PLEASE PRINT

PERSONAL DATA FORM

RETURN TO HR

_____ NEW EMPLOYEE _____CURRENT EMPLOYEE _____ FT OR _____PT

If Current Employee, Reason for Change & Effective Date:_____

NAME: _____
First MI Last

Social Security#_____ Maiden Name: _____

ADDRESS:

Street: _____Apt. #_____

City: _____County: _____ State: _____Zip: _____

Home Phone: _____Personal Email :_____**(optional)**

Work Email: _____**(required)** **If No Work Email Check Here:**_____

EMERGENCY CONTACT:

Name _____ **Relationship:**_____ Phone #_____

NOTE: This section should be completed by NEW EMPLOYEES only

Race: _____ White (not Hispanic or Latino) _____Black or African American (not Hispanic or Latino)

_____ Asian (not Hispanic or Latino) _____ Hispanic or Latino _____Native Hawaiian or Pacific Islander

_____ American Indian or Alaska Native _____Two or More Races (not Hispanic or Latino)

Gender: ____ Male ____Female **Marital Status**: ____ Single ____ Married

Birth Date: _____ **Employment Date:**_____

Dependents	Name	Gender	Birth Date
Spouse:			
Children:			

Employee Signature: _____ **Date:** _____

Company/Facility: _____ **Department:** _____

6/1/2011

Donald L. Tucker Civic Center
FLORIDA STATE UNIVERSITY

SPECTRA

505 W Pensacola Street
Tallahassee, FL 32301

If you become a Spectra employee, there will be times that necessary or useful information needs to be passed along to you. Internal job postings, appreciation events and policy changes are examples of the information that may be communicated. Providing an email address below will allow you to receive this useful information. However, if you do not have an email address or simply prefer not to provide one, a supervisor will be able to provide alternative methods for receiving the information. Upon your request, your email address can be removed from the internal mailing list at any time.

_____
Email Address

_____ _____
Signature Date

_____
Printed Name

Form **W-4**

Department of the Treasury
Internal Revenue Service

Employee's Withholding Certificate

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

OMB No. 1545-0074

2021

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 2021 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

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 2021 if you meet both of the following conditions: you had no federal income tax liability in 2020 **and** you expect to have no federal income tax liability in 2021. You had no federal income tax liability in 2020 if (1) your total tax on line 24 on your 2020 Form 1040 or 1040-SR is zero (or less than the sum of lines 27, 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 2021 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, 2022.

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. 972, Child Tax Credit and Credit for Other Dependents. You can also include **other tax credits** in this step, such as education tax credits and the foreign tax credit. 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 2021 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 2021 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 10% of your income . . . . . **1** $

2 Enter:
- $25,100 if you're married filing jointly or qualifying widow(er)
- $18,800 if you're head of household
- $12,550 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	$190	$850	$890	$1,020	$1,020	$1,020	$1,020	$1,020	$1,100	$1,870	$1,870
$10,000 - 19,999	190	1,190	1,890	2,090	2,220	2,220	2,220	2,220	2,300	3,300	4,070	4,070
$20,000 - 29,999	850	1,890	2,750	2,950	3,080	3,080	3,080	3,160	4,160	5,160	5,930	5,930
$30,000 - 39,999	890	2,090	2,950	3,150	3,280	3,280	3,360	4,360	5,360	6,360	7,130	7,130
$40,000 - 49,999	1,020	2,220	3,080	3,280	3,410	3,490	4,490	5,490	6,490	7,490	8,260	8,260
$50,000 - 59,999	1,020	2,220	3,080	3,280	3,490	4,490	5,490	6,490	7,490	8,490	9,260	9,260
$60,000 - 69,999	1,020	2,220	3,080	3,360	4,490	5,490	6,490	7,490	8,490	9,490	10,260	10,260
$70,000 - 79,999	1,020	2,220	3,160	4,360	5,490	6,490	7,490	8,490	9,490	10,490	11,260	11,260
$80,000 - 99,999	1,020	3,150	5,010	6,210	7,340	8,340	9,340	10,340	11,340	12,340	13,260	13,460
$100,000 - 149,999	1,870	4,070	5,930	7,130	8,260	9,320	10,520	11,720	12,920	14,120	15,090	15,290
$150,000 - 239,999	2,040	4,440	6,500	7,900	9,230	10,430	11,630	12,830	14,030	15,230	16,190	16,400
$240,000 - 259,999	2,040	4,440	6,500	7,900	9,230	10,430	11,630	12,830	14,030	15,270	17,040	18,040
$260,000 - 279,999	2,040	4,440	6,500	7,900	9,230	10,430	11,630	12,870	14,870	16,870	18,640	19,640
$280,000 - 299,999	2,040	4,440	6,500	7,900	9,230	10,470	12,470	14,470	16,470	18,470	20,240	21,240
$300,000 - 319,999	2,040	4,440	6,500	7,940	10,070	12,070	14,070	16,070	18,070	20,070	21,840	22,840
$320,000 - 364,999	2,720	5,920	8,780	10,980	13,110	15,110	17,110	19,110	21,190	23,490	25,560	26,860
$365,000 - 524,999	2,970	6,470	9,630	12,130	14,560	16,860	19,160	21,460	23,760	26,060	28,130	29,430
$525,000 and over	3,140	6,840	10,200	12,900	15,530	18,030	20,530	23,030	25,530	28,030	30,300	31,800

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	$440	$940	$1,020	$1,020	$1,410	$1,870	$1,870	$1,870	$1,870	$2,030	$2,040	$2,040
$10,000 - 19,999	940	1,540	1,620	2,020	3,020	3,470	3,470	3,470	3,640	3,840	3,840	3,840
$20,000 - 29,999	1,020	1,620	2,100	3,100	4,100	4,550	4,550	4,720	4,920	5,120	5,120	5,120
$30,000 - 39,999	1,020	2,020	3,100	4,100	5,100	5,550	5,720	5,920	6,120	6,320	6,320	6,320
$40,000 - 59,999	1,870	3,470	4,550	5,550	6,690	7,340	7,540	7,740	7,940	8,140	8,150	8,150
$60,000 - 79,999	1,870	3,470	4,690	5,890	7,090	7,740	7,940	8,140	8,340	8,540	9,190	9,990
$80,000 - 99,999	2,000	3,810	5,090	6,290	7,490	8,140	8,340	8,540	9,390	10,390	11,190	11,990
$100,000 - 124,999	2,040	3,840	5,120	6,320	7,520	8,360	9,360	10,360	11,360	12,360	13,410	14,510
$125,000 - 149,999	2,040	3,840	5,120	6,910	8,910	10,360	11,360	12,450	13,750	15,050	16,160	17,260
$150,000 - 174,999	2,220	4,830	6,910	8,910	10,910	12,600	13,900	15,200	16,500	17,800	18,910	20,010
$175,000 - 199,999	2,720	5,320	7,490	9,790	12,090	13,850	15,150	16,450	17,750	19,050	20,150	21,250
$200,000 - 249,999	2,970	5,880	8,260	10,560	12,860	14,620	15,920	17,220	18,520	19,820	20,930	22,030
$250,000 - 399,999	2,970	5,880	8,260	10,560	12,860	14,620	15,920	17,220	18,520	19,820	20,930	22,030
$400,000 - 449,999	2,970	5,880	8,260	10,560	12,860	14,620	15,920	17,220	18,520	19,910	21,220	22,520
$450,000 and over	3,140	6,250	8,830	11,330	13,830	15,790	17,290	18,790	20,290	21,790	23,100	24,400

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	$820	$930	$1,020	$1,020	$1,020	$1,420	$1,870	$1,870	$1,910	$2,040	$2,040
$10,000 - 19,999	820	1,900	2,130	2,220	2,220	2,620	3,620	4,070	4,110	4,310	4,440	4,440
$20,000 - 29,999	930	2,130	2,360	2,450	2,850	3,850	4,850	5,340	5,540	5,740	5,870	5,870
$30,000 - 39,999	1,020	2,220	2,450	2,940	3,940	4,940	5,980	6,630	6,830	7,030	7,160	7,160
$40,000 - 59,999	1,020	2,470	3,700	4,790	5,800	7,000	8,200	8,850	9,050	9,250	9,380	9,380
$60,000 - 79,999	1,870	4,070	5,310	6,600	7,800	9,000	10,200	10,850	11,050	11,250	11,520	12,320
$80,000 - 99,999	1,880	4,280	5,710	7,000	8,200	9,400	10,600	11,250	11,590	12,590	13,520	14,320
$100,000 - 124,999	2,040	4,440	5,870	7,160	8,360	9,560	11,240	12,690	13,690	14,690	15,670	16,770
$125,000 - 149,999	2,040	4,440	5,870	7,240	9,240	11,240	13,240	14,690	15,890	17,190	18,420	19,520
$150,000 - 174,999	2,040	4,920	7,150	9,240	11,240	13,290	15,590	17,340	18,640	19,940	21,170	22,270
$175,000 - 199,999	2,720	5,920	8,150	10,440	12,740	15,040	17,340	19,090	20,390	21,690	22,920	24,020
$200,000 - 249,999	2,970	6,470	9,000	11,390	13,690	15,990	18,290	20,040	21,340	22,640	23,880	24,980
$250,000 - 349,999	2,970	6,470	9,000	11,390	13,690	15,990	18,290	20,040	21,340	22,640	23,880	24,980
$350,000 - 449,999	2,970	6,470	9,000	11,390	13,690	15,990	18,290	20,040	21,340	22,640	23,900	25,200
$450,000 and over	3,140	6,840	9,570	12,160	14,660	17,160	19,660	21,610	23,110	24,610	26,050	27,350

Employment Eligibility Verification

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

USCIS
Form I-9
OMB No. 1615-0047
Expires 08/31/2019

►**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

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 Birth Abroad issued by the Department of State (Form FS-545)
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.** Certification of Report of Birth issued by the Department of State (Form DS-1350)
4. Employment Authorization Document that contains a photograph (Form I-766)		**4.** Voter's registration card		**4.** Original or certified copy of birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal
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.** Native American tribal document
		6. Military dependent's ID card		**6.** U.S. Citizen ID Card (Form I-197)
		7. U.S. Coast Guard Merchant Mariner Card		**7.** Identification Card for Use of Resident Citizen in the United States (Form I-179)
		8. Native American tribal document		**8.** Employment authorization document issued by the Department of Homeland Security
		9. Driver's license issued by a Canadian government authority		
		For persons under age 18 who are unable to present a document listed above:		
		10. School record or report card		
		11. Clinic, doctor, or hospital record		
		12. Day-care or nursery school record		
6. Passport from the Federated States of Micronesia (FSM) or the Republic of the Marshall Islands (RMI) with Form I-94 or Form I-94A indicating nonimmigrant admission under the Compact of Free Association Between the United States and the FSM or RMI				

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

Refer to the instructions for more information about acceptable receipts.

COMCAST SPECTACOR

NON-DISCLOSURE AGREEMENT

The undersigned ("Employee") hereby acknowledges that it is the policy of Comcast Spectacor L.P. and its subsidiaries (Spectrum Arena Limited Partnership, Philadelphia Flyers L.P., Comcast Spectacor Foundation, Ed Snider Youth Hockey Foundation, Patron Solutions, L.P. d/b/a New Era Tickets, Global Spectrum L.P., Paciolan, Inc., Front Row Marketing Services, L.P., Flyers Skate Zone L.P. and FPS Rinks L.P.), hereinafter collectively referred to as the "Company", to maintain as confidential all valuable information pertaining to its operations, businesses and affairs. Employee agrees that he or she shall not divulge any knowledge or information with respect to the operations, finances, customer lists, marketing plans or other affairs of the Company or otherwise pertaining to the Company's customers or employees. Employee understands that any information concerning the operations, business and affairs of the Company, including customer lists and marketing plans, are the sole property of the Company. Employee further agrees to return to the Company's premises at or prior to the termination of his or her employment any of the Company's records or written materials in Employee's possession.

In the event of an actual or threatened breach of this Agreement, the Company shall be entitled to an injunction restraining Employee from in any way breaching or violating any of the obligations or restraints agreed to herein. Company's right to injunctive relief shall not be the exclusive remedy available to it and nothing herein shall limit Company from pursuing any and all other remedies available in the event of breach or threatened breach, including the recovery of damages from Employee. Should the Company seek to pursue any or all of the remedies available to it, Employee hereby agrees that either the Courts of the Commonwealth of Pennsylvania or the United States District Courts for the Eastern District of Pennsylvania are appropriate forums for the determination of such claims and Employee hereby consents to said Court's exercise of jurisdiction over his or her person.

Witness Name - **PRINT**	Employee Name - **PRINT**
Witness Signature	Employee Signature
Date	Date

[Rev.02/12]

INDIVIDUAL STATEMENT OF FAMILIARITY WITH PERSONNEL POLICIES

I have received and read a copy of the Global Spectrum Personnel Policy Manual including the Code of Ethics and Business Conduct. I understand the most updated version of the Policy Manual is available online (www.enrollonline.com/comcastspectacor) for reference at any time. The HR Representative in my building also has access to the most recent copy of the Personnel Policy Manual.

I understand that this Manual is designed to be a working guide for supervisory and staff personnel in the day-to-day administration of my company's personnel policies.

I agree to conform to the rules and regulations contained in the Personnel Policy Manual and the Code of Ethics and Business Conduct. My employment and compensation can be terminated, with or without cause and with or without notice at any time, at the option of either the company or myself. I understand, however, that if I resign without notice or without sufficient notice, there may be an impact on compensation and benefits that may otherwise be due to me. For specific information regarding this, I should refer to the "Statement of Policy" and "Termination of Employment" contained in the Manual and seek advice from my immediate supervisor.

The information contained in this Personnel Policy Manual does not constitute a contract and can be revised at any time, and from time to time. Such revisions will be sent to my department manager for inclusion in our copy of the Manual.

A copy of this statement will be placed in my personnel file.

_____

Print: Employee Name

_____ _____

Signature **Date**

_____ _____

Entity **Department**

_____

Date received by Human Resources

Technical Resources Policy

EMPLOYEE ACKNOWLEDGEMENT

As an intern of Comcast-Spectacor/Global Spectrum, I, the undersigned, hereby acknowledge and understand that all electronic communications systems, including but not limited to computer, e-mail, Internet, telephones, voice mail (the "Company systems"), and all communications and information transmitted, received, stored or otherwise contained in the Company systems are the property of the Company and are to be used for job-related purposes only. I understand that excessive use of such Company systems for private purposes is strictly prohibited. If I use the Company systems for personal purposes, I do so at my own risk. Further, I agree not to use encryption, access a file, or retrieve any stored communications other than where authorized unless there has been prior clearance by an authorized Company representative.

I am aware that violations of this policy may subject me to disciplinary action, up to and including termination. I acknowledge that I do not have a privacy right in any information on the Company systems and have been notified that authorized representatives of the Company may monitor the use of the Company systems from time to time to insure that the use of these systems is consistent with the Company's legitimate business interests. In addition, I acknowledge that the use of my Company-provided password or code does not in any way restrict the Company's right to access any such communications.

_____ _____

Employee Signature Date

Please Print :

_____

Employee Name

Workers' Compensation Employee Notification

Workers' Compensation is designed to provide wage loss benefits and reimbursement for reasonable medical care for one who is injured on the job. All work related injuries, regardless of severity, must be reported to your supervisor immediately. The insurance carrier shall provide payment for reasonable surgical and medical services, services rendered by physicians or other health care providers, medicines, and supplies as and when needed.

If you are faced with an immediate medical emergency, you may secure assistance from the closest hospital, physician or other health care provider of your choice. If follow-up treatment is needed, you must then seek treatment from a physician or other health care provider established by your employer. If you do not seek treatment at your employers medical provider for the initial 90 days following your first visit, the insurance carrier may not have to pay for the services rendered. If invasive surgery is recommended, you are entitled to a second opinion from a physician of your choice. Should your physician's opinion differ, and you choose that opinion, the insurance carrier's physician will abide by the same for 90 days.

Should you desire to change providers, you must speak with your employer. Failure to notify your employer will relieve your employer of the responsibility for the payment of the services rendered if such services are determined to have been unreasonable or unnecessary.

Upon the occurrence of any workplace accident where any injury occurs, the employee involved in the accident shall be required to submit to a drug and/or alcohol test. The results of all drug/alcohol tests shall be treated as confidential. Failure to immediately report a work-related injury and/or to immediately seek medical attention at a Company-designated facility may result in termination of employment. Refusal to submit to testing will result in immediate termination.

Any person who knowingly and with intent to defraud any insurance company/employer or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Your signature on this form indicates that you understand your rights and duties under the above provisions of the Workers' Compensation Act.

I hereby acknowledge that I have been informed of and understand my rights and duties under the Workers' Compensation Act.

PRINT: Employee Name:_____

Employee SS#:_____

EMPLOYEE SIGNATURE:_____

Date: _____

Revised June 2013

Global Spectrum Event Employee Classification

As a part-time event employee of the Global Spectrum, I understand that my position is mainly an event based position. Event employees are considered "on-call" employees that work events and occasionally special projects. The amount of hours scheduled is solely dependent upon work availability as determined by the Facility.

Event employees ARE NOT GUARANTEED any certain number of hours.

By signing below, I understand the terms of my event based part-time position at Global Spectrum.

Print Name: _____

Signature: _____

Date: _____

NOTICE - DRUG-FREE WORKPLACE POLICY

As a part of our commitment to safeguard the health of our employees, to provide a safe place for our employees to work, and to promote a drug-free community, ***Global Spectrum*** has established this policy on the use and abuse of alcohol and drugs by our employees.

Substance abuse, at work or otherwise, seriously endangers the safety of our employees, as well as the general public. It also creates a variety of problems in the workplace including increased health care and benefits costs, increased theft, decreased morale and productivity, and an overall decline in the quality of products and services we provide. This program has been established to detect users and remove abusers of drugs and alcohol from our work force. It is also our policy to prevent the use and/or presence of these substances in our workplace and to assist any employee in overcoming any substance abuse dependency.

It is the goal of ***Global Spectrum*** to have our work force free of those who choose to use illegal drugs, misuse prescription drugs, and abuse alcohol. This policy was designed to achieve this goal.

It is a condition of continued employment to refrain from using drugs or alcohol on the job.

Each employee and job applicant may review a copy of the Drug-Free Workplace Policy Manual upon request. A copy of the policy will be posted in a common area.

This policy shall be effective as of the undersigned date. All employees who remain in ***Global Spectrum*** employ after this date shall, by remaining employed, demonstrate that they agree to abide by the terms and conditions of this policy as it now exists and as it may, from time to time, be amended.

Employee: _____
Print Name

Signed: _____

Date: _____

PERSONNEL POLICY MANUAL

SUBJECT: ATTENDANCE, ABSENTEEISM and LATENESS

Chronic absence or lateness is not in the interest of the employee or the company, impairs the company's ability to perform, and jeopardizes the job security of the employee.

1. Your participation and attendance is important to Global Spectrum and our customers. It is your responsibility to know and/or find out what your work schedule is in advance of your scheduled time to report to work.

2. It is the employee's responsibility to notify his/her supervisor before the start of the workday of his/her absence or lateness and reason, as well as the expected time of date he/she will report to work.

3. Absences, which are planned in advance, should have prior supervisor approval. Employees traveling on business should maintain daily contact with their office.

4. If you are unable to come to work, Global Spectrum requests that you:
   a. Call your supervisor in advance
   b. Talk directly to your supervisor
   c. Give the reason for your absence
   d. Leave a phone number where you can be reached
   e. Advise us when you plan to return to work
   f. Call <u>every</u> day you are out

5. Each department is responsible for accurately recording daily attendance of employees at all locations. Global Spectrum reserves the right to request a medical statement whenever the situation reasonably warrants such.

6. Excessive or chronic unexcused or unexplained absence or lateness (management reserves the right to define what is considered chronic, excessive or a pattern) may result in termination of employment, unless your absence is related to an approved state or federal mandated leave.

7. Employees will be required to utilize their time off benefits before requesting unpaid leave.

8. If you fail to meet your regular work schedule or fail to call your supervisor with a valid reason on days you are absent, unless extenuating circumstances exist, within 3 concurrent business days, we will consider you to have abandoned your employment with the Company.

I have read and understand the attendance policy:

_____ _____
Employee Name Date

_____
Employee Signature

COMCAST
SPECTACOR

DIRECT DEPOSIT AUTHORIZATION

☐ New Employee

☐ Current Employee

I (we) authorize Comcast-Spectacor, L.P. to make direct deposit payroll deposit(s) to:

Account #1

Account type: ____ Checking ____ Savings

Banking Institution Name: _____

Bank Routing # / ABA #: _____ Account #: _____

Amount to be deposited into this account: _____

Account #2

Account type: ____ Checking ____ Savings

Banking Institution Name: _____

Bank Routing # / ABA #: _____ Account #: _____

Amount to be deposited into this account: _____

Account #3

Account type: ____ Checking ____ Savings

Banking Institution Name: _____

Bank Routing # / ABA #: _____ Account #: _____

Amount to be deposited into this account: _____

Employee Name: _____

Social Security #: _____

Employee Signature: _____ Date: _____

Note: Please attach or scan a voided check with this form.

Direct Deposit of net paychecks will commence on the second pay following receipt of this form and continue until your authorization to stop is received in writing.

Form **8850**
(Rev. March 2016)
Department of the Treasury
Internal Revenue Service

Pre-Screening Notice and Certification Request for the Work Opportunity Credit

▶ Information about Form 8850 and its separate instructions is at *www.irs.gov/form8850.*

OMB No. 1545-1500

Job applicant: Fill in the lines below and check any boxes that apply. Complete only this side.

First name | Social security number ▶ ___ - ___ - ___

Last name

Street address where you live

City or town, state, and ZIP code | State | Zip Code

County | Telephone number ( ) ___ - ___

If you are under age 40, enter your date of birth (month, day, year) ___ / ___ / ___ (m m / d d / y y y y)

1 ☐ Check here if you received a conditional certification from the state workforce agency (SWA) or a participating local agency for the work opportunity credit.

2 ☐ Check here if **any** of the following statements apply to you.
- I am a member of a family that has received assistance from Temporary Assistance for Needy Families (TANF) for any 9 months during the past 18 months.
- I am a veteran and a member of a family that received Supplemental Nutrition Assistance Program (SNAP) benefits (food stamps) for at least a 3-month period during the past 15 months.
- I was referred here by a rehabilitation agency approved by the state, an employment network under the Ticket to Work program, or the Department of Veteran Affairs.
- I am at least age 18 but not age 40 or older and I am a member of a family that:
  a. Received SNAP benefits (food stamps) for the ast 6 months: **or**
  b. Received SNAP benefits (food stamps) for at least 3 of the past 5 months, but is no longer eligible to receive them.
- During the past year, I was convicted of a felony or released from prison for a felony.
- I received supplemental security income (SSI) benefits for any month ending during the past 60 days.
- I am a veteran and I was unemployed for a period or periods totaling at least 4 weeks but less than 6 months during the past year.

3 ☐ Check here if you are veteran and you were unemployed for a period or periods totaling at least 6 months during the past year.

4 ☐ Check here if you are a veteran entitled to compensation for a service-connected disability and you were discharged or released from active duty in the U.S. Armed Forces during the past year.

5 ☐ Check here if you are a veteran entitled to compensation for a service-connected disability and you were unemployed for a period or periods totaling at least 6 months during the past year.

6 ☐ Check here if you are a member of a family that:
- Received TANF payments for at least the past 18 months: **or**
- Received TANF payments for any 18 months beginning after August 5 1997, **and** the earliest 18-month period beginning after August 5, 1997, ended during the past 2 years; **or**
- Stopped being eligible for TANK payments during the past 2 years because federal or state law limited the maximum time those payments could be made.

7 ☐ Check here if you are in a period of unemployment that is at least 27 consecutive weeks and for all or part of that period you received unemployment compensation.

Signature – All Applicants Must Sign

Under penalties of perjury, I declare that I gave the above information to the employer on or before the day I was offered a job, and it is, to the best of my knowledge, true, correct, and complete.

Job applicant's signature ▶ **Date** ___ / ___ / ___ (m m / d d / y y y y)

For Employer's Use Only

Employer's name _____ Telephone no. _____ EIN ▶ _____

Street address _____

City or town, state, and ZIP code _____

Person to contact, if different from above ADP Tax Credit Services Telephone no. (843) 667-1836

Street address PO Box 108850/ 2205 Enterprise Drive, Suite C

City or town, state, and ZIP code Florence, SC 29501

If, based on the individual's age and home address, he or she is a member of group 4 or 6 (as described under *Members of Targeted Groups* in the separate instructions), enter that group number (4 or 6) . . . . . ▶ _____

Date applicant:

Gave information ☐☐/☐☐/☐☐☐☐ (m m d d y y y y)

Was offered job ☐☐/☐☐/☐☐☐☐ (m m d d y y y y)

Was hired ☐☐/☐☐/☐☐☐☐ (m m d d y y y y)

Started job ☐☐/☐☐/☐☐☐☐ (m m d d y y y y)

Under penalties of perjury, I declare that the applicant provided the information on this form on or before the day a job was offered to the applicant and that the information I have furnished is, to the best of my knowledge, true, correct, and complete. Based on the information the job applicant furnished on page 1, I believe the individual is a member of a targeted group. I hereby request a certification that the individual is a member of a targeted group.

Employer's signature ▶ **Title** **Date**

Privacy Act and Paperwork Reduction Act Notice

Section references are to the Internal Revenue Code.

Section 51(d)(13) permits a prospective employer to request the applicant to complete this form and give it to the prospective employer. The information will be used by the employer to complete the employer's federal tax return. Completion of this form is voluntary and may assist members of targeted groups in securing employment. Routine uses of this form include giving it to the state workforce agency (SWA), which will contact appropriate sources to confirm that the applicant is a member of a targeted group. This form may also be given to the Internal Revenue Service for administration of the Internal Revenue laws, to the Department of Justice for civil and criminal litigation, to the Department of Labor for oversight of the certifications performed by the SWA, and to cities, states, and the District of Columbia for use in administering their tax laws. 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 section 6103.

The time needed to complete and file this form will vary depending on individual circumstances. The estimated average time is:

Recordkeeping . . . 6 hr., 27 min.

Learning about the law or the form . . . . . 24 min.

Preparing and sending this form to the SWA . . . . . 31 min.

If you have comments concerning the accuracy of these time estimates or suggestions for making this form simpler, we would be happy to hear from you. You can send us comments from www.irs.gov/formspubs. Click on "More Information" and then on "Give us feedback." Or you can send your comments to:

Internal Revenue Service
Tax Forms and Publications
1111 Constitution Ave. NW, IR-6526
Washington, DC 20224

Do not send this form to this address. Instead, see *When and Where To File* in the separate instructions.

04192016

Request for Verification

This company participates in various federal and state tax credit programs. The information you provide will be used to determine eligibility for these programs and will in no way negatively impact any hiring, retention, or promotion decisions. Your responses will only be shared with your employer's management and federal, state and local governmental agencies as needed in the administration of these programs. By completing this form, you knowingly and voluntarily waive any objection to providing your Social Security Number. Any information provided will be used in a manner consistent with the Americans with Disabilities Act (ADA).

Section 1: Please print carefully in blue or black ink.

First Name

Last Name

Job Title: _____

Starting Hourly Wage: _____

Home Address: _____ City: _____ State: _____

Section 2: Please provide the following information by completing the boxes and filling in the corresponding circles.

Social Security Number

Date of Birth (mm-dd-yyyy)

Zip Code

Job Start Date (mm-dd-yyyy)

Under penalty of perjury, I state that the information I provided is, to the best of my knowledge, true, correct and complete. I hereby authorize this company's management, and federal, state, Tribal, and local government agencies to provide information to ADP and/or State Workforce Agencies (SWA), to determine and document eligibility for federal and state tax credit programs.

Employee Signature: _____ Date: _____

Section 3: Please fill in the appropriate Yes or No circle for each of the following questions. Please complete additional information as required.

	YES	NO
Have you worked for this company before?	○	○
Are you a Veteran of the US Armed Forces?	○	○
If Yes to Veteran: Which Branch? _____		
Are you receiving compensation for a service-connected disability?	○	○
Were you discharged or released from active duty in the past year?	○	○
Have you been unemployed for at least 4 weeks but less than 6 months in the past year?	○	○
Have you been unemployed for 6 months or more in the past year?	○	○
Have you, or a household family member, received Food Stamps anytime within the last 15 months?	○	○
Are you a member of a family that received Welfare (AFDC or TANF) or Assistance (child care, housing or transportation) in the last 2 years or are you no longer eligible because you have collected for the maximum time period?	○	○
If yes to either: What city and state were benefits received? City: _____ State Abbreviation: ☐☐ If someone other than you received benefits, please list their name: _____		
Have you been continuously unemployed for the last 27 weeks?	○	○
If yes, During your period of unemployment, did you, at any time, receive State or Federal unemployment compensation?	○	○
If yes, when did your unemployment period begin? (mm /yyyy): ☐☐ ☐☐☐☐		
If yes, in which State did you receive compensation? State Abbreviation: ☐☐		

	YES	NO
Have you participated in a vocational rehab program?	○	○
If yes: Which one? ○ Veteran Administration ○ Ticket to Work ○ State or Local Agency		
City: _____ State Abbreviation: ☐☐		
Counselor's Name: _____		
Did you receive Supplemental Security Income (SSI) in the last 90 days?	○	○
Have you been convicted of a felony or received deferred adjudication for a felony charge?	○	○
If yes: What type of conviction? ○ Federal ○ State ○ None (Deferred Adjudication)		
Were you released or did you start a work release program or transition center within the past year?	○	○
Conviction Date (mm/yyyy): ☐☐ ☐☐☐☐ Release Date (mm-yyyy): ☐☐ ☐☐☐☐		
Inmate #: _____ City: _____ State Abbreviation: ☐☐		
Probation Officer: _____ Probation Officer Phone #: _____		

U.S. Department Labor
Employment and Training Administration

OMB Control No. 1205-0371
Expiration Date: August 31, 2018

LONG-TERM UNEMPLOYMENT RECIPIENT SELF-ATTESTATION FORM
Work Opportunity Tax Credit (WOTC) Program

Instructions: This Self-Attestation Form (SAF) is to be completed, signed, and dated by the new hire only. Employers or consultants submit this SAF to the State Workforce Agency with IRS Form 8850 or if filed separately, with ETA Form 9061 (or ETA Form 9062) for each certification request filed for the new target group.

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

New Hire's Signature: _____ Date_____

New Hire Name: _____

Social Security Number: _____-☐☐☐☐ Date of Birth: _____
(Enter last four digits) (Enter date)

Employer Name: _____

Employer Federal ID (EIN) Number: _____-☐☐☐☐
(Enter last four digits)

Please check all the statements that apply to you and provide all requested dates. Sign and date this form where indicated below.

☐ I declare that I was in a period of unemployment that is at least 27 consecutive weeks the day before I began to work for this employer, or, if earlier, the day I completed IRS Form 8850. I have been in a period of unemployment of not less than 27 consecutive weeks, from _____ to _____.
(Enter start date) (Enter end date)

I make this declaration on the day I completed IRS Form 8850 _____.
(Enter date)

☐ I declare I have received unemployment compensation/benefits under State or Federal law during a period of unemployment.

Privacy Act Notice:
The Internal Revenue Code of 1986, Section 51, as amended and its enacting legislation, P.L. 104-188, specify that the State Workforce Agencies are the "designated" agencies responsible for administering the WOTC certification procedures of this program. The information you have provided completing this form will be disclosed by your employer to the State Workforce Agency. Provision of this information is voluntary; however the information is required to determine your employer's eligibility for the federal tax credit.

Public Burden Statement:
Persons are not required to respond to this collection of information unless it displays a currently valid OM B control number. Respondents' obligation to complete this form is required to obtain or retain benefits (P.L. 111-5). Public reporting burden is estimated to average 10 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of Information. Send comments regarding this burden estimate to the U.S. Department of Labor, Division of National Programs Tools Technical Assistance, Room C-4510, Washington, D.C. 20210 (Paperwork Reduction Project 1205-0371). Please do not submit completed forms to this address.

Workplace Face Covering Requirement

The health and safety of employees is Spectra's highest priority. To prevent the transmission of COVID-19, each employee that is not fully vaccinated is required to wear a face covering at work, whether working indoors or outdoors. For purposes of this policy, an employee will be considered fully vaccinated beginning two weeks after the employee's second dose in a two-dose COVID-19 vaccine series (such as the Pfizer or Moderna vaccines) or two weeks after the employee's single-dose COVID-19 vaccine (such as Johnson & Johnson's Janssen vaccine).

Fully vaccinated employees are also encouraged to wear a face covering at work and are required to do so, except in the following limited circumstances:

- The Spectra manager at each Spectra facility, in coordination with the Regional Vice President and Senior Vice President, has discretion to implement a facility-wide policy exempting fully vaccinated employees from the workplace face covering requirement. Any such exemption will apply consistently across all fully vaccinated employees and contractors under Spectra's control at the facility, except that the manager may choose to create a policy applying the exemption only to employees working outdoors, if deemed appropriate in the manager's discretion.
- A Spectra manager's discretion to implement a facility-wide policy exempting fully vaccinated employees from wearing face coverings is subject to limitations. Where applicable federal, state, local, tribal, or territorial laws, rules, or regulations impose more restrictive requirements regarding face coverings, all employees must comply with the more restrictive requirements. If an employee works at a facility where Spectra's client requires that all venue workers wear face coverings, the employee will be required to abide by the client's requirements.
- Any fully vaccinated employee that is exempt from the face covering requirement and chooses not to wear a face covering is required to truthfully attest to the employee's fully vaccinated status in the attached Acknowledgment and Attestation Form.

Regardless of vaccination status, an employee at any Spectra facility that requires face coverings is <u>not</u> required to wear a face covering where:

- The face covering impedes the employee's vision or creates an unsafe condition in which to operate equipment or perform a task. In that case, the employee must maintain a distance of at least 6 feet from other people.
- The employee works alone in their own office seated at least six feet from the doorway. These employees must still wear a face covering when they leave their individual office or invite a colleague into their office.
- Wearing a face covering poses a risk to the employee's health or the employee has trouble breathing. If this applies to you, please contact your manager or human resources to discuss potential accommodations.
- An employee objects to wearing a face covering for religious reasons. If this applies to you, please contact your manager or human resources to discuss potential accommodations.
- The employee is eating or drinking, provided he/she is situated at least six feet away from other people.
- The employee is unable to remove his/her face covering without assistance.
- The employee is performing job duties outdoors and expects to be able to maintain a distance of at least 6 feet from another person during the entire time he/she is performing those duties (e.g., mowing grass). The employee must carry the face covering with him/her and put it on if he/she comes within 6 feet of another person.

Face coverings are required at all other times for all employees, unless the employee is a fully vaccinated employee exempt from the face covering requirement as outlined above. Additionally, employees that are not fully vaccinated should continue to practice social distancing even when wearing a face covering.

Some Spectra employees may work at a facility where Spectra's client is not requiring that all persons working at the facility wear face coverings. Even if the client does not require workers to wear face coverings, it is Spectra's policy that all Spectra employees wear face coverings in accordance with this policy, unless otherwise exempt as outlined above.

Please note the following:

- Subject to supply limitations, Spectra will provide disposable face coverings for employees' daily use.
- While in use, the face covering must cover the employee's nose and mouth. Employees may not alter their face coverings to reduce coverage of the face, such as by creating mouth or nose holes or reducing the size of the face covering. Employees may not wear the face covering in a manner that leaves the nose and/or mouth exposed.
- Do not wear a disposable face covering for more than one day. Properly dispose of the disposable face covering after it is used.
- Employees may use their own face coverings, subject to their supervisor's approval. Personal face coverings must be at least as protective as the face coverings provided by Spectra and must not contain exhalation valves or vents. Employees are responsible for cleaning their personal face coverings in accordance with CDC guidelines. If an employee is not able to clean his/her face covering accordingly, he/she should use the disposable face covering provided by the venue.
- An employee may wear his/her own face shield in addition to a face covering, but note that a face shield may not be worn as a substitute for a face covering.
- Remember that Spectra's dress code policy applies to face coverings. Face coverings must be professional and workplace appropriate, and not include any images or text that may be deemed offensive to others. For example, a face covering with a loud graphic pattern or political message would not be considered workplace appropriate.
- If an employee declines to wear a face covering as required, the employee will be referred to Human Resources. Failure to comply with Spectra's Workplace Face Covering Requirement may result in discipline, up to and including termination.

Thank you doing your part to keep the workplace safe.

Policy last revised June 17, 2021

Acknowledgment and Attestation Form

I, _____ (employee name), acknowledge that on _____ (date) I received a copy of Spectra's Workplace Face Covering Requirement Policy and understand that it is my responsibility to be familiar with and abide by its terms. I understand that this Policy is intended to help keep the workplace safe for all employees, and that Spectra has the maximum discretion permitted by law to interpret, administer, change, modify, or delete this policy at any time. I also understand that any delay or failure by Spectra to enforce any rule, regulation, or procedure contained in the Policy will not constitute a waiver of Spectra's right to do so in the future. I understand that this Policy is not intended in any way to create an employment contract.

I understand that I am required to provide accurate information about my vaccination status in response to the questions below, or alternatively I may decline to provide my vaccination status. If I decline to provide information about my vaccination status in this document, Spectra will assume that I am unvaccinated for purposes of rules or requirements in the workplace that are different for vaccinated or unvaccinated employees, including Spectra's Workplace Face Covering Requirement Policy. For example, if requirements on face coverings allow fully vaccinated employees not to wear face coverings in certain settings, the information collected below will be used to determine whether I will be required to wear a face covering. For purposes of this certification, an employee is considered "fully vaccinated" beginning two weeks after the employee's second dose in a two-dose COVID-19 vaccine series (such as the Pfizer or Moderna vaccines) or two weeks after the employee's single-dose COVID-19 vaccine (such as Johnson & Johnson's Janssen vaccine).

Please select the statement below that accurately describes your vaccination status:

- ☐ I am fully vaccinated (as defined above).
- ☐ I am not fully vaccinated (as defined above), or I decline to answer whether I have been vaccinated.

I understand that I am required to provide accurate information in response to the above question. I hereby attest and affirm that I have accurately and truthfully answered the above question. I understand that if I stated that I am fully vaccinated, Spectra may request documentation of my vaccination status (including a copy of my vaccine card or other similar official document confirming vaccination status).

_____
Employee's Signature

_____
Employee's Printed Name

_____
Date