New Employee Paperwork Checklist

To Be Completed by Employee & Returned to Jordan Office:

- [ ] **New Employee Paperwork Checklist (this sheet)**
- [ ] **Application - Only needed if not completed online**
- [ ] **Confidential Employee Information**
- [ ] **I-9 Employment Eligibility (***Return with* ***required forms of ID within 2 Days of Hire*****)**
- [ ] **W-4 Employee Withholding (Federal & State)**
- [ ] **Direct Deposit Authorization (***Include VOIDED Blank Check* **)**
- [ ] **Acknowledgement Form (Multiple Policies)**
- [ ] **Electronic Comm & ERISA Disclosures**
- [ ] **Voluntary Self Ident of Disability**
- [ ] **Work Opportunity Credit Form 8850**
- [ ] **Drug & Alcohol Policy Acknowledgement**

To Be Completed by Abhe:

- [ ] **I9 Form - Page 1 Section 2 (EE completes Page 1 Section 1)**

To Be Given to Employee for Reference:

- [ ] **I9 Form - Acceptable Documents & Preparer/Translator**
- [ ] **Employee Safety, Health, & Environmental (Orange Handbook)**
- [ ] **Employee Information and Consent Form - OJI Policy**
- [ ] **Employee Verification to Report Injuries**
- [ ] **EEO & Sexual Harassment Policies**
- [ ] **Vehicle and Equipment Policy**
- [ ] **Electronic Communication Policy**
- [ ] **Drug & Alcohol Policy**

California Employees:

CA Notice to Employee LC 2810.5
CA EEO Policy Supplement
CA EEO Policy Supplement Acknowledgement

WA Employees:

WA Sick Leave Notification
WA 4-10 Agreement

System User Access Request (Abhe email or network access)

Driver? ____NO____YES

If Yes, complete Company Driver Qualification Packet

PRINT EMPLOYEE NAME: ______________________________

EMPLOYEE SIGNATURE: ______________________________ DATE: ______________

Rev Feb 2024

CORPORATE OFFICE
18100 DAIRY LANE
JORDAN, MN 55352
PH (952) 447-6025
FAX (952) 447-1000

AN EQUAL OPPORTUNITY EMPLOYER

Confidential Employee Information Sheet

We are an equal opportunity employer. All employees are treated during employment without regard to race, color, religion, sex, national origin, age, marital status, or disability. To help us comply with Federal/State equal opportunity and other record keeping requirements, please answer the questions below. The information on this form will be kept confidential.

Date of Hire: ____ First actual date of work: ______________________

Full Name (First, Middle, Last): ____ Nickname: __________________

Permanent Address: ____ Telephone: (_____) ______-________
____
____

Veteran Status: Are you a veteran? ☐ Yes ☐ No (**If yes, thanks for your service!)**

Protected Veteran Status: Were you awarded a Campaign Badge (active duty in a war, campaign or expedition)? YES NO

Were you awarded the Armed Forces Service Medal (Executive Order 12985)? YES NO

Are you a disabled veteran (service-connected disability or receiving compensation)? YES NO

Separated from Service Date ____________________

Sex: ☐ Male ☐ Female ☐ Non-binary

Place of Birth: City: _________________________
State: _________________________
Country: _______________________

Emergency Contact - Person you want us to contact in case of emergency.
Permanent Contact - Person who will know how to contact you. (Needed for: mailing your W-2 Form, Cobra Insurance Notices, Pension Information, etc.). This can be the same as Emergency Contact, but should be a phone # other than your own.

	Emergency Contact	Permanent Contact
Contact Name:	______________________________	__________________________________
Contacts Address:	______________________________	__________________________________
City, State, Zip:	______________________________	__________________________________
Telephone:	______________________________	__________________________________
Relationship to you:	______________________________	__________________________________

Are you a member of one of the following minority groups? Yes / No If so, please indicate which:

☐ Hispanic or Latino ☐ Black or African American ☐ Native Hawaiian or Pacific Islander

☐ Native American or Alaska Native* ☐ Asian ☐ Two or More Races

*Tribe: __________________________

Do you have a passport? Yes / No Passport No: _________________________ Expiration Date: ___________

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 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 (if any)	Other Last Names Used (if any)

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

Date of Birth (mm/dd/yyyy)	U.S. Social Security Number	Employee's Email Address	Employee's Telephone Number

I am aware that federal law provides for imprisonment and/or fines for false statements, or the use of false documents, in connection with the completion of this form. I attest, under penalty of perjury, that this information, including my selection of the box attesting to my citizenship or immigration status, is true and correct.

Check one of the following boxes to attest to your citizenship or immigration status (See page 2 and 3 of the instructions.):

- ☐ 1. A citizen of the United States
- ☐ 2. A noncitizen national of the United States (See Instructions.)
- ☐ 3. A lawful permanent resident (Enter USCIS or A-Number.)
- ☐ 4. A noncitizen (other than **Item Numbers 2.** and **3.** above) authorized to work until (exp. date, if any)

If you check **Item Number 4.**, enter one of these:

USCIS A-Number	OR	Form I-94 Admission Number	OR	Foreign Passport Number and Country of Issuance

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

If a preparer and/or translator assisted you in completing Section 1, that person MUST complete the Preparer and/or Translator Certification on Page 3.

Section 2. Employer Review and Verification: Employers or their authorized representative must complete and sign **Section 2** within three business days after the employee's first day of employment, and must physically examine, or examine consistent with an alternative procedure authorized by the Secretary of DHS, documentation from List A OR a combination of documentation from List B and List C. Enter any additional documentation in the Additional Information box; see Instructions.

	List A	OR	List B	AND	List C
Document Title 1					
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					

	List A
Document Title 2 (if any)	
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)	

Additional Information

Check here if you used an alternative procedure authorized by DHS to examine documents.

Certification: I attest, under penalty of perjury, that (1) I have examined the documentation presented by the above-named employee, (2) the above-listed documentation appears 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.

First Day of Employment (mm/dd/yyyy):

Last Name, First Name and Title of Employer or Authorized Representative	Signature of Employer or Authorized Representative	Today's Date (mm/dd/yyyy)

Employer's Business or Organization Name	Employer's Business or Organization Address, City or Town, State, ZIP Code

For reverification or rehire, complete Supplement B, Reverification and Rehire on Page 4.

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

2024

Step 1: Enter Personal Information

(a) First name and middle initial	Last name	(b) Social security number
Address		**Does your name match the name on your social security card?** If not, to ensure you get credit for your earnings, contact SSA at 800-772-1213 or go to *www.ssa.gov*.
City or town, state, and ZIP code		

(c) ☐ **Single** or **Married filing separately**
☐ **Married filing jointly** or **Qualifying surviving spouse**
☐ **Head of household** (Check only if you're unmarried and pay more than half the costs of keeping up a home for yourself and a qualifying individual.)

Complete Steps 2–4 ONLY if they apply to you; otherwise, skip to Step 5. See page 2 for more information on each step, who can claim exemption from withholding, and when to use the estimator at *www.irs.gov/W4App*.

Step 2: Multiple Jobs or Spouse Works

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

Do **only one** of the following.

(a) Use the estimator at *www.irs.gov/W4App* for most accurate withholding for this step (and Steps 3–4). If you or your spouse have self-employment income, use this option; **or**

(b) Use the Multiple Jobs Worksheet on page 3 and enter the result in Step 4(c) below; **or**

(c) If there are only two jobs total, you may check this box. Do the same on Form W-4 for the other job. This option is generally more accurate than (b) if pay at the lower paying job is more than half of the pay at the higher paying job. Otherwise, (b) is more accurate . . . . ☐

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

Step 3: Claim Dependent and Other Credits

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

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

Multiply the number of other dependents by $500 . . . . . $

Add the amounts above for qualifying children and other dependents. You may add to this the amount of any other credits. Enter the total here . . . . | **3** | $

Step 4 (optional): Other Adjustments

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

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

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

Step 5: Sign Here

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

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

Employers Only

Employer's name and address	First date of employment	Employer identification number (EIN)

DIRECT DEPOSIT AUTHORIZATION FORM

____________________________________ ______________________

Employee Name Employee Number

I authorize Abhe & Svoboda, Inc. and the financial institution named below to automatically deposit my net pay and employee reimbursements to the account(s) listed below (this includes my authorization to reverse entries made in error). This authority will remain in effect until I give written notice to Abhe & Svoboda, Inc.'s payroll department.

CHECKING Account Number: ______________________________

ABA Routing Number: ______________________________

Financial Institution: ______________________________

____

City State

SAVINGS Account Number: ______________________________

ABA Routing Number: ______________________________

Financial Institution: ______________________________

____

City State

Attach a **VOIDED CHECK, SCREEN PRINT** or a **BANK ACCOUNT INFORMATION DOCUMENT** from your bank to ensure accurate bank routing and account numbers.

Select One:

☐ ONLINE ACCESS – view your paystub at: https://spectrum.abheonline.com

Your Email Address: ______________________________@________________

☐ RECEIVE A PRINTED COPY – Mailed to the address printed on the paystub. This option will NOT allow access to the Employee Dashboard including on-line paystubs/W-2's.

____________________________________ ________________________

Signature Date

CORPORATE OFFICE
18100 DAIRY LANE
JORDAN, MN 55352
PH (952) 447-6025
FAX (952) 447-1000

AN EQUAL OPPORTUNITY EMPLOYER

Policies Acknowledgement Form

I, ______________________________________, acknowledge that I have
Print Full Name

received the following documents & policies:

- Employee Safety, Health, & Environmental Handbook, Rev Jan 2023
- Employee Information Release, Rev Jan 2023
- Employee Verification to Report Injuries, Rev Jan 2023
- EEO and Sexual Harassment & Offensive Behavior Policy, Rev Jan 2023
- Vehicle and Equipment Policy, Rev 2023
- Electronic Communication Policy, Rev 2023

I have been given the opportunity to read the documents in their entirety. I have been informed that I can have someone read this information to me, if necessary. I thoroughly understand the documents/policies and my responsibilities as an employee and the expectations contained herein.

I further acknowledge that it is my responsibility to work within the Equal Employment Opportunity Policy (EEOC), Drug and Alcohol Abuse Policy, Injury Reporting Policy and Safety, Health and Environmental rules. I also understand the Code of Conduct Policy and its repercussions.

I have been provided an adequate opportunity to ask questions regarding all of the subject matter contained in these documents/policies. At this time, I have no questions regarding the content. I also understand that if I have questions later that I can approach Management without fear of reprisal and have my questions answered in a timely manner.

I acknowledge that I have read, understand & agree to comply.

Employee Name (Printed): ___________________________

Employee Signature: ____________________ Date: _______________

Electronic Communications & ERISA Disclosures

______________________________ ____________________
Employee Name Employee Number

The following documents will be available through Electronic Media:

- 401K & Medical Summary Plan Descriptions (SPD)
- Summary Annual Reports (SAR)
- Pension Qualified Default Investment Notice
- Domestic Partner Policy
- General Notice on Family & Medical Leave Act (FMLA)
- HIPAA Notice of Privacy Practices
- Summary of Benefits and Coverage (SBC)
- Any other disclosure or notice which is available electronically.

Please select one option below and sign.

☐ I agree to receive communications and disclosure documents by electronic media.

☐ Use Email Address on file; or

Your Email Address: __________________________@______________

☐ I opt out of electronic communications and will receive paper copies.

____
Employee Signature

Voluntary Self-Identification of Disability

Form CC-305
Page 1 of 1

OMB Control Number 1250-0005
Expires 04/30/2026

Name: ______________________________ Date: ____________________

Employee ID: ______________________________
(if applicable)

Why are you being asked to complete this form?

We are a federal contractor or subcontractor. The law requires us to provide equal employment opportunity to qualified people with disabilities. We have a goal of having at least 7% of our workers as people with disabilities. The law says we must measure our progress towards this goal. To do this, we must ask applicants and employees if they have a disability or have ever had one. People can become disabled, so we need to ask this question at least every five years.

Completing this form is voluntary, and we hope that you will choose to do so. Your answer is confidential. No one who makes hiring decisions will see it. Your decision to complete the form and your answer will not harm you in any way. If you want to learn more about the law or this form, visit the U.S. Department of Labor's Office of Federal Contract Compliance Programs (OFCCP) website at www.dol.gov/ofccp.

How do you know if you have a disability?

A disability is a condition that substantially limits one or more of your "major life activities." If you have or have ever had such a condition, you are a person with a disability. **Disabilities include, but are not limited to:**

- Alcohol or other substance use disorder (not currently using drugs illegally)
- Autoimmune disorder, for example, lupus, fibromyalgia, rheumatoid arthritis, HIV/AIDS
- Blind or low vision
- Cancer (past or present)
- Cardiovascular or heart disease
- Celiac disease
- Cerebral palsy
- Deaf or serious difficulty hearing
- Diabetes
- Disfigurement, for example, disfigurement caused by burns, wounds, accidents, or congenital disorders
- Epilepsy or other seizure disorder
- Gastrointestinal disorders, for example, Crohn's Disease, irritable bowel syndrome
- Intellectual or developmental disability
- Mental health conditions, for example, depression, bipolar disorder, anxiety disorder, schizophrenia, PTSD
- Missing limbs or partially missing limbs
- Mobility impairment, benefiting from the use of a wheelchair, scooter, walker, leg brace(s) and/or other supports
- Nervous system condition, for example, migraine headaches, Parkinson's disease, multiple sclerosis (MS)
- Neurodivergence, for example, attention-deficit/hyperactivity disorder (ADHD), autism spectrum disorder, dyslexia, dyspraxia, other learning disabilities
- Partial or complete paralysis (any cause)
- Pulmonary or respiratory conditions, for example, tuberculosis, asthma, emphysema
- Short stature (dwarfism)
- Traumatic brain injury

Please check one of the boxes below:

☐ Yes, I have a disability, or have had one in the past
☐ No, I do not have a disability and have not had one in the past
☐ I do not want to answer

PUBLIC BURDEN STATEMENT: According to the Paperwork Reduction Act of 1995 no persons are required to respond to a collection of information unless such collection displays a valid OMB control number. This survey should take about 5 minutes to complete.

For Employer Use Only

Employers may modify this section of the form as needed for recordkeeping purposes.
For example:
Job Title: _______________ Date of Hire: _______________

Form **8850**
(Rev. March 2016)
Department of the Treasury
Internal Revenue Service

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

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

OMB No. 1545-1500

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

Your name ____________________ Social security number ▶ ____________

Street address where you live ____________________

City or town, state, and ZIP code ____________________

County ____________________ Telephone number ____________

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

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

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

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

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

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

6 ☐ Check here if you are a member of a family that:
- Received TANF payments for at least the past 18 months; **or**
- Received TANF payments for any 18 months beginning after August 5, 1997, **and** the earliest 18-month period beginning after August 5, 1997, ended during the past 2 years; **or**
- Stopped being eligible for TANF payments during the past 2 years because federal or state law limited the maximum time those payments could be made.

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

Signature—All Applicants Must Sign

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

Job applicant's signature ▶ ____________________ **Date** ____________

ACKNOWLEDGMENT OF RECEIPT
OF DRUG AND ALCOHOL POLICY

I, ____________________________________, acknowledge receipt of Abhe & Svoboda, Inc.'s Corporate Drug and Alcohol Policy.

____ _______________________
Employee's Signature Date

____ _______________________
Witness Date