

**The below information MUST ACCOMPANY YOUR NC  
CNA APPLICATION**

**CURRENT DRIVER'S LICENSE OR STATE ISSUED ID CARD \_\_\_\_\_**

**LIABILITY INSURANCE FOR AUTOMOBILE WHEN TRANSPORTING CLIENTS (NC ONLY)**

**NAME OF INSURANCE COMPANY \_\_\_\_\_**

**COPY OF INSURANCE CARD \_\_\_\_\_**

**SOCIAL SECURITY CARD \_\_\_\_\_**

**CERTIFIED NURSING ASSISTANT \_\_\_\_\_**

**CURRENT CPR \_\_\_\_\_**

**CURRENT FIRST AID \_\_\_\_\_**

**TB TEST (WITHIN 24 MONTHS)**

### Employment Application

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

Full Name: \_\_\_\_\_ D.O.B. \_\_\_\_\_ SSN: \_\_\_\_\_

Current Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_

Zip Code: \_\_\_\_\_ County: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Position Applied for: \_\_\_\_\_ Salary Desired: \$ \_\_\_\_\_ C.N.A. \_\_\_ PCA \_\_\_ LPN \_\_\_ RN \_\_\_ Med Tech \_\_\_

Full Time  Part Time When are you available to begin work? \_\_\_\_\_

| Type of School   | Name Of School | Years Completed | Diploma/ Degree |
|------------------|----------------|-----------------|-----------------|
| High School      |                |                 |                 |
| College or Trade |                |                 |                 |
| Professional     |                |                 |                 |
| Other            |                |                 |                 |

Do you drive?  Yes  No

Do you have a car?  Yes  No

First Aid:  Yes  No

CPR:  Yes  No

Current TB Test:  Yes  No

**Employment History:**

| Name Of Company | Company Address | Job Title: | Salary: | Phone Number | Supervisor | Can we contact this employer as a reference? If not, please explain why |
|-----------------|-----------------|------------|---------|--------------|------------|---|
|                 |                 |            |         |              |            |   |
|                 |                 |            |         |              |            |   |
|                 |                 |            |         |              |            |   |

**References:**

| Name Of Reference | Phone Number | Relationship |
|-------------------|--------------|--------------|
|                   |              |              |
|                   |              |              |
|                   |              |              |

**I certify that all statements in this application and any attached documents are true, complete and accurate. I understand that false information may result in rejection or termination of my employment.**

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

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

# Employee's Withholding Certificate

**2020**

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

**Step 1:**  
**Enter Personal Information**

|   |           |   |
|---|-----------|---|
| (a) First name and middle initial   | Last name | (b) Social security number  |
| Address   |           | ▶ Does your name match the name on your social security card? If not, to ensure you get credit for your earnings, contact SSA at 800-772-1213 or go to <a href="http://www.ssa.gov">www.ssa.gov</a> . |
| City or town, state, and ZIP code   |           |   |
| (c) <input type="checkbox"/> Single or Married filing separately  |           |   |
| <input type="checkbox"/> Married filing jointly (or Qualifying widow(er))   |           |   |
| <input type="checkbox"/> Head of household (Check only if you're unmarried and pay more than half the costs of keeping up a home for yourself and a qualifying individual.) |           |   |

**Complete Steps 2-4 ONLY if they apply to you; otherwise, skip to Step 5.** See page 2 for more information on each step, who can claim exemption from withholding, when to use the online estimator, and privacy.

**Step 2:**  
**Multiple Jobs or Spouse Works**

Complete this step if you (1) hold more than one job at a time, or (2) are married filing jointly and your spouse also works. The correct amount of withholding depends on income earned from all of these jobs.

Do **only one** of the following.

- (a) Use the estimator at [www.irs.gov/W4App](http://www.irs.gov/W4App) for most accurate withholding for this step (and Steps 3-4); or
- (b) Use the Multiple Jobs Worksheet on page 3 and enter the result in Step 4(c) below for roughly accurate withholding; or
- (c) If there are only two jobs total, you may check this box. Do the same on Form W-4 for the other job. This option is accurate for jobs with similar pay; otherwise, more tax than necessary may be withheld . . . . .

**TIP:** To be accurate, submit a 2020 Form W-4 for all other jobs. If you (or your spouse) have self-employment income, including as an independent contractor, use the estimator.

**Complete Steps 3-4(b) on Form W-4 for only ONE of these jobs.** Leave those steps blank for the other jobs. (Your withholding will be most accurate if you complete Steps 3-4(b) on the Form W-4 for the highest paying job.)

**Step 3:**  
**Claim Dependents**

If your income will be \$200,000 or less (\$400,000 or less if married filing jointly):

Multiply the number of qualifying children under age 17 by \$2,000 ▶ \$ \_\_\_\_\_

Multiply the number of other dependents by \$500 . . . . . ▶ \$ \_\_\_\_\_

Add the amounts above and enter the total here . . . . . **3** \$ \_\_\_\_\_

**Step 4 (optional):**  
**Other Adjustments**

(a) **Other income (not from jobs).** If you want tax withheld for other income you expect this year that won't have withholding, enter the amount of other income here. This may include interest, dividends, and retirement income . . . . . **4(a)** \$ \_\_\_\_\_

(b) **Deductions.** If you expect to claim deductions other than the standard deduction and want to reduce your withholding, use the Deductions Worksheet on page 3 and enter the result here . . . . . **4(b)** \$ \_\_\_\_\_

(c) **Extra withholding.** Enter any additional tax you want withheld each pay period . . . . . **4(c)** \$ \_\_\_\_\_

**Step 5:**  
**Sign Here**

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

▶ \_\_\_\_\_  
**Employee's signature** (This form is not valid unless you sign it.)

▶ \_\_\_\_\_  
**Date**

**Employers Only**

Employer's name and address

First date of employment

Employer identification number (EIN)

**COMMUNITY HEALTH CARE, INC.**

**Title:** Home Health Provider

**Purpose:** Home Health Provider is responsible for rendering safe and adequate services to individuals in their private home environment. Supportive services of home management, personnel care and respite/custodial supervision will enable individuals to remain in their homes without premature institutionalization.

**Hours:** 35 Hours per week

**QUALIFICATIONS:**

- High School Diploma
- CPR Certification
- Current Criminal Record Report

**KNOWLEDGE, SKILLS AND ABILITIES**

- Must have understanding of disabled, aged and frail individuals requiring services
- Must understand the needs of caregivers
- Must be able to communicate well
- Must be able to deliver the level of home management and personal care required for assigned clients
- Must be able to demonstrate competency in correctly performing tasks as required through recommended training

**LINE OF AUTHORITY:**

Home Health Provider is guided by the Home Health Supervisor.

**DUTIES:**

- Provide home management services which are essential to client's care
- Assist with personal care such as, bathing, care of mouth, skin and hair
- Assist with ambulation
- Provide respite/custodial care
- Assist with self-administration of medications which are ordered by a physician or other authorized person by state law to prescribe
- Record and report changes in client's condition, family situation or needs to the appropriate professional
- Complete appropriate reports of hours worked and tasks performed
- Participate in ongoing staff in-service training and development

**OVERTIME STATUS:**

Non-exempt      Salary: \$7.25-13.50 per hour

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

**Declination Form**

The Federal Occupational Safety and Health Administration (OSHA) which address occupational exposure to bloodborne pathogens requires that vaccinations for Hepatitis B be made available to all employees who have occupational exposure to bloodborne pathogens. Community health Care, Inc. will incur all cost for employees or volunteers to receive the Hepatitis B vaccination. Prior approval is needed by the Agency director before an employee takes the vaccination.

I have been informed of OSHA requirements and understand the need or purpose of the vaccination but I decline to take the Hepatitis B vaccination.

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

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

**Employee Statement of Acknowledgement**

This is to acknowledge that I have received a copy of Community Health Care, Inc.'s personnel policies and procedures. I understand that it provides guidelines and summary information about Community Health Care, Inc. personnel policies, procedures, benefits and rules of conduct. I also understand that it is my responsibility to read, understand, become familiar with and comply with the standards that have been established. I further understand that Community Health Care, Inc. reserves the right to modify, supplement, rescind or revise any provision, benefit, or policy from time to time, with or without notice, as it deems necessary or appropriate.

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

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

**Transportation Waiver**

I consent and agree transporting of clients and family caregivers during work hours and for completing required task activities will be my sole responsibility for assuring that proper liability insurance is kept current on all of the vehicles used for this purpose. Further, I accept full risk of liability for any expense, damage, loss of property or injury that may occur while transporting clients and family caregivers during approved work hours; and that the agency, Community Health Care, Inc. will not be liable for such aforementioned conditions involving accident liabilities.

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

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

**Medication Administration**

I understand that I am not to administer medication unless I have a current Medication Technician's license issued by the North Carolina Board of Nursing. I also understand that I am not to administer medication unless the Agency's Registered Nurse (RN) has delegated the task on the client's Plan of Care.

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

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

**WAIVER OF LIABILITY FOR WORK PERFORMED  
AFTER CLIENT SCHEDULED HOURS AND  
VOLUNTEERSERVTCES**

I understand any work activities or visits performed by me after completing authorized hours according to my Work Schedule for clients receiving official home care/health services through Community Health Care is my sole responsibility regarding any type of risk of liability that may be incurred after approved hours. Therefore, I agree that any expense, damage, accident or loss is not the liability of Community Health Care.

I further agree that if I am assisting clients through Community Health Care in a Volunteer capacity, the agency also is released from any expense, damage, accident or loss that may be incurred at any time with work, activities or visits.

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

**NOTICE OF NO SMOKING IN CLIENTS' HOMES**

According to the Division of Health Service Regulations, a bill was issued in effect October 1, 2007 which prohibits the smoking by employees in homes of their clients. As employees of Community Health Care, you are, hereby, notified of this bill and required to follow this "No Smoking in Clients' Homes" notice. Violators will be subject to disciplinary action.

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

**NOTICE OF NON-PAYMENT OF SERVICE HOURS PROVIDED  
TO CLIENT WHEN DENIAL OF CLAIM BY MEDICAID**

I am hereby notified of non-payment of service hours provided by me to clients who are denied claim reimbursement from Medicaid to the agency due to hospitalization, ineligible for services due to Medicaid expiration, inpatient skilled nursing facility service, adult care home or any other conditions described by Medicaid to be non-reimbursable for Personal Care Services.

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

**Use of Confidential Information by Employee**

I as an Employee of Community Health Care do hereby acknowledge that I must comply with a number of State and Federal Laws which regulate the handling of confidential and personal information regarding both customers/clients of this company and its other employees. These laws may include but not be limited to FACTA, The Privacy Act, GrammLeachBliley, and ID Theft Laws (where applicable). I understand that I must maintain the confidentiality of ALL documents, credit card information, and personal information of any type and that such information may be used only for the intended business purpose. Any other use of said information is strictly prohibited. Additionally, should I misuse or breach, any personal information of said clients and/or employee; I understand I will be held fully accountable both civilly and criminally, which may include, but not limited to Federal and State fines, criminal terms, real or implied financial damages incurred by the client, employee, or this company.

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

**Employee Non-Compete Clause**

I \_\_\_\_\_, understand when a client recruited by Community Health Care is assigned to me and I later terminate the assignment from the Agency, I cannot be placed with the client for 90 days under another working relationship. If another working relationship outside of Community Health Care is formed, a finder's fee of \$500.00 will be charged by deducting money owed from my pay.

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

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

**Required Employee Certifications**

It is required that First Aid (\$35), CPR (\$35), current TB Test (\$40) and a Criminal Background Check be submitted to the office of Community Health Care within 14 days of hiring. Criminal Background: State Name Check \$10, State Finger Print \$14, and National Fingerprint Check \$38. You will be charged for each document not turned in after 30 days by payroll deduction.

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

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

**Property Damages and Bodily Injuries Responsibility**

I \_\_\_\_\_ consent and agree that property damages to the structure of the client's dwelling inside and outside which includes such things, and is not limited to frame, windows, furniture, lawn, trees and shrubberies are my responsibilities. I further accept full responsibility and liability for any expenses, damages, losses of personal properties of client, family, friends, and whosoever is present inside or outside the home for which I am involved during approved work hours. It is also my responsibility to be accountable for any bodily injuries that may occur on my behalf to client, family, friends and whosoever is present inside and outside the home during approved work hours.

Community Health Care Inc. will not be liable for such aforementioned conditions involving negligence or accidents that are not covered under the company's General Liability insurance client.

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

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

**Required Drug Testing**

To ensure the well being of our clients and the proper use of techniques by our employees, we are enforcing safety within the work environment. Therefore, in case of an injury or any type of accident involving you and or the client, you are required to submit to a drug test within 24 hours of the occurrence from a reputable facility such as a hospital, doctors office, Urgent Care and Laboratory Centers.

My signature below indicates that I have been made aware of this required personnel procedure.

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

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



**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 (See instructions)  |   |
| <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): _____<br>Some aliens may write "N/A" in the expiration date field. (See instructions)  |   |
| <p>Aliens authorized to work must provide only one of the following document numbers to complete Form I-9:<br/>         An Alien Registration Number/USCIS Number OR Form I-94 Admission Number OR Foreign Passport Number.</p> <p>1. Alien Registration Number/USCIS Number: _____<br/> <b>OR</b><br/>         2. Form I-94 Admission Number: _____<br/> <b>OR</b><br/>         3. Foreign Passport Number: _____<br/>         Country of Issuance: _____</p> | QR Code - Section 1<br>Do Not Write In This Space |

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

**Preparer and/or Translator Certification (check one):**

I did not use a preparer or translator.     A preparer(s) and/or translator(s) assisted the employee in completing Section 1.  
 (Fields below must be completed and signed when preparers and/or translators assist an employee in completing Section 1.)

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

|                                     |  |                           |                |
|-------------------------------------|--|---------------------------|----------------|
| Signature of Preparer or Translator |  | Today's Date (mm/dd/yyyy) |                |
| Last Name (Family Name)             |  | First Name (Given Name)   |                |
| Address (Street Number and Name)    |  | City or Town              | State ZIP Code |

● *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.")*

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

List A                                      OR                                      List B                                      AND                                      List C  
 Identity and Employment Authorization                                      Identity                                      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 <div style="border: 1px solid black; width: 100%; height: 100%;"></div>                                 |                                      |
| Issuing Authority                    |  |                                      |
| Document Number                      |  |                                      |
| Expiration Date (if any)(mm/dd/yyyy) |  |                                      |
| Document Title                       | OR Code - Sections 2 & 3<br>Do Not Write In This Space <div style="border: 1px solid black; width: 100%; height: 100%;"></div> |                                      |
| 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 |          |
| Last Name of Employer or Authorized Representative                   | First Name of Employer or Authorized Representative | Employer's Business or Organization Name       |          |
| Employer's Business or Organization Address (Street Number and Name) | City or Town  | State  | ZIP Code |

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

|                                    |                         |                |  |
|------------------------------------|-------------------------|----------------|--|
| <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 |
|--|---------------------------|---|

## LISTS OF ACCEPTABLE DOCUMENTS

**All documents must be UNEXPIRED**

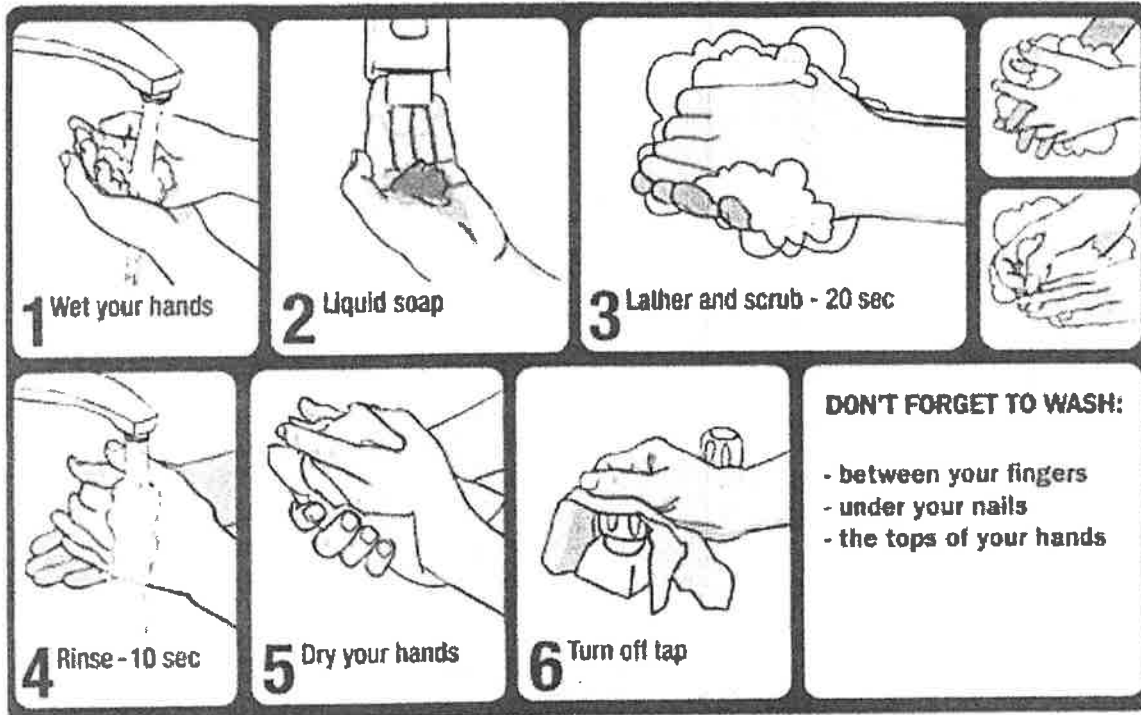
Employees may present one selection from List A  
or a combination of one selection from List B and one selection from List C.

| LIST A<br>Documents that Establish<br>Both Identity and<br>Employment Authorization  | LIST B<br>Documents that Establish<br>Identity   | LIST C<br>Documents that Establish<br>Employment Authorization  |
|--|--|---|
| <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> | <p style="text-align: center;"><b>OR</b></p> <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> | <p style="text-align: center;"><b>AND</b></p> <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.**

## How to wash your hands properly



By signing this form, you confirm that you have completed and understand the procedures for washing your hands. If you have questions or concerns, please contact the office at 301-341-2273 (Maryland location) or 335-285-7001 (North Carolina location).

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Employee Signature