Oneida Sales and Service, Inc.

Corporate Headquarters:
155 Commerce Drive
Lackawanna, NY 14218

APPLICATION FOR EMPLOYMENT

This application is for all positions without regard to race, color, religion, sex, national origin, age, marital or veteran status, the presence of non-job related medical condition or handicap or any other legally protected status.

PERSONAL INFORMATION

Date: _____ Social Security Number _____

Name: _____
First Middle Last

Address: _____
Street City State Zip

Home Phone: ( ) _____ Cell Phone: ( ) _____

If hired can you furnish proof that you are either a U.S. citizen or a non-citizen entitled to work in the United States? Y ☐ N ☐

Are you under 18 years of age now? Y ☐ N ☐

Have you ever been convicted of a crime? Y ☐ N ☐ If yes, when? _____

What was the specific charge(s)? _____

EMPLOYMENT DESIRED

Position Applied for _____ Date Available _____

Are you employed now? Y ☐ N ☐ If so, may we contact your present employer? Y ☐ N ☐ Salary Desired_____

Type of employment you are seeking: Full Time ☐ Part Time ☐ Temporary ☐ If temporary from _____ to _____

EDUCATION HISTORY

	Name and Location of School	Circle Last Year Completed	Did You Graduate?	Subjects Studied and Degree(s) Received
High School		1 2 3 4	Yes ☐ No ☐	
Trade, Business or Correspondence School		1 2 3 4	Yes ☐ No ☐	
College		1 2 3 4	Yes ☐ No ☐	
Do you have your OSHA 10-Hour labor card? Yes ☐ No ☐				
Do you have your OSHA 30-Hour labor card? Yes ☐ No ☐				
Are you a member of a union? Yes ☐ No ☐ If yes what is the union name?_____				
Skill level: Journeyman Yes ☐ No ☐ Apprentice Yes ☐ No ☐ If Apprentice, what level (circle one)? 1 2 3 4				

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FORMER EMPLOYERS

List Below Last Three Employers, Starting with Most Recent

Date Month and Year	Name, Address and Telephone # of Employer	Last Pay Rate	Position	Immediate Supervisor	Reason for Leaving
From To					
From To					
From To					

REFERENCES

Give Below the Name of Three Persons Not Related to You, Whom You Have Known at Least One Year

Name	Address	Business	Telephone

I voluntarily give Oneida Sales & Service, Inc. the right to make inquiry of my past employment and activities and to release from all liability and/or responsibility all persons, companies, or corporations supplying such information. I agree to abide by all rules and policies of the Company and I further understand that any direct and/or implied misrepresentation by me on this application or supplemental information will be sufficient grounds for disciplinary actions and/or possible charges. If employed, my employment may be terminated with or without cause, and with or without notice, at any time, at the option of either the company or me, I further understand that no representation, whether oral or written by any representative or agent of the Company, at any time, can constitute a contract of employment. I understand that the Company sand all Plan Administrators shall have the maximum discretion permitted by law to administer, interpret, modify, discontinue, enhance or otherwise change all polices, procedures, benefits or other terms or conditions of employment. No representative or agent of the company, has the authority to enter into any agreement for employment for any specified period of time or to make any change in any policy, procedure, benefit or other term or condition of employment other than in a document signed by the president, or to make any agreement contrary to the foregoing.

I acknowledge that I have read and understand the above statements and hereby grant permission to confirm the information supplied on this application by me.

Signature: _____ Date: _____

Oneida Sales and Service, Inc.

Corporate Headquarters:
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Lackawanna, NY 14218

AUTHORIZATION FOR PAYROLL DEDUCTIONS

Date _____

Employee Name _____

Address _____

City _____ State _____ Zip _____

_____ I understand that I am eligible for benefits under the Group Medical Plan provided by Oneida Sales & Service, Inc. Further, I realize that I am eligible to request coverage at a later date. **Right now I am declining coverage under such Plan and waive all claims to benefits.**

_____ I hereby authorize Oneida Sales & Service, Inc. to deduct from my paycheck each pay period the following benefits:

- ☐ Union Dues
- ☐ Life Insurance
- ☐ Other _____
- ☐ Medical Insurance
- ☐ Dental Insurance
- ☐ Vision Insurance
- ☐ Flexible Spending Account

_____ I understand that any premiums I am obligated to pay for health care coverage for myself and/or my dependents will be deducted from my pay on a BEFORE TAX basis unless I direct otherwise

_____ _____
Date Employee Signature

_____ _____
Date Authorized Signature

Oneida Sales and Service, Inc.

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AUTHORIZATION FOR DIRECT DEPOSIT

Employee Name _____

Social Security Number _____ Date of Request _____

_____ I do not wish to participate in the direct deposit program at this time.

_____ I hereby authorize Oneida Sales & Service, Inc. to direct deposit my payroll to the following account(s) and/or make the followi changes to my existing account(s):

Check one: Add _____ Change _____ Cancel _____

1) Bank Name: _____

Checking _____ Savings _____

Account Number _____ ACH Routing Number _____

Amount to be deposited:

Full Check _____ Balance of Check _____ $ _____

Check one: Add _____ Change _____ Cancel _____

2) Bank Name: _____

Checking _____ Savings _____

Account Number _____ ACH Routing Number _____

Amount to be deposited:

Full Check _____ Balance of Check _____ $ _____

Attach voided check(s), if checking account(s). Attached pre-printed deposit slip(s) with 9-digit routing number, if savings account(s). It may take two full pay periods before the direct deposit begins.

I fully understand that once the deposit(s) has been initiated, all regular payroll processing will result in net payroll amounts being deposited directly into the account(s) indicated above. The deposits will normally take place for availability of funds on the morning of the payday. I understand that occasionally, due to bank holidays, deposits may be unavailable until the next banking day.

In the event that a processing error causes me to receive direct deposit for more than my proper pay amount, I authorize Oneida Sales & Service, Inc. to withdraw the excess amount from my account without advanced notice, additional consent, or further approval.

Note: Management of your bank account is your personal responsibility. Oneida Sales & Service, Inc. assumes no responsibility for overdrawn accounts due to delay in processing. Employees should always first check their account balances to validate deposit information prior to withdrawals.

Employee Signature _____ Date _____

Oneida Sales & Service, Inc.

155 Commerce Drive
Lackawanna, NY 14218

BACKGROUND INVESTIGATION CONSENT

I, _____, hereby authorize Oneida Sales & Service, Inc. and/or its agents to make an independent investigation of my background, references, character, past employment, education, credit history, Motor Vehicle Reports (MVR), criminal or police records, including those maintained by both public and private organizations and all public records for the purpose of confirming the information contained on my Application and/or obtaining other information which may be material to my qualifications for employment now and, if applicable, during the tenure of my employment with Oneida Sales and Service.

I release Oneida Sales & Service, Inc. and /or its agents and any person or entity, which provides information pursuant to this authorization, from any and all of the above referenced sources used.

The following is my true and complete legal name, and all information is true and correct to the best of my knowledge:

_____

Full Name (Printed)

_____

Maiden Name or Other Names Used

_____

Present Address **How Long?**

_____

City/State **Zip Code**

_____

Former Address **How Long?**

_____

City/State **Zip Code**

_____	_____	_____	_____
***Date of Birth**	**Social Security Number**	**Driver's License Number**	**State of License**

Signature_____

***Note: The above information is required for identification purposes only, and is in no manner used as qualifications for employment. Oneida & Sales and Service, Inc. is an Equal Opportunity Employer, and does not discriminate on the basis of Sex, Race, Religion, Age (40 and over), Handicap or National Origin.**

Oneida Sales & Service, Inc.
155 Commerce Drive
Lackawanna, NY 14218

Emergency Contact Sheet

Date: _____

Employee: _____

Signature: _____

Gender: Male Female (Circle one)

Race: _____

Marital Status: Single Married Divorced

Military Veteran: Yes No (Circle one)

Emergency Contact #1

Name: _____

Address: _____

_____

Home Phone: _____ Work Phone: _____

Emergency Contact #2

Name: _____

Address: _____

_____

Home Phone: _____ Work Phone: _____

Voluntary Self-Identification
(Confidential – For Statistical Use ONLY)

We are an equal opportunity employer and do not discriminate on the basis of race, color, religion, sex, age, national origin, disability, veteran status, sexual orientation or any other classification protected by federal, state or local law. The information below will be used only in the compilation of data for affirmative action reporting.

Completion of this data is voluntary and will not affect your opportunity for employment or terms or conditions of employment, if hired. Identification can declared at any time prior to or, if applicable, after hire. Please return this page with your application.

PLEASE COMPELTE IN FULL:

Date: _____ Position applied for: _____

Name: _____

Social Security # _____

Sex: (Circle appropriate response) Male Female

Date of Birth: _____

Applicant's Zip code: _____

RACE/ETHNICITY:
(Please check one of the descriptions below corresponding to the ethnic group with which you most identify.)

___ **Hispanic or Latino** – A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin regardless of race.

___ **White (Not Hispanic or Latino)** – A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.

___ **Black or African American (Not Hispanic or Latino**) – A person having origins in any of the black racial groups of Africa.

___ **Native Hawaiian or Other Pacific Islander (Not Hispanic or Latino)** – A person having origins in any of the peoples of Hawaii, Guam, Samoa, or other Pacific Islanders.

___ **Asian (Not Hispanic or Latino) –** A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian Subcontinent, including (for example) Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.

___ **American Indian or Alaska Native (Not Hispanic or Latino)** – A person having origins in any of the original peoples of North and South America (including Central America), and who maintain tribal affiliation or community attachment.

___ **Two or More Races (Not Hispanic or Latino)** – All persons who identify with more than one of the above five races.

___ **Race missing or unknown** – Applies to Applicants only, where a resume or application that is screened is received without any racial or ethnic identification and no further contact is made with the applicant.

VETERAN STATUS:
(Please check on if it describes your veteran status.*)

___ **SPECIAL DISABLED VETERAN:** Means (A) a veteran who is entitled to compensation (or who, but for the receipt of military retired pay, would be entitles to compensation) under laws administered by the Department of Veteran Affairs for a disability rated at 10 or 20 percent in the case of a veteran who has been determined to have a serious employment disability or (B) a person who was discharged or released from active duty because of a service-connected disability.

___ **VIETNAM ERA VETERAN:** A Vietnam Era Veteran is a person who (1) Served on Active Duty for a period of more than 180 days, any part of which occurred between August 5, 1964, and May 7, 1975, and was discharged or released with other than a dishonorable discharge: (2) was discharged or released from active duty for a service connected disability if any part of such active duty was performed between August 5, 1964, and May 7, 1975; or (3) served on active duty for more than 180 days and served in the Republic of Vietnam between February 28, 1961, and May 7, 1975.

*Veteran status may only be requested after a job offer is made.

Personal and Confidential
This page contains sensitive information, store in secure
“Affirmative Action Forms” files, separately from Personnel records.

NEW YORK STATE 2017

Department of Taxation and Finance

Employee's Withholding Allowance Certificate

New York State • New York City • Yonkers

IT-2104

First name and middle initial	Last name	Your social security number
Permanent home address *(number and street or rural route)*	Apartment number	Single or Head of household ☐ Married ☐
		Married, but withhold at higher single rate ☐
City, village, or post office	State / ZIP code	**Note:** If married but legally separated, mark an ***X*** in the *Single or Head of household* box.

Are you a resident of New York City? ..... Yes ☐ No ☐

Are you a resident of Yonkers? ..... Yes ☐ No ☐

Complete the worksheet on page 3 before making any entries.

1 Total number of allowances you are claiming for New York State and Yonkers, if applicable *(from line 17)*	**1**	
2 Total number of allowances for New York City *(from line 28)*	**2**	

Use lines 3, 4, and 5 below to have additional withholding per pay period under special agreement with your employer.

3 New York State amount	**3**	
4 New York City amount	**4**	
5 Yonkers amount	**5**	

I certify that I am entitled to the number of withholding allowances claimed on this certificate.

Employee's signature	Date

Penalty – A penalty of $500 may be imposed for any false statement you make that decreases the amount of money you have withheld from your wages. You may also be subject to criminal penalties.

Employee: detach this page and give it to your employer; keep a copy for your records.

Employer: Keep this certificate with your records.

Mark an ***X*** in box A and/or box B to indicate why you are sending a copy of this form to New York State *(see instructions)*:

A Employee claimed more than 14 exemption allowances for NYS ..... A ☐

B Employee is a new hire or a rehire ... B ☐ First date employee performed services for pay *(mm-dd-yyyy) (see instr.)*:

Are dependent health insurance benefits available for this employee? ..... Yes ☐ No ☐

If *Yes*, enter the date the employee qualifies *(mm-dd-yyyy)*:

Employer's name and address *(Employer: complete this section only if you are sending a copy of this form to the NYS Tax Department.)*	Employer identification number

Instructions

Changes effective for 2017

Form IT-2104 has been revised for tax year 2017. The worksheet on page 3 and the charts beginning on page 4, used to compute withholding allowances or to enter an additional dollar amount on line(s) 3, 4, or 5, have been revised. If you previously filed a Form IT-2104 and used the worksheet or charts, you should complete a new 2017 Form IT-2104 and give it to your employer.

Who should file this form

This certificate, Form IT-2104, is completed by an employee and given to the employer to instruct the employer how much New York State (and New York City and Yonkers) tax to withhold from the employee's pay. The more allowances claimed, the lower the amount of tax withheld.

If you do not file Form IT-2104, your employer may use the same number of allowances you claimed on federal Form W-4. Due to differences in tax law, this may result in the wrong amount of tax withheld for New York State, New York City, and Yonkers. Complete Form IT-2104 each year and file it with your employer if the number of allowances you may claim is different from federal Form W-4 or has changed. Common reasons for completing a new Form IT-2104 each year include the following:

- You started a new job.
- You are no longer a dependent.
- Your individual circumstances may have changed (for example, you were married or have an additional child).
- You moved into or out of NYC or Yonkers.
- You itemize your deductions on your personal income tax return.
- You claim allowances for New York State credits.
- You owed tax or received a large refund when you filed your personal income tax return for the past year.
- Your wages have increased and you expect to earn $107,650 or more during the tax year.
- The total income of you and your spouse has increased to $107,650 or more for the tax year.
- You have significantly more or less income from other sources or from another job.
- You no longer qualify for exemption from withholding.

Form W-4 (2017)

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. If you are exempt, complete **only** lines 1, 2, 3, 4, and 7 and sign the form to validate it. Your exemption for 2017 expires February 15, 2018. See Pub. 505, Tax Withholding and Estimated Tax.

Note: If another person can claim you as a dependent on his or her tax return, you can't claim exemption from withholding if your total income exceeds $1,050 and includes more than $350 of unearned income (for example, interest and dividends).

Exceptions. An employee may be able to claim exemption from withholding even if the employee is a dependent, if the employee:

- Is age 65 or older,
- Is blind, or
- Will claim adjustments to income; tax credits; or itemized deductions, on his or her tax return.

The exceptions don't apply to supplemental wages greater than $1,000,000.

Basic instructions. If you aren't exempt, complete the **Personal Allowances Worksheet** below. The worksheets on page 2 further adjust your withholding allowances based on itemized deductions, certain credits, adjustments to income, or two-earners/multiple jobs situations.

Complete all worksheets that apply. However, you may claim fewer (or zero) allowances. For regular wages, withholding must be based on allowances you claimed and may not be a flat amount or percentage of wages.

Head of household. Generally, you can claim head of household filing status on your tax return only if you are unmarried and pay more than 50% of the costs of keeping up a home for yourself and your dependent(s) or other qualifying individuals. See Pub. 501, Exemptions, Standard Deduction, and Filing Information, for information.

Tax credits. You can take projected tax credits into account in figuring your allowable number of withholding allowances. Credits for child or dependent care expenses and the child tax credit may be claimed using the **Personal Allowances Worksheet** below. See Pub. 505 for information on converting your other credits into withholding allowances.

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 may owe additional tax. If you have pension or annuity income, see Pub. 505 to find out if you should adjust your withholding on Form W-4 or W-4P.

Two earners or multiple jobs. If you have a working spouse or more than one job, figure the total number of allowances you are entitled to claim on all jobs using worksheets from only one Form W-4. Your withholding usually will be most accurate when all allowances are claimed on the Form W-4 for the highest paying job and zero allowances are claimed on the others. See Pub. 505 for details.

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

Check your withholding. After your Form W-4 takes effect, use Pub. 505 to see how the amount you are having withheld compares to your projected total tax for 2017. See Pub. 505, especially if your earnings exceed $130,000 (Single) or $180,000 (Married).

Future developments. Information about any future developments affecting Form W-4 (such as legislation enacted after we release it) will be posted at *www.irs.gov/w4*.

Personal Allowances Worksheet (Keep for your records.)

A	Enter "1" for **yourself** if no one else can claim you as a dependent	**A** _____
B	Enter "1" if: { • You're single and have only one job; or • You're married, have only one job, and your spouse doesn't work; or • Your wages from a second job or your spouse's wages (or the total of both) are $1,500 or less. } . . .	**B** _____
C	Enter "1" for your **spouse.** But, you may choose to enter "-0-" if you are married and have either a working spouse or more than one job. (Entering "-0-" may help you avoid having too little tax withheld.)	**C** _____
D	Enter number of **dependents** (other than your spouse or yourself) you will claim on your tax return	**D** _____
E	Enter "1" if you will file as **head of household** on your tax return (see conditions under **Head of household** above) . .	**E** _____
F	Enter "1" if you have at least $2,000 of **child or dependent care expenses** for which you plan to claim a credit . . . (**Note:** Do **not** include child support payments. See Pub. 503, Child and Dependent Care Expenses, for details.)	**F** _____
G	**Child Tax Credit** (including additional child tax credit). See Pub. 972, Child Tax Credit, for more information. • If your total income will be less than $70,000 ($100,000 if married), enter "2" for each eligible child; then **less** "1" if you have two to four eligible children or **less** "2" if you have five or more eligible children. • If your total income will be between $70,000 and $84,000 ($100,000 and $119,000 if married), enter "1" for each eligible child.	**G** _____
H	Add lines A through G and enter total here. (**Note:** This may be different from the number of exemptions you claim on your tax return.) ►	**H** _____

For accuracy, complete all worksheets that apply.

- If you plan to **itemize** or **claim adjustments to income** and want to reduce your withholding, see the **Deductions and Adjustments Worksheet** on page 2.
- If you are **single and have more than one job** or are **married and you and your spouse both work** and the combined earnings from all jobs exceed $50,000 ($20,000 if married), see the **Two-Earners/Multiple Jobs Worksheet** on page 2 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 below.

---------- **Separate here and give Form W-4 to your employer. Keep the top part for your records.** ----------

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

Employee's Withholding Allowance Certificate

► **Whether you are 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

2017

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, but legally separated, or spouse is a nonresident alien, check the "Single" box.	
	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 1-800-772-1213 for a replacement card.** ► ☐	

5	Total number of allowances you are claiming (from line **H** above **or** from the applicable worksheet on page 2)	**5**	
6	Additional amount, if any, you want withheld from each paycheck	**6**	$
7	I claim exemption from withholding for 2017, 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 lines 8 and 10 only if sending to the IRS.)	**9** Office code (optional)	**10** Employer identification number (EIN)

Employment Eligibility Verification

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

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

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

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

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

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

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

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

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

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

☐ 1. A citizen of the United States

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

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

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

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

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

QR Code - Section 1
Do Not Write In This Space

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

Preparer and/or Translator Certification (check one):

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

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

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

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

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

STOP *Employer Completes Next Page* STOP

Section 2. Employer or Authorized Representative Review and Verification

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

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

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

Additional Information

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

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

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

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

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

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

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

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

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

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

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

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

Notice and Acknowledgement of Pay Rate and Payday
Under Section 195.1 of the New York State Labor Law
Notice for Hourly Rate Employees

1. Employer Information

Name:
Iroquois Bar Corp.

Doing Business As (DBA) Name(s):

FEIN (optional):
16-1570355

Physical Address:
155 Commerce Drive
Lackawanna, NY 14218

Mailing Address:
same as above

Phone: 716-270-8205

2. Notice given:

- ☑ At hiring
- ☐ Before a change in pay rate(s), allowances claimed or payday

3. Employee's rate of pay:

$ _____ per hour

4. Allowances taken:

- ☑ None
- ☐ Tips _____ per hour
- ☐ Meals _____ per meal
- ☐ Lodging _____
- ☐ Other _____

5. Regular payday: Friday

6. Pay is:

- ☑ Weekly
- ☐ Bi-weekly
- ☐ Other

7. Overtime Pay Rate:

$ _____ per hour (This must be at least 1½ times the worker's regular rate with few exceptions.)

8. Employee Acknowledgement:

On this day I have been notified of my pay rate, overtime rate (if eligible), allowances, and designated pay day on the date given below. I told my employer what my primary language is.

Check one:

- ☑ I have been given this pay notice in English because it is my primary language.
- ☐ My primary language is _____. I have been given this pay notice in English only, because the Department of Labor does not yet offer a pay notice form in my primary language.

_____
Print Employee Name

_____
Employee Signature

_____
Date

_____
Preparer's Name and Title

The employee must receive a signed copy of this form. The employer must keep the original for 6 years.

LS 54 (02/15)

CERTIFICATE OF WORKER'S ACKNOWLEDGEMENT

Contractor's Name: *Oneida Sales and Service*

Contractor's Asbestos Handling Number: 83735

WORKING WITH ASBESTOS CAN BE DANGEROUS. INHALING ASBESTOS FIBERS HAS BEEN LINKED WITH VARIOUS TYPES OF CANCER. IF YOU SMOKE AND INHALE ASBESTOS FIBERS, THE CHANCE THAT YOU WILL DEVELOP LUNG CANCER IS GREATER THAN THAT OF THE NON-SMOKING PUBLIC.

Your employer requires that:

1. You be supplied with the proper respirator and be trained in its use.
2. You be trained in safe work practices and in the use of equipment found on the job.
3. You receive a medical examination.

These things are to have been done at no cost to you. By signing this certification, you are assuring the owner that you employer has met these obligations to you.

RESPIRATORY PROTECTION: I have been trained in the proper use of respirators, and I have been informed of the type of respirator to be used on the above referenced project. I have a copy of the written respiratory protection manual issued by my employer. I have been equipped at no cost with the respirator to be used on the above project.

TRAINING COURSE: I have been trained in the dangers inherent in handling asbestos and breathing asbestos dust, in proper work procedures, and personal and area protective measures. The topics covered in the course included the following:

1. Physical characteristics of asbestos.
2. Health hazards associated with asbestos.
3. Use of protective equipment.
4. Negative air systems.
5. Work practices including hands-on or on-job training.
6. Personal decontamination procedures.
7. Air monitoring, personal and area.

MEDICAL EXAMINATION: I have had a medical examination within the past twelve (12) months which has been paid for by my employer. This examination included health history, pulmonary function tests, and may have included an evaluation of a chest x-ray.

Signature: _____

Printed Name: _____

Social Security Number: _____

Worker's Asbestos Handling Certificate Number: _____

RESPIRATOR ASSIGNMENT & TRAINING RECORD Date: _____

Employee _____ Social Security No.: _____

Respirator: ☐ Self Contained ☐ Supplied Air ☐ Hepa Filter
☐ Powered Air ☐ Chemical Cartridge ☐ Other _____

Model: Size: NIOSH Approval No.

Limitations: ☐ Beard ☐ Denture ☐ Glasses ☐ None
Explain:

Fitting: ☐ Satisfactory Positive Pressure Test ☐ Satisfactory Isoamyl ☐ Irritant Smoke
☐ Satisfactory Negative Pressure Test ☐ Satisfactory Sweetener Test

Maintenance:
Cleaning ☐ Daily ☐ Weekly ☐ Other

Respirator Wearers Statement

I understand that the respirator fit test which has just been performed applies only to the model and size tested, which is listed above. I recognize that air purifying respirators will not supply oxygen. If there is an oxygen deficiency, only air-supplying respirators will provide protection. I understand that I must inspect the respirator each time I wear it and to make sure all parts are present and undamaged. I must perform a positive and negative pressure fit test each time I don the respirator to ensure an adequate seal against my face.

I certify that I have received and passed a medical examination and that I am able to wear a respirator safely. I have been informed of the hazards present and have been trained in the proper work practices, emergency procedures, and respirator use.

_____ _____
Employee Signature Date

_____ _____
Approved By Date