center, you are a "consumer" with rights under the FCRA.

A "consumer reporting agency" as utilized by Mercy Medical Center is a person or business that, for monetary fees, dues or on a cooperative non-profit basis, regularly assembles or evaluates information on consumers for the purpose of furnishing "consumer reports" to others, such as Mercy Medical Center. The "consumer reporting agency" in this case will provide a criminal background record check and in applicable cases a driving record check on you, the applicant.

A "consumer report" is any written, oral or other communication of any information by a "consumer reporting agency" bearing on a consumer's credit worthiness, credit standing, credit capacity, character, general reputation, personal characteristics or mode of living which is used or collected for the purpose of serving as a factor in establishing the consumer's eligibility for purposes including, but not limited to, employment.

A "consumer report" as utilized by Mercy Medical Center includes a background report by a consumer reporting agency regarding criminal record and in applicable cases a driving record check. Under the FCRA, a consumer report is used for "employment purposes" when it is used to evaluate a consumer for hiring.

If Mercy Medical Center obtains a "consumer report" about you, and if Mercy Medical Center considers any information in the "consumer report" when making an employment-related decision that directly and adversely affects you, you will be provided with a copy of the "consumer report" before the decision is finalized. You also may contact the Federal Trade Commission (FTC) about your rights under the FCRA as a "consumer" with respect to "consumer reports" and "consumer reporting agencies."

Authorization

By signing below, I hereby voluntarily authorize Mercy Medical Center to obtain "consumer reports" (criminal background record check and in applicable cases a driving record check) about me from a "consumer reporting agency" and consider such reports when making decisions about my application for employment with Mercy Medical Center and any related job offer, or regarding my employment status if I am hired by Mercy Medical Center.

I understand that I have rights under the FCRA, including those discussed above. (Please print)

Name: _____

Social Security Number _____ DOB ** _____

Current Address _____

City _____ State _____ Zip _____

Signature: _____ Date: _____

***Date of Birth is being requested in order to obtain accurate retrieval of records.*

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

2022

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 widow(er)**
☐ **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.)

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, when to use the estimator at *www.irs.gov/W4App*, and privacy.

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 most accurate withholding for this step (and Steps 3–4); **or**

(b) Use the Multiple Jobs Worksheet on page 3 and enter the result in Step 4(c) below for roughly accurate withholding; **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 accurate for jobs with similar pay; otherwise, more tax than necessary may be withheld . . ▶ ☐

TIP: To be accurate, submit a 2022 Form W-4 for all other jobs. If you (or your spouse) have self-employment income, including as an independent contractor, use the estimator.

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 Dependents

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 and 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)

General Instructions

Section references are to the Internal Revenue Code.

Future Developments

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

Purpose of Form

Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay. If too little is withheld, you will generally owe tax when you file your tax return and may owe a penalty. If too much is withheld, you will generally be due a refund. Complete a new Form W-4 when changes to your personal or financial situation would change the entries on the form. For more information on withholding and when you must furnish a new Form W-4, see Pub. 505, Tax Withholding and Estimated Tax.

Exemption from withholding. You may claim exemption from withholding for 2022 if you meet both of the following conditions: you had no federal income tax liability in 2021 **and** you expect to have no federal income tax liability in 2022. You had no federal income tax liability in 2021 if (1) your total tax on line 24 on your 2021 Form 1040 or 1040-SR is zero (or less than the sum of lines 27a, 28, 29, and 30), or (2) you were not required to file a return because your income was below the filing threshold for your correct filing status. If you claim exemption, you will have no income tax withheld from your paycheck and may owe taxes and penalties when you file your 2022 tax return. To claim exemption from withholding, certify that you meet both of the conditions above by writing "Exempt" on Form W-4 in the space below Step 4(c). Then, complete Steps 1(a), 1(b), and 5. Do not complete any other steps. You will need to submit a new Form W-4 by February 15, 2023.

Your privacy. If you prefer to limit information provided in Steps 2 through 4, use the online estimator, which will also increase accuracy.

As an alternative to the estimator: if you have concerns with Step 2(c), you may choose Step 2(b); if you have concerns with Step 4(a), you may enter an additional amount you want withheld per pay period in Step 4(c). If this is the only job in your household, you may instead check the box in Step 2(c), which will increase your withholding and significantly reduce your paycheck (often by thousands of dollars over the year).

When to use the estimator. Consider using the estimator at *www.irs.gov/W4App* if you:

1. Expect to work only part of the year;

2. Have dividend or capital gain income, or are subject to additional taxes, such as Additional Medicare Tax;

3. Have self-employment income (see below); or

4. Prefer the most accurate withholding for multiple job situations.

Self-employment. Generally, you will owe both income and self-employment taxes on any self-employment income you receive separate from the wages you receive as an employee. If you want to pay these taxes through withholding from your wages, use the estimator at *www.irs.gov/W4App* to figure the amount to have withheld.

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

Specific Instructions

Step 1(c). Check your anticipated filing status. This will determine the standard deduction and tax rates used to compute your withholding.

Step 2. Use this step if you (1) have more than one job at the same time, or (2) are married filing jointly and you and your spouse both work.

Option **(a)** most accurately calculates the additional tax you need to have withheld, while option **(b)** does so with a little less accuracy.

If you (and your spouse) have a total of only two jobs, you may instead check the box in option **(c)**. The box must also be checked on the Form W-4 for the other job. If the box is checked, the standard deduction and tax brackets will be cut in half for each job to calculate withholding. This option is roughly accurate for jobs with similar pay; otherwise, more tax than necessary may be withheld, and this extra amount will be larger the greater the difference in pay is between the two jobs.

Multiple jobs. *Complete Steps 3 through 4(b) on only one Form W-4. Withholding will be most accurate if you do this on the Form W-4 for the highest paying job.*

Step 3. This step provides instructions for determining the amount of the child tax credit and the credit for other dependents that you may be able to claim when you file your tax return. To qualify for the child tax credit, the child must be under age 17 as of December 31, must be your dependent who generally lives with you for more than half the year, and must have the required social security number. You may be able to claim a credit for other dependents for whom a child tax credit can't be claimed, such as an older child or a qualifying relative. For additional eligibility requirements for these credits, see Pub. 501, Dependents, Standard Deduction, and Filing Information. You can also include **other tax credits** for which you are eligible in this step, such as the foreign tax credit and the education tax credits. To do so, add an estimate of the amount for the year to your credits for dependents and enter the total amount in Step 3. Including these credits will increase your paycheck and reduce the amount of any refund you may receive when you file your tax return.

Step 4 (optional).

Step 4(a). Enter in this step the total of your other estimated income for the year, if any. You shouldn't include income from any jobs or self-employment. If you complete Step 4(a), you likely won't have to make estimated tax payments for that income. If you prefer to pay estimated tax rather than having tax on other income withheld from your paycheck, see Form 1040-ES, Estimated Tax for Individuals.

Step 4(b). Enter in this step the amount from the Deductions Worksheet, line 5, if you expect to claim deductions other than the basic standard deduction on your 2022 tax return and want to reduce your withholding to account for these deductions. This includes both itemized deductions and other deductions such as for student loan interest and IRAs.

Step 4(c). Enter in this step any additional tax you want withheld from your pay **each pay period**, including any amounts from the Multiple Jobs Worksheet, line 4. Entering an amount here will reduce your paycheck and will either increase your refund or reduce any amount of tax that you owe.

Step 2(b)—Multiple Jobs Worksheet *(Keep for your records.)*

If you choose the option in Step 2(b) on Form W-4, complete this worksheet (which calculates the total extra tax for all jobs) on **only ONE** Form W-4. Withholding will be most accurate if you complete the worksheet and enter the result on the Form W-4 for the highest paying job.

Note: If more than one job has annual wages of more than $120,000 or there are more than three jobs, see Pub. 505 for additional tables; or, you can use the online withholding estimator at *www.irs.gov/W4App*.

1 **Two jobs.** If you have two jobs or you're married filing jointly and you and your spouse each have one job, find the amount from the appropriate table on page 4. Using the "Higher Paying Job" row and the "Lower Paying Job" column, find the value at the intersection of the two household salaries and enter that value on line 1. Then, **skip** to line 3 . . . . . **1** $ _____

2 **Three jobs.** If you and/or your spouse have three jobs at the same time, complete lines 2a, 2b, and 2c below. Otherwise, skip to line 3.

a Find the amount from the appropriate table on page 4 using the annual wages from the highest paying job in the "Higher Paying Job" row and the annual wages for your next highest paying job in the "Lower Paying Job" column. Find the value at the intersection of the two household salaries and enter that value on line 2a . . . . . **2a** $ _____

b Add the annual wages of the two highest paying jobs from line 2a together and use the total as the wages in the "Higher Paying Job" row and use the annual wages for your third job in the "Lower Paying Job" column to find the amount from the appropriate table on page 4 and enter this amount on line 2b . . . . . **2b** $ _____

c Add the amounts from lines 2a and 2b and enter the result on line 2c . . . . . **2c** $ _____

3 Enter the number of pay periods per year for the highest paying job. For example, if that job pays weekly, enter 52; if it pays every other week, enter 26; if it pays monthly, enter 12, etc. . . . . **3** _____

4 **Divide** the annual amount on line 1 or line 2c by the number of pay periods on line 3. Enter this amount here and in **Step 4(c)** of Form W-4 for the highest paying job (along with any other additional amount you want withheld) . . . . . **4** $ _____

Step 4(b)—Deductions Worksheet *(Keep for your records.)*

1 Enter an estimate of your 2022 itemized deductions (from Schedule A (Form 1040)). Such deductions may include qualifying home mortgage interest, charitable contributions, state and local taxes (up to $10,000), and medical expenses in excess of 7.5% of your income . . . . . **1** $ _____

2 Enter:
- $25,900 if you're married filing jointly or qualifying widow(er)
- $19,400 if you're head of household
- $12,950 if you're single or married filing separately

. . . . . **2** $ _____

3 If line 1 is greater than line 2, subtract line 2 from line 1 and enter the result here. If line 2 is greater than line 1, enter "-0-" . . . . . **3** $ _____

4 Enter an estimate of your student loan interest, deductible IRA contributions, and certain other adjustments (from Part II of Schedule 1 (Form 1040)). See Pub. 505 for more information . . . . **4** $ _____

5 **Add** lines 3 and 4. Enter the result here and in **Step 4(b)** of Form W-4 . . . . . **5** $ _____

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

You 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.

Married Filing Jointly or Qualifying Widow(er)

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	$0 - 9,999	$10,000 - 19,999	$20,000 - 29,999	$30,000 - 39,999	$40,000 - 49,999	$50,000 - 59,999	$60,000 - 69,999	$70,000 - 79,999	$80,000 - 89,999	$90,000 - 99,999	$100,000 - 109,999	$110,000 - 120,000
$0 - 9,999	$0	$110	$850	$860	$1,020	$1,020	$1,020	$1,020	$1,020	$1,020	$1,770	$1,870
$10,000 - 19,999	110	1,110	1,860	2,060	2,220	2,220	2,220	2,220	2,220	2,970	3,970	4,070
$20,000 - 29,999	850	1,860	2,800	3,000	3,160	3,160	3,160	3,160	3,910	4,910	5,910	6,010
$30,000 - 39,999	860	2,060	3,000	3,200	3,360	3,360	3,360	4,110	5,110	6,110	7,110	7,210
$40,000 - 49,999	1,020	2,220	3,160	3,360	3,520	3,520	4,270	5,270	6,270	7,270	8,270	8,370
$50,000 - 59,999	1,020	2,220	3,160	3,360	3,520	4,270	5,270	6,270	7,270	8,270	9,270	9,370
$60,000 - 69,999	1,020	2,220	3,160	3,360	4,270	5,270	6,270	7,270	8,270	9,270	10,270	10,370
$70,000 - 79,999	1,020	2,220	3,160	4,110	5,270	6,270	7,270	8,270	9,270	10,270	11,270	11,370
$80,000 - 99,999	1,020	2,820	4,760	5,960	7,120	8,120	9,120	10,120	11,120	12,120	13,150	13,450
$100,000 - 149,999	1,870	4,070	6,010	7,210	8,370	9,370	10,510	11,710	12,910	14,110	15,310	15,600
$150,000 - 239,999	2,040	4,440	6,580	7,980	9,340	10,540	11,740	12,940	14,140	15,340	16,540	16,830
$240,000 - 259,999	2,040	4,440	6,580	7,980	9,340	10,540	11,740	12,940	14,140	15,340	16,540	17,590
$260,000 - 279,999	2,040	4,440	6,580	7,980	9,340	10,540	11,740	12,940	14,140	16,100	18,100	19,190
$280,000 - 299,999	2,040	4,440	6,580	7,980	9,340	10,540	11,740	13,700	15,700	17,700	19,700	20,790
$300,000 - 319,999	2,040	4,440	6,580	7,980	9,340	11,300	13,300	15,300	17,300	19,300	21,300	22,390
$320,000 - 364,999	2,100	5,300	8,240	10,440	12,600	14,600	16,600	18,600	20,600	22,600	24,870	26,260
$365,000 - 524,999	2,970	6,470	9,710	12,210	14,670	16,970	19,270	21,570	23,870	26,170	28,470	29,870
$525,000 and over	3,140	6,840	10,280	12,980	15,640	18,140	20,640	23,140	25,640	28,140	30,640	32,240

Single or Married Filing Separately

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	$0 - 9,999	$10,000 - 19,999	$20,000 - 29,999	$30,000 - 39,999	$40,000 - 49,999	$50,000 - 59,999	$60,000 - 69,999	$70,000 - 79,999	$80,000 - 89,999	$90,000 - 99,999	$100,000 - 109,999	$110,000 - 120,000
$0 - 9,999	$400	$930	$1,020	$1,020	$1,250	$1,870	$1,870	$1,870	$1,870	$1,970	$2,040	$2,040
$10,000 - 19,999	930	1,570	1,660	1,890	2,890	3,510	3,510	3,510	3,610	3,810	3,880	3,880
$20,000 - 29,999	1,020	1,660	1,990	2,990	3,990	4,610	4,610	4,710	4,910	5,110	5,180	5,180
$30,000 - 39,999	1,020	1,890	2,990	3,990	4,990	5,610	5,710	5,910	6,110	6,310	6,380	6,380
$40,000 - 59,999	1,870	3,510	4,610	5,610	6,680	7,500	7,700	7,900	8,100	8,300	8,370	8,370
$60,000 - 79,999	1,870	3,510	4,680	5,880	7,080	7,900	8,100	8,300	8,500	8,700	8,970	9,770
$80,000 - 99,999	1,940	3,780	5,080	6,280	7,480	8,300	8,500	8,700	9,100	10,100	10,970	11,770
$100,000 - 124,999	2,040	3,880	5,180	6,380	7,580	8,400	9,140	10,140	11,140	12,140	13,040	14,140
$125,000 - 149,999	2,040	3,880	5,180	6,520	8,520	10,140	11,140	12,140	13,320	14,620	15,790	16,890
$150,000 - 174,999	2,040	4,420	6,520	8,520	10,520	12,170	13,470	14,770	16,070	17,370	18,540	19,640
$175,000 - 199,999	2,720	5,360	7,460	9,630	11,930	13,860	15,160	16,460	17,760	19,060	20,230	21,330
$200,000 - 249,999	2,970	5,920	8,310	10,610	12,910	14,840	16,140	17,440	18,740	20,040	21,210	22,310
$250,000 - 399,999	2,970	5,920	8,310	10,610	12,910	14,840	16,140	17,440	18,740	20,040	21,210	22,310
$400,000 - 449,999	2,970	5,920	8,310	10,610	12,910	14,840	16,140	17,440	18,740	20,040	21,210	22,470
$450,000 and over	3,140	6,290	8,880	11,380	13,880	16,010	17,510	19,010	20,510	22,010	23,380	24,680

Head of Household

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	$0 - 9,999	$10,000 - 19,999	$20,000 - 29,999	$30,000 - 39,999	$40,000 - 49,999	$50,000 - 59,999	$60,000 - 69,999	$70,000 - 79,999	$80,000 - 89,999	$90,000 - 99,999	$100,000 - 109,999	$110,000 - 120,000
$0 - 9,999	$0	$760	$910	$1,020	$1,020	$1,020	$1,190	$1,870	$1,870	$1,870	$2,040	$2,040
$10,000 - 19,999	760	1,820	2,110	2,220	2,220	2,390	3,390	4,070	4,070	4,240	4,440	4,440
$20,000 - 29,999	910	2,110	2,400	2,510	2,680	3,680	4,680	5,360	5,530	5,730	5,930	5,930
$30,000 - 39,999	1,020	2,220	2,510	2,790	3,790	4,790	5,790	6,640	6,840	7,040	7,240	7,240
$40,000 - 59,999	1,020	2,240	3,530	4,640	5,640	6,780	7,980	8,860	9,060	9,260	9,460	9,460
$60,000 - 79,999	1,870	4,070	5,360	6,610	7,810	9,010	10,210	11,090	11,290	11,490	11,690	12,170
$80,000 - 99,999	1,870	4,210	5,700	7,010	8,210	9,410	10,610	11,490	11,690	12,380	13,370	14,170
$100,000 - 124,999	2,040	4,440	5,930	7,240	8,440	9,640	10,860	12,540	13,540	14,540	15,540	16,480
$125,000 - 149,999	2,040	4,440	5,930	7,240	8,860	10,860	12,860	14,540	15,540	16,830	18,130	19,230
$150,000 - 174,999	2,040	4,460	6,750	8,860	10,860	12,860	15,000	16,980	18,280	19,580	20,880	21,980
$175,000 - 199,999	2,720	5,920	8,210	10,320	12,600	14,900	17,200	19,180	20,480	21,780	23,080	24,180
$200,000 - 449,999	2,970	6,470	9,060	11,480	13,780	16,080	18,380	20,360	21,660	22,960	24,250	25,360
$450,000 and over	3,140	6,840	9,630	12,250	14,750	17,250	19,750	21,930	23,430	24,930	26,420	27,730

Mercy Medical Center
SHIFT AGREEMENT

NOTICE TO EMPLOYEE OF CHANGES TO HOURS OF WORK, WORK TRANSFER, WORK SHIFT OR WEEKEND/HOLIDAY ROTATION, AND AVAILIABLITY TO WORK DURING EMERGENCIES

Mercy Medical Center is dedicated to providing the best possible care twenty-four (24) hours a day, seven (7) days a week. As a healthcare employee, you play an important part in maintaining this level of care. It is recognized that shortages of personnel or changes in workload may require your work hours to be rescheduled or adjusted to meet these special demands. You may also be transferred between departments to adjust the work forces according to workload demands.

I understand that, upon my acceptance of employment at Mercy Medical Center, I also accept that I may be required to work a shift rotation (day, evening, or night shift) and /or a weekend/holiday rotation schedule.

I understand that I may be required to report to work during nonscheduled time in the case of emergencies.

I understand these are conditions of employment and this form will be maintained in my personnel file.

_____

Employee Name

_____ _____

Signature Date

As of 12/7/20 this new version of the IT 4 combines and replaces the following forms: IT 4 (previous version), IT 4NR, IT 4 MIL, and IT MIL SP.

Ohio | Department of Taxation

IT 4
Rev. 12/20

Employee's Withholding Exemption Certificate

Submit form IT 4 to your employer on or before the start date of employment so your employer will withhold and remit Ohio income tax from your compensation. If applicable, your employer will also withhold school district income tax. You must file an updated IT 4 when any of the information listed below changes (including your marital status or number of dependents). You should contact your employer for instructions on how to complete an updated IT 4. **Your employer may require you to complete this form electronically.**

Section I: Personal Information

Employee Name:	Employee SSN:
Address, city, state, ZIP code:	
School district of residence (See *The Finder* at tax.ohio.gov):	School district number (####):

Section II: Claiming Withholding Exemptions

1. Enter "0" if you are a dependent on another individual's Ohio return; otherwise enter "1" ....._____
2. Enter "0" if single or if your spouse files a separate Ohio return; otherwise enter "1"....._____
3. Number of dependents ....._____
4. Total withholding exemptions (sum of line 1, 2, and 3) ....._____
5. Additional Ohio income tax withholding per pay period (optional) .....$_____

Section III: Withholding Waiver

I am **not** subject to Ohio or school district income tax withholding because (check all that apply):

- ☐ I am a full-year resident of Indiana, Kentucky, Michigan, Pennsylvania, or West Virginia.
- ☐ I am a resident military servicemember who is stationed outside Ohio on active duty military orders.
- ☐ I am a nonresident military servicemember who is stationed in Ohio due to military orders.
- ☐ I am a nonresident civilian spouse of a military servicemember and I am present in Ohio solely due to my spouse's military orders.
- ☐ I am exempt from Ohio withholding under R.C. 5747.06(A)(1) through (6).

Section IV: Signature (required)

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

Signature _____ Date _____

As of 12/7/20 this new version of the IT 4 combines and replaces the following forms: IT 4 (previous version), IT 4NR, IT 4 MIL, and IT MIL SP.

IT 4 Instructions

Most individuals are subject to Ohio income tax on their wages, salaries, or other compensation. To ensure this tax is paid, employers maintaining an office or transacting business in Ohio must withhold Ohio income tax, and school district income tax if applicable, from each individual who is an employee.

Such employees who are subject to Ohio income tax (and school district income tax, if applicable) should complete sections I, II, and IV of the IT 4 to have their employer withhold the appropriate Ohio taxes from their compensation. If the employee does not complete the IT 4 and return it to his/her employer, the employer:

- Will withhold Ohio tax based on the employee claiming **zero exemptions**, and
- **Will not** withhold school district income tax, even if the employee lives in a taxing school district.

An individual may be subject to an interest penalty for underpayment of estimated taxes (on form IT/SD 2210) based on under-withholding.

Certain employees may be **exempt** from Ohio withholding because their income is not subject to Ohio tax. Such employees should complete sections I, III, and IV of the IT 4 **only**.

The IT 4 does not need to be filed with the Department of Taxation. Your employer must maintain a copy as part of its records.

R.C. 5747.06(A) and Ohio Adm.Code 5703-7-10.

Section I

Enter the four-digit school district number of your primary address. If you do not know your school district of residence or its school district number, use *The Finder* at **tax.ohio.gov**. You can also verify your school district by contacting your county auditor or county board of elections.

If you move during the tax year, complete an updated IT 4 immediately reflecting your new address and/ or school district of residence.

Section II

Line 1: If you can be claimed on someone else's Ohio income tax return as a dependent, then you are to enter "0" on this line. Everyone else may enter "1".

Line 2: If you are single, enter "0" on this line. If you are married and you and your spouse file separate Ohio Income tax returns as "Married filing Separately" then enter "0" on this line.

Line 3: You are allowed one exemption for each dependent. Your dependents for Ohio income tax purposes are the same as your dependents for federal income tax purposes. See R.C. 5747.01(O).

Line 5: If you expect to owe more Ohio income tax than the amount withheld from your compensation, you can request that your employer withhold an additional amount of Ohio income tax. This amount should be reported in whole dollars.

Note: If you do not request additional withholding from your compensation, you may need to make estimated income tax payments using form IT 1040ES or estimated school district income tax payments using the SD 100ES. Individuals who commonly owe more in Ohio income taxes than what is withheld from their compensation include:

- Spouses who file a joint Ohio income tax return and both report income, and
- Individuals who have multiple jobs, all of which are subject to Ohio withholding.

Section III

This section is for individuals whose income is deductible or excludable from Ohio income tax, and thus employer withholding is not required. Such employee should check the appropriate box to indicate which exemption applies to him/her. Checking the box will cause your employer to not withhold Ohio income tax and/or school district income tax. The exemptions include:

- Reciprocity Exemption: If you are a resident of Indiana, Kentucky, Pennsylvania, Michigan or West Virginia and you work in Ohio, you do not owe Ohio income tax on your compensation. Instead, you should have your employer withhold income tax for your resident state. R.C. 5747.05(A)(2).
- Resident Military Servicemember Exemption: If you are an Ohio resident and a member of the United States Army, Air Force, Navy, Marine Corps, or Coast Guard (or the reserve components of these branches of the military) or a member of the National Guard, you do not owe Ohio income tax or school district income tax on your active duty military pay and allowances received while stationed outside of Ohio.

This exemption does not apply to compensation for nonactive duty status or received while you are stationed in Ohio.

R.C. 5747.01(A)(21).

- Nonresident Military Servicemember Exemption: If you are a nonresident of Ohio and a member of the uniformed services (as defined in 10 U.S.C. §101), you do not owe Ohio income tax or school district income tax on your military pay and allowances.

- Nonresident Civilian Spouse of a Military Servicemember Exemption: If you are the civilian spouse of a military servicemember, your pay may be exempt from Ohio income tax and school district income tax if all of the following are true:
  - Your spouse is a nonresident of Ohio;
  - You and your spouse are residents of the same state;
  - Your spouse is stationed in Ohio on military orders; and
  - You are present in Ohio solely to be with your spouse.

You must provide a copy of the employee's spousal military identification card issued to the employee by the Department of Defense when completing the IT 4.

Note: For more information on taxation of military servicemembers and their civilian spouses, see 50a U.S.C. §571.

- Statutory Withholding Exemptions: Compensation earned in any of the following circumstances is not subject to Ohio income tax or school district income tax withholding:

  - Agricultural labor (as defined in 26 U.S.C. §3121(g));
  - Domestic service in a private home, local college club, or local chapter of a college fraternity or sorority;
  - Services performed by an employee who is regularly employed by an employer to perform such service if she or he earns less than $300 during a calendar quarter;
  - Newspaper or shopping news delivery or distribution directly to a consumer, performed by an individual under the age of 18;
  - Services performed for a foreign government or an international organization; and
  - Services performed outside the employer's trade or business if paid in any medium other than cash.

*These exemptions are not common.

Note: While the employer is not required to withhold on these amounts, the income is still subject to Ohio income tax and school district income tax (if applicable). As such, you may need to make estimated income tax payments using form IT 1040ES and/or estimated school district income tax payments using form SD 100ES.

See R.C. 5747.06(A)(1) through (6).