SOUTHEAST PERSONNEL LEASING, INC.

SPLI Fax Numbers

Payroll:	(727) 437-0000
New Client Setup:	(727) 682-6003

SOUTH EAST PERSONNEL LEASING, INC. (SPLI*) EMPLOYEE LEASING APPLICATION *(SOLICITUD PARA CONTRATO DE EMPLEADOS ARRENDADOS)*

* **Client Company Name** *(Compañia del Cliente)* _____ **Location** *(Ubicación)* **(if multiple client locations/offices exist)** _____

SECTION 1 – TO BE COMPLETED BY THE EMPLOYEE *(SECCIÓN 1 – PARA SER COMPLETADO POR EL SOLICITANTE)*

* **Last Name** *(Apellido)* _____ * **First Name** *(Primer Nombre)* _____ **MI** *(Initial del segundo)* _____ * **SSN** *(Numero de Seguro Social)* _____

* **Applicant Address** *(Dirección del Solicitante)* _____ **Apt/Lot/Unit/etc** *(Apt. o lote)* _____ * **City** *(Ciudad)* _____ * **State** *(Estado)* _____ * **Zip Code** *(Codigo postal)* _____

Phone Number *(Numero de Teléfono)* _____ * **Application Date** *(Fecha de Aplicación)* _____ * **Birthdate** *(Fecha de Nacimiento)* _____ **Email Address** *(Correo Electrónico)* _____

Federal Tax Filing Status and Allowances (refer to Form W-4 for instructions) *(Estado civil y exenciones de Federales - consulte el formulario W-4 para obtener instrucciones)*

* **Status** *(estado)* Check one *(marque uno)*

☐ **Single** *(Soltero)* ☐ **Married** *(Casado)* ☐ **Married but withhold at higher Single rate** *(Casado, pero retiene con la tasa mayor de Soltero)* ☐ **Exempt** *(Exento)*

Total number of allowances *(Número total de exenciones)* _____

Additional amount you want withheld each paycheck *(Cantidad adicional)* $_____

EEO Data: We are subject to certain government recordkeeping and reporting requirements for the administration of civil rights laws and regulations. To comply with these laws, we invite you to voluntarily self-identify your race or ethnicity and gender. Submission of this information is voluntary and refusal to provide it will not subject you to any adverse treatment. The information obtained will be kept confidential and may only be used in accordance with the provisions of applicable laws, executive orders and regulations, including those that require the information to be summarized and reported to the federal government for civil rights enforcement. When reported, data will not identify any specific individual. *(Nosotros estamos sujetos a ciertos requerimientos de compilación de datos y reportes para la administración de leyes y regulaciones de los derechos civiles. Para cumplir con estas leyes, te invitamos a voluntariamente identificar tu raza y género. Proveer está información es voluntario y negarse a suministrarla no traerá ninguna consecuencia adversa. La información obtenida se mantendrá confidencial y solamente se utilizara de acuerdo con las leyes aplicables, ordenanzas y regulaciones ejecutivas incluyendo aquellas que requieren el resumen y reporte de la información al gobierno federal para el cumplimiento de derechos civiles. Cuando se reporten, estos datos no identificaran a ningún individuo en específico.)*

Gender: ☐ **M** ☐ **F** **Ethnicity:** ☐ **White/ Caucasian** ☐ **Black/African American** ☐ **Hispanic/ Latino** ☐ **Asian** ☐ **American Indian/ Alaskan Native** ☐ **Hawaiian/ Pacific Islander** ☐ **Two or More Races**

I understand and agree to the following: I am not yet a leased employee of SPLI. If I suffer an injury or have suffered an injury related to work while working for the Client Company but before I am accepted as a leased employee by SPLI, the Client Company (not SPLI) will be responsible for providing Workers' Compensation Coverage, even if I am paid by SPLI or subsequently accepted as an employee of SPLI. I will not be accepted as an employee of SPLI, and workers' compensation coverage will not be provided by SPLI for any accidents until after all pages of the SPLI Employee Leasing Application are completed and signed by me, the complete SPLI Employee Leasing Application is delivered to SPLI, and SPLI accepts me as a leased employee. The SPLI Employee Leasing Application includes all of the following documents: This page, the Applicant Acknowledgement, the Safe Working Practices Acknowledgement, Acknowledgement of the Post Accident/Reasonable Suspicion Program, Acknowledgement of Alcohol and Drug Policy, Form I-9, and Form W-4. The complete Form I-9, and Form W-4, including instructions, can be obtained at https://spli.com/docs.php. *(Yo entiendo y estoy de acuerdo con lo siguiente: Aún no soy un empleado contratado de South East Personnel Leasing, Inc. (SPLI). En consecuencia, si yo sufriera una lesión o hubiera sufrido una lesión relacionada con el trabajo mientras trabajaba para la Compañía Cliente y antes de ser aceptado como un empleado contratado por SPLI, la Compañía Cliente será responsable de esa lesión. No se procesará la Planilla de Pago y no se proporcionará cobertura de Compensación Obrera hasta y a menos que todas las páginas de la aplicación de SPLI para contrato de empleados, hayan sido llenadas y firmadas por el Solicitante, se haya sido entregada a SPLI y SPLI haya aceptado al Solicitante como un empleado contratado. La Solicitud de SPLI de Contratación de Empleados incluye la totalidad de los siguientes documentos: Esta página, el Reconocimiento del Solicitante, el Reconocimiento de Prácticas de Seguridad en el Trabajo, el Reconocimiento del Programa de Sospecha Razonable Posterior al Accidente, el Formulario I-9 y el Formulario W-4. La versión completa del Formulario I-9 y el Formulario W-4, incluyendo las instrucciones, se pueden obtener en https://spli.com/docs.php.)*

_____ _____

* **Applicant Signature** ***(Firma del Solicitante)*** * **Date** ***(Fecha)***

SECTION 2 – TO BE COMPLETED BY THE CLIENT COMPANY *(SECCIÓN 2 – PARA SER COMPLETADO POR EL CLIENTE)*

* **Original Hire Date with Client** *(Fecha original de empleo con el Cliente)* _____ * **Job Description** *(Descripción del Trabajo)* _____

* **Work State** *(Estado de Trabajo)* _____ **W/C Code** *(Codigo de Trabajo)* _____ **Home Department** *(Departamento)* _____ **Employee ID** *(ID de Empleado)* _____

* **Pay Rate and Method** *(Tasa y método de pago)* Must comply with FLSA guidelines *(debe cumplir con las directrices)*

☐ Hourly *(por Hora)* $_____
☐ Salary *(Salario)* $_____
☐ Commission/Piecework *(Comisión/Pagos por pieza)*

☐ Check if salary employee qualifies for OT exemption *(empleado califica para la excepción de horas extras)*

* **Pay Cycle** *(Ciclo de Paga)*

☐ Weekly *(Semanal)*
☐ Bi-Weekly *(Quincenal)*
☐ Other *(Otros)*: _____

* **Employment Type** *(Tipo de Empleo)*

☐ FT Employee (> 30 hours avg. per week) – *empleado a tiempo completo (promedio > 30 hrs por semana)*
☐ PT Employee (< 30 hours avg. per week) – *empleado a tiempo parcial (promedio < 30 hrs por semana)*
☐ Variable Hour Employee (cannot determine whether the employee will avg. at least 30 hours per week) – *empleado de horas variables (no se puede determinar si el empleado va promediar al menos 30 hrs por semana)*
☐ Seasonal Employee (< 6 consecutive months worked during calendar year) – *empleado de temporada (trabajando 6 meses consecutivos durante el año calendario)*

*(SPLI) means South East Personnel Leasing, Inc and its subsidiaries (SPLI) significa South East Personnel Leasing, Inc y its subsidiaries

FL – Revised 3/1/2018

* **Required Fields (Los Campos Obligatorios)**

APPLICANT ACKNOWLEDGEMENT *(RECONOCIMIENTO DEL SOLICITANTE)*

I, the undersigned applicant, acknowledge by my signature that I have been informed that if accepted as a leased employee of SPLI I will be leased to: _____ (Client Company). I further understand that if accepted as a leased employee of SPLI, either SPLI or I can terminate our relationship at any time, as I will be an at-will leased employee of SPLI. I also understand and agree that if accepted, while I am a leased employee of SPLI, if SPLI does not receive payment from the Client Company for services which I perform, SPLI will still pay me the applicable minimum wage (or the legally required overtime pay, at the applicable minimum wage rate, in a workweek in which I have worked overtime) for any such pay period and I agree to this method of compensation.

As a term of employment with SPLI, I understand and agree that all of my compensation for work done for the Client Company must be paid by SPLI. It is expressly prohibited for me to accept compensation from any source other than SPLI for work done for the Client Company without the express written consent from SPLI. The moment I accept compensation from any source other than SPLI for work performed for the Client Company without SPLI's written consent, my employment with SPLI will be automatically terminated/dissolved, effective the beginning of the pay period in which I received that compensation, even if SPLI is not yet aware of it and even if SPLI continues to pay me. Therefore, I understand and agree that if I receive any compensation from any source other than SPLI for work done for the Client Company without SPLI's written consent, I will be considered an employee of that source and not an employee of SPLI. I understand and agree that this means that if I get paid by any source other than SPLI for work done for the Client Company without SPLI's written consent and I get hurt while working, I will not be an employee of SPLI and will, therefore, not be covered by SPLI or SPLI's workers' compensation policy. This paragraph does not apply to tips from patrons.

I also agree to comply with any drug/alcohol testing policy, which SPLI has or may adopt. I specifically agree to post-accident drug/alcohol testing after every work injury regardless of whether I am able to give consent at that time. This document is my authority to post-accident drug/alcohol testing in all instances. SPLI is in agreement with the Federal Government that marijuana is a controlled substance and will not recognize medical marijuana as a legitimate prescription. A positive test result for marijuana will be treated the same as any other positive test result, even if an employee has a medical marijuana prescription. I acknowledge that I am required to promptly report all incidents of discrimination, harassment, or retaliation, regardless of the offender's identity or position, to the Client Company. I further acknowledge that the Client Company is responsible for investigating my complaint and taking appropriate action, if any is determined to be necessary, to end or remediate the discrimination or retaliation. I further acknowledge and agree that because SPLI does not have actual control over my work with the Client Company, and as such is not in a position to know of any alleged discrimination, harassment, or retaliation, all action to end or remediate any discrimination, harassment, or retaliation must come solely from the Client Company.

Yo, el solicitante infrascrito, reconozco atravez de mi firma que se me ha informado que si me aceptan como un empleado arrendado por SPLI seré arrendado a: _____ (Compañía del Cliente). Al igual entiendo que si me aceptan como empleado arrendado de SPLI, cualquier SPLI o Yo podemos terminar nuestra relación en cualquier momento, ya que seré un empleado arrendado de SPLI por mi propia voluntad. Yo también entiendo y estoy de acuerdo que si soy aceptado, mientras sea un empleado arrendado de SPLI, si SPLI no recibe pago por parte de la Compañía del Cliente por los servicios que yo preste, SPLI me pagara el salario mínimo aplicable (o el pago por tiempo extra exigido por la ley, a la tasa de salario aplicable en una semana de trabajo durante la cual yo haya laborado tiempo extra) por cualquier periodo de pago y yo estoy de acuerdo con este método de Compensación.

Como un término de empleo con SPLI, yo entiendo y estoy de acuerdo que toda mi Compensación por trabajo prestado mediante a la Compañía del Cliente debe de ser pagada atravez de SPLI. Esta expresamente prohibido el aceptar Compensación de cualquier otra fuente que no sea SPLI por trabajo prestado para la Compañía del Cliente sin el consentimiento por escrito de SPLI. En el momento que Yo acepte Compensación de otra fuente que no sea SPLI por trabajo prestado para la Compañía del Cliente sin el consentimiento por escrito de SPLI, mi empleo con SPLI sera automáticamente terminado/disuelto, efectivamente iniciando el periodo de pago en el cual Yo recibí la Compensación, aun si SPLI no este enterado de esto y aun si SPLI continué pagándome. Por lo tanto, Yo entiendo y estoy de acuerdo que si Yo recibo cualquier Compensación de cualquier fuente aparte de SPLI por trabajo prestado para la Compañía del Cliente sin el consentimiento por escrito de SPLI, Yo seré considerado un empleado de esa fuente y no un empleado de SPLI. Yo entiendo y estoy de acuerdo que esto significa que si Yo recibo pago de otra fuente que no sea SPLI por trabajo prestado para la Compañía del Cliente sin el consentimiento por escrito de SPLI y me lastimo mientras estoy haciendo mi trabajo, no seré un empleado de SPLI y por lo tanto no seré cubierto por SPLI o por la póliza de Compensación de obreros de SPLI. Este párrafo no se aplica a las propinas de patrones.

Yo también estoy de acuerdo en cumplir con cualquier póliza de pruebas de drogas/alcohol, la cual SPLI pueda adoptar. Yo específicamente estoy de acuerdo en la prueba de drogas//alcohol después de cada accidente en el trabajo aunque Yo no pueda dar consentimiento en ese momento. Este documento es mi autorización a una prueba de drogas//alcohol después de un accidente de trabajo en cualquier caso. SPLI está de acuerdo con el gobierno federal que la marijuana es una substancia controlada y no reconocerá la marijuana médica como prescripción legítima. Un resultado de prueba positivo para la marijuana será tratada igual que cualquier otro resultado de prueba positivo, aunque el empleado tenga una prescripción médica para la marijuana. Yo reconozco que es requerido que reporte prontamente al a Compañía del Cliente, todos incidentes de discriminación, acoso, o venganza, no importa la identificación o posición del ofensor. Yo también reconozco que la Compañía del Cliente es responsable de investigar mis quejas y tomar la acción apropiada, si determinada necesaria, para terminar o remediar la discriminación o venganza. Al igual reconozco y estoy de acuerdo que ya que SPLI no tiene el control actual sobre mi trabajo con la Compañía del Cliente, y como tal no está en posición de saber sobre cualquier alegación de discriminación, acoso, o venganza, todas las acciones para terminar o remediar cualquier discriminación, acoso o venganza deben venir totalmente de la Compañía del Cliente.

SAFE WORKING PRACTICES ACKNOWLEDGEMENT *(RECONOCIMIENTO DE PRACTICAS DE SEGURIDAD DE TRABAJO)*

1. I agree to follow all safety requirements, procedures and practices, including but not limited to those imposed or recommended by: any government entity, OSHA, Client Company, SPLI or any other entity whatsoever without exception.
2. I agree to report any work-related accident, or injury, to my supervisor with the Client Company as soon as it occurs, without exception.
3. If I need treatment for a work-related injury, I agree to:
    A. Notify my supervisor with the Client Company of the need for treatment.
    B. Only go to Client Company/SPLI directed physicians for the initial treatment.
    C. On the initial visit, hand carry a Medical Authorization for Treatment form to the authorized treating facility.
    D. Notify SPLI or SPLI's workers' compensation carrier when I am referred to any specialist for treatment.
    E. Only go to SPLI or SPLI's workers' compensation carrier's directed specialists for care.

I understand that failure on my part, to follow the above procedures, could result in disciplinary action, not to exclude termination! I agree to inform SPLI of any safety violations I encounter in the workplace. I also understand that according to Section 440.09 (4) of the Florida Workers' Compensation Law, my compensation benefits could be reduced for any injury, which occurs because of a failure to follow established safety procedures. I understand if I do not report my accident to South East Personnel Leasing, Inc. within 30 days, my claim will be denied for lack of notice.

1. *Yo convengo en seguir todos los requerimientos, procedimientos y prácticas, incluyendo y no limitada a esas impuestas o recomendadas por: cualquier entidad gubernamental, OSHA, Compañía del Cliente, SPLI o cualquier otra entidad cualquiera sin excepción.*
2. *Yo convengo en reportar cualquier accidente relacionado al trabajo, o lesión, a mi supervisor de la Compañía del Cliente tan pronto como ocurra, sin excepción.*
3. *Si Yo necesito tratamiento médico por una lesión relacionada al trabajo, Yo convengo a:*
    a. *Notificar a mi supervisor de la Compañía del Cliente de la necesidad de tratamiento médico.*
    b. *Solo ver un médico asignado por la Compañía del Cliente/SPLI para el tratamiento inicial.*
    c. *En la visita inicial, llevar el formulario Autorización Medica para Tratamiento, para autorizar a esa facilidad proveer tratamiento médico.*
    d. *Notificar a SPLI o portador de Compensación de obreros de SPLI cuando haya sido referido a un especialista para tratamiento médico.*
    e. *Solo ir a especialistas para tratamiento dirigido por SPLI o por el portador de Compensación de obreros de SPLI.*

Yo entiendo que sería una falta de mi parte, si no he de seguir los procedimientos mencionados anteriormente, y puede resultar en una acción disciplinaria, no excluye terminación. Yo convengo a informar a SPLI de cualquier violación a la seguridad que yo encuentre en el lugar de trabajo. Yo también entiendo que de acuerdo a la Sección 440.09 (4) de las Leyes de Compensación de Obreros del Estado de La Florida, mis beneficios de Compensación pueden ser reducidos por cualquier lesión, que haya ocurrido por falta de seguir los procedimientos de seguridad establecidos. Yo entiendo si no reporto mi accidente a South East Personnel Leasing, Inc. en el plazo de 30 días, mi demanda seré negado por falta de aviso.

ACKNOWLEDGEMENT OF THE POST-ACCIDENT/REASONABLE SUSPICION PROGRAM *(RECONOCIMIENTO DEL PROGRAMA DE SOSPECHA RAZONABLE POSTERIOR AL ACCIDENTE)*

I understand that SPLI maintains a Post-Accident/Reasonable Suspicion Program requiring all leased employees to report to work in a substance free condition.

I have read, or had read to me, a copy of this policy and I understand the consequences of violating the policy, including my obligations under the Post-Accident/Reasonable Suspicion Policy. If I did not understand the policy, I have asked for and have received an explanation. I specifically understand that if I am injured on the job and have a confirmed positive test result; refuse to consent or submit to a drug or alcohol test; tamper with or adulterate a drug and/or alcohol specimen, refuse to authorize the release of drug or alcohol test results to Southeast, or otherwise violate this policy I may forfeit all benefits under this state's workers' compensation and unemployment compensation laws. SPLI is in agreement with the Federal Government that marijuana is a controlled substance and will not recognize medical marijuana as a legitimate prescription. A positive test result for marijuana will be treated the same as any other positive test result, even if an employee has a medical marijuana prescription. I understand that as a condition of my continued employment, where reasonable suspicion of drug and/or alcohol use exists, SPLI will require me to undergo substance screening by urinalysis for drugs and blood for alcohol. I hereby agree to submit to such tests including follow up to rehabilitation testing and the required post-accident testing. I further consent to the results of any such drug or alcohol tests being released to SPLI's authorized representative by the Medical Review Officer (MRO). I understand that I am legally authorized to receive a copy of this consent form if requested. The results will not be released to any additional parties without my written authorization, except I acknowledge that SPLI, agents of SPLI'S, and the testing laboratory will have access to the test results and may disclose such results to its attorney in connection with workers' compensation proceedings, and may use the test results when relevant to its defense in other civil or administrative matters. I release any testing facility personnel and/or any physicians who have tested me from any liability arising from a release or use of any and all test results, written reports, medical records and data concerning my test(s) to the appropriate SPLI officials. I further release all SPLI officials from liability arising from the release or use of the test results. I also understand that the Post-Accident/Reasonable Suspicion Policy and related documents are not intended to constitute a contract between the SPLI and me. I acknowledge receipt of a copy of this policy.

Yo entiendo que SPLI mantiene el Programa de Sospecha Razonable Posterior al Accidente requiriendo que todos los empleados arrendados se reporten al trabajo en condición libre de drogas.

He leído, o me han leído, una copia de esta póliza y Yo entiendo las consecuencias de violar la póliza, incluyendo mis obligaciones de la póliza del Programa de Sospecha Razonable Posterior al Accidente. Si Yo no entendí la póliza, he pedido y he recibido una explicación. Yo específicamente entiendo que si me lesiono en el trabajo y rechazo someterme a una prueba de drogas o alcohol o mi resultado es positivo, Yo de tal modo puedo perder mi elegibilidad a todos los beneficios médicos, e indemnificacion de Compensación de obreros. Yo entiendo que como una condición para continuar mi empleo, donde hay sospecha razonable de uso de drogas y o de alcohol, SPLI requerirá que Yo me someta a una prueba urinaria de drogas y de sangre para alcohol. Yo convengo a someterme a estas pruebas incluyendo seguimiento pruebas de rehabilitación y las pruebas requeridas después de un accidente. SPLI está de acuerdo con el gobierno federal que la marijuana es una substancia controlada y no reconocerá la marijuana médica como prescripción legítima. Un resultado de prueba positivo para la marijuana será tratada igual que cualquier otro resultado de prueba positivo, aunque el empleado tenga una prescripción médica para la marijuana. Yo doy consentimiento a que los resultados de cualquier prueba de droga o alcohol hechas por un Oficial de Revisión Médica sean entregada al represéntate autorizado de SPLI. Yo entiendo que yo estoy legalmente autorizado a recibir una copia de este consentimiento en el caso de que yo lo requiera. El resultado no será entregado a ningún partido adicional sin mi autorización por escrito, excepto Yo convengo que SPLI, agentes de SPLI, y el laboratorio de pruebas tendrán acceso al resultado de la prueba y que puedan divulgar este resultado con sus abogados en coneccion a procedimientos de Compensación de obreros, y puedan usar el resultado de la prueba cuando sea relevante a su defensa en casos civiles o administrativos. Yo libero a cualquier personal de la facilidad de pruebas y o cualquier médico quien me haya tomado la prueba de cualquier responsabilidad proveniente de la entrega o de usar cualquier y todos los resultados, reportes escritos, expedientes médicos y datos que traten sobre mi prueba(s) a los oficiales apropiados de SPLI. Yo también libero a todos los oficiales de SPLI de cualquier responsabilidad proveniente de la comunicación o uso de tales resultados. Yo también entiendo que la Póliza del Programa de Sospecha Razonable Posterior al Accidente y los documentos relaciónados no están intencionados para constituir un contrato entre SPLI y Yo. Yo reconozco haber recibído una copia de esta póliza.

ACKNOWLEDGEMENT OF ALCOHOL AND DRUG POLICY *(RECONOCIMIENTO DE PRACTICAS DE SEGURIDAD DE TRABAJO)*

South East Personnel Leasing, Inc. has recognized that drug and alcohol abuse is a social problem, as well as a problem on the job site. We believe the abuse of alcohol and use of illegal drugs endangers the health and safety of the abuser(s) as well as others in the immediate area. South East is committed to maintaining a Post-Accident / Reasonable Suspicion Program without jeopardizing the job security of valued, but troubled employees, provided they seek help. Complying with South East's Post Accident / Reasonable Suspicion Program, as a condition of employment, requires an employee to refrain from reporting to work or working with the presence of illegal drugs or alcohol in his/her body. This prohibition includes the possession, use, or sale of illegal drugs and the abuse of alcohol. Company sponsored events or social activities, at which alcoholic beverages are served and consumed, will not be considered alcohol abuse just because alcohol is served. Employees, who are on the job site, under the influence of alcohol or illegal drugs are violating this policy and may be terminated. To maintain a safer and more rewarding place to work, it is important that we work together when dealing with a substance abuse problem.

SouthEast Personnel Leasing, Inc. reconoce que el abuso de drogas y alcohol es un problema social, al igual que un problema en el lugar de trabajo. Nosotros creemos que el abuso de alcohol y el uso de drogas ilegales ponen en peligro la salud y seguridad del abusador(es) al igual que los demás en su área inmediata. SouthEast esta comprometido a mantener un Programa de Sospecha Razonable Posterior al Accidente sin poner en riesgo la seguridad de empleados valiosos, pero que tiene problemas, siempre y cuando estos soliciten ayuda. Al cumplir con el Programa de Sospecha Razonable Posterior al Accidente de SouthEast, como condición de empleo, requiere que el empleado se abstenga de presentarse a trabajar o que trabaje con la presencia de drogas ilegales o alcohol en su cuerpo. Esta prohibición incluye a la posesión, uso, o venta de drogas ilegales y del abuso de alcohol. Actividades socialeas realizadas por la compañía en las cuales se sirven y se consumen bebidas alcoholicas no seran consideras como abuso de alcohol solo por que se sirva alcohol Empleados, que estén en el lugar de trabajo, bajo la influenza de alcohol o drogas ilegales están violando esta póliza y pueden ser despedido. Para mantener un lugar de trabajo seguro y gratificante, es importante que trabajemos unidos cuando estemos tratando con este problema de abuso de substancias.

I have read, or had read to me, and understand the APPLICANT ACKNOWLEDGEMENT, the SAFE WORKING PRACTICES ACKNOWLEDGEMENT, the ACKNOWLEDGEMENT OF THE POST-ACCIDENT/REASONABLE SUSPICION PROGRAM, and the ACKNOWLEDGEMENT OF ALCOHOL AND DRUG POLICY.

He leído, o se me ha leído, y comprendo el RECONOCIMIENTO DEL SOLICITANTE, el RECONOCIMIENTO DE PRACTICAS DE SEGURIDAD DE TRABAJO, el RECONOCIMIENTO DEL PROGRAMA DE SOSPECHA RAZONABLE POSTERIOR AL ACCIDENTE, y el RECONOCIMIENTO DE POLIZA DE ALCOHOL Y DROGA.

Applicant's Signature *(Firma del Solicitante)*	**Printed Name** *(Nombre Impreso del Solicitante)*	**Date** *(Fecha)*

Form W-4 (2018)

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*.

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 2018 if **both** of the following apply.

- For 2017 you had a right to a refund of **all** federal income tax withheld because you had **no** tax liability, **and**
- For 2018 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 2018 expires February 15, 2019. 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 2018 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*** 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 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 2018. 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 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, 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 Other Income Worksheet on page 3 or the calculator at *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* 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 can 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 might be eligible to claim a credit for each of your qualifying children. To qualify, the child must be under age 17 as of December 31 and must be your dependent who lives with you for more than half the year. 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, during the year.

Line F. Credit for other dependents. When you file your tax return, you might be eligible to claim a credit for each of your dependents that don't qualify for the child tax credit, such as any dependent children age 17 and older. To learn more about this credit, see Pub. 505. 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 income includes all of

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

Form **W-4**
Department of the Treasury
Internal Revenue Service

Employee's Withholding Allowance Certificate

► 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.

OMB No. 1545-0074

2018

1	Your first name and middle initial	Last name	**2 Your social security number**
	Home address (number and street or rural route)	**3** ☐ Single ☐ Married ☐ Married, but withhold at higher Single rate. **Note:** 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.** ► ☐	

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 2018, and I certify that I meet **both** of the following conditions for exemption. • Last year I had a right to a refund of **all** federal income tax withheld because I had **no** tax liability, **and** • This year I expect a refund of **all** federal income tax withheld because I expect to have **no** tax liability. If you meet both conditions, write "Exempt" here . . . . . ►	**7**	

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

Employee's signature
(This form is not valid unless you sign it.) ► **Date** ►

8 Employer's name and address (**Employer:** 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)

Instructions | Acceptable Documents

Employment Eligibility Verification

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

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

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

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

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

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

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

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

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

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

☐ 1. A citizen of the United States

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

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

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

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

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

QR Code - Section 1
Do Not Write In This Space

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

Preparer and/or Translator Certification (check one):

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

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

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

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

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

STOP *Employer Completes Next Page* STOP

Instructions | Acceptable Documents

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

Step 1: Ensure all parts of Form I-9 are properly completed. For complete instructions including the List of Acceptable Documents, please visit https://www.uscis.gov/i-9 or https://www.uscis.gov/i-9-central/.

Step 2 - Employee Info from Section 1 area: Enter the employee's last name, first name, middle initial exactly as he or she entered them in Section 1. This area also includes a Citizenship/Immigration Status field to select the number of the citizenship or immigration status checkbox the employee selected in Section 1.

Step 3 - Document area: You must physically examine, in the employee's physical presence, the unexpired documents(s) the employee presents from the List of Acceptable Documents to complete the Document fields in Section 2. You cannot specify which document(s) an employee may present from the lists. You must examine and record one document from List A OR a combination of one document from List B AND one document from List C. **If the employee presents documents from List B and List C, you must select N/A from List A before you can enter the List B and List C documents**. Refer to I-9 Central for more guidance.

Step 4 - Certification area: Record the employee's first day of employment. The person who physically examines the employee's original document(s) and completes Section 2 must sign and date the form, list their full legal last name and first name and complete the Business name and address fields.

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

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

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

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

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

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

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

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

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

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

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

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

USE BLACK OR BLUE INK ONLY

Form **8850** (Rev. March 2016)

Department of the Treasury
Internal Revenue Service

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

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

OMB No. 1545-1500

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

Your name _____ Social security number ► _____

Street address where you live _____

City or town, state, and ZIP code _____

County _____ Telephone number _____

If you are under age 40, enter your date of birth (month, day, year) _____ Division _____

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

2 ☐ Check here if **any** of the following statements apply to you.

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

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

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

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

6 ☐ Check here if you are a member of a family that:

- Received TANF payments for at least the past 18 months; **or**
- Received TANF payments for any 18 months beginning after August 5, 1997, **and** the earliest 18-month period beginning after August 5, 1997, ended during the past 2 years; **or**
- Stopped being eligible for TANF payments during the past 2 years because federal or state law limited the maximum time those payments could be made.

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

Signature—All Applicants Must Sign

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

Job applicant's signature ► **Date**

U.S. Department Labor
Employment and Training Administration

Individual Characteristics Form (ICF)
Work Opportunity Tax Credit

OMB Control No. 1205-0371
Expiration Date: January 31, 2020

1. Control No. (For Agency use only)	**APPLICANT INFORMATION** **(See instructions on reverse)**	2. Date Received (For Agency Use only)

EMPLOYER INFORMATION

3. Employer Name	4. Employer Address and Telephone	5. Employer Federal ID Number (EIN)
South East Personnel Leasing, Inc.	**2739 US Highway 19 North** **Holiday, FL 34691** **727-938-5562**	**59-3298197**

APPLICANT INFORMATION

6. Applicant Name (Last, First, MI)	7. Social Security Number **USE BLACK OR BLUE INK ONLY**	8. Have you worked for this employer before? Yes ____ No ____ **If YES,** enter last date of employment: _____

APPLICANT CHARACTERISTICS FOR WOTC TARGET GROUP CERTIFICATION

9. Employment Start Date	10. Starting Wage	11. Position

12. Are you at least age 16, but under age 40? Yes ___ No ___
If YES, enter your *date of birth* _____

13. Are you a Veteran of the U.S. Armed Forces? Yes ___ No ___
If NO, go to Box 14.
If YES, are you a member of a family that received Supplemental Nutrition Assistance Program (SNAP) benefits (Food Stamps) for at least 3 months during the 15 months before you were hired? Yes ___ No ___
If YES, enter name of *primary recipient* _____ and *city and state* where benefits were received _____.
OR, are you a veteran entitled to compensation for a service-connected disability? Yes ___ No ___
If YES, were you discharged or released from active duty within a year before you were hired? Yes ___ No ___
OR, were you unemployed for a combined period of at least 6 months (whether or not consecutive) during the year before you were hired? Yes ___ No ___

14. Are you a member of a family that received Supplemental Nutrition Assistance Program (SNAP) (formerly Food Stamps) benefits for the 6 months before you were hired? Yes ___ No___
OR, received SNAP benefits for at least a 3-month period within the last 5 months **But** you are no longer receiving them? Yes ___ No___
If YES to either question, enter name of *primary recipient* _____ and city And *state* where benefits were received _____.

15. Were you referred to an employer by a Vocational Rehabilitation Agency approved by a State? Yes ___ No___
OR, by an Employment Network under the Ticket to Work Program? Yes ___ No___
OR, by the Department of Veterans Affairs? Yes ___ No___

16. Are you a member of a family that received TANF assistance for at least the last 18 months

50537

before you were hired? Yes___ No___

OR, are you a member of a family that received TANF benefits for **any** 18 months beginning after August 5, 1997, and the earliest 18-month period beginning after August 5, 1997, ended within 2 years before you were hired? Yes___ No___

OR, did your family stop being eligible for TANF assistance within 2 years before you were hired because a Federal or state law limited the maximum time those payments could be made? Yes___No___

If NO, are you a member of a family that received TANF assistance for any 9 months during the 18-month period before you were hired? Yes___No___

If YES, to any question, enter name of *primary recipient* _____ and the *city and state* where benefits were received _____.

17. Were you convicted of a felony or released from prison after a felony conviction during the year before you were hired? Yes___No___

If YES, enter *date of conviction* _____ and *date of release* _____.

Was this a Federal ____ or a State conviction____? (Check one)

18. Do you live in an Empowerment Zone or Rural Renewal County (RRC)? Yes__ No __

19. Do you live in an Empowerment Zone and are at least age 16, but not yet 18, on your hiring date? Yes__ No__

20. Did you receive Supplemental Security Income (SSI) benefits for any month ending within 60 days before you were hired? Yes__ No__

21. Are you a veteran unemployed for a combined period of at least 6 months (whether or not consecutive) during the year before you were hired? Yes__ No__

22. Are you a veteran unemployed for a combined period of at least 4 weeks but less than 6 months (whether or not consecutive) during the year before you were hired? Yes__ No__

23. Are you an individual who is or was in a period of unemployment that is at least 27 consecutive weeks and for all or part of that period you received unemployment compensation? Yes__ No__

If YES, what state did you receive unemployment compensation in? _____

(Enter state where UI compensation was received)

24. **Sources used to document eligibility:** (**Employers/Consultants:** List all documentation provided or forthcoming. **For SWA Staff:** List all documentation used in determining target group eligibility and enter your initials and date when the determination was made.

I certify that this information is true and correct to the best of my knowledge. I understand that the information above may be subject to verification.

25(a). Signature: (See instructions in Box 25.(b) for who signs this signature block)	25.(b) Indicate with a ✓ mark who signed this form: ☐ Employer, ☐ Consultant, ☐ SWA, ☐ Participating Agency, ☑ Applicant, or ☐ Parent/Guardian (if applicant is a minor)	26. Date:

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

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

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

New Hire's Signature: _____Date_____

New Hire Name: _____

Social Security Number: _____-☐☐☐☐
(Enter last four digits)

Employer Name: **South East Personnel Leasing, Inc.**

Please check the statements below if they apply to you.

☐ I declare that I was in a period of unemployment that is at least 27 consecutive weeks and for all or part of that period I received unemployment compensation.

☐ I declare that I have been in a period of unemployment since _____.
(Enter start date)
(MM/DD/YYYY)

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

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

DEDUCTION AUTHORIZATION *(AUTORIZACION DE DEDUCCIÓN)*

Employee Name *(Nombre del Empleado)*: ______________________________ SSN *(Número de Seguridad Social)*: ______________

Client Name *(Compañia del Cliente)*: ____

Payroll Deductions *(Deducciones de Nómina)* ○ Yes, I have payroll deductions *(Sí, tengo deducciones de nómina)* ○ No, I do not have payroll deductions *(No, no tengo deducciones de nómina)* Initials *(Iniciales)*: _______

	Type of Deduction (Uniform, Loan, Advance, etc.) *(Tipo de deduccion: uniforme, prestamo, adelanto, etc.)*	Payroll Commencement Date *(Fecha de Comienzo de Nomina)*	Total Amount of Deduction *(Cantidad Total De Deucción)*	Amount Per Pay Period *(Cantidad por Periodo de Paga)*
1				
2				
3				
4				

***Child Support (CS) Deductions** **(Deducciones de Manutención)* ○ Yes, I have CS deductions *(Sí, tengo deducciones de Manutención)* ○ No, I do not have CS deductions *(No, no tengo deducciones de Manutención* Initials (*Iniciales*): _______

	State of Order *(Estado de Orden)*	Case # *(Caso #)*	Address for Distribution *(Dirección para distribución)*	Amount Per Pay Period *(Cantidad por Período de Paga)*
1				
2				
3				
4				

***Child Support Order(s) MUST be attached** *(*La orden de manutención debe estar adjunta)*

Benefits Deductions *(Deducciones para Beneficios)*

Benefit deductions will be completed by your worksite employer, if applicable. (Las deducciones para beneficios serán completadas por su compañia cliente empleadora, si aplica.)

Check One *(marque uno)*	Insurance Company Name or Third Party Administrator *(Nombre de la compañía de seguros o Administrador del Plan)*	Type of Deduction Health/Dental/401K/Roth/Simple IRA *(Tipo de Deducción)*	Deduction Begin Date *(Fecha de Comienzo)*	Amount per Pay Period *(Cantidad por Período de Paga)*	
○ New Deduction *(Nueva)* ○ Change Current Amount *(Camio)* ○ Add to Current Amount *(Incrementar)*				Pre-Tax Amount	Post-Tax Amount
Check One *(marque uno)*	Insurance Company Name or Third Party Administrator *(Nombre de la compañía de seguros o Administrador del Plan)*	Type of Deduction Health/Dental/401K/Roth/Simple IRA *(Tipo de Deducción)*	Deduction Begin Date *(Fecha de Comienzo)*	Amount per Pay Period *(Cantidad por Período de Paga)*	
○ New Deduction *(Nueva)* ○ Change Current Amount *(Camio)* ○ Add to Current Amount *(Incrementar)*				Pre-Tax Amount	Post-Tax Amount
Check One *(marque uno)*	Insurance Company Name or Third Party Administrator *(Nombre de la compañía de seguros o Administrador del Plan)*	Type of Deduction Health/Dental/401K/Roth/Simple IRA *(Tipo de Deducción)*	Deduction Begin Date *(Fecha de Comienzo)*	Amount per Pay Period *(Cantidad por Período de Paga)*	
○ New Deduction *(Nueva)* ○ Change Current Amount *(Camio)* ○ Add to Current Amount *(Incrementar)*				Pre-Tax Amount	Post-Tax Amount
Check One *(marque uno)*	Insurance Company Name or Third Party Administrator *(Nombre de la compañía de seguros o Administrador del Plan)*	Type of Deduction Health/Dental/401K/Roth/Simple IRA *(Tipo de Deducción)*	Deduction Begin Date *(Fecha de Comienzo)*	Amount per Pay Period *(Cantidad por Período de Paga)*	
○ New Deduction *(Nueva)* ○ Change Current Amount *(Camio)* ○ Add to Current Amount *(Incrementar)*				Pre-Tax Amount	Post-Tax Amount

I hereby authorize SouthEast Personnel Leasing, Inc. (SPLI) to make the above deductions from my pay in accordance with the above terms. I understand and agree that I am responsible for satisfying the above amounts. I further understand and agree that deductions will be made after any federal or state requirements as well as for any SPLI or ______________________________ (Client Name) programs in which I have enrolled, for which I am eligible, or to which I have agreed.

Por este medio autorizo a SouthEast Personnel, Inc (SPLI) a hacer las susodichas deducciones de mi paga de acuerdo con los susodichos terminos. Entiendo y estoy de acuerdo que soy responsable de satisfacer las susodichas cantidades. Comprendo aún más y concuerdo que deducciones serán hechas después de cualquier exigencia federal o estatal así como para cualquier SPLI o ______________________________ (nombre del cliente) programas en los cuales me he matriculado, por los que soy elegible, o con que he estado de acuerdo.

Employee Signature *(Firma del Solicitante)*: ______________________________ Date *(Fecha)*: ______________

Client Representative Signature (*Firma del representante del cliente)*: ______________________________ Date *(Fecha)*: ______________