

Dr. Therese T. Walter Education Center 11771 Edinboro Road Matthew Lane, Ed.D., Superintendent of Jacquelynn Dutchcot, Business Manager

Payroll Forms for Employees, Regular and Substitute

Please complete the attached forms. These forms and identification documents (identity and employment authorization) must be submitted to the Education Center prior to your first work day.

- 1. Personal Information Sheet
- 2. Form W-4
- 3. Residency Certification Form (complete the employee information section AND the certification section)
- 4. Form I-9, Employment Eligibility Verification (complete section 1)
 - Note: The list of acceptable documents that establish your identity and your employment authorization follow the I-9 form. You will need to show a document from list A or a document from list B & list C.
- 5. Direct Deposit Authorization Form (direct deposit is mandatory for all employees, regular and substitute)
- 6. Local Services Tax-Exemption Certificate (only complete this form if you are exempt from this tax for the current calendar year)
- 7. Designated Physicians List (review information and then sign/return page 2 of this document)
- 8. School Personnel Health Record (Only sections 1 and 3 need completed for substitute employees and coaches. The entire form needs completed for regular employees.)

If you have questions on any of these forms, please contact Jennifer Berger in the Education Center at 814-273-1033, extension 5906.

Thank you.

GENERAL MCLANE SCHOOL DISTRICT PERSONAL INFORMATION SHEET

First Name:	pears on your social security card Middle Initia		
Social Security Num		ars on your social security card	As it appears on your social security card
Address:			
City, State, Zip Code			
Home Phone #:			
			○City ○Boro ○Township
Name of school distr	rict in your municipality:		
Home Email:			
Date of Birth:			
	Contact:		
The questions in this Marital Status:	section are for demographic purpo oSingle oMarried		
Ethnicity:	○American Indian/Alaskan Native ○Native Hawaiian/Pacific Island ○Black not of Hispanic origin ○Hispanic	○White not of Hispanic○Multi-Racial○Asian	origin
Gender:	oMale oFemale		
Are you a veteran:			
o I do not choose to	disclose the information in this section	on.	
W-2 will also b	Il have their W-2s and pay stub(s) be provided. Printed pay stubs are bloyees will have a printed W-2 and	available upon request.	employee web portal. A paper
Please note the follo	wing Retirement Information:		
This is determined by service requirements	blic School Employees Retirement the State of Pennsylvania. Part-to to qualify for PSERS membership count owed to them and retirement	ime hourly or substitute em (500 hours or 80 days). On	ployees must meet minimum nce qualified, you will be billed
	Retired Public School Employee a enrolled and contributions will not		∘Yes ∘No
By signing below, I counderstand and agree retirement deduction	ertify that all of the above information to the electronic submission of my requirements.	ation is true and correct to the way W-2 and pay stub (if apple)	ne best of my knowledge. I also icable) and to the PSERS
Employee Signature:			Date:



Form W-4

Department of the Treasury Internal Revenue Service **Employee's Withholding Certificate**

Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay.

Give Form W-4 to your employer.

Your withholding is subject to review by the IRS.

OMB No. 1545-0074

Step 1:	(a) First name and middle initial	Last name		(b) Social security number		
Enter Personal Information	Address City or town, state, and ZIP code			Does your name match the name on your social security card? If not, to ensure you get credit for your earnings,		
				contact SSA at 800-772-1213 or go to www.ssa.gov.		
	(c) Single or Married filing separately					
	Married filing jointly or Qualifying surviving s	pouse				
	Head of household (Check only if you're unmar	ried and pay more than half the costs	of keeping up a home for you	urself and a qualifying individual.)		
are completing marital status, deductions, or	using the estimator at www.irs.gov/W4App to this form after the beginning of the year; explaining of the year at the year at the year at the year at the year. It is a stimator again to recheck your withholding.	pect to work only part of the y if married filing jointly), depen	ear; or have changes dents, other income (during the year in your not from jobs),		
•	ps 2–4 ONLY if they apply to you; otherwis on from withholding, and when to use the est			on each step, who can		
Step 2: Multiple Job	Complete this step if you (1) hold mor also works. The correct amount of with					
or Spouse	Do only one of the following.					
Works	(a) Use the estimator at www.irs.gov/ you or your spouse have self-emp	선생님		step (and Steps 3-4). If		
	(b) Use the Multiple Jobs Worksheet	on page 3 and enter the resu	It in Step 4(c) below; o	or		
	(c) If there are only two jobs total, you option is generally more accurate higher paying job. Otherwise, (b) is	than (b) if pay at the lower pa				
	ps 3–4(b) on Form W-4 for only ONE of the ate if you complete Steps 3–4(b) on the Form	W-4 for the highest paying j	ob.)	s. (Your withholding will		
Claim						
Dependent and Other	Multiply the number of qualifying o		. \$			
Credits	ind Other					
Step 4 (optional):	(a) Other income (not from jobs). expect this year that won't have we This may include interest, dividend	rithholding, enter the amount				
Other Adjustments (b) Deductions. If you expect to claim deductions other than the standard deduction and want to reduce your withholding, use the Deductions Worksheet on page 3 and enter the result here						
	(c) Extra withholding. Enter any addi	tional tax you want withheld e	each pay period	4(c) \$		
Step 5: Sign Here	Under penalties of perjury, I declare that this cert	ificate, to the best of my knowled	dge and belief, is true, co	rrect, and complete.		
	Employee's signature (This form is not va	alid unless you sign it.)	Da	te		
Employers Only	Employer's name and address			Employer identification number (EIN)		

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Future Developments

For the latest information about developments related to Form W-4, such as legislation enacted after it was published, go to www.irs.gov/FormW4.

Purpose of Form

Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay. If too little is withheld, you will generally owe tax when you file your tax return and may owe a penalty. If too much is withheld, you will generally be due a refund. Complete a new Form W-4 when changes to your personal or financial situation would change the entries on the form. For more information on withholding and when you must furnish a new Form W-4, see Pub. 505, Tax Withholding and Estimated Tax.

Exemption from withholding. You may claim exemption from withholding for 2025 if you meet both of the following conditions: you had no federal income tax liability in 2024 and you expect to have no federal income tax liability in 2025. You had no federal income tax liability in 2024 if (1) your total tax on line 24 on your 2024 Form 1040 or 1040-SR is zero (or less than the sum of lines 27, 28, and 29), or (2) you were not required to file a return because your income was below the filing threshold for your correct filing status. If you claim exemption, you will have no income tax withheld from your paycheck and may owe taxes and penalties when you file your 2025 tax return. To claim exemption from withholding, certify that you meet both of the conditions above by writing "Exempt" on Form W-4 in the space below Step 4(c). Then, complete Steps 1(a), 1(b), and 5. Do not complete any other steps. You will need to submit a new Form W-4 by February 17, 2026.

Your privacy. Steps 2(c) and 4(a) ask for information regarding income you received from sources other than the job associated with this Form W-4. If you have concerns with providing the information asked for in Step 2(c), you may choose Step 2(b) as an alternative; if you have concerns with providing the information asked for in Step 4(a), you may enter an additional amount you want withheld per pay period in Step 4(c) as an alternative.

When to use the estimator. Consider using the estimator at www.irs.gov/W4App if you:

- 1. Are submitting this form after the beginning of the year;
- 2. Expect to work only part of the year;
- 3. Have changes during the year in your marital status, number of jobs for you (and/or your spouse if married filing jointly), or number of dependents, or changes in your deductions or credits;
- Receive dividends, capital gains, social security, bonuses, or business income, or are subject to the Additional Medicare Tax or Net Investment Income Tax; or
- 5. Prefer the most accurate withholding for multiple job situations.

TIP: Have your most recent pay stub(s) from this year available when using the estimator to account for federal income tax that has already been withheld this year. At the beginning of next year, use the estimator again to recheck your withholding.

Self-employment. Generally, you will owe both income and self-employment taxes on any self-employment income you receive separate from the wages you receive as an employee. If you want to pay these taxes through withholding from your wages, use the estimator at www.irs.gov/W4App to figure the amount to have withheld.

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

Step 1(c). Check your anticipated filing status. This will determine the standard deduction and tax rates used to compute your withholding.

Step 2. Use this step if you (1) have more than one job at the same time, or (2) are married filing jointly and you and your spouse both work. Submit a separate Form W-4 for each job.

Option (a) most accurately calculates the additional tax you need to have withheld, while option (b) does so with a little less accuracy.

Instead, if you (and your spouse) have a total of only two jobs, you may check the box in option (c). The box must also be checked on the Form W-4 for the other job. If the box is checked, the standard deduction and tax brackets will be cut in half for each job to calculate withholding. This option is accurate for jobs with similar pay; otherwise, more tax than necessary may be withheld, and this extra amount will be larger the greater the difference in pay is between the two jobs.



Multiple jobs. Complete Steps 3 through 4(b) on only one Form W-4. Withholding will be most accurate if you do this on the Form W-4 for the highest paying job.

Step 3. This step provides instructions for determining the amount of the child tax credit and the credit for other dependents that you may be able to claim when you file your tax return. To qualify for the child tax credit, the child must be under age 17 as of December 31, must be your dependent who generally lives with you for more than half the year, and must have the required social security number. You may be able to claim a credit for other dependents for whom a child tax credit can't be claimed, such as an older child or a qualifying relative. For additional eligibility requirements for these credits, see Pub. 501, Dependents, Standard Deduction, and Filing Information. You can also include other tax credits for which you are eligible in this step, such as the foreign tax credit and the education tax credits. To do so, add an estimate of the amount for the year to your credits for dependents and enter the total amount in Step 3. Including these credits will increase your paycheck and reduce the amount of any refund you may receive when you file your tax return.

Step 4 (optional).

Step 4(a). Enter in this step the total of your other estimated income for the year, if any. You shouldn't include income from any jobs or self-employment. If you complete Step 4(a), you likely won't have to make estimated tax payments for that income. If you prefer to pay estimated tax rather than having tax on other income withheld from your paycheck, see Form 1040-ES, Estimated Tax for Individuals.

Step 4(b). Enter in this step the amount from the Deductions Worksheet, line 5, if you expect to claim deductions other than the basic standard deduction on your 2025 tax return and want to reduce your withholding to account for these deductions. This includes both itemized deductions and other deductions such as for student loan interest and IRAs.

Step 4(c). Enter in this step any additional tax you want withheld from your pay each pay period, including any amounts from the Multiple Jobs Worksheet, line 4. Entering an amount here will reduce your paycheck and will either increase your refund or reduce any amount of tax that you owe.

Step 2(b) - Multiple Jobs Worksheet (Keep for your records.)



If you choose the option in Step 2(b) on Form W-4, complete this worksheet (which calculates the total extra tax for all jobs) on **only ONE** Form W-4. Withholding will be most accurate if you complete the worksheet and enter the result on the Form W-4 for the highest paying job. To be accurate, submit a new Form W-4 for all other jobs if you have not updated your withholding since 2019.

Note: If more than one job has annual wages of more than \$120,000 or there are more than three jobs, see Pub. 505 for additional tables; or, you can use the online withholding estimator at www.irs.gov/W4App.

1	Two jobs. If you have two jobs or you're married filing jointly and you and your spouse each have one job, find the amount from the appropriate table on page 4. Using the "Higher Paying Job" row and the "Lower Paying Job" column, find the value at the intersection of the two household salaries and enter that value on line 1. Then, skip to line 3	1	\$
2	Three jobs. If you and/or your spouse have three jobs at the same time, complete lines 2a, 2b, and 2c below. Otherwise, skip to line 3.		
	a Find the amount from the appropriate table on page 4 using the annual wages from the highest paying job in the "Higher Paying Job" row and the annual wages for your next highest paying job in the "Lower Paying Job" column. Find the value at the intersection of the two household salaries and enter that value on line 2a	2a	\$
	b Add the annual wages of the two highest paying jobs from line 2a together and use the total as the wages in the "Higher Paying Job" row and use the annual wages for your third job in the "Lower Paying Job" column to find the amount from the appropriate table on page 4 and enter this amount on line 2b	2b	\$
	c Add the amounts from lines 2a and 2b and enter the result on line 2c	2c	\$
3	Enter the number of pay periods per year for the highest paying job. For example, if that job pays weekly, enter 52; if it pays every other week, enter 26; if it pays monthly, enter 12, etc	3	
4	Divide the annual amount on line 1 or line 2c by the number of pay periods on line 3. Enter this amount here and in Step 4(c) of Form W-4 for the highest paying job (along with any other additional amount you want withheld)	4	\$
	Step 4(b) — Deductions Worksheet (Keep for your records.)		
1	Enter an estimate of your 2025 itemized deductions (from Schedule A (Form 1040)). Such deductions may include qualifying home mortgage interest, charitable contributions, state and local taxes (up to \$10,000), and medical expenses in excess of 7.5% of your income	1	\$
2	Enter: • \$30,000 if you're married filing jointly or a qualifying surviving spouse • \$22,500 if you're head of household • \$15,000 if you're single or married filing separately	2	\$
3	If line 1 is greater than line 2, subtract line 2 from line 1 and enter the result here. If line 2 is greater than line 1, enter "-0-"	3	\$
4	Enter an estimate of your student loan interest, deductible IRA contributions, and certain other adjustments (from Part II of Schedule 1 (Form 1040)). See Pub. 505 for more information	4	\$
5	Add lines 3 and 4. Enter the result here and in Step 4(b) of Form W-4	5	\$

Privacy Act and Paperwork Reduction Act Notice. We ask for the information on this form to carry out the Internal Revenue laws of the United States. Internal Revenue Code sections 3402(f)(2) and 6109 and their regulations require you to provide this information; your employer uses it to determine your federal income tax withholding. Failure to provide a properly completed form will result in your being treated as a single person with no other entries on the form; providing fraudulent information may subject you to penalties. Routine uses of this information include giving it to the Department of Justice for civil and criminal litigation; to cities, states, the District of Columbia, and U.S. commonwealths and territories for use in administering their tax laws; and to the Department of Health and Human Services for use in the National Directory of New Hires. We may also disclose this information to other countries under a tax treaty, to federal and state agencies to enforce federal nontax criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism.

You are not required to provide the information requested on a form that is subject to the Paperwork Reduction Act unless the form displays a valid OMB control number. Books or records relating to a form or its instructions must be retained as long as their contents may become material in the administration of any Internal Revenue law. Generally, tax returns and return information are confidential, as required by Code section 6103.

The average time and expenses required to complete and file this form will vary depending on individual circumstances. For estimated averages, see the instructions for your income tax return.

If you have suggestions for making this form simpler, we would be happy to hear from you. See the instructions for your income tax return.

Form W-4 (20	025)												Page 4
Married Filing Jointly or Qualifying Surviving Spouse													
Higher Pay					Lowe	r Paying .	Job Annua	al Taxable	Wage & S	Salary			
Annual Ta Wage & S		\$0 - 9,999	\$10,000 - 19,999	\$20,000 - 29,999	\$30,000 - 39,999	\$40,000 - 49,999	\$50,000 - 59,999	\$60,000 - 69,999	\$70,000 - 79,999	\$80,000 - 89,999	\$90,000 - 99,999	\$100,000 - 109,999	\$110,000 - 120,000
\$0 -	574 ASS (5) A	\$0	\$0	\$700	\$850	\$910	\$1,020	\$1,020	\$1,020	\$1,020	\$1,020	\$1,020	\$1,020
\$10,000 -	120002000000000000000000000000000000000	0	700	1,700	1,910	2,110	2,220	2,220	2,220	2,220	2,220	2,220	3,220
\$20,000 -		700	1,700	2,760	3,110	3,310	3,420	3,420	3,420	3,420	3,420	4,420	5,420
\$30,000 -	- 0.000	850	1,910	3,110	3,460	3,660	3,770	3,770	3,770	3,770	4,770	5,770	6,770
\$40,000 -		910	2,110	3,310	3,660	3,860	3,970	3,970	3,970	4,970	5,970	6,970	7,970
\$50,000 -		1,020	2,220	3,420	3,770	3,970	4,080	4,080	5,080	6,080	7,080	8,080	9,080
\$60,000 -	500000000000000000000000000000000000000	1,020	2,220	3,420	3,770	3,970	4,080	5,080	6,080	7,080	8,080	9,080	10,080
\$70,000 -	N. 66. 50. 45. 11. 12.	1,020	2,220	3,420	3,770	3,970	5,080	6,080	7,080	8,080	9,080	10,080	11,080
\$80,000 -		1,020	2,220	3,420	4,620	5,820	6,930	7,930	8,930	9,930	10,930	11,930	12,930
\$100,000 -	\$100000 \$10000000	1,870	4,070	6,270	7,620	8,820	9,930	10,930	11,930	12,930	14,010	15,210	16,410
\$150,000 - \$240,000 -	A CONTRACTOR OF THE PARTY OF TH	1,870	4,240	6,640	8,190	9,590	10,890	12,090	13,290	14,490	15,690	16,890	18,090
\$260,000 -		2,040	4,440 4,440	6,840	8,390 8,390	9,790 9,790	11,100	12,300 12,300	13,500	14,700	15,900 15,900	17,100 17,100	18,300 18,300
\$280,000 -		2,040	4,440	6,840 6,840	8,390	9,790	11,100	12,300	13,500	14,700	15,900	17,100	18,300
\$300,000 -	TOTAL PROPERTY.	2,040	4,440	6,840	8,390	9,790	11,100	12,300	13,500	14,700	15,900	17,170	19,170
\$320,000 -		2,040	4,440	6,840	8,390	9,790	11,100	12,470	14,470	16,470	18,470	20,470	22,470
\$365,000 -	and the second s	2,790	6,290	9,790	12,440	14,940	17,350	19,650	21,950	24,250	26,550	28,850	31,150
\$525,000 a		3,140	6,840	10,540	13,390	16,090	18,700	21,200	23,700	26,200	28,700	31,200	33,700
		-			0.0000000000000000000000000000000000000	USE OF CHICAGO STORY	Union 1987 (1987)						
Higher Pay	vina Job	Single or Married Filing Separately Lower Paying Job Annual Taxable Wage & Salary											
Annual Ta Wage &	axable	\$0 - 9,999	\$10,000 - 19,999	\$20,000 - 29,999	\$30,000 - 39,999	\$40,000 - 49,999	\$50,000 - 59,999	\$60,000 - 69,999	\$70,000 - 79,999	\$80,000 - 89,999	\$90,000 - 99,999	\$100,000 - 109,999	\$110,000 - 120,000
\$0 -	9,999	\$200	\$850	\$1,020	\$1,020	\$1,020	\$1,370	\$1,870	\$1,870	\$1,870	\$1,870	\$1,870	\$2,040
\$10,000 -	19,999	850	1,700	1,870	1,870	2,220	3,220	3,720	3,720	3,720	3,720	3,890	4,090
\$20,000 -	29,999	1,020	1,870	2,040	2,390	3,390	4,390	4,890	4,890	4,890	5,060	5,260	5,460
\$30,000 -	39,999	1,020	1,870	2,390	3,390	4,390	5,390	5,890	5,890	6,060	6,260	6,460	6,660
\$40,000 -	59,999	1,220	3,070	4,240	5,240	6,240	7,240	7,880	8,080	8,280	8,480	8,680	8,880
\$60,000 -	79,999	1,870	3,720	4,890	5,890	7,030	8,230	8,930	9,130	9,330	9,530	9,730	9,930
\$80,000 -	99,999	1,870	3,720	5,030	6,230	7,430	8,630	9,330	9,530	9,730	9,930	10,130	10,580
\$100,000 -	564 1000 * 10 40 40 40 40 40 40 40 40 40 40 40 40 40	2,040	4,090	5,460	6,660	7,860	9,060	9,760	9,960	10,160	10,950	11,950	12,950
\$125,000 -		2,040	4,090	5,460	6,660	7,860	9,060	9,950	10,950	11,950	12,950	13,950	14,950
\$150,000 -	2001 - \$1800 COSCO	2,040	4,090	5,460	6,660	8,450	10,450	11,950	12,950	13,950	15,080	16,380	17,680
\$175,000 -	more and a second	2,040	4,290	6,450	8,450	10,450	12,450	13,950	15,230	16,530	17,830	19,130	20,430
\$200,000 -		2,720	5,570	7,900	10,200	12,500	14,800	16,600	17,900	19,200	20,500	21,800	23,100
\$250,000 -	and the second order to the	2,970	6,120	8,590	10,890	13,190	15,490	17,290	18,590	19,890	21,190	22,490	23,790
\$400,000 - \$450,000 a	100 Call 5 Call 100 C	2,970	6,120	8,590	10,890	13,190	15,490	17,290	18,590	19,890	21,190	22,490	23,790
\$450,000 a	na over j	3,140	6,490	9,160	11,660	14,160 Head of	16,660	18,660	20,160	21,660	23,160	24,660	26,160
Higher Pay	ing Joh								Wage & S	Salary			
Annual Ta	axable	\$0 - 9,999	\$10,000 - 19,999	\$20,000 - 29,999	\$30,000 - 39,999	\$40,000 - 49,999	\$50,000 - 59,999	\$60,000 - 69,999	\$70,000 - 79,999	\$80,000 - 89,999	\$90,000 - 99,999	\$100,000 - 109,999	\$110,000 - 120,000
\$0 -		\$0	\$450	\$850	\$1,000	\$1,020	\$1,020	\$1,020	\$1,020	\$1,870	\$1,870	\$1,870	\$1,890
\$10,000 -	***************************************	450	1,450	2,000	2,200	2,220	2,220	2,220	3,180	4,070	4,070	4,090	4,290
\$20,000 -		850	2,000	2,600	2,800	2,820	2,820	3,780	4,780	5,670	5,690	5,890	6,090
\$30,000 -		1,000	2,200	2,800	3,000	3,020	3,980	4,980	5,980	6,890	7,090	7,290	7,490
\$40,000 -	59,999	1,020	2,220	2,820	3,830	4,850	5,850	6,850	8,050	9,130	9,330	9,530	9,730
\$60,000 -	79,999	1,020	3,030	4,630	5,830	6,850	8,050	9,250	10,450	11,530	11,730	11,930	12,130
\$80,000 -	99,999	1,870	4,070	5,670	7,060	8,280	9,480	10,680	11,880	12,970	13,170	13,370	13,570
\$100,000 -	124,999	1,950	4,350	6,150	7,550	8,770	9,970	11,170	12,370	13,450	13,650	14,650	15,650
\$125,000 -	149,999	2,040	4,440	6,240	7,640	8,860	10,060	11,260	12,860	14,740	15,740	16,740	17,740
\$150,000 -	174,999	2,040	4,440	6,240	7,640	8,860	10,860	12,860	14,860	16,740	17,740	18,940	20,240
\$175,000 -		2,040	4,440	6,640	8,840	10,860	12,860	14,860	16,910	19,090	20,390	21,690	22,990
\$200,000 -		2,720	5,920	8,520	10,960	13,280	15,580	17,880	20,180	22,360	23,660	24,960	26,260
\$250,000 -		2,970	6,470	9,370	11,870	14,190	16,490	18,790	21,090	23,280	24,580	25,880	27,180
\$450,000 a	nd over	3,140	6,840	9,940	12,640	15,160	17,660	20,160	22,660	25,050	26,550	28,050	29,550

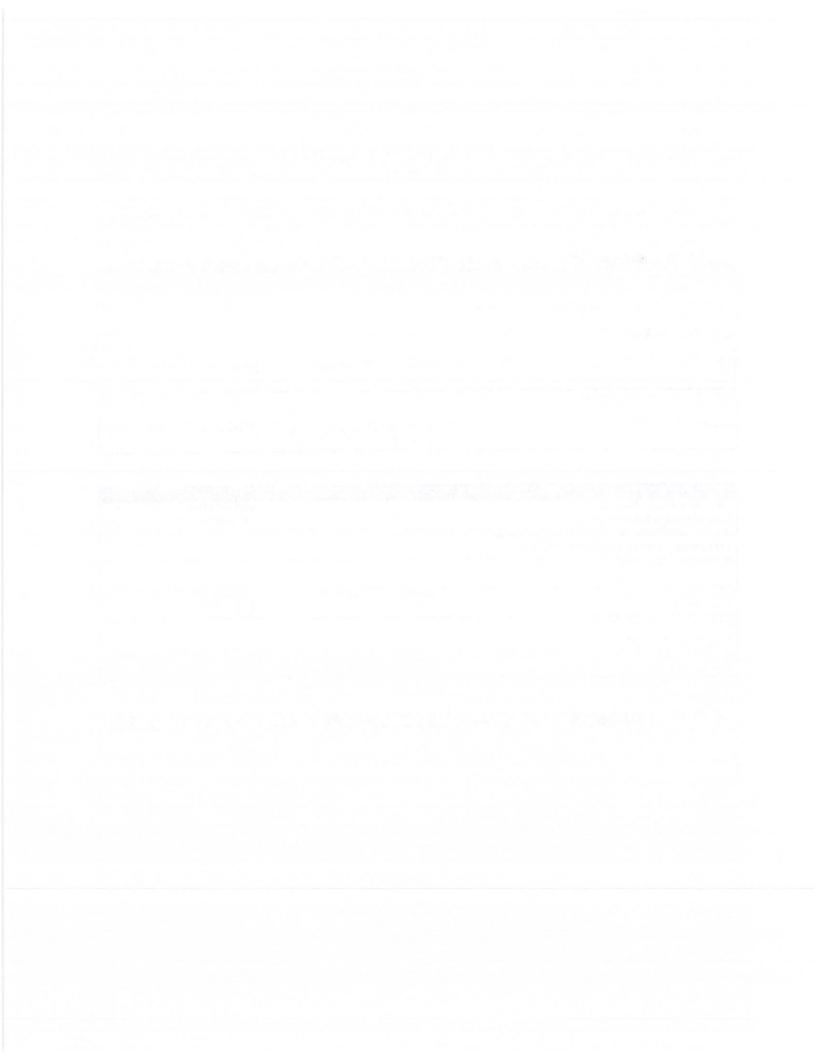


LOCAL EARNED INCOME TAX RESIDENCY CERTIFICATION FORM

TO EMPLOYERS/TAXPAYERS:

This form is to be used by employers and/or taxpayers to report essential information for the collection and distribution of Local Earned Income Taxes. This form must be utilized by employers when a new employee is hired or when a current employee notifies employer of a name and/or address change.

NAME (Last, First, Middle Initial)			SOCIAL SECURITY NUMBER
FIRST LINE OF ADDRESS (If PO Box, please include actual st	reet address)		
SECOND LINE OF ADDRESS			
СПҮ	STATE	ZIP CODE	DAYTIME PHONE NUMBER
MUNICIPALITY (City, Borough, Township)			
COUNTY	PSD CODE	Perilade popular (Perilade) Properties de la	TOTAL RESIDENT EIT RATE
	NFORMATION - EMPL	OYMENT LOCAT	ION
EMPLOYER NAME (Use Federal ID Name)			EMPLOYER FEIN
General McLane School District			25-6010560
FIRST LINE OF ADDRESS (If PO Box, please include actual str	reet address)		
11771 Edinboro Road, Edinboro, PA 16412			
SECOND LINE OF ADDRESS			
CITY	STATE	7710 0005	
Edinboro	PA	ZIP CODE 16412	PHONE NUMBER
	117	10412	814-273-1033
MUNICIPALITY (City, Borough, Township)			
Washington Township	Loop cont		
Erie County	PSD CODE		MUNICIPAL NON-RESIDENT EIT RATE
Life County	2 5	0 5 0 5] 1%
The Control of Section 18 Control of Control	CERTIFICATION	ACTOR OF A CONTRACTOR	
SIGNATURE OF EMPLOYEE			DATE
PHONE NUMBER	EMAIL ADDRE	ESS	
COLUMN A STREET AND ADDRESS OF AD	IPALITY (City, Borough, To	wnship), PSD CODE	S and EIT (Earned Income Tax) RATES,
places refer to the Removile to Describe with			
please refer to the Pennsylvania Department of Com	munity & Economic Develo	opment website:	





Employment Eligibility Verification

Department of Homeland Security

U.S. Citizenship and Immigration Services

USCIS Form I-9

OMB No.1615-0047 Expires 07/31/2026

START HERE: Employers must ensure the form instructions are available to employees when completing this form. Employers are liable for failing to comply with the requirements for completing this form. See below and the Instructions.

ANTI-DISCRIMINATION NOTICE: All employees can choose which acceptable documentation to present for Form I-9. Employers cannot ask employees for documentation to verify information in Section 1, or specify which acceptable documentation employees must present for Section 2 or Supplement B, Reverification and Rehire. Treating employees differently based on their citizenship, immigration status, or national origin may be illegal.

Section 1. Employee Info	ormation not before	and Attestation	n: Employe b offer.	ees must com	olete and si	gn Sect	ion 1 of Fo	orm I-9 no	later than the first
Last Name (Family Name)		First Name	(Given Name)		Middle Initia	al (if any)	Other Last	Names Use	ed (if any)
Address (Street Number and Nat	me)	A	pt. Number (if a	any) City or Tov	vn			State	ZIP Code
Date of Birth (mm/dd/yyyy)	U.S. Soc	cial Security Number	Emplo	yee's Email Addre	ss			Employee's	Telephone Number
I am aware that federal law provides for imprisonment fines for false statements, use of false documents, in connection with the compl this form. I attest, under pof perjury, that this informaticulating my selection of tattesting to my citizenship immigration status, is true correct.	etion of enalty ation, he box or	1. A citizen o 2. A noncitiz 3. A lawful p	of the United Si en national of t ermanent residen en (other than	tates he United States lent (Enter USCIS ltem Numbers 2.	(See Instruction or A-Number. and 3. above)	ns.)) authorized	d to work unt	il (exp. date	3 of the instructions.): , if any)
Signature of Employee					Tod	ay's Date	(mm/dd/yyyy)	
If a preparer and/or transla	ator assiste	ed vou in completir	na Section 1. t	hat person MUS	Complete th	e Prepare	r and/or Tra	nslator Cer	tification on Page 3.
Section 2. Employer Rev business days after the emplo authorized by the Secretary or documentation in the Addition Document Title 1 Issuing Authority Document Number (if any) Expiration Date (if any)	yee's first f DHS, do	t day of employme cumentation from	ent, and must List A OR a	physically exar combination of	nine or exar	nine cons on from L	sistent with	an alterna	tive procedure
Document Title 2 (if any)	realedg		Addi	tional Informat	ion				
Issuing Authority									
Document Number (if any)									
Expiration Date (if any)									
Document Title 3 (if any)		-							
Issuing Authority									
Document Number (if any)									
Expiration Date (if any)				neck here if you u	sed an alterna	tive proced	dure authoriz		to examine documents.
Certification: I attest, under per employee, (2) the above-listed d best of my knowledge, the empl	ocumenta	tion appears to be	genuine and t	o relate to the en	presented by oployee name	the aboved, and (3)	e-named to the	(mm/dd/y	of Employment yyy):
Last Name, First Name and Title o	f Employer	or Authorized Repre	esentative	Signature of Er	nployer or Aut	horized Re	epresentative	Т	oday's Date (mm/dd/yyyy)
Employer's Business or Organizati	ion Name		Employer's E	l Business or Organ	ization Addres	s, City or	Town, State,	ZIP Code	

LISTS OF ACCEPTABLE DOCUMENTS

All documents containing an expiration date must be unexpired.

* Documents extended by the issuing authority are considered unexpired.

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

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

LIST A		LIST B	LIST C
Documents that Establish Both Identity and Employment Authorization	OR	Documents that Establish Identity Al	ND Documents that Establish Employment Authorization
 U.S. Passport or U.S. Passport Card Permanent Resident Card or Alien Registration Receipt Card (Form I-551) Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa Employment Authorization Document that contains a photograph (Form I-766) For an individual temporarily authorized to work for a specific employer because of his or her status or parole: Foreign passport; and Form I-94 or Form I-94A that has the following: The same name as the passport; and An endorsement of the individual's status or parole as long as that period of endorsement has not yet expired and the proposed employment is not in conflict with any restrictions or limitations identified on the form. Passport from the Federated States of Micronesia (FSM) or the Republic of the Marshall Islands (RMI) with Form I-94 or Form I-94A indicating nonimmigrant admission under the Compact of Free Association Between the United States 		 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 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 School ID card with a photograph Voter's registration card U.S. Military card or draft record Military dependent's ID card U.S. Coast Guard Merchant Mariner Card Native American tribal document Driver's license issued by a Canadian government authority For persons under age 18 who are unable to present a document listed above: School record or report card Clinic, doctor, or hospital record Day-care or nursery school record 	A Social Security Account Number card, unless the card includes one of the followin restrictions: (1) NOT VALID FOR EMPLOYMEN (2) VALID FOR WORK ONLY WITH INS AUTHORIZATION (3) VALID FOR WORK ONLY WITH DHS AUTHORIZATION
and the FSM or RMI		Accordable D. 1.1	
		Acceptable Receipts	
May be prese		in lieu of a document listed above for a for receipt validity dates, see the M-274.	
B			T
stolen, or damaged List A document.	OR	Receipt for a replacement of a lost, stolen, or damaged List B document.	Receipt for a replacement of a lost, stolen, or damaged List C document.
Form I-94 issued to a lawful permanent resident that contains an I-551 stamp and a photograph of the individual.			
Form I-94 with "RE" notation or refugee stamp issued to a refugee.			

^{*}Refer to the Employment Authorization Extensions page on <u>I-9 Central</u> for more information.



Supplement A, Preparer and/or Translator Certification for Section 1

USCIS Form I-9 **Supplement A** OMB No. 1615-0047

Department of Homeland Security

U.S. Citizenship and Immigration Services

Expires 07/31/2026

Last Name (Family Name) from Section 1.	First Na	me (Given Name) from Section 1.		Middle initial	(if any) from Section 1.
Instructions: This supplement must be comp of Form I-9. The preparer and/or translator mu must complete, sign, and date a separate cert completed Form I-9.	ust enter the empl	oyee's name in the spaces p	provided ab	ove. Each	preparer or translato
I attest, under penalty of perjury, that I have knowledge the information is true and corr		completion of Section 1 o	of this form	and that	to the best of my
Signature of Preparer or Translator			Date (m	nm/dd/yyyy)	
Last Name (Family Name)	First	Name (Given Name)			Middle Initial (if any)
Address (Street Number and Name)		City or Town State		State	ZIP Code
I attest, under penalty of perjury, that I have knowledge the information is true and corr	e assisted in the	completion of Section 1 o	of this form	and that	to the best of my
Signature of Preparer or Translator			Date (m	m/dd/yyyy)	hni nauki sa kisani
Last Name (Family Name)	First	First Name (Given Name)			Middle Initial (if any)
Address (Street Number and Name)		City or Town Sta		State	ZIP Code
I attest, under penalty of perjury, that I have knowledge the information is true and corn	e assisted in the	completion of Section 1 o	f this form	and that	to the best of my
Signature of Preparer or Translator		emic mar u portavam, v mili tem postupista sa transporta	Date (m	m/dd/yyyy)	na yili o kasahan medh kati metika kuji je yili k
Last Name (Family Name)	First	Name (Given Name)			Middle Initial (if any)
Address (Street Number and Name)		City or Town		State	ZIP Code
I attest, under penalty of perjury, that I have knowledge the information is true and corn	e assisted in the	completion of Section 1 o	f this form	and that	to the best of my
Signature of Preparer or Translator	-		Date (m	m/dd/yyyy)	
Last Name (Family Name)	First	Name (Given Name)			Middle Initial (if any)
Address (Street Number and Name)		City or Town		State	ZIP Code
L					



Supplement B, Reverification and Rehire (formerly Section 3)

USCIS Form I-9 Supplement B OMB No. 1615-0047 Expires 07/31/2026

Department of Homeland Security

U.S. Citizenship and Immigration Services

Last Name (Family Name) from Section 1.	First Name (Given Name) from Section 1.	Middle initial (if any) from Section 1.

Instructions: This supplement replaces Section 3 on the previous version of Form I-9. Only use this page if your employee requires reverification, is rehired within three years of the date the original Form I-9 was completed, or provides proof of a legal name change. Enter the employee's name in the fields above. Use a new section for each reverification or rehire. Review the Form I-9 instructions before completing this page. Keep this page as part of the employee's Form I-9 record. Additional guidance can be found in the

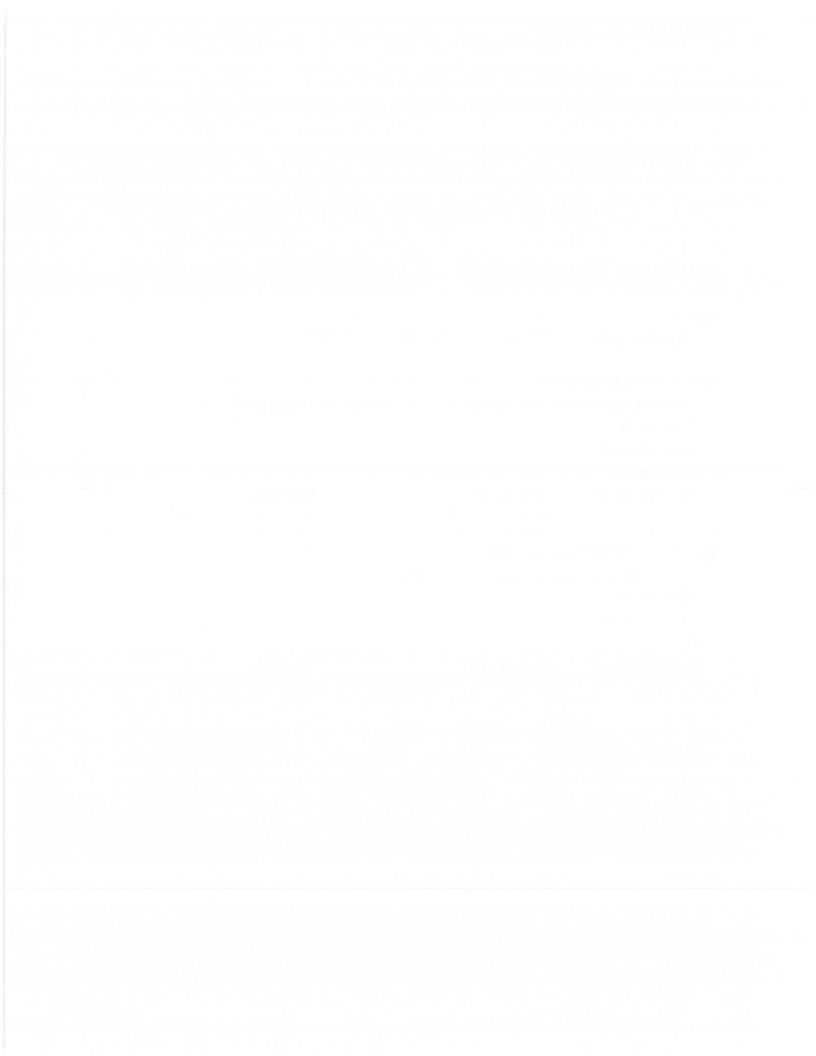
Date of Rehire (if applicable)	New Name (if applicable)					
Date (mm/dd/yyyy)	Last Name (Family Name)		First Name (Given Name)	nor separati		Middle Initial
	I ree requires reverification, your prization. Enter the documen		L present any acceptable List A below.	orList	C documental	l tion to show
Document Title		Document Number (if any)		Expira	ation Date (if an	y) (mm/dd/yyyy)
I attest, under penalty of employee presented doc	perjury, that to the best of umentation, the documenta	my knowledge, this emplo ation I examined appears	yee is authorized to work in to be genuine and to relate t	the Ur	nited States, a	and if the presented it.
Name of Employer or Authorize	ed Representative	Signature of Employer or Au	horized Representative		Today's Date	(mm/dd/yyyy)
Additional Information (Initi	ial and date each notation.)					ou used an cedure authorized mine documents.
Date of Rehire (if applicable)	New Name (if applicable)					
Date (mm/dd/yyyy)	Last Name (Family Name)		First Name (Given Name)			Middle Initial
	I ree requires reverification, your prization. Enter the documen		l present any acceptable List A pelow.	or List	C documentat	ion to show
Document Title		Document Number (if any)		Expira	ation Date (if any	y) (mm/dd/yyyy)
I attest, under penalty of employee presented doc	perjury, that to the best of unmentation, the documenta	my knowledge, this emplo ation I examined appears	yee is authorized to work in to be genuine and to relate to	the Un	ited States, a	and if the presented it.
Name of Employer or Authorize	ed Representative	Signature of Employer or Aut	horized Representative		Today's Date	(mm/dd/yyyy)
Additional Information (Initial	al and date each notation.)					ou used an edure authorized nine documents.
Date of Rehire (if applicable)	New Name (if applicable)					
Date (mm/dd/yyyy)	Last Name (Family Name)		First Name (Given Name)		30.000 ALBERT 119991 120	Middle Initial
Reverification: If the employ continued employment authorities	requires reverification, you orization. Enter the documen	ur employee can choose to t information in the spaces	present any acceptable List A pelow.	or List (L C documentat	ion to show
Document Title		Document Number (if any)		Expira	ation Date (if any	y) (mm/dd/yyyy)
I attest, under penalty of employee presented docu	perjury, that to the best of rumentation, the documenta	my knowledge, this emplo tion I examined appears t	yee is authorized to work in o be genuine and to relate to	the Un	ited States, a dividual who	and if the presented it.
Name of Employer or Authorize	ed Representative	Signature of Employer or Aut	horized Representative		Today's Date	(mm/dd/yyyy)
Additional Information (Initia	al and date each notation.)				Check here if your alternative proceution by DHS to example to the control of the	edure authorized



Dr. Therese T. Walter Education Center 11771 Edinboro Road Matthew Lane, Ed.D., Superintendent of Schools Jacquelynn Dutchcot, Business Manager

Direct Deposit Authorization Form

Name: (please print)			
Step I Action to Take:	oStart oCha	nge oStor	0
Step II – for net pay or I request that my no Bank Name: Bank Routing #: Account #:		and deduction	s) be deposited to:
Account Type:	oChecking (please attach a voided o	heck)	O Savings (please attach a deposit slip)
Step III – for a fixed am	ount only		
I request that a fixe Bank Name: Bank Routing #: Account #:		sited to:	
Account Type:	OChecking (please attach a voided o	heck)	O Savings (please attach a deposit slip)
In the amount of:	\$		
Step IV: Review the fo your authorization.	llowing note. You	· signature at t	he bottom of this page is
I understand that th	s authorization wil	remain in effe	ect until my employer has
rece	ived written notific	ation of its terr	mination.
Step V:			
	Signatur	e	Date



LOCAL SERVICES TAX – EXEMPTION CERTIFICATE

Tax Year

APPLICATION FOR EXEMPTION FROM LOCAL SERVICES TAX

A copy of this application for exemption from the Local Services Tax (LST), and all necessary supporting documents,

Name:	Soc Sec #:
Address:	Phone #:
City/State:	Zip:
	REASON FOR EXEMPTION
1	MULTIPLE EMPLOYERS: Attach a copy of a current pay statement from your principal employer that shows the name of the employer, the length of the payroll period and the amount of Local Services Tax withheld. List all employers on the reverse side of this form. You must notif your other employers of a change in principal place of employment within two weeks of the change.
2	EXPECTED TOTAL EARNED INCOME AND NET PROFITS FROM ALL SOURCES WITHIN (municipality or school district) WILL BE LESS THAN \$: Attach copies of your last pay statements or your W-2 for the year prior.
	If you are self-employed, please attach a copy of your PA Schedule C, F, or RK-1 for the prior year.
3	ACTIVE DUTY MILITARY EXEMPTION: Please attach a copy of your orders directing you to active duty status. Annual training is not eligible for exemption. You are required to advise the tax office when you are discharged from active duty status.
4	MILITARY DISABILITY EXEMPTION: Please attach copy of your discharge orders and a statement from the United States Veterans Administrator documenting your disability. Only 100% permanent disabilities are recognized for this exemption.
portion of the ca	Once you receive this Exemption Certificate, you shall not withhold the Local Services Tax for the alendar year for which this certificate applies, unless you are otherwise notified or instructed by the withhold the tax.
Tax Office: Ber	kheimer Tax Administrator
Address: PO Bo	Phone #: (610) 588-0965
Tity/State: Tabl	gh Valley, PA Zip: 18002

IMPORTANT NOTE TO EMPLOYERS

- 1. The municipality is required by law to exempt from the LST employees whose earned income from all sources (employers and self-employment) in their municipality is less than \$12,000 when the combined rate exceeds \$10.00.
- 2. The school district for the municipality in which your worksite(s) is located may or may not levy an LST. If it does, the income exemption provided <u>may differ</u> from the municipality and can be anywhere from \$0 to \$11,999.
- 3. Contact the tax office where your business worksites are located to obtain this information.

Employment Information: List all places of employment for the applicable tax year. Please list your PRIMARY EMPLOYER under #1 below and your secondary employers under the other columns. If self employed, write SELF under Employer Name column.

	1. PRIMARY EMPLOYER	2.	3.
Employer Name			
Address			
Address 2			
City, State Zip			
Municipality			
Phone			
Start Date			
End Date			
Status (FT or PT)			
Gross Earnings			
	4.	5.	6.
Employer Name			J.
Address			
Address 2			
City, State Zip			
Municipality			
Phone			
Start Date			
End Date			
Status (FT or PT)			2
Gross Earnings			
PLEASE NOTE:			
All information roa	polyed by the Tay Collector is	considered to be CONFIDEN	TIAL
official purposes i	ceived by the Tax Collector is relating to the collection, adm	inistration and enforcement	of the LOCAL SERVICES
I DECLARE LIND	ER PENALTY OF LAW THA	AT THE INCODMATION OF	ATED ON AND
	THIS FORM IS TRUE AND (ALLU UN ANU
SIGNATURE:		DAT	TE:
, 7 - 3 - 3			

➤ What To Do If You Are Injured At Work

As soon as practical, report the incident to your supervisor, Human Resources or your employer's Worker's Compensation Coordinator so they can report it to our office, even if you don't think you need medical treatment.

 Make sure your employer has your up-to-date contact information, including phone numbers, home address and personal email.

Your employer will file your claim electronically with Clear Spring, who will assign a Claim Representative to work with you going forward.

- If you require medical treatment, make sure to get a doctor's note after your visit to give to your employer.
- When seeking medical attention for a work-related injury occurring after hours, tell the medical provider that yours is a Workers' Compensation injury. Remember to report the incident to your employer the next business day.

Your employer should give you a copy of your Provider Panel.

 A Provider Panel is a list of medical providers you may see for the first 90 days following a work-related injury. You must sign a form acknowledging you received the Provider Panel information.

PLEASE NOTE: If immediate emergency care is needed, go to the nearest emergency room for the initial visit. Follow-up visits should then be scheduled with a medical provider on the Provider Panel.

Write down questions you may have for your medical provider and take them with you on your first visit.

 Communicate any concerns about your treatment to your medical provider and to your Clear Spring Claim Representative.

WORKERS' COMPENSATION EMPLOYEE NOTIFICATION

The Pennsylvania Workers' Compensation Act is designed to provide reimbursement for reasonable medical care for someone who suffers an injury arising in the course of his/her employment and causally related thereto. Pursuant to the Act, your employer will provide payment for reasonable surgical and medical services, services rendered by physicians or other health care providers, medicines and supplies, as and when needed.

If you require emergency medical treatment, you may seek it from any provider; however, any subsequent nonemergency treatment shall be obtained from one of the designated health care providers whose names appear on the list posted on your employer's premises. If you are faced with a medical emergency, you may secure assistance from a hospital or physician/health care provider of your choice. However, once the emergency no longer exists, the injured employee must treat with a listed provider for the remainder of the ninety (90) day period.

During the initial ninety (90) days from the date of your first visit, you have the right to switch from one health care provider on the list to another, and your employer will pay for that treatment.

If a designated health care provider refers you for treatment to another health care provider whose name is not on the list, your employer will pay for the treatment rendered by the provider to whom you were referred.

Naturally, you have the right to seek treatment or medical consultation from a non-designated health care provider during the initial ninety (90) day period following the first visit, but you are personally responsible for payment for those services.

You have the right to seek treatment from any health care provider at the expiration of the ninety (90) day period from the date of first visit. Your employer will pay for this treatment unless the treatment is found to be unreasonable or unnecessary by a utilization review organization pursuant to the utilization review process contained in the Workers' Compensation Act.

Your employer will be responsible for the cost of that treatment after the initial ninety (90) day period has ended but only if you notify the employer that you are receiving treatment from non-designated health care provider and only if that notice is provided to your employer within five (5) days of the first visit to that provider. If you provide notice to your employer of treatment by a non-designated provider more than five (5) days after the first visit to that provider, the employer will not be responsible to pay for treatment rendered by that non-designated provider until it receives notification from you that you are receiving such treatment.

Should a designated health care provider prescribe invasive surgery, your employer will pay for an additional opinion from a health care provider of your choice. If the additional opinion differs from the opinion of the designated health care provider and if the additional opinion provides a specific and detailed course of treatment, you will then determine which course of treatment to follow. If you choose to follow the procedures recommended in the additional opinion, your employer will pay to have such procedures performed by one of its designated health care providers and will not be responsible for payment for treatment provided by a non-designated provider for a period of ninety (90) days from the date of your visit to the health care provider from whom you obtained the additional opinion.

	AT I HAVE BEEN INFORMED OF AND UN NSYLVANIA WORKERS' COMPENSATIC	
Employee Name	Employee Signature	Date
I hereby acknowledge that I have	TION AT OR NEAR THE TIME OF THE Columbia been informed again and that I understan ensation Act. I have received a copy of the	d my rights and duties under
Employee Name	Employee Signature	Date.

		•			
			-		
				# 9 1	
				•	
				X 1	

SCHOOL PERSONNEL HEALTH RECORD (FOR USE AFTER OFFER OF EMPLOYMENT HAS BEEN MADE)

I. INFORMATION School Position Offered _____ Last Name **First** MI Sex Date of Birth Home Phone Cell Phone Work Phone Mailing Address: Street City State Zip **Emergency Contact** Relationship: Name: Address: Telephone number: (Home) (Work) (Cell)

II. IMMUNIZATION HISTORY (Recommended, but not mandated by law)

VACCINE Check appropriate box		Enter Month, Day, and Year Each Immunization DOSE Was Given							
Diphtheria, Tetanus with Pertussis ☐Td ☐TdaP	1	2	3	4	5				
Hepatitis B	1	2	3		- Author				
Measles-Mumps-Rubella (MMR)	1	2	Mumps dise	Rubella Serology/Date/Titer Mumps disease diagnosed by a physician: Date Measles Serology/Date/Titer					
Varicella Vaccine Disease Serology Date: Neg/Pos	1	2							
Influenza	- 1	2	3						

III. TUBERCULOSIS SKIN TEST RESULTS (Testing required per Regulations of the Department of Health)

L	SITE: GIVEN BY:	ANTIGEN NAME	MANUFACTURER / LOT # / EXP DATE	SIGNATURE
DATE READ	RESULTS in MM		READ BY SIGNATURE	

IGRA TEST RESULTS

Lungs - Adventious Findings

DATE COLLECTED	TEST NAME (QFT-GIT, T- SPOT, etc)	POSITIV	/E NE	GATIVE	INDETERMINATE	QUANTITATIVE RESULT
DATE TEST COMPL	LETED			SIG	NATURE	
Previously known/new	positive reactors:					
Chest X-ray: (Attach a copy of the re	Other: (Attacl	h a copy of the	Date: e report.)	Results:		
Preventive Anti-Tuberc	ulosis Chemotherapy	ordered: No	,	Yes Da	ate:	_
IF SIGNIFICANT REA IS CURRENTLY FREI	CTION WAS REPOI E FROM TUBERCUI	RTED, THE PRI LOSIS DISEASE	MARY CARE P	ROVIDER R	EPORT MUST STATE	THAT THE APPLIC
IV. MEDICAL CON						
Allergies	Ye	es No	If Yes, Expla	ıin:		
Asthma		┥ ├┤				
Cardiac		<u> </u>				
Chemical Dependency.		╡ ├┤				
Drugs		╡				
Alcohol		i H				
Diabetes Mellitus	F	i H				
, mo		╡				
Gastrointestinal Disorde						
Hearing Disorder	Ē] []] []				
Hearing Disorder Hypertension						
Hearing Disorder Hypertension Neuromuscular Disorde	pr]				
Hearing Disorder Hypertension Neuromuscular Disorde Orthopedic Condition	r]				
Hearing Disorder	т					
Hearing Disorder						
Hearing Disorder						
Hearing Disorder						
Hearing Disorder						
Hearing Disorder				NOT		
Hearing Disorder		NORMAL	ABNORMAL	NOT EXAMINED	CO	MMENTS
Hearing Disorder		NORMAL	ABNORMAL) COI	MMENTS
Hearing Disorder		NORMAL	ABNORMAL) COI	MMENTS
Hearing Disorder		NORMAL	ABNORMAL) CO!	MMENTS
Hearing Disorder		NORMAL	ABNORMAL) COI	MMENTS
Hearing Disorder Hypertension Neuromuscular Disorde Orthopedic Condition Respiratory Illness Seizure Disorder Vision Disorder Other (Specify) W. PHYSICAL EXA Height (inches) Weight (pounds) Pulse		NORMAL	ABNORMAL) COI	MMENTS
Hearing Disorder Hypertension Neuromuscular Disorde Orthopedic Condition Respiratory Illness Seizure Disorder Vision Disorder Other (Specify) W. PHYSICAL EXA Height (inches) Weight (pounds) Pulse Blood Pressure		NORMAL	ABNORMAL) COI	MMENTS
Hearing Disorder Hypertension Neuromuscular Disorder Orthopedic Condition Respiratory Illness Seizure Disorder Vision Disorder Other (Specify) Height (inches) Weight (pounds) Pulse Blood Pressure	AMINATION (🗸)	NORMAL	ABNORMAL) COI	MMENTS
Hearing Disorder	AMINATION (🗸)	NORMAL	ABNORMAL) COI	MMENTS
Hearing Disorder Hypertension Neuromuscular Disorder Orthopedic Condition Respiratory Illness Seizure Disorder Other Disorder Other (Specify) W. PHYSICAL EXA Height (inches) Weight (pounds) Pulse Blood Pressure Hair/Scalp Skin Eyes – Visual Acuity: RL Eyes – Color Vision	AMINATION (🗸)	NORMAL	ABNORMAL) COI	MMENTS
Hearing Disorder Hypertension Neuromuscular Disorder Orthopedic Condition Respiratory Illness Seizure Disorder Vision Disorder Other (Specify) W. PHYSICAL EXA Height (inches) Weight (pounds) Pulse Blood Pressure Hair/Scalp Skin Eyes – Visual Acuity: RL Eyes – Color Vision Ears – Hearing (dB) RL	AMINATION (🗸)	NORMAL	ABNORMAL) COI	MMENTS
Hearing Disorder Hypertension Neuromuscular Disorder Orthopedic Condition Respiratory Illness Seizure Disorder Other (Specify) W. PHYSICAL EXA Height (inches) Weight (pounds) Pulse Blood Pressure Hair/Scalp Skin Eyes – Visual Acuity: RL Eyes – Color Vision Ears – Hearing (dB) RL Nose and Throat	AMINATION (🗸)	NORMAL	ABNORMAL		COI	MMENTS
Hearing Disorder Hypertension Neuromuscular Disorder Orthopedic Condition Respiratory Illness Seizure Disorder Vision Disorder Other (Specify) W. PHYSICAL EXA Height (inches) Weight (pounds) Pulse Blood Pressure Hair/Scalp Skin Eyes – Visual Acuity: RL Eyes – Color Vision Ears – Hearing (dB) RL	AMINATION (🗸)	NORMAL	ABNORMAL) COI	MMENTS

Abdomen	- Trans - Migney I mar			
Genitourinary				
Neuromuscular System				
Extremities				
Are there any special medical proble his/her work role? If so, specify	ems or chronic dise	ases which re	quire restriction	of activity, medication which might affect
Are there any special equipment or a	accommodations ne	eeded to enabl	e this person to p	perform their duties? If so, specify
Physician Name (Print) Signature of Examiner			Date	
			•	
Physician Address				
The statements and answers as recorded above are termination of my employment.	: full, complete and true to	the best of my kno	wledge and belief. I u	nderstand that any false or misleading statements may cause
I authorize the physician or other person to disclo	se any knowledge or infor	mation pertaining to	my health to the emp	loying authority for whom this examination is performed.
Signature of Employee	Date			