



NEW EMPLOYEE PACKET

INSTRUCTIONS: **EMPLOYEE – Complete all YELLOW Sections**
EMPLOYER – Complete all BLUE Sections

ALL EMPLOYEES MUST COMPLETE THIS PACKET TO BE ENTERED INTO THE PAYROLL SYSTEM

Form W-4 Department of the Treasury Internal Revenue Service	Employee's Withholding Allowance Certificate	OMB No. 1545-0010 2005
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1 First Name	Middle Initial	Last Name	2 Social Security Number
Home Address		Apt #	3 <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Married, but withhold at higher Single Rate <small>Note: If married, but legally separated, or spouse is a nonresident alien, check the "Single" box.</small>
City	State	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 new card. <input type="checkbox"/>
5 Total number of allowances you are claiming			5
6 Additional amount, if any, you want withheld from each paycheck			6 \$
7 I claim exemption from withholding for 2004, and I certify that I meet both of the following conditions for exemption: <ul style="list-style-type: none"> • 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 certify that I am entitled to the number of withholding allowances claimed on this certificate, or I am entitled to claim exempt status. (Form is not valid unless you sign it.)

Employee's Signature		Date	
9 Employer's Name and Address: Modern Business Associates 9455 Koger Boulevard, Suite 200 St. Petersburg, FL 33702	9 Office Code (optional)	10 Employer's Identification Number	

Instructions and worksheets for completing the W-4 are available upon request.

Employee Date of Birth	Employee Residence Phone Number (1)	Employee Alternate Phone Number (2)
Emergency Contact Name	Relationship	Phone Number

TO BE COMPLETED BY THE SUPERVISOR OR MANAGER ONLY

Client Company: _____ Client Location: _____ Department Name/Number: _____ Employee ID Number: _____ Hire Date: _____ (By Client Company) Employee Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female Job Title: _____ Workers' Comp Class: _____ Supervisor, Manager or Authorized Signature: _____	Pay Type: <input type="checkbox"/> Hourly <input type="checkbox"/> Salary Pay Status: <input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time Pay Cycle: <input type="checkbox"/> Weekly <input type="checkbox"/> Bi-Weekly <input type="checkbox"/> Semi-Monthly <input type="checkbox"/> Monthly Rate of Pay: \$ _____ per _____ Tipped Employee: <input type="checkbox"/> No <input type="checkbox"/> Yes Shift Pay: <input type="checkbox"/> No <input type="checkbox"/> Yes Rate: \$ _____ per _____ Piece Work: <input type="checkbox"/> No <input type="checkbox"/> Yes Rate: \$ _____ per _____ Commissions: <input type="checkbox"/> No <input type="checkbox"/> Yes Rate: \$ _____ per _____ Other: _____	
_____ Signature	_____ Title	_____ Date

EMPLOYEE ACKNOWLEDGEMENTS AND RELEASE AUTHORIZATION

I understand that _____ ("Client") has entered into a Client Service Agreement ("Agreement") with Modern Business Associates, Inc. and/or its subsidiaries and affiliated companies, (hereinafter collectively referred to as ("MBA"), whereby MBA has agreed to become an employer of individuals who will perform services for the Client.

In consideration of my hiring by MBA, I acknowledge and agree to the following: I understand and agree that I am an **AT-WILL** employee of MBA and that there is no contract of employment which exists between me and the Client to which I have been assigned, nor between MBA and me. I understand and agree that either MBA, the Client, or I can terminate our employment relationship **at any time, as I am an at-will employee**. I also agree that if I am a leased employee of MBA, if MBA does not receive payment from Client for services which I perform as a leased employee, and if applicable law requires such payment, MBA will still pay me the applicable minimum wage (or the legally required minimum salary or overtime pay) for any such period, and I agree to this method of compensation. I understand and agree that MBA has no obligation to pay me any other compensation or benefit unless MBA has specifically, in a written agreement with me, adopted the Client's obligation to pay me such compensation or benefit. I understand that the Client to which I am assigned at all times remains obligated to pay me my regular wage. I understand and agree that MBA does not assume responsibility for compensation, profit sharing, vacation, sick or other paid time off pay, or for any other such payment for such items or services has not been received by MBA from the Client to which I am assigned.

In recognition of the fact that my work related injuries which might be sustained by me are covered by state workers' compensation statutes, and to avoid the circumvention of such state statutes which may result from suits against the customers or clients of MBA or against MBA based on the same injury or injuries, and to the extent permitted by law, I **hereby waive and forever release any rights I might have to make claims or bring suit against any client or customer of MBA or against MBA for damages based upon injuries which are covered under such workers' compensation statutes**. I also agree to comply with any drug testing policy which MBA or its Client's may adopt, and I specifically agree to post-accident drug testing in any situation where it is allowed by law.

I understand that the first ninety (90) days of employment are considered an introductory period. Further, I understand that the employment relationship with MBA may end at any time for any reason.

I agree to abide by all discrimination and harassment policies. I also acknowledge and agree that if at any time during the application process or during the period of my employment, I am subjected to any type of discrimination based upon my race, sex, age, color, religion, national origin, marital status, disability, veteran's status, or any other status protected by applicable law. I will immediately contact MBA's Human Resources Department at 727-563-1500 or 888-622-6460 to obtain assistance in the resolution of such matters. I also understand and agree that if during the term of my employment, I am subjected to any form of sexual harassment, or any other type of harassment, from a supervisory employee, co-worker, vendor, or anyone else, I will immediately report such harassment to MBA's Human Resources Department at 727-563-1500 or 888-622-6460.

I acknowledge receipt of the Employee Handbook, and if I am eligible for medical benefits and subsequently COBRA coverage, I have received notification of my and my dependent's continuation of medical coverage rights under COBRA.

I have been informed and agree that if my assignment with any MBA client to which I am assigned ends for any reason, I must report back to MBA within seventy-two (72) hours for possible reassignment **and that unemployment benefits may be denied to me if I fail to do so**. Also, if I do not notify MBA within such time, MBA may assume that I have voluntarily resigned.

I certify that all the information on this document, my resume and any supporting documents are correct, and I understand that any misrepresentation or omission of any information may result in my termination.

I understand and agree that should my assignment end, MBA may refer my resume and/or work history to other potential employers and/or selected placement agencies.

I understand that as a condition of employment, I may be required to sign a non-compete agreement and/or a conflict of interest statement.

I understand that this company hires only U.S. citizens or individuals who are legally eligible to work in the United States.

I have read and acknowledge all of the above statements contained on this page, and I have received a copy of the Employee Handbook and have either read it or have had it read to me carefully. I understand that any provisions in the Employee Handbook may be amended or revised at any time with or without notice. I further understand that the Employee Handbook does not guarantee me any specific policies, procedures, rules, or length of employment. All references to policies and procedures are discretionary guidelines. However, I understand that, as a condition of my employment, I will comply with all policies, procedures and rules set forth in the Employee Handbook. Moreover, I understand that my employment is **AT-WILL**.

Signature: _____ Date: _____

ACKNOWLEDGMENT OF GROUP BENEFITS

ALL EMPLOYEES ELIGIBLE FOR GROUP BENEFITS SHOULD COMPLETE THIS SECTION

I understand that I may be eligible or become eligible for certain benefits under the group plans provided by MBA and/or the Client to which I am assigned. Furthermore, I understand, in order for my benefits to be effective, I must complete my assigned benefit waiting period and submit the required enrollment forms/correspondence prior to my effective date of coverage. I acknowledge that it is my responsibility and/or that of appropriate family member(s) to read and understand the various benefit plans presented to me in my benefit packet. I also understand that I should refer to the certificates of insurance and/or plan documents for detailed information regarding benefit provisions and that the provisions may be subject to change. I understand that if I enroll, my benefit choices must remain in effect until the following annual enrollment unless I experience a qualifying event as discussed below.

I understand that if I do not receive my benefit packet during my benefit waiting period, I am responsible for notifying MBA's Benefits Department prior to my effective date of coverage. If I am uncertain of my assigned benefit waiting period, I understand I am responsible for obtaining confirmation of my assigned benefit waiting period from my on-site contact or MBA's Benefits Department. Furthermore, I understand that if I do not return my signed enrollment form to MBA, or if appropriate, to the Client to which I am assigned after I begin working as an eligible employee and before the date my coverage is to be effective, this will be considered a refusal of group coverage. I understand that if I do not elect benefits at the time of my initial eligibility, I will not be permitted to enroll or make mid-year election changes unless a qualifying event occurs. I understand if I experience a qualifying event and would like to enroll, I must notify MBA, or if appropriate, the Client to which I am assigned and submit the required forms and documentation within 30 days of my qualifying event or I will not be permitted to make changes or enroll until the following annual enrollment. Furthermore, I understand if I request coverage for myself and eligible dependents at a later date, I may be required to furnish health information for each individual, and the Plan(s) reserves the right to reject any such request for coverage.

I authorize deductions for required employee contributions toward group benefits. I understand that I must meet the eligibility requirements for coverage to be effective. If a premium is deducted and I do not meet the eligibility requirements, the premium will be refunded.

Signature: _____ Date: _____

Employment Eligibility Verification

Please read instructions carefully before completing this form. The instructions must be available during completion of this form. **ANTI-DISCRIMINATION NOTICE.** It is illegal to discriminate against work eligible individuals. Employers **CANNOT** specify which document(s) they will accept from an employee. The refusal to hire an individual because of a future expiration date may also constitute illegal discrimination.

Section 1. Employee Information and Verification. To be completed and signed by employee at the time employment begins.

Print Name: Last	First	Middle Initial	Maiden Name
Address (Street Name and Number)		Apt.#	Date of Birth
City	State	Zip Code	Social Security 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:)

- A citizen or national of the United States
- A Lawful Permanent Resident - Alien # A _____
- An alien authorized to work until ____ / ____ / ____
(Alien # or Admission # _____)

Employees Signature	Date (month/day/year)
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Preparer and/or Translator Certification. (To be completed and signed if Section 1 is prepared by a person other than the employee.) I attest, under penalty of perjury, that I have assisted in the completion of this form and that to the best of my knowledge the information is true and correct.

Preparers/Translators Signature	Print Name
Address (Street Name and Number, City, State, Zip Code)	Date (month/day/year)

Section 2. Employer Review and Verification. To be completed and signed by employer. Examine one document from List A OR examine one from List B and one from List C, as listed on the reverse of this form. Record the title, number and expiration date, if any, of the document(s).

List A	OR	List B	AND	List C
Document title: _____	_____	_____	_____	_____
Issuing authority: _____	_____	_____	_____	_____
Document #: _____	_____	_____	_____	_____
Expiration Date (if any): _____	_____	_____	_____	_____
Document #: _____	_____	_____	_____	_____
Expiration Date (if any): _____	_____	_____	_____	_____

CERTIFICATION - I attest, under penalty of perjury, that I have examined the document(s) presented by the above-named employee, that the above-listed document(s) appear to be genuine and to relate to the employee named, that the employee began employment on (month/day/year) ____ / ____ / ____ and that to the best of my knowledge the employee is eligible to work in the United States. (State employment agencies may omit the date the employee began employment).

Signature of Employer or Authorized Representative	Print Name	Title
Business or Organization Name	Address (Street Name and Number, City, State, Zip Code)	Date (month/day/year)

Section 3. Updating and Reverification. To be completed and signed by employer.

A. New Name (if applicable)	B. Date of rehire (month/day/year) (if applicable)
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C. If employees previous grant of work authorization has expired, provide the information below for the document that establishes current employment eligibility

Document Title: _____ Document #: _____ Expiration Date (if any): _____

I attest, under penalty of perjury, that to the best of my knowledge, this employee is eligible 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	Date (month/day/year)
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LISTS OF ACCEPTABLE DOCUMENTS

LIST A

OR

LIST B

AND

LIST C

<p style="text-align: center;">Documents that Establish Both Identity and Employment Eligibility</p>	<p style="text-align: center;">Documents that Establish Identity</p>	<p style="text-align: center;">Documents that Establish Employment Eligibility</p>
<ol style="list-style-type: none"> 1. U.S. Passport (unexpired or expired) 2. Certificate of U.S. Citizenship (INS Form N-560 or N-561) 3. Certificate of Naturalization (INS Form N-550 or N-570) 4. Unexpired foreign passport, with I-551 stamp or attached INS Form I-94 indicating unexpired employment authorization 5. Permanent Resident Card or Alien Registration Receipt Card with photograph (INS Form I-151 or I-551) 6. Unexpired Temporary Resident Card (INS Form I-688) 7. Unexpired Employment Authorization Card (INS Form I-688A) 8. Unexpired Re-entry Permit (INS Form I-327) 9. Unexpired Refugee Travel Document (INS Form I-571) 10. Unexpired Employment Authorization Document issued by the INS which contains a photograph (INS Form I-688B) 	<ol style="list-style-type: none"> 1. Driver's license or ID card issued by a state or outlying possession of the United States provided it contains a photograph or information such as name, date of birth, gender, height, eye color and address 2. ID card issued by federal, state or local government agencies or entities, provided it contains a photograph or information such as name date of birth, gender, height, eye color and address 3. School ID card with a photograph 4. Voter's registration card 5. U.S. Military card or draft record 6. Military dependent's ID card 7. U.S. Coast Guard Merchant Mariner Card 8. Native American tribal document 9. Driver's license issued by a Canadian government authority <p style="text-align: center; font-weight: bold;">For persons under age 18 who are unable to present a document listed above:</p> <ol style="list-style-type: none"> 10. School record or report card 11. Clinic, doctor or hospital record 12. Day-care or nursery school record 	<ol style="list-style-type: none"> 1. U.S. social security card issued by the Social Security Administration (other than a card stating it is not valid for employment) 2. Certification of Birth Abroad issued by the Department of State (Form FS-545 of Form DS-1350) 3. Original or certified copy of a birth certificate issued by a state county, municipal authority or outlying possession of the United States bearing an official seal 4. Native American tribal document 5. U.S. Citizen ID Card (INS Form I-197) 6. ID Card for use of Resident Citizen in the United States (INS Form I-179) 7. Unexpired employment authorization document issued by the INS (other than those listed under list A)

MEDICAL INFORMATION

This release of medical information is not used to determining eligibility for health or dental insurance and may not be retained with the personnel file.

Have you ever received treatment for back, neck, knee condition or head injury?

Do you now, or have you ever, suffered from aches or pains of the back?

Have you ever had any surgery?

Do you now, or have you ever had any physical disabilities, impairments or handicaps?

Have you ever had a workers' compensation injury?

Have you ever received a disability rating for any reason?
(Explain fully any yes answer; use additional paper if necessary)

I have been fully advised that if I am injured on the job, regardless of how minor the injury may seem, I am to report that injury immediately to my supervisor. Yes No

I certify the above answers to be true and correct. I understand that any false or misleading answers to these questions will be sufficient reason for denial of benefits under a state Workers' Compensation Act and basis for termination of employment. I also understand that my answers will be verified by investigation.

Signature: _____ **Date:** _____



DIRECT DEPOSIT AUTHORIZATION

IMPORTANT: REQUIRED FOR MBA TO PROCESS DIRECT DEPOSIT

The following amounts will be deducted from my paycheck **EACH PAY PERIOD**:

Description	Amount or Net
<input type="checkbox"/> Direct *Financial Institution Name: _____ Deposit Account No.: _____ #1 Routing Number: _____ Type of Account: <input type="checkbox"/> Checking <input type="checkbox"/> Savings <input type="checkbox"/> Investment Account	Net Pay
<input type="checkbox"/> Direct *Financial Institution Name: _____ Deposit Account No.: _____ #2 Routing Number: _____ Type of Account: <input type="checkbox"/> Checking <input type="checkbox"/> Savings <input type="checkbox"/> Investment Account	\$ _____
<input type="checkbox"/> Direct *Financial Institution Name: _____ Deposit Account No.: _____ #3 Routing Number: _____ Type of Account: <input type="checkbox"/> Checking <input type="checkbox"/> Savings <input type="checkbox"/> Investment Account	\$ _____

*Financial institutions include banks, savings and loans, credit unions, and investment accounts.

I hereby authorize Modern Business Associates to deduct from my paycheck the noted amounts **EACH PAY PERIOD** and to initiate adjustments if necessary for any entries made in error. Any changes must be in writing on the Direct Deposit Authorization form. I understand that it may take up to 30 days before my deposit request is initiated.

Signature: _____ Date: ____/____/____

Social Security Number _____

Please attach one of the following for each direct deposit:

- a voided **check** or copy of a **check**
- a copy of the *Financial Institution Identification Card*
(for savings accounts)

Note: Incomplete or unacceptable information will delay the start of your direct deposit(s).