



# HIRING PACKAGE

## FOR FIELD EMPLOYEES

### INSIDE THIS PACKAGE:

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- FIELD SAFETY PROCEDURES ACKNOWLEDGMENT
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- HAZCOM ORIENTATION ACKNOWLEDGMENT
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- PANEL OF PHYSICIANS ACKNOWLEDGMENT
- FORM I-9
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- COLOR COPY VALID ID
- COLOR COPY SOCIAL SECURITY CARD

FOR OFFICE USE ONLY			
Interviewed by:		Presentation:	
Date of Interview:		Skills:	
Classification:	F O L M I S L W L	Notes:	
Rate of Pay:			
Start Date:			
Crew Assignment:		Review In:	30 60 90 1Year



**ACKNOWLEDGMENT OF RECEIPT AND UNDERSTANDING OF EMPLOYEE HANDBOOK**

**Acknowledgment of Receipt of Employee Handbook**

I acknowledge, understand and/or agree that:

- The statements contained in the Employee Handbook are intended to serve as general information concerning CCSI's existing policies, procedures and practices and employee benefits.
- Nothing contained in the Employee Handbook is intended to create (nor shall be construed as creating) a contract of employment (express or implied) or guarantee employment for a definite or indefinite term.
- From time to time CCSI may desire to clarify, amend and/or supplement the information contained in the Employee Handbook. CCSI will inform current employees when changes occur.
- I acknowledge that I have received and reviewed a copy of the Employee Handbook; that I have read and understand the information outlined in the Employee Handbook; that I have asked any questions I may have concerning its contents; and that I will comply with all policies and procedures to the best of my ability.
- I understand that by my signature below, if I am given the use of a CCSI credit card, vehicle or expense account, that I have a legal responsibility to report their use to CCSI and that improper use of these items will be considered theft and/or conversion of corporate property. I understand that such improper use may subject me to legal action taken by CCSI and that all CCSI's remedy rights are reserved.
- I acknowledge that the procedures for enrolling in the insurance program have been explained to me as well as the consequences should I choose not to participate at this time.

By marking the box below, I hereby **DECLINE HEALTH INSURANCE COVERAGE**, and I hereby acknowledge that by doing so, I am declining health insurance coverage of my own free will.

**I hereby DECLINE and/or REJECT health insurance coverage.**

**APPLICANT:**

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

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

**COMPOSITE CONSTRUCTION SYSTEMS, INC.**

I, the undersigned, affirm that I have given to the applicant a copy of the *Employee Handbook* and have directed the applicant to the appropriate Supervisor for further clarification if necessary.

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

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

Title: \_\_\_\_\_



## ACKNOWLEDGMENT OF UNDERSTANDING OF FIELD SAFETY PROCEDURES

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**The following procedures must be adhered to and practiced at all times.**

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I acknowledge, understand and/or agree that:

- **Personal Protective Equipment (PPE).** The following articles must be used/worn at all times while on the jobsite:
  - Hardhat
  - Approved safety glasses with side shields
  - Sturdy work boots in good condition
  - Full-length pants
  - Shirts, tucked in and covering entire mid-section
  - Shirts, sleeves must cover entire shoulder and be at least 4" in length
  - At elevations above six (6) feet, an anchored harness and lanyard
  - Adequate eye protection when using welding or torch machine
  - Hearing protection in abnormally high noise levels
  - Gloves, when handling materials
  
- All accidents and injuries must be reported to the site Supervisor immediately no matter how small.
- Fighting and horseplay shall not be tolerated.
- No employee shall possess, be under the use of/influence of drugs or alcohol on the jobsite.
- No firearms shall be brought to the jobsite.
- All employees shall report to work on time. If unable to, the employee shall notify the office or site Supervisor to obtain prior permission to be late or absent.
- All employees must be willing to travel and work overtime. Employees must arrange their own transportation to work.
- No employee is to enter the jobsite without a Supervisor present.
- Mandatory safety meetings are held on the jobsite on a weekly basis.
- All employees shall report to the site Supervisor any and all unsafe conditions on the jobsite immediately.
- No work shall be performed on elevated surfaces without proper perimeter protection.
- No work shall be performed without floor openings being protected.
- Employees are responsible for checking ladders for damage before use. Ladders should be secured at bottom and tied off at the top. Ladders should extend at least three (3) feet above the landing surface.

Employees must face the ladder and use both hands to hold on while climbing. Loose materials should not be carried in hand; hand lines should be used to hoist and lower materials.

- All employees shall use proper lifting techniques, including bending knees and keeping back straight. An employee should request help for lifting items too heavy for one person to lift safely.
- When using a torch machine, bottles are to be upright and secured. Stored bottles must have tops attached. Torch hoses and regulators must be checked before each use for leaks, cracks, holes or unsafe wear.
- Electrical cords should be checked before each use for unsafe wear.
- Fire extinguishers must be present and within reach when torch machine is used.
- Fuel must not be added to a hot or running engine.
- Employees shall be alert when on the jobsite and be aware of movements of heavy equipment, lifted loads and vehicle traffic.
- Employees shall be alert when on the jobsite and be aware of excavations and other trip hazards while walking.
- Only trained and certified employees shall operate:
  - Fork Lifts
  - Boom and Scissor Lifts
  - Powder-Actuated Tools
  - Welding Machinery
- Only trained and certified employees shall:
  - Perform Rigging and Signaling
  - Operate Cranes
  - Administer First Aid/CPR
- All questions about procedures, policies, conditions or work techniques should be directed to the site Supervisor.
- First aid supplies at located in the jobsite trailer and/or CCSI work trucks.
- **CCSI's Hazard Communication Program shall be reviewed with each employee by the appropriate site Supervisor. Employee will not start work until he/she understands such procedures.**

**APPLICANT:**

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

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



**SAFETY SYSTEMS.NET BOOKLETS  
COPY OF BACK OF BOOKLET  
ACKNOWLEDGMENTS**

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**Acknowledgment of Receipt of SAFE and SDS Booklets**

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**Acknowledgement of Basic Safety  
Rules for Construction**

I, the undersigned, have read or have had read to me, the rules listed in the Basic Safety Rules for Construction handbook. I understand it is my responsibility to follow these rules at all times. I understand that if I do not know or understand a safety rule, I am supposed to ask my supervisor.

\_\_\_\_\_  
Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**Acknowledgement of Hazard  
Communication Orientation**

I, the undersigned, have been made aware of this company's Hazard Communication Program. I understand that I have the right to review any Hazard Communication Information including Material Safety Data Sheets (MSDS), at any time.

\_\_\_\_\_  
Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**Acknowledgement of HazCom  
Goes Global Orientation**

I, the undersigned, have been made aware of this company's SDS program. I understand that I have the right to review any Hazard Communication Information including Safety Data Sheets (SDS), at any time.

\_\_\_\_\_  
Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**APPLICANT:**

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

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

**WITNESSED BY:**

CCSI: \_\_\_\_\_ Date: \_\_\_\_\_

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



**ACKNOWLEDGMENT OF RECEIPT AND  
UNDERSTANDING OF OFFICIAL  
POSTED PANEL OF PHYSICIANS**

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**Attached is the Official Posted Panel of Physicians**

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By signing below, I \_\_\_\_\_ certify that I have received and reviewed a copy of CCSI's  
(Print Name)  
official posted panel of physicians.

I understand that should I suffer an on-the-job injury, I must select medical services from a physician on the official posted panel of physicians. Otherwise, CCSI will not be liable for paying for any medical treatment that I may require. If I am dissatisfied with the physician selected, I may make one change to a second physician who is listed on the official posted panel of physicians. Without the approval of the State Board of Workers' Compensation. Thereafter, I may have to formally request a change of physicians if I want to seek treatment from a third physician.

I further certify that I understand that it is my duty to notify my Supervisor and/or office personnel as soon as the injury occurs. I understand that a delay in notification may result in denial of payment for medical services.

**APPLICANT:**

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

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

**WITNESS:**

CCSI: \_\_\_\_\_ Date: \_\_\_\_\_

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

(This notice must be posted in a conspicuous place readily accessible to the employee at all times.)

# OFFICIAL NOTICE

This business operates under the Georgia Workers' Compensation Law.

## WORKERS MUST REPORT ALL ACCIDENTS IMMEDIATELY TO THE EMPLOYER BY ADVISING THE EMPLOYER PERSONALLY, AN AGENT, REPRESENTATIVE, BOSS, SUPERVISOR, OR FOREMAN.

If a worker is injured at work, the employer shall pay medical and rehabilitation expenses within the limits of the law. In some cases the employer will also pay a part of the worker's lost wages.

Work injuries and occupational diseases should be reported in writing whenever possible. The worker may lose the right to receive compensation if an accident is not reported within 30 days (see O.C.G.A. § 34-9-80).

The employer will supply free of charge, upon request, a form for reporting accidents and will also furnish, free of charge, information about workers' compensation. The employer will also furnish to the employee, upon request, copies of board forms on file with the employer pertaining to an employee's claim.

A worker injured on the job must select a doctor from the list below. The minimum panel shall consist of at least six physicians, including an orthopedic surgeon with no more than two physicians from industrial clinics (see O.C.G.A. § 34-9-201). Further, this panel shall include one minority physician, whenever feasible (see Rule 201 for definition of minority physician). The Board may grant exceptions to the required size of the panel where it is demonstrated that more than four physicians are not reasonably accessible. One change to another doctor from the list may be made without permission. Further changes require the permission of the employer or the State Board of Workers' Compensation.

### State Board of Workers' Compensation

270 Peachtree Street, N.W.  
Atlanta, Georgia 30303-1299  
404-656-3818  
or 1-800-533-0682

<http://www.sbcw.georgia.gov>

Urgent Care Center  
Kevin Lokkesmoe  
Urgent Care and Occupational Medicine  
4328 Armour Rd  
Columbus, GA 31904-5204  
(706)507-1213

Approximate mileage to Provider 4.6

name/address/phone

Family Practice  
Craig Phillips  
AFC Physicians Of Georgia Primary Care  
6509 Gateway Rd  
Columbus, GA 31909-5681  
(706)243-0174

Approximate mileage to Provider 1.4

name/address/phone

Family Practice  
Jennifer Evans  
Applecare  
1365 Sam Nunn Blvd Ste D  
Perry, GA 31069-2175  
(478)287-6276

Approximate mileage to Provider 66.1

name/address/phone

Orthopaedic Surgery  
Leland McCluskey

2300 Manchester Expy Ste 101A  
Columbus, GA 31904-6802  
(706)322-6646

Approximate mileage to Provider 5.0

name/address/phone

Orthopaedic Surgery  
Douglas Pahl  
Hughston Clinic, PC  
2548 Weems Rd  
Columbus, GA 31909-6248  
(404)265-4000

Approximate mileage to Provider 4.7

name/address/phone

Orthopaedic Surgery  
John Calhoun Floyd  
Hughston Clinic Southeast  
2000 10th Ave Ste 270  
Columbus, GA 31901-3706  
(706)571-1011

Approximate mileage to Provider 6.6

name/address/phone

General Surgery  
James Majors  
St Francis Center for Surgical Care  
2119 Warm Springs Rd  
Columbus, GA 31904-7355  
(706)324-3243

Approximate mileage to Provider 5.2

name/address/phone

Ophthalmology  
North Columbus Eye Center  
1240 Brookstone Centre Pkwy  
Columbus, GA 31904-2954  
(706)323-8127

Approximate mileage to Provider 6.3

name/address/phone

(Additional doctors may be added on a separate sheet)  
The insurance company providing coverage for this business  
under the Workers' Compensation Law is:

Bridgefield Casualty Insurance Company

Name

P.O. Box 600 Gainesville, GA 30503-0600

address

1-800-863-2181

phone

IF YOU HAVE QUESTIONS PLEASE CONTACT THE STATE BOARD OF WORKERS' COMPENSATION AT 404-656-3818 OR 1-800-533-0682 OR VISIT <http://www.sbcw.georgia.gov>

Willfully making a false statement for the purpose of obtaining or denying benefits is a crime subject to penalties of up to \$10,000.00 per violation (O.C.G.A. §34-9-18 and §34-9-19).

WC-P1 (7/2006)

**GEORGIA STATE BOARD OF WORKERS' COMPENSATION****BILL OF RIGHTS FOR THE INJURED WORKER**

As required by law, O.C.G.A. §34-9-81.1, this is a summary of your rights and responsibilities. The Workers' Compensation Law provides you, as a worker in the State of Georgia, with certain rights and responsibilities should you be injured on the job. The Workers' Compensation Law provides you coverage for a work-related injury even if an injury occurs on the first day on the job. In addition to rights, you also have certain responsibilities. Your rights and responsibilities are described below.

**Employee's Rights**

1. If you are injured on the job, you may receive medical rehabilitation and income benefits. These benefits are provided to help you return to work. Your dependents may also receive benefits if you die as a result of a job-related injury.
2. Your employer is required to post a list of at least six doctors or the name of the certified WC/MCO that provides medical care, unless the Board has granted an exception. You may choose a doctor from the list and make one change to another doctor on the list without the permission of your employer. However, in an emergency, you may get temporary medical care from any doctor until the emergency is over, then you must get treatment from a doctor on the posted list.
3. Your authorized doctor bills, hospital bills, rehabilitation in some cases, physical therapy, prescriptions, and necessary travel expenses will be paid if injury was caused by an accident on the job. All injuries occurring on or before June 30, 2013 shall be entitled to lifetime medical benefits. If your accident occurred on or after July 1, 2013 medical treatment shall be limited to a maximum of 400 weeks from the accident date. If your injury is catastrophic in nature you may be entitled to lifetime medical benefits.
4. You are entitled to weekly income benefits if you have more than seven days of lost time due to an injury. Your first check should be mailed to you within 21 days after the first day you missed work. If you are out more than 21 consecutive days due to your injury, you will be paid for the first week.
5. Accidents are classified as being either catastrophic or non-catastrophic. Catastrophic injuries are those involving amputations, severe paralysis, severe head injuries, severe burns, blindness, or of a nature and severity that prevents the employee from being able to perform his or her prior work and any work available in substantial numbers within the national economy. In catastrophic cases, you are entitled to receive two-thirds of your average weekly wage but not more than \$675 per week for a job-related injury for as long as you are unable to return to work. You also are entitled to receive medical and vocational rehabilitation benefits to help in recovering from your injury. If you need help in this area call the State Board of Workers' Compensation at (404) 656-0849.
6. In all other cases (non-catastrophic), you are entitled to receive two-thirds of your average weekly wage but not more than \$675 per week for a job related injury. You will receive these weekly benefits as long as you are totally disabled, but no longer than 400 weeks. If you are not working and it is determined that you have been capable of performing work with restrictions for 52 consecutive weeks or 78 aggregate weeks, your weekly income benefits will be reduced to two-thirds of your average weekly wage but no more than \$450 per week, not to exceed 350 weeks.
7. When you are able to return to work, but can only get a lower paying job as a result of your injury, you are entitled to a weekly benefit of not more than \$450 per week for no longer than 350 weeks.
8. Your dependent(s), in the event you die as a result of an on-the-job accident, will receive burial expenses up to \$7,500 and two-thirds of your average weekly wage, but not more than \$675 per week. A widowed spouse with no children will be paid a maximum of \$270,000. Benefits continue until he/she remarries or openly cohabits with a person of the opposite sex.
9. If you do not receive benefits when due, the insurance carrier/employer must pay a penalty, which will be added to your payments.

**Employee's Responsibilities**

1. You should follow written rules of safety and other reasonable policies and procedures of the employer.
2. You must report any accident immediately, but not later than 30 days after the accident, to your employer, your employer's representative, your foreman or immediate supervisor. Failure to do so may result in the loss of the benefits.
3. An employee has a continuing obligation to cooperate with medical providers in the course of their treatment for work related injuries. You must accept reasonable medical treatment and rehabilitation services when ordered by the State Board of Workers' Compensation or the Board may suspend your benefits.
4. No compensation shall be allowed for an injury or death due to the employee's willful misconduct.
5. You must notify the insurance carrier/employer of your address when you move to a new location. You should notify the insurance carrier/employer when you are able to return to full-time or part-time work and report the amount of your weekly earnings because you may be entitled to some income benefits even though you have returned to work.
6. A dependent spouse of a deceased employee shall notify the insurance carrier/employer upon change of address or remarriage.
7. You must attempt a job approved by the authorized treating physician even if the pay is lower than the job you had when you were injured. If you do not attempt the job, your benefits may be suspended.
8. If you believe you are due benefits and your insurance carrier/employer denies these benefits, you must file a claim within one year after the date of last authorized medical treatment or within two years of your last payment of weekly benefits or you will lose your right to these benefits.
9. If your dependent(s) do not receive allowable benefit payments, the dependent(s) must file a claim with the State Board of Workers' Compensation within one year after your death or lose the right to these benefits.
10. Any request for reimbursement to you for mileage or other expenses related to medical care must be submitted to the insurance carrier/employer within one year of the date the expense was incurred.
11. If an employee unjustifiably refuses to submit to a drug test following an on-the-job injury, there shall be a presumption that the accident and injury were caused by alcohol or drugs. If the presumption is not overcome by other evidence, any claim for workers' compensation benefits would be denied.
12. You shall be guilty of a misdemeanor and upon conviction shall be punished by a fine of not more than \$10,000.00 or imprisonment, up to 12 months, or both, for making false or misleading statements when claiming benefits. Also, any false statements or false evidence given under oath during the course of any administrative or appellate division hearing is perjury.

The State Board of Workers' Compensation will provide you with information regarding how to file a claim and will answer any other questions regarding your rights under the law. If you are calling in the Atlanta area the telephone number is (404) 656-3818, outside the metro Atlanta area call 1-800-533-0682, or write the State Board of Workers' Compensation at: 270 Peachtree Street, N.W., Atlanta, Georgia 30303-1299 or visit our website: <http://www.sbwcc.georgia.gov>. A lawyer is not needed to file a claim with the Board; however, if you think you need a lawyer and do not have your own personal lawyer, you may contact the Lawyer Referral Service at (404) 521-0777 or 1-800-237-2629.

IF YOU HAVE QUESTIONS PLEASE CONTACT THE STATE BOARD OF WORKERS' COMPENSATION AT 404-656-3818 OR 1-800-533-0682 OR VISIT <http://www.sbwcc.georgia.gov>  
WILLFULLY MAKING A FALSE STATEMENT FOR THE PURPOSE OF OBTAINING OR DENYING BENEFITS IS A CRIME SUBJECT TO PENALTIES OF UP TO \$10,000.00 PER VIOLATION (O.C.G.A. §34-9-18 AND §34-9-19).

(Este aviso debe ser puesto en un lugar accesible al empleado todo el tiempo.)

# AVISO OFICIAL

Esta compañía opera bajo las Leyes de Compensación de Trabajadores de Georgia

**LOS TRABAJADORES DEBEN REPORTAR TODOS LOS ACCIDENTES INMEDIATAMENTE AL EMPLEADOR Y AVISAR AL EMPLEADOR PERSONALMENTE, UN AGENTE, PREPRESENTANTE, PATRON, SUPERVISOR O CAPATAZ.**

Si un trabajador es lesionado en el trabajo el empleador debe pagar gastos médicos y rehabilitación dentro de los límites de la ley. En algunos casos el empleador también pagara una parte de los salarios perdidos de los empleados.

Lesiones de trabajo y enfermedades ocupacionales deben ser reportados por escrito cuando sea posible. El trabajador puede perder el derecho a recibir compensación si un accidente no es reportado dentro de 30 días (referencia O.C.G.A. § 34-9-80).

El empleador ofrecerá sin costo alguno, si es pedido, un formulario para reportar accidentes y también debe suministrar, sin costo alguno, información acerca de compensación de trabajadores. El empleador también debe suministrar al empleado, cuando sea pedido, copias de formularios de la Junta archivados con el empleador pertenecientes a reclamos de los empleados.

Un trabajador lesionado en el trabajo debe seleccionar un doctor de la lista abajo. El panel mínimo debe consistir de por lo menos seis médicos, incluyendo un cirujano ortopédico con no más de dos médicos de clínicas industriales (referencia O.C.G.A. § 34-9-201). Además, este panel debe incluir un medico minoritario, cuando sea posible (vea la regla 201 de definición de médicos minoritarios.) La Junta puede otorgar excepciones al tamaño requerido del panel donde se demuestre que más de cuatro médicos no son razonablemente accesibles. Un cambio de un doctor a otro en la lista se puede hacer fin permiso. Cambios adicionales requieren el permiso del empleador o de la Junta Estatal de Compensación de Trabajadores.

### Junta Estatal de Compensación de Trabajadores

270 Peachtree Street, N.W.  
Atlanta, Georgia 30303-1299  
404-656-3818  
o 1-800-533-0682  
<http://www.sbwg.georgia.gov>

Urgent Care Center  
Kevin Lokkesmoe  
Urgent Care and Occupational Medicine  
4328 Armour Rd  
Columbus, GA 31904-5204  
(706)507-1213

Approximate mileage to Provider 4.6

name/address/phone

Family Practice  
Jennifer Evans  
Applecare  
1365 Sam Nunn Blvd Ste D  
Peru, GA 31069-2175  
(478)287-6276

Approximate mileage to Provider 66.1

nombre /dirección /teléfono

Family Practice  
Craig Phillips  
AFC Physicians Of Georgia Primary Care  
6509 Gateway Rd  
Columbus, GA 31909-5681  
(706)243-0174

Approximate mileage to Provider 1.4

name/address/phone

Orthopaedic Surgery  
Douglas Pahl  
Hughston Clinic, PC  
2548 Weems Rd  
Columbus, GA 31909-6248  
(404)265-4000

Approximate mileage to Provider 4.7

nombre /dirección /teléfono

Orthopaedic Surgery  
Leland McCluskey  
2300 Manchester Expy Ste 101A  
Columbus, GA 31904-6802  
(706)322-6646

Approximate mileage to Provider 5.0

nombre /dirección /teléfono

Orthopaedic Surgery  
John Calhoun Floyd  
Hughston Clinic Southeast  
2000 10th Ave Ste 270  
Columbus, GA 31901-3706  
(706)571-1011

Approximate mileage to Provider 6.6

nombre /dirección /teléfono

General Surgery  
James Majors  
St Francis Center for Surgical Care  
2119 Warm Springs Rd  
Columbus, GA 31904-7355  
(706)324-3243

Approximate mileage to Provider 5.2

nombre /dirección /teléfono

Ophthalmology  
North Columbus Eye Center  
1240 Brookstone Centre Pkwy  
Columbus, GA 31904-2954  
(706)323-8127

Approximate mileage to Provider 6.3

nombre /dirección /teléfono

(Médicos adicionales pueden ser agregados en una hoja separada.)

La compañía de seguro que provee cobertura para esta Empresa bajo la ley de Compensación de Trabajadores es:

Bridgefield Casualty Insurance Company

Nombre

P.O. Box 600 Gainesville, GA 30503-0600

dirección

1-800-863-2181

teléfono

SI USTED TIENE PREGUNTAS LLAME AL (404) 656-3818 o 1-800-533-0682 o VISITA SITIO WEB: <http://www.sbwg.georgia.gov>

HACER FALSOS TESTIMONIOS VOLUNTARIAMENTE CON EL PROPÓSITO DE OBTENER O NEGAR BENEFICIOS ES UN CRIMEN SUJETO A PENALIDADES DE HASTA 10,000.00 POR VIOLACIÓN ( O.C.G.A. §34-9-18 Y §34-9-19.)

WC-P1 (7/2006)

# JUNTA ESTATAL DE COMPENSACIÓN DE TRABAJADORES DE GEORGIA

## DECLARACIÓN DE DERECHOS PARA EL TRABAJADOR LESIONADO

Según lo requiere la Ley O.C.G.A. §34-9-81.1, esto es un recuento de sus derechos y responsabilidades. La Ley de Compensación de Trabajadores le provee a usted, como trabajador en el Estado de Georgia, ciertos derechos y responsabilidades si usted se lesiona en el trabajo. La Ley de Compensación de Trabajador lo provee a usted con cobertura de lesiones relacionadas con el trabajo aunque su lesión sea en el primer día de trabajo. Además de sus derechos, usted también tiene ciertas responsabilidades. Sus derechos y responsabilidades están descritos abajo.

### Derechos de los Empleados

1. Si usted se lesiona en el trabajo, usted puede recibir rehabilitación médica y beneficios de ingresos. Estos beneficios son proveídos para ayudarlo a regresar al trabajo. También sus dependientes pueden recibir beneficios si usted muere como resultado de lesiones recibidas en el trabajo.
2. Se le requiere a su empleador que anuncie una lista de seis doctores o por lo menos el nombre de un WC/ MCO certificado que provee cuidados médicos, al menos que la Junta halla otorgado una excepción. Usted puede escoger un doctor de la lista sin el permiso de su empleador. Sin embargo, en una emergencia, usted puede recibir asistencia médica temporaria de cualquier otro médico hasta que la emergencia termine después usted debe recibir tratamiento de los médicos que se anuncian en la lista.
3. Sus cuentas médicas autorizadas, cuentas de hospital, rehabilitación en algunos casos, terapia física, recetas y gastos de transporte serán pagados si la lesión fue ocasionada por un accidente en el trabajo. Todas las lesiones que ocurren en o antes 30 de junio de 2013 se tendrá derecho a beneficios médicos de por vida. Si el accidente ocurrió en o 1 de julio del 2013 el tratamiento médico será limitado a un máximo de 400 semanas a partir de la fecha del accidente. Si su lesión es catastrófica en la naturaleza que puede tener derecho a beneficios médicos de por vida.
4. Usted tiene derecho a recibir beneficios de ingresos semanales si usted ha perdido tiempo por más de siete días debido a una lesión. Su primer cheque debe ser enviado a usted dentro de 21 días, después del primer día que faltó al trabajo. Si esta fuera más de 21 días consecutivos debido a su lesión, se le pagará la primera semana.
5. Los accidentes son clasificados ya sea catastróficos o no catastróficos. Lesiones catastróficas son las que envuelven amputación, parálisis severas, lesiones severas de la cabeza, quemaduras severas, ceguera que prevenga al empleado a que pueda realizar el o ella su trabajo anterior o cualquier otro trabajo disponible en numero considerable dentro de la economía nacional. En casos catastróficos usted tiene derecho a recibir un promedio de dos terceras partes de su ingreso semanal pero no más de \$675 por semana por una lesión relacionada con el trabajo durante todo el tiempo que usted no pueda regresar a su trabajo. Usted también tiene derecho a recibir beneficios médicos y de rehabilitación. Si usted necesita ayuda en esta área llame a la Junta Estatal de Compensación de Trabajadores al (404) 656-0849.
6. En todos los otros casos (no catastróficos) usted tiene el derecho a recibir dos terceras partes de su sueldo promedio semanal pero no más de \$675 por semana de una lesión relacionada de trabajo, usted recibirá estos beneficios mientras usted este incapacitado. Pero no más de 400 semanas si no esta trabajando y se determina que usted esta capacitado a desempeñar con restricción por 52 semanas consecutivas o 78 semanas agregadas sus ingresos semanales serán reducidos a dos terceras partes de su sueldo promedio pero no más de \$450 por semana, que no excedan 350 semanas.
7. Cuando usted pueda regresar a trabajar pero solo pueda conseguir empleo de salario bajo como resultado de su lesión usted tiene derecho a un beneficio semanal de no más de \$450 por semana pero no más de 350 semanas.
8. En caso de que usted muera como resultado de un accidente en el trabajo, su dependiente (s) recibirán para gastos de entierro \$7,500 y dos terceras partes de su sueldo promedio semanal, pero no más de \$675 por semana. Una esposa viuda sin niños se le pagará un máximo de \$270,000 en beneficios continuos hasta que EL/ELLA se vuelva a casar o abiertamente cohabite con una persona del sexo opuesto.
9. Si usted no recibe beneficios cuando sea debido, la compañía de seguro/empleador debe de pagar penalidades, que se agregaran a sus pagos.

### Responsabilidades de los Empleados

1. Usted debe de seguir las reglas escritas de seguridad y otras pólizas razonables y procedimientos del empleador.
2. Usted debe reportar cualquier accidente inmediatamente, pero no más tarde de 30 días después del accidente, a su empleador, los representantes del empleador, su capataz o supervisor inmediato. Fallar en hacerlo puede resultar en la pérdida de sus beneficios.
3. Un empleado tiene la continua obligación de cooperar con proveedores médicos en el curso de su tratamiento relacionado con lesiones de trabajo. Usted debe aceptar tratamientos médicos razonables y servicios de rehabilitación cuando sean ordenados por la Junta Estatal de Compensación de Trabajadores o la Junta puede suspender sus beneficios.
4. No se permitirá compensación por una lesión o muerte debido a una conducta mal intencionada de los empleados.
5. Debe de notificar a la compañía de seguro/empleador de su dirección cuando se mude a un nuevo lugar. Usted debe notificar a la compañía de seguros/empleador cuando usted halla regresado a trabajar de tiempo completo o medio tiempo y reportar la cantidad de su salario semanal porque usted puede tener derecho a algún beneficio de ingreso aun así halla regresado al trabajo.
6. Una esposa dependiente de un empleado difunto debe notificar a la compañía de seguro/ empleador de cambios de dirección o nuevo matrimonio.
7. Usted debe intentar un trabajo aprobado por su medico autorizado aunque el pago sea mas bajo que en el trabajo que usted tenia cuando se lesionó, si usted no intenta el trabajo sus beneficios pueden ser suspendidos.
8. Si usted cree que debe recibir beneficios y su compañía de seguros/empleador niega estos beneficios. Usted debe de hacer un reclamo dentro de un año después del último tratamiento medico o dentro de dos años de su último pago de beneficios semanales o usted perderá sus derechos a estos beneficios.
9. Si su (s) dependiente (s) no reciben beneficio de pagos permitidos. El dependiente debe hacer un reclamo con la Junta Estatal de Compensación de Trabajadores dentro de un año después de su muerte o perderán los derechos a estos beneficios.
10. Algún pedido de reembolso a usted por millas o otros gastos relacionados con tratamiento medico debe ser sometidos a la compañía de seguros/empleador dentro de un año del día que los gastos fueron incurridos.
11. Si un empleado injustificadamente rehúsa a someterse a una prueba de droga después de una lesión en el trabajo habrá una presunción de que el accidente y lesión fueran causados por droga o alcohol. Si la presunción no se sobrepone por otras evidencias, algún reclamo hecho para beneficios de compensación de Trabajador serán negados.
12. Usted será culpable de un delito menor y una vez convicto debe ser castigado con una multa de no más de \$10,000.00 o encarcelamiento de hasta 12 meses o las dos, por hacer declaraciones falsas o engañosos testimonios cuando reclame beneficios. También cualquier declaración falsa o evidencia falsa dadas bajo juramento durante el curso de alguna audiencia de división de apelación o administración es perjurio.

La Junta de Compensación de Trabajadores le proporcionará la información relativa a la manera de presentar una reclamación y responderá a cualquier preguntas adicionales sobre sus derechos en virtud de la ley. Si usted llama en la zona de Atlanta, el teléfono es el (404) 656-3818 y fuera de la zona metropolitana de Atlanta, llame al 1-800-533-0682, o escriba a la Junta Estatal de Compensación de Trabajadores a 270 Peachtree Street, NW, Atlanta, Georgia 30303-1299 o visita sitio web: <http://www.sbcw.georgia.gov>. No es necesario tener un abogado para presentar una reclamación a la Junta; sin embargo, si usted cree que necesita los servicios de un abogado y no tiene uno propio, usted puede ponerse en contacto con el Servicio de Referencia de Abogados (Lawyers Referral Service) al teléfono (404) 521-0777 o al 1-800-237-2629.

SI USTED TIENE PREGUNTAS LLAME AL (404) 656-3818 O 1-800-533-0682 O VISITA SITIO WEB: <http://www.sbcw.georgia.gov>  
CUALQUIER DECLARACIÓN FALSA Y DELIBERADA PARA OBTENER O NEGAR BENEFICIOS ES UNA OFENSA CRIMINAL Y ES SUJETO A PENALIDADES DE HASTA \$10,000 POR CADA VIOLACIÓN (O.C.G.A. §34-9-18 Y §34-9-19).

REVISIÓN 07/2019

WC-BILL OF RIGHTS



**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):**

<input type="checkbox"/> 1. A citizen of the United States	
<input type="checkbox"/> 2. A noncitizen national of the United States <i>(See instructions)</i>	
<input type="checkbox"/> 3. A lawful permanent resident (Alien Registration Number/USCIS Number): _____	
<input type="checkbox"/> 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. <i>(See instructions)</i>	
<i>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.</i>	
1. Alien Registration Number/USCIS Number: _____ <b>OR</b> 2. Form I-94 Admission Number: _____ <b>OR</b> 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)
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**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



*Employer Completes Next Page*





**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

**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.")*

<b>Employee Info from Section 1</b>	Last Name (Family Name)	First Name (Given Name)	M.I.	Citizenship/Immigration Status
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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		Additional Information		QR Code - Sections 2 & 3 Do Not Write In This Space
Issuing Authority				
Document Number				
Expiration Date (if any)(mm/dd/yyyy)				
Document Title				
Issuing Authority				
Document Number				
Expiration Date (if any)(mm/dd/yyyy)				

**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 <b>Payroll Administrator</b>	
Last Name of Employer or Authorized Representative	First Name of Employer or Authorized Representative		Employer's Business or Organization Name Composite Construction Systems, Inc.	
Employer's Business or Organization Address (Street Number and Name) <b>5300 Transport Boulevard</b>		City or Town <b>Columbus</b>	State <b>GA</b>	ZIP Code <b>31907</b>

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

<b>A. New Name (if applicable)</b>			<b>B. Date of Rehire (if applicable)</b>	
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 <b>CCSI</b>
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## 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.

<b>LIST A</b> <b>Documents that Establish Both Identity and Employment Authorization</b>	OR	<b>LIST B</b> <b>Documents that Establish Identity</b>	AND	<b>LIST C</b> <b>Documents that Establish Employment Authorization</b>
<ol style="list-style-type: none"> <li>1. U.S. Passport or U.S. Passport Card</li> <li>2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551)</li> <li>3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa</li> <li>4. Employment Authorization Document that contains a photograph (Form I-766)</li> <li>5. For a nonimmigrant alien authorized to work for a specific employer because of his or her status:               <ol style="list-style-type: none"> <li>a. Foreign passport; and</li> <li>b. Form I-94 or Form I-94A that has the following:                   <ol style="list-style-type: none"> <li>(1) The same name as the passport; and</li> <li>(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.</li> </ol> </li> </ol> </li> <li>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</li> </ol>	OR	<ol style="list-style-type: none"> <li>1. Driver's license or ID card issued by a State or outlying possession of the United States provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address</li> <li>2. ID card issued by federal, state or local government agencies or entities, provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address</li> <li>3. School ID card with a photograph</li> <li>4. Voter's registration card</li> <li>5. U.S. Military card or draft record</li> <li>6. Military dependent's ID card</li> <li>7. U.S. Coast Guard Merchant Mariner Card</li> <li>8. Native American tribal document</li> <li>9. Driver's license issued by a Canadian government authority</li> <li style="text-align: center;"><b>For persons under age 18 who are unable to present a document listed above:</b></li> <li>10. School record or report card</li> <li>11. Clinic, doctor, or hospital record</li> <li>12. Day-care or nursery school record</li> </ol>	AND	<ol style="list-style-type: none"> <li>1. A Social Security Account Number card, unless the card includes one of the following restrictions:               <ol style="list-style-type: none"> <li>(1) NOT VALID FOR EMPLOYMENT</li> <li>(2) VALID FOR WORK ONLY WITH INS AUTHORIZATION</li> <li>(3) VALID FOR WORK ONLY WITH DHS AUTHORIZATION</li> </ol> </li> <li>2. Certification of report of birth issued by the Department of State (Forms DS-1350, FS-545, FS-240)</li> <li>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</li> <li>4. Native American tribal document</li> <li>5. U.S. Citizen ID Card (Form I-197)</li> <li>6. Identification Card for Use of Resident Citizen in the United States (Form I-179)</li> <li>7. Employment authorization document issued by the Department of Homeland Security</li> </ol>

**Examples of many of these documents appear in Part 13 of the Handbook for Employers (M-274).**

**Refer to the instructions for more information about acceptable receipts.**

# Form W-4 (2019)

**Future developments.** For the latest information about any future developments related to Form W-4, such as legislation enacted after it was published, go to [www.irs.gov/FormW4](http://www.irs.gov/FormW4).

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

**Exemption from withholding.** You may claim exemption from withholding for 2019 if **both** of the following apply.

- For 2018 you had a right to a refund of **all** federal income tax withheld because you had **no** tax liability, **and**
- For 2019 you expect a refund of **all** federal income tax withheld because you expect to have **no** tax liability.

If you're exempt, complete **only** lines 1, 2, 3, 4, and 7 and sign the form to validate it. Your exemption for 2019 expires February 17, 2020. See Pub. 505, Tax Withholding and Estimated Tax, to learn more about whether you qualify for exemption from withholding.

## General Instructions

If you aren't exempt, follow the rest of these instructions to determine the number of withholding allowances you should claim for withholding for 2019 and any additional amount of tax to have withheld. For regular wages, withholding must be based on allowances you claimed and may not be a flat amount or percentage of wages.

You can also use the calculator at [www.irs.gov/W4App](http://www.irs.gov/W4App) to determine your tax withholding more accurately. Consider

using this calculator if you have a more complicated tax situation, such as if you have a working spouse, more than one job, or a large amount of nonwage income not subject to withholding outside of your job. After your Form W-4 takes effect, you can also use this calculator to see how the amount of tax you're having withheld compares to your projected total tax for 2019. If you use the calculator, you don't need to complete any of the worksheets for Form W-4.

Note that if you have too much tax withheld, you will receive a refund when you file your tax return. If you have too little tax withheld, you will owe tax when you file your tax return, and you might owe a penalty.

**Filers with multiple jobs or working spouses.** If you have more than one job at a time, or if you're married filing jointly and your spouse is also working, read all of the instructions including the instructions for the Two-Earners/Multiple Jobs Worksheet before beginning.

**Nonwage income.** If you have a large amount of nonwage income not subject to withholding, such as interest or dividends, consider making estimated tax payments using Form 1040-ES, Estimated Tax for Individuals. Otherwise, you might owe additional tax. Or, you can use the Deductions, Adjustments, and Additional Income Worksheet on page 3 or the calculator at [www.irs.gov/W4App](http://www.irs.gov/W4App) to make sure you have enough tax withheld from your paycheck. If you have pension or annuity income, see Pub. 505 or use the calculator at [www.irs.gov/W4App](http://www.irs.gov/W4App) to find out if you should adjust your withholding on Form W-4 or W-4P.

**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

### Personal Allowances Worksheet

Complete this worksheet on page 3 first to determine the number of withholding allowances to claim.

**Line C. Head of household please note:** Generally, you may claim head of household filing status on your tax return only if you're unmarried and pay more than 50% of the costs of keeping up a home for yourself and a qualifying individual. See Pub. 501 for more information about filing status.

**Line E. Child tax credit.** When you file your tax return, you may be eligible to claim a child tax credit for each of your eligible children. To qualify, the child must be under age 17 as of December 31, must be your dependent who lives with you for more than half the year, and must have a valid social security number. To learn more about this credit, see Pub. 972, Child Tax Credit. To reduce the tax withheld from your pay by taking this credit into account, follow the instructions on line E of the worksheet. On the worksheet you will be asked about your total income. For this purpose, total income includes all of your wages and other income, including income earned by a spouse if you are filing a joint return.

**Line F. Credit for other dependents.** When you file your tax return, you may be eligible to claim a credit for other dependents for whom a child tax credit can't be claimed, such as a qualifying child who doesn't meet the age or social security number requirement for the child tax credit, or a qualifying relative. To learn more about this credit, see Pub. 972. To reduce the tax withheld from your pay by taking this credit into account, follow the instructions on line F of the worksheet. On the worksheet, you will be asked about your total income. For this purpose, total

----- Separate here and give Form W-4 to your employer. Keep the worksheet(s) for your records. -----

<b>Form W-4</b> Department of the Treasury Internal Revenue Service		<b>Employee's Withholding Allowance Certificate</b>		OMB No. 1545-0074 <span style="font-size: 2em; font-weight: bold;">2019</span>	
<b>▶ Whether you're entitled to claim a certain number of allowances or exemption from withholding is subject to review by the IRS. Your employer may be required to send a copy of this form to the IRS.</b>					
1 Your first name and middle initial		Last name		2 Your social security number	
Home address (number and street or rural route)			3 <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Married, but withhold at higher Single rate. <b>Note:</b> If married filing separately, check "Married, but withhold at higher Single rate."		
City or town, state, and ZIP code			4 If your last name differs from that shown on your social security card, check here. You must call 800-772-1213 for a replacement card. <input type="checkbox"/>		
5 Total number of allowances you're claiming (from the applicable worksheet on the following pages) . . . . .				5	
6 Additional amount, if any, you want withheld from each paycheck . . . . .				6 \$	
7 I claim exemption from withholding for 2019, and I certify that I meet <b>both</b> of the following conditions for exemption.					
<ul style="list-style-type: none"> <li>• Last year I had a right to a refund of <b>all</b> federal income tax withheld because I had <b>no</b> tax liability, <b>and</b></li> <li>• This year I expect a refund of <b>all</b> federal income tax withheld because I expect to have <b>no</b> tax liability.</li> </ul> If you meet both conditions, write "Exempt" here . . . . . ▶					
Under penalties of perjury, I declare that I have examined this certificate and, to the best of my knowledge and belief, it is true, correct, and complete.					
<b>Employee's signature</b> (This form is not valid unless you sign it.) ▶					
8 Employer's name and address ( <b>Employer:</b> Complete boxes 8 and 10 if sending to IRS and complete boxes 8, 9, and 10 if sending to State Directory of New Hires.)				9 First date of employment	
				10 Employer identification number (EIN)	

income includes all of your wages and other income, including income earned by a spouse if you are filing a joint return.

**Line G. Other credits.** You may be able to reduce the tax withheld from your paycheck if you expect to claim other tax credits, such as tax credits for education (see Pub. 970). If you do so, your paycheck will be larger, but the amount of any refund that you receive when you file your tax return will be smaller. Follow the instructions for Worksheet 1-6 in Pub. 505 if you want to reduce your withholding to take these credits into account. Enter “-0-” on lines E and F if you use Worksheet 1-6.

### Deductions, Adjustments, and Additional Income Worksheet

Complete this worksheet to determine if you're able to reduce the tax withheld from your paycheck to account for your itemized deductions and other adjustments to income, such as IRA contributions. If you do so, your refund at the end of the year will be smaller, but your paycheck will be larger. You're not required to complete this worksheet or reduce your withholding if you don't wish to do so.

You can also use this worksheet to figure out how much to increase the tax withheld from your paycheck if you have a large amount of nonwage income not subject to withholding, such as interest or dividends.

Another option is to take these items into account and make your withholding more accurate by using the calculator at [www.irs.gov/W4App](http://www.irs.gov/W4App). If you use the calculator, you don't need to complete any of the worksheets for Form W-4.

### Two-Earners/Multiple Jobs Worksheet

Complete this worksheet if you have more than one job at a time or are married filing jointly and have a working spouse. If you

don't complete this worksheet, you might have too little tax withheld. If so, you will owe tax when you file your tax return and might be subject to a penalty.

Figure the total number of allowances you're entitled to claim and any additional amount of tax to withhold on all jobs using worksheets from only one Form W-4. Claim all allowances on the W-4 that you or your spouse file for the highest paying job in your family and claim zero allowances on Forms W-4 filed for all other jobs. For example, if you earn \$60,000 per year and your spouse earns \$20,000, you should complete the worksheets to determine what to enter on lines 5 and 6 of your Form W-4, and your spouse should enter zero (“-0-”) on lines 5 and 6 of his or her Form W-4. See Pub. 505 for details.

Another option is to use the calculator at [www.irs.gov/W4App](http://www.irs.gov/W4App) to make your withholding more accurate.

**Tip:** If you have a working spouse and your incomes are similar, you can check the “Married, but withhold at higher Single rate” box instead of using this worksheet. If you choose this option, then each spouse should fill out the Personal Allowances Worksheet and check the “Married, but withhold at higher Single rate” box on Form W-4, but only one spouse should claim any allowances for credits or fill out the Deductions, Adjustments, and Additional Income Worksheet.

### Instructions for Employer

**Employees, do not complete box 8, 9, or 10. Your employer will complete these boxes if necessary.**

**New hire reporting.** Employers are required by law to report new employees to a designated State Directory of New Hires. Employers may use Form W-4, boxes 8, 9,

and 10 to comply with the new hire reporting requirement for a newly hired employee. A newly hired employee is an employee who hasn't previously been employed by the employer, or who was previously employed by the employer but has been separated from such prior employment for at least 60 consecutive days. Employers should contact the appropriate State Directory of New Hires to find out how to submit a copy of the completed Form W-4. For information and links to each designated State Directory of New Hires (including for U.S. territories), go to [www.acf.hhs.gov/css/employers](http://www.acf.hhs.gov/css/employers).

If an employer is sending a copy of Form W-4 to a designated State Directory of New Hires to comply with the new hire reporting requirement for a newly hired employee, complete boxes 8, 9, and 10 as follows.

**Box 8.** Enter the employer's name and address. If the employer is sending a copy of this form to a State Directory of New Hires, enter the address where child support agencies should send income withholding orders.

**Box 9.** If the employer is sending a copy of this form to a State Directory of New Hires, enter the employee's first date of employment, which is the date services for payment were first performed by the employee. If the employer rehired the employee after the employee had been separated from the employer's service for at least 60 days, enter the rehire date.

**Box 10.** Enter the employer's employer identification number (EIN).

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

<b>A</b>	Enter "1" for yourself . . . . .	<b>A</b>	<u>      </u>
<b>B</b>	Enter "1" if you will file as married filing jointly . . . . .	<b>B</b>	<u>      </u>
<b>C</b>	Enter "1" if you will file as head of household . . . . .	<b>C</b>	<u>      </u>
<b>D</b>	Enter "1" if: <span style="font-size: 2em; vertical-align: middle;">{</span> <ul style="list-style-type: none"> <li>• You're single, or married filing separately, and have only one job; or</li> <li>• You're married filing jointly, have only one job, and your spouse doesn't work; or</li> <li>• Your wages from a second job or your spouse's wages (or the total of both) are \$1,500 or less.</li> </ul> <span style="font-size: 2em; vertical-align: middle;">}</span>	<b>D</b>	<u>      </u>
<b>E</b>	<p><b>Child tax credit.</b> See Pub. 972, Child Tax Credit, for more information.</p> <ul style="list-style-type: none"> <li>• If your total income will be less than \$71,201 (\$103,351 if married filing jointly), enter "4" for each eligible child.</li> <li>• If your total income will be from \$71,201 to \$179,050 (\$103,351 to \$345,850 if married filing jointly), enter "2" for each eligible child.</li> <li>• If your total income will be from \$179,051 to \$200,000 (\$345,851 to \$400,000 if married filing jointly), enter "1" for each eligible child.</li> <li>• If your total income will be higher than \$200,000 (\$400,000 if married filing jointly), enter "-0-" . . . . .</li> </ul>	<b>E</b>	<u>      </u>
<b>F</b>	<p><b>Credit for other dependents.</b> See Pub. 972, Child Tax Credit, for more information.</p> <ul style="list-style-type: none"> <li>• If your total income will be less than \$71,201 (\$103,351 if married filing jointly), enter "1" for each eligible dependent.</li> <li>• If your total income will be from \$71,201 to \$179,050 (\$103,351 to \$345,850 if married filing jointly), enter "1" for every two dependents (for example, "-0-" for one dependent, "1" if you have two or three dependents, and "2" if you have four dependents).</li> <li>• If your total income will be higher than \$179,050 (\$345,850 if married filing jointly), enter "-0-" . . . . .</li> </ul>	<b>F</b>	<u>      </u>
<b>G</b>	<p><b>Other credits.</b> If you have other credits, see Worksheet 1-6 of Pub. 505 and enter the amount from that worksheet here. If you use Worksheet 1-6, enter "-0-" on lines E and F . . . . .</p>	<b>G</b>	<u>      </u>
<b>H</b>	Add lines A through G and enter the total here . . . . .	<b>H</b>	<u>      </u>

For accuracy, **complete all worksheets that apply.**

- If you plan to **itemize** or **claim adjustments to income** and want to reduce your withholding, or if you have a large amount of nonwage income not subject to withholding and want to increase your withholding, see the **Deductions, Adjustments, and Additional Income Worksheet** below.
- If you **have more than one job at a time** or are **married filing jointly and you and your spouse both work**, and the combined earnings from all jobs exceed \$53,000 (\$24,450 if married filing jointly), see the **Two-Earners/Multiple Jobs Worksheet** on page 4 to avoid having too little tax withheld.
- If **neither** of the above situations applies, **stop here** and enter the number from line H on line 5 of Form W-4 above.

**Deductions, Adjustments, and Additional Income Worksheet**

**Note:** Use this worksheet *only* if you plan to itemize deductions, claim certain adjustments to income, or have a large amount of nonwage income not subject to withholding.

<b>1</b>	Enter an estimate of your 2019 itemized deductions. These 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. See Pub. 505 for details . . . . .	<b>1</b>	\$ <u>      </u>
<b>2</b>	Enter: <span style="font-size: 2em; vertical-align: middle;">{</span> <ul style="list-style-type: none"> <li>\$24,400 if you're married filing jointly or qualifying widow(er)</li> <li>\$18,350 if you're head of household</li> <li>\$12,200 if you're single or married filing separately</li> </ul> <span style="font-size: 2em; vertical-align: middle;">}</span> . . . . .	<b>2</b>	\$ <u>      </u>
<b>3</b>	<b>Subtract</b> line 2 from line 1. If zero or less, enter "-0-" . . . . .	<b>3</b>	\$ <u>      </u>
<b>4</b>	Enter an estimate of your 2019 adjustments to income, qualified business income deduction, and any additional standard deduction for age or blindness (see Pub. 505 for information about these items) . . . . .	<b>4</b>	\$ <u>      </u>
<b>5</b>	<b>Add</b> lines 3 and 4 and enter the total . . . . .	<b>5</b>	\$ <u>      </u>
<b>6</b>	Enter an estimate of your 2019 nonwage income not subject to withholding (such as dividends or interest) . . . . .	<b>6</b>	\$ <u>      </u>
<b>7</b>	<b>Subtract</b> line 6 from line 5. If zero, enter "-0-". If less than zero, enter the amount in parentheses . . . . .	<b>7</b>	\$ <u>      </u>
<b>8</b>	<b>Divide</b> the amount on line 7 by \$4,200 and enter the result here. If a negative amount, enter in parentheses. Drop any fraction . . . . .	<b>8</b>	<u>      </u>
<b>9</b>	Enter the number from the <b>Personal Allowances Worksheet</b> , line H, above . . . . .	<b>9</b>	<u>      </u>
<b>10</b>	<b>Add</b> lines 8 and 9 and enter the total here. If zero or less, enter "-0-". If you plan to use the <b>Two-Earners/Multiple Jobs Worksheet</b> , also enter this total on line 1 of that worksheet on page 4. Otherwise, <b>stop here</b> and enter this total on Form W-4, line 5, page 1 . . . . .	<b>10</b>	<u>      </u>

**Two-Earners/Multiple Jobs Worksheet**

**Note:** Use this worksheet *only* if the instructions under line H from the **Personal Allowances Worksheet** direct you here.

- 1 Enter the number from the **Personal Allowances Worksheet**, line H, page 3 (or, if you used the **Deductions, Adjustments, and Additional Income Worksheet** on page 3, the number from line 10 of that worksheet) . . . . . **1** \_\_\_\_\_
  - 2 Find the number in **Table 1** below that applies to the **LOWEST** paying job and enter it here. **However**, if you're married filing jointly and wages from the highest paying job are \$75,000 or less and the combined wages for you and your spouse are \$107,000 or less, don't enter more than "3" . . . . . **2** \_\_\_\_\_
  - 3 If line 1 is **more than or equal to** line 2, subtract line 2 from line 1. Enter the result here (if zero, enter "-0-") and on Form W-4, line 5, page 1. **Do not** use the rest of this worksheet . . . . . **3** \_\_\_\_\_
- Note:** If line 1 is **less than** line 2, enter "-0-" on Form W-4, line 5, page 1. Complete lines 4 through 9 below to figure the additional withholding amount necessary to avoid a year-end tax bill.
- 4 Enter the number from line 2 of this worksheet . . . . . **4** \_\_\_\_\_
  - 5 Enter the number from line 1 of this worksheet . . . . . **5** \_\_\_\_\_
  - 6 **Subtract** line 5 from line 4 . . . . . **6** \_\_\_\_\_
  - 7 Find the amount in **Table 2** below that applies to the **HIGHEST** paying job and enter it here . . . . . **7** \$ \_\_\_\_\_
  - 8 **Multiply** line 7 by line 6 and enter the result here. This is the additional annual withholding needed . . . . . **8** \$ \_\_\_\_\_
  - 9 **Divide** line 8 by the number of pay periods remaining in 2019. For example, divide by 18 if you're paid every 2 weeks and you complete this form on a date in late April when there are 18 pay periods remaining in 2019. Enter the result here and on Form W-4, line 6, page 1. This is the additional amount to be withheld from each paycheck . . . . . **9** \$ \_\_\_\_\_

Table 1				Table 2			
Married Filing Jointly		All Others		Married Filing Jointly		All Others	
If wages from <b>LOWEST</b> paying job are—	Enter on line 2 above	If wages from <b>LOWEST</b> paying job are—	Enter on line 2 above	If wages from <b>HIGHEST</b> paying job are—	Enter on line 7 above	If wages from <b>HIGHEST</b> paying job are—	Enter on line 7 above
\$0 - \$5,000	0	\$0 - \$7,000	0	\$0 - \$24,900	\$420	\$0 - \$7,200	\$420
5,001 - 9,500	1	7,001 - 13,000	1	24,901 - 84,450	500	7,201 - 36,975	500
9,501 - 19,500	2	13,001 - 27,500	2	84,451 - 173,900	910	36,976 - 81,700	910
19,501 - 35,000	3	27,501 - 32,000	3	173,901 - 326,950	1,000	81,701 - 158,225	1,000
35,001 - 40,000	4	32,001 - 40,000	4	326,951 - 413,700	1,330	158,226 - 201,600	1,330
40,001 - 46,000	5	40,001 - 60,000	5	413,701 - 617,850	1,450	201,601 - 507,800	1,450
46,001 - 55,000	6	60,001 - 75,000	6	617,851 and over	1,540	507,801 and over	1,540
55,001 - 60,000	7	75,001 - 85,000	7				
60,001 - 70,000	8	85,001 - 95,000	8				
70,001 - 75,000	9	95,001 - 100,000	9				
75,001 - 85,000	10	100,001 - 110,000	10				
85,001 - 95,000	11	110,001 - 115,000	11				
95,001 - 125,000	12	115,001 - 125,000	12				
125,001 - 155,000	13	125,001 - 135,000	13				
155,001 - 165,000	14	135,001 - 145,000	14				
165,001 - 175,000	15	145,001 - 160,000	15				
175,001 - 180,000	16	160,001 - 180,000	16				
180,001 - 195,000	17	180,001 and over	17				
195,001 - 205,000	18						
205,001 and over	19						

**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 who claims no withholding allowances; 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 aren't required to provide the information requested on a form that's 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.



1811004012

STATE OF GEORGIA EMPLOYEE'S WITHHOLDING ALLOWANCE CERTIFICATE

1a. YOUR FULL NAME 1b. YOUR SOCIAL SECURITY NUMBER
2a. HOME ADDRESS (Number, Street, or Rural Route) 2b. CITY, STATE AND ZIP CODE

PLEASE READ INSTRUCTIONS ON REVERSE SIDE BEFORE COMPLETING LINES 3 - 8

3. MARITAL STATUS

(If you do not wish to claim an allowance, enter "0" in the brackets beside your marital status.)

- A. Single: Enter 0 or 1
B. Married Filing Joint, both spouses working: Enter 0 or 1
C. Married Filing Joint, one spouse working: Enter 0 or 1 or 2
D. Married Filing Separate: Enter 0 or 1
E. Head of Household: Enter 0 or 1

4. DEPENDENT ALLOWANCES [ ]

5. ADDITIONAL ALLOWANCES [ ]
(worksheet below must be completed)

6. ADDITIONAL WITHHOLDING \$ \_\_\_\_\_

WORKSHEET FOR CALCULATING ADDITIONAL ALLOWANCES
(Must be completed in order to enter an amount on step 5)

- 1. COMPLETE THIS LINE ONLY IF USING STANDARD DEDUCTION:
Yourself: [ ] Age 65 or over [ ] Blind
Spouse: [ ] Age 65 or over [ ] Blind Number of boxes checked \_\_\_\_\_ x 1300.....\$ \_\_\_\_\_
2. ADDITIONAL ALLOWANCES FOR DEDUCTIONS:
A. Federal Estimated Itemized Deductions (If Itemizing Deductions).....\$ \_\_\_\_\_
B. Georgia Standard Deduction (enter one): Single/Head of Household \$4,600
Each Spouse \$3,000 \$ \_\_\_\_\_
C. Subtract Line B from Line A (If zero or less, enter zero).....\$ \_\_\_\_\_
D. Allowable Deductions to Federal Adjusted Gross Income .....\$ \_\_\_\_\_
E. Add the Amounts on Lines 1, 2C, and 2D .....\$ \_\_\_\_\_
F. Estimate of Taxable Income not Subject to Withholding .....\$ \_\_\_\_\_
G. Subtract Line F from Line E (if zero or less, stop here).....\$ \_\_\_\_\_
H. Divide the Amount on Line G by \$3,000. Enter total here and on Line 5 above.....

(This is the maximum number of additional allowances you can claim. If the remainder is over \$1,500 round up)

7. LETTER USED (Marital Status A, B, C, D, or E) \_\_\_\_\_ TOTAL ALLOWANCES (Total of Lines 3 - 5) \_\_\_\_\_
(Employer: The letter indicates the tax tables in Employer's Tax Guide)

8. EXEMPT: (Do not complete Lines 3 - 7 if claiming exempt) Read the Line 8 instructions on page 2 before completing this section.

- a) I claim exemption from withholding because I incurred no Georgia income tax liability last year and I do not expect to have a Georgia income tax liability this year. Check here [ ]
b) I certify that I am not subject to Georgia withholding because I meet the conditions set forth under the Servicemembers Civil Relief Act as provided on page 2. My state of residence is \_\_\_\_\_. My spouse's (servicemember) state of residence is \_\_\_\_\_. The states of residence must be the same to be exempt. Check here [ ]

I certify under penalty of perjury that I am entitled to the number of withholding allowances or the exemption from withholding status claimed on this Form G-4. Also, I authorize my employer to deduct per pay period the additional amount listed above.

Employee's Signature \_\_\_\_\_ Date \_\_\_\_\_

Employer: Complete Line 9 and mail entire form only if the employee claims over 14 allowances or exempt from withholding. If necessary, mail form to: Georgia Department of Revenue, Withholding Tax Unit, 1800 Century Blvd NE, Suite 8200, Atlanta, GA 30345

9. EMPLOYER'S NAME AND ADDRESS: EMPLOYER'S FEIN: \_\_\_\_\_

EMPLOYER'S WH#: \_\_\_\_\_

Do not accept forms claiming additional allowances unless the worksheet has been completed. Do not accept forms claiming exempt if numbers are written on Lines 3 - 7.

### INSTRUCTIONS FOR COMPLETING FORM G-4

Enter your full name, address and social security number in boxes 1a through 2b.

Line 3: Write the number of allowances you are claiming in the brackets beside your marital status.

- A. Single – enter 1 if you are claiming yourself
- B. Married Filing Joint, both spouses working – enter 1 if you claim yourself
- C. Married Filing Joint, one spouse working – enter 1 if you claim yourself or 2 if you claim yourself and your spouse
- D. Married Filing Separate – enter 1 if you claim yourself
- E. Head of Household – enter 1 if you claim yourself

Line 4: Enter the number of dependent allowances you are entitled to claim.

Line 5: Complete the worksheet on Form G-4 if you claim additional allowances. Enter the number on Line H here.

**Failure to complete and submit the worksheet will result in automatic denial on your claim.**

Line 6: Enter a specific dollar amount that you authorize your employer to withhold in addition to the tax withheld based on your marital status and number of allowances.

Line 7: Enter the letter of your marital status from Line 3. Enter total of the numbers on Lines 3-5.

Line 8:

- a) Check the first box if you qualify to claim exempt from withholding. You can claim exempt if you filed a Georgia income tax return last year and the amount of Line 4 of Form 500EZ or Line 16 of Form 500 was zero, **and** you expect to file a Georgia tax return this year and will not have a tax liability. You cannot claim exempt if you did not file a Georgia income tax return for the previous tax year. **Receiving a refund in the previous tax year does not qualify you to claim exempt.**

**EXAMPLES:** Your employer withheld \$500 of Georgia income tax from your wages. The amount on Line 4 of Form 500EZ (or Line 16 of Form 500) was \$100. Your tax liability is the amount on Line 4 (or Line 16); therefore, you **do not qualify** to claim exempt.

Your employer withheld \$500 of Georgia income tax from your wages. The amount on Line 4 of Form 500EZ (or Line 16 of Form 500) was \$0 (zero). Your tax liability is the amount on Line 4 (or Line 16) and you filed a prior year income tax return; therefore you **qualify** to claim exempt.

- b) Check the second box if you are not subject to Georgia withholding and meet the conditions set forth under the Servicemembers Civil Relief Act. Under the Act, a spouse of a servicemember may be exempt from Georgia income tax on income from services performed in Georgia if:
  - 1. The servicemember is present in Georgia in compliance with military orders;
  - 2. The spouse is in Georgia solely to be with the servicemember;
  - 3. The servicemember maintains domicile in another state; and
  - 4. The domicile of the spouse is the same as the domicile of the servicemember or the spouse of the servicemember has elected to use the same residence for purposes of taxation as the servicemember.

Additional information for employers regarding the Military Spouses Residency Relief Act:

- 1. On the W-2 the employer should not report any of the wages as Georgia wages.
- 2. If the spouse of a servicemember is entitled to the protection of the Military Spouses Residency Relief Act in another state and files a withholding exemption form in such other state, the spouse is required to submit a Georgia Form G-4 so that withholding will occur as is required by Georgia Law when a Georgia domiciliary works in another state and withholding is not required by such other state. If the spouse does not fill out the form, the employer shall withhold Georgia income tax as if the spouse is single with zero allowances.

**Worksheet for calculating additional allowances.** Enter the information as requested by each line. For Line 2D, enter items such as Retirement Income Exclusion, U.S. Obligations, and other allowable deductions per Georgia Law, see the IT-511 booklet for more information.

**Do not complete Lines 3-7 if claiming exempt.**

**O.C.G.A. § 48-7-102** requires you to complete and submit Form G-4 to your employer in order to have tax withheld from your wages. By correctly completing this form, you can adjust the amount of tax withheld to meet your tax liability. Failure to submit a properly completed Form G-4 will result in your employer withholding tax as though you are single with zero allowances.

Employers are required to mail any Form G-4 claiming more than 14 allowances or exempt from withholding to the Georgia Department of Revenue for approval. Employers will honor the properly completed form as submitted pending notification from the Withholding Tax Unit. Upon approval, such forms remain in effect until changed or until February 15 of the following year. Employers who know that a G-4 is erroneous should not honor the form and should withhold as if the employee is single claiming zero allowances until a corrected form has been received.

# Occupational Medicine of Columbus

7301 Northlake Drive

Columbus, GA 31909

Phone: (706) 221 - 1600 Fax:(706) 221 - 1605

## EMPLOYER'S TREATMENT/EXAMINATION AUTHORIZATION

(MUST HAVE VALID PHOTO ID AVAILABLE AT TIME OF SERVICE)

Today's Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_ SSN: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

**WORK RELATED:**  INJURY  ILLNESS

Date of injury/illness: \_\_\_\_\_

Injury/illness to be treated: \_\_\_\_\_

Post-Accident Substance Abuse Testing Required: If not checked a 5-Panel Rapid is required automatically on any injury/illness.

Urine Drug Screen  DOT Regulated

Breath Alcohol  Non-Regulated

Saliva Alcohol (Non-Regulated Only)

**SUBSTANCE ABUSE TESTING ONLY:**

DOT Urine  CC Alcohol

Non-DOT Urine [  Collection ]  COC 9-Panel

5-Panel Rapid  8-Panel Rapid  Hair

Saliva Alcohol  OBSERVED COLLECTION

Breath Alcohol [  DOT  Non-DOT ]

**REASON FOR TESTING:**

Pre-employment  Return to Duty/Follow-up  
(only after positive test)

Random

Post Accident

Reasonable Suspicion/Cause

Other \_\_\_\_\_

### PHYSICALS:

Job Title/Position: \_\_\_\_\_

One-Page Exam

Two-Page Exam

DOT (Federal Exam) with Medical Examiner's Certificate

[  Recertification  New Certification ]

Other \_\_\_\_\_

**ADDITIONAL SERVICES REQUESTED:**

Audiometry [  Baseline  Annual ]

Spirometry  PPD  HEP B

Chest X-Ray  Other \_\_\_\_\_

Authorized by: \_\_\_\_\_

Company: Composite Construction Systems, Inc.

Phone: 706-561-8500 Fax# 706-569-7004

E-mail: [leigh@ccsicol.com](mailto:leigh@ccsicol.com)

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

### BILLING:

Employee Pays at Time of Service

Bill to Worker's Compensation Insurance

Invoice Employer

# WHAT YOU NEED TO KNOW

GEORGIA HANDS FREE LAW EFFECTIVE 07.01.2018



## ABOUT GEORGIA HANDS FREE LAW

The Georgia Hands-Free Law prohibits the use of stand alone telecommunication devices while operating a vehicle by using hands or with the support of any other body part.

This summary is provided to you by Hutchinson Traylor Insurance Company. To learn more about Hutchinson Traylor visit [www.hutchinsontraylor.com](http://www.hutchinsontraylor.com).

## WHAT IS A TELECOMMUNICATION DEVICE?

A device that stores audio or video data files that user retrieves on demand.



iPods  
Cellular phones  
Portable telephones or text messaging devices  
Personal digital assistant  
Stand-alone computer (laptop or tablet)  
GPS receiver  
Any similar portable wireless device used to send/receive communications or data



Radio  
CB Radio or CB Radio Hybrid  
Commercial two-way radio (or functional equivalent)  
A subscription-based emergency communication device  
Prescribed medical device  
Amateur or ham radio device  
In-vehicle security, navigation, or remote diagnostics system



According to the National Highway Traffic Safety Administration, distracted driving caused 391,000 accidents with injuries in 2015 and 3,450 accidents with fatalities in 2018.

The Georgia Governor's Office of Highway Safety stated that nearly all motor vehicle crashes are a result of distracted driving.

VISIT [HUTCHINSONTRAYLOR.COM](http://HUTCHINSONTRAYLOR.COM) TO SCHEDULE A NO-COST CONSULTATION

Below are some snapshots and highlights of the new Hands Free Law and how it will affect you.

### Definitions

"Stand-alone electronic device" – 40-6-241 (a)(1)

- A device that stores audio or video data files to be retrieved on demand by a user. (Ex. – iPod)

"Wireless Telecommunications Device" - 40-6-241 (a) (3)

1. What it is:

- Cell phones
- Portable telephones or text-messaging devices
- Personal digital assistant
- Stand-alone computer (laptop or tablet)
- GPS receiver
- Any similar portable wireless device used to send/receive communications or data

2. What it is NOT:

- Radio
- CB Radio OR CB Radio hybrid
- Commercial two-way radio (or functional equivalent)
- Subscription based emergency communications device
- Prescribed medical device
- Amateur or ham radio device
- In-vehicle security, navigation, or remote diagnostics system.



### What does the new law actually mean to me?

BASICALLY, the new law means you cannot operate a motor vehicle while operating a cell phone, holding a cell phone with your hand or supporting a cell phone with another part of your body.



For some, the basic explanation is enough. To understand the most important points of the law, let's start with definitions and then move into the rules.

*There is NO requirement that an officer observe another violation or write any other citation to enforce this new law.*

According to the National Highway Traffic Safety Administration, distracted driving caused 391,000 accidents with injuries in 2015 and 3,450 accidents with fatalities in 2016. <https://www.nhtsa.gov/risky-driving/distracted-driving>

The Georgia Governor's Office of Highway Safety stated that nearly all motor vehicle crashes are a result of distracted driving, simply because one of the drivers involved wasn't paying attention to the road. <https://www.gaighighwaysafety.org/research/distracted-driving/>

*Please take time to familiarize yourself with the new law BEFORE it goes into effect July 1, 2018.*

Our goal in sharing this information with you is simple: educate the motoring public about the new law and hopefully reduce future traffic accidents.

### Rules

#### Motor Vehicle Operations (40-6-241)

1. A driver may not hold / support a wireless telecommunications device or stand-alone computer with any part of their body.
  - Exceptions – Earpiece, headphone, smart watch
2. May not write, send, or read any text-based communication
  - Exceptions – Voice based communication automatically converted to written message
3. Navigation / GPS may only be accessed by the driver while vehicle is lawfully parked. The screen may be viewed while the vehicle is in motion but may not be held or supported by any part of the driver's body.
4. May not watch a video
  - Exception – Navigation Device
5. May not record a video
  - Exception – Continuous recording / broadcasting (dash cams)

#### School Bus Operations (40-6-165)

1. A school bus driver may not use a wireless telecommunications device or two-way radio while loading or unloading passengers.
2. A school bus driver may not use a wireless telecommunications device while the bus is in motion, unless it is used in a manner similar to a two-way radio to allow communication with school or public safety officials.

### WHAT YOU NEED TO KNOW ABOUT

## Hands Free Georgia Law



Information about the new law and how it will be enforced

Provided by:

Smyrna Police Department  
"Exceeding Expectation"  
Chief David Lee

### What about COMMERCIAL drivers?!

For commercial motor vehicle operators ONLY: 40-6-241 (d)

1. May not use more than a single button to initiate a voice conversation
2. May not reach for a wireless telecommunications device in such a manner that they are:
  - a. No longer in a seated driving position
  - b. Or properly restrained by a seat belt

*(Note – CMV provisions remain unchanged from previous law (former 40-6-241.2 (b)(2)) – avoids conflict with FMCSA regulations)*

### Wait, are you telling me there are NO exceptions?

Exceptions that apply to all drivers 40-6-241 (g)

1. Reporting a traffic accident, medical emergency, fire, crime, or hazardous road condition.
2. Employee / contractor of utility service provider acting within the scope of their employment while responding to a utility emergency.
3. By a first responder (police, fire, EMS) during the performance of their official duties.
4. When in a lawfully parked vehicle.

# MOTOR VEHICLE SAFETY POLICY ACKNOWLEDGEMENT

Company Name: \_\_\_\_\_

Employee Name: \_\_\_\_\_

Using a cell phone while driving increases the risk of a crash by four times, and texting increases crash risk by 23 times. Employees must refrain from using PDAs and cell phones, either hand-held or hands-free, while operating a motor vehicle. Employees must not initiate or respond to phone calls, read or respond to text messages or emails while driving a passenger or commercial vehicle. Employees who need to make an emergency call while on the road must first park the vehicle in a safe location.

Failure to follow company policy and refrain from talking on the phone, texting or emailing while driving on or off the job may result in further disciplinary action.

## MOTOR VEHICLE SAFETY POLICY ACKNOWLEDGEMENT

I have reviewed the Georgia Hands-free driving policy. I fully understand the terms of this policy and agree to abide by them.

Employee Signature : \_\_\_\_\_

Courtesy of Hutchinson Traylor Insurance Company

200 Broad Street Lagrange, GA 30240 · 706-884-2361

[www.hutchinsontraylor.com](http://www.hutchinsontraylor.com)

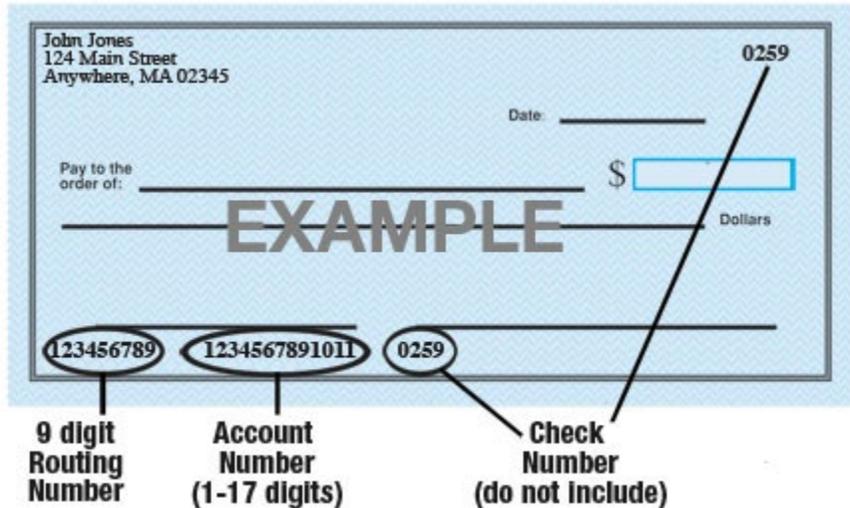
# Direct Deposit Authorization Form

Please print and complete ALL the information below.

Name: \_\_\_\_\_

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

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



Name of Bank: \_\_\_\_\_

Account #: \_\_\_\_\_

9-Digit Routing #: \_\_\_\_\_

Amount:  \$ \_\_\_\_\_  \_\_\_\_\_% or  Entire Paycheck

Type of Account:    Checking    Savings    (Circle One)

*Please attach a voided check for each bank account to which funds should be deposited.*

Composite Construction Systems, Inc. is hereby authorized to directly deposit my pay to the account listed above. This authorization will remain in effect until I modify or cancel it in writing.

Employee Signature: \_\_\_\_\_

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

**APPLICANT INFORMATION** (Please Print) YWCA Vendor - Composite Construction **Account Number: 101-104731**

Applicant Name: (First Middle Last)	Current Address: (street address)		
Other Name(s) Used: (like Maiden)	City:	State:	Zip:
Gender: * <input type="checkbox"/> Male <input type="checkbox"/> Female	Former Address: (1)		
Social Security Number:*	City:	State:	Zip:
Driver's License Number.: State:	Former Address: (2)		
Date of Birth: * Place of Birth: (City, State, Country)	City:	State:	Zip:

\* This information will be used for purposes of background screening only and will not be used in making any employment decisions.

DISCLOSURE REGARDING BACKGROUND INVESTIGATION

Employer ("the Company") may obtain information about you from a consumer reporting agency for employment purposes. Thus, you may be the subject of a "consumer report" and/or an "investigative consumer report" which may include information about your character, general reputation, personal characteristics, and/or mode of living, and which can involve personal interviews with sources such as your neighbors, friends, or associates, including motor vehicle record (or "driving record") checks, workers compensation records, credit bureau files, employment references, personal references, social networking (i.e. Facebook, Twitter), drug screening, any educational and licensing institution or military branch and to receive any criminal record information pertaining to you which may be in the files of any federal, state or local criminal justice agency in any state. Credit reports will only be requested where such information is substantially related to the duties and responsibilities of the position for which you are applying. These reports may be obtained at any time after receipt of your signed authorization and, if you are hired, throughout your employment. An "investigative consumer report" includes information from personal interviews, except in California where that term means any consumer report. You have the right, upon written request made within a reasonable time after receipt of this notice, to request disclosure of the nature and scope of any investigative consumer report and to request a copy of your report. Please be advised that the nature and scope of the most common form of investigative consumer report obtained with regard to applicants for employment is an investigation into your education and/or employment history conducted by InfoMart, 1582 Terrell Mill Road, Marietta, GA 30067, 800-800-3774 www.infomart-usa.com or another outside organization. The scope of this disclosure and authorization is all-encompassing, however, allowing Employer to obtain from any outside organization all manner of consumer reports and investigative consumer reports now and, if you are hired, throughout the course of your employment to the extent permitted by law. As a result, you should carefully consider whether to exercise your right to request disclosure of the nature and scope of any investigative consumer report.

<b>New York and Maine applicants or employees only:</b> You have the right to inspect and receive a copy of any investigative consumer report requested by Employer by contacting the consumer reporting agency identified directly above. You may also contact the Company to request the name, address and telephone number of the nearest unit of the consumer reporting agency designated to handle inquiries, which Employer shall provide within 5 days.
<b>New York applicants or employees only:</b> Upon request, you will be informed whether or not a consumer report was requested by Employer, and if such report was requested, informed of the name and address of the consumer reporting agency that furnished the report.
<b>Oregon applicants or employees only:</b> Information describing your rights under federal and Oregon law regarding consumer identity theft protection, the storage and disposal of your credit information, and remedies available should you suspect or find that Employer has not maintained secured records is available to you upon request.
<b>Washington State applicants or employees only:</b> Under the Washington Fair Credit Reporting Act, you have the right to ask InfoMart for a written summary of your rights. If you submit a request to Employer in writing, you have the right to get from Employer a complete and accurate disclosure of the nature and scope of the investigative consumer report Employer ordered, if any. If Employer obtains information bearing on your credit worthiness, credit standing or credit capacity, it will be used to evaluate whether you would present an unacceptable risk of theft or other dishonest behavior in the job for which you are being considered.
<b>Minnesota and Oklahoma applicants or employees only:</b> Please check this box if you would like to receive a copy of a consumer report if one is obtained by the Company. <input type="checkbox"/>

**APPLICANT:**

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

Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

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



**Fax BOTH pages to:  
(770) 984-8997**

Applicant Name: (First Middle Last)

**Account Number: 101-104731**

ACKNOWLEDGMENT AND AUTHORIZATION

I acknowledge receipt of the **DISCLOSURE REGARDING BACKGROUND INVESTIGATION** and **A SUMMARY OF YOUR RIGHTS UNDER THE FAIR CREDIT REPORTING ACT** and certify that I have read and understand both of those documents. I hereby authorize the obtaining of "consumer reports" and/or "investigative consumer reports" at any time after receipt of this Acknowledgement and Authorization and, if I am hired, throughout my employment. I understand that, except in California, InfoMart, 1582 Terrell Mill Road, Marietta, GA 30067 800.800.3774 www.infomart-usa.com, and its agents, and/or another outside organization acting on behalf of Employer, and/or Employer itself may rely on this authorization to order additional consumer reports, including investigative consumer reports, from time to time during my employment, as deemed necessary for employment purposes and as allowed by law. I also authorize the following agencies and entities to disclose to InfoMart and its agents, and/or another outside organization acting on behalf of Employer, and/or Employer itself, all information about or concerning me, including, but not limited to: my past or present employers; learning institutions, including colleges and universities; law enforcement and all other federal, state and local agencies; federal, state and local courts; the military; credit bureaus; insurance companies; testing facilities; motor vehicle records agencies; all other private and public sector repositories of information; and any other person, organization, or agency with any information about or concerning me. The information that can be disclosed includes, but is not limited to, information concerning my employment history, earnings history, education, credit history, motor vehicle history, criminal history, military service, drug testing results, and professional credentials and licenses. I agree that a facsimile ("fax") or photographic copy of this Acknowledgement and Authorization shall be as valid as the original.

**New York applicants or employees only:** By signing below, you also acknowledge receipt of Article 23-A of the New York Correction Law.

**California applicants or employees only:** By signing below, you also acknowledge receipt of the **NOTICE REGARDING BACKGROUND INVESTIGATION AND CREDIT CHECKS PURSUANT TO CALIFORNIA LAW**. Please check this box if you would like to receive a copy of an investigative consumer report or consumer credit report if one is obtained by the Company at no charge whenever you have a right to receive such a copy under California law.

**APPLICANT:**

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

Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

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



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