AFFECTIONATE
Home Health Care LLC
14 South Lansdowne Ave Lansdowne PA 19050

DIRECT CARE WORKER (DSW)
APPLICATION FORM

Affectionate Home Health Care Services LLC. is an equal opportunity employer that does not discriminate on the basis of race, creed, color, sex, marital status, religion, age, national origin, handicap, veteran status or sexual preferences.

The information below will be collected for the pre-employment purposes and do not guarantee the employment with Affectionate Home Health Care services LLC. Please return the completed form to our office.

PERSONAL INFORMATION

Last name, First name and middle name		
Date of Birth	Ethnicity	Sex
Street Address		
City	State	Zip
Social Security Number		Phone
Emergency Contact	Relationship	

1. Have you ever applied for employment with us? Yes___ No___
If YES, month and Year _____
2. Will you work overtime? Yes____ No _____
3. Are you legally eligible for employment in the United States? Yes ____ No ____

Do you have any condition which would require job accommodations? Yes No

If yes, please describe accommodations required below.

Have you ever been convicted of a criminal offense (felony or misdemeanor)? Yes No

If yes, please state the nature of the crime(s), when and where convicted and disposition of the case:

(Note: No applicant will be denied employment solely on the grounds of conviction of a criminal offense. The date of the offense, the nature of the offense, including any significant details that affect the description of the event, and the surrounding circumstances and the relevance of the offense to the position(s) applied for may, however, be considered.)

Job Skills/Qualifications

Please list below the skills and qualifications you possess for the position for which you are applying:

(Note: Affectionate Home Health Care Services complies with the ADA and considers reasonable accommodation measures that may be necessary for eligible applicants/employees to perform essential functions.)

Education and Training

High School

Name	Location (City, State)	Year Graduated	Degree Earned

College/University

Name	Location (City, State)	Year Graduated	Degree Earned

Vocational School/Specialized Training

Name	Location (City, State)	Year Graduated	Degree Earned

Military:

Are you a member of the Armed Services?

What branch of the military did you enlist?

What was your military rank when discharged?

How many years did you serve in the military?

What military skills do you possess that would be an asset for this position?

_____

_____

Previous Employment

Employer Name: _____
Job Title: _____
Supervisor Name: _____
Employer Address: _____
City, State and Zip Code: _____
Employer Telephone: _____
Dates Employed: _____
Reason for leaving: _____

Employer Name: _____
Job Title: _____
Supervisor Name: _____
Employer Address: _____
City, State and Zip Code: _____
Employer Telephone: _____
Dates Employed: _____
Reason for leaving: _____

Employer Name: _____
Job Title: _____
Supervisor Name: _____
Employer Address: _____
City, State and Zip Code: _____
Employer Telephone: _____
Dates Employed: _____
Reason for leaving: _____

References

Please provide 3 personal and professional reference(s) below:

Reference	Contact Information

AT-WILL EMPLOYMENT

The relationship between you and the Affectionate Home Health Care Services referred to as "employment at will." This means that your employment can be terminated at any time for any reason, with or without cause,

with or without notice, by you or the Affectionate Home Health Care Services No representative ofAffectionate Home Health Care Serviceshas authority to enter into any agreement contrary to the foregoing "employment at will" relationship. You understand that your employment is "at will," and that you acknowledge that no oral or written statements or representations regarding your employment can alter your at-will employment status, except for a written statement signed by you and either our Executive Vice-President/Chief Operations Officer or the Company's President.

Applicant Signature: _____ Dated: _____

Affectionate Home Health Care
145 Lansdowne Ave
Lansdowne Pa, 19050
484-461-4369
Affectionatehhc@yahoo.com

NON DISCRIMINATION

Attention: Employees of Affectionate Home Health Care:

In accordance with title VI of the Civil Rights Act of 1964 and its implementing regulation, the agency will not, directly or through contractual arrangements discriminate on the basis of race, color, or national origin in its admissions or its provision of services and benefits, including assignments of transfers or referrals to or from the agency. Staff privileges (if appropriate) are granted without regard to race, color, or national origin.
In accordance with Section 504 of the Rehabilitation Act of 1973 and its implementing regulation, the agency will not directly or through contractual arrangements, discriminate on the basis of disability in admission, access, treatment or employment. The agency Director of Nursing will serve as the section 504 Coordinator.
In accordance with the Age Discrimination Act 1975 and its implementing regulation, the agency will not directly or through contractual or other arrangements, discriminate on the basis of age in the provision of services, unless age is a factor necessary to normal operations or the achievement of any statutory objective.
In accordance with the "Pennsylvania Human Relations Act", the agency will not directly or through contractual or other arrangements, discriminate because of race, color, religious creed, ancestry, age, or national origin.. If you have any questions or concerns regarding our policy, please.do not hesitate to contact Affectionate Home Health Care.

Thank you, in advance, for your understanding in this matter.

Sincerely,

Affectionate Home Health Care *Your signature indicates that you fully understand and agree to follow the rules of the above statement.*

Print_____

Sign _____

Date_____

AFFECTIONATE HOME HEALTH CARE LLC.

14 South Lansdowne Ave, Lansdowne PA, 29050 P:484-461-4269 F:484-461-4598

This pay rate agreement is between Affectionate Home Health Care LLC. and _____ to
(Print Name)

Confirm that in the event of an Hour(s) Increase or Decrease the Direct Care Workers Pay Rate may be subject to change.

Pay Rate: _____
Overtime Rate: _____

Employee Signature:_____ Date_____

Employer Signature :_____ Date_____

AFFECTIONATE HHC
14 S LANSDOWNE AVE
LANSDOWNE PA 19050
Phone 484-461-4369 Fax 484-461-4598

Attention all staff as you guys may know Affectionate Home Health Care Agency runs on a weekly pay, due to the fact of late time sheets there will be a fee applied to those who submit the time sheets late, It's going to be a cost for us to submit two weeks worth of pay so there will be a fee applied to those who time sheets are submitted late and want a two weeks pay.

Thank You.

Affectionate Home Health Care

Employee signature of agreement to the above statement, in which they clearly understand if the time sheets are turned in after 12pm Monday afternoon pay will be withheld, if time sheets are turned in on time but are incorrectly filled out or incomplete pay will be withheld.

Print(first and last name)

_____

sign

_____

*Date*_____

AFFECTIONATE HOME HEALTH CARE LLC.

14 South Lansdowne Ave, Lansdowne PA, 29050 P:484-461-4269 F:484-461-4598

This pay rate agreement is between Affectionate Home Health Care LLC. and _____ to
(Print Name)

Confirm that in the event of an Hour(s) Increase or Decrease the Direct Care Workers Pay Rate may be subject to change.

Pay Rate: _____
Overtime Rate: _____

Employee Signature: _____ Date _____

Employer Signature : _____ Date _____

AFFECTIONATE HOME HEALTH CARE, LLC
14 South Lansdowne Ave, Lansdowne, PA. 19050
o *Phone 484-461-4369 Fax: 484-461-4598*
PHYSICAL EXAMINATION

PATIENT NAME_____ BIRTHDATE_____ PHONE_____

SOCIAL SECURITY #___-___-_____ DATE OF EXAMINATION___/___/_____

MAILING ADRESS _____

Height_____ weight_____ Temp____ Pulse_____ Resp_____ Standing_____/_____
Seating_____/_____
Lying_____/_____

Chief Complaint:_____

History of Present Illness: (note location, qualities, severity, duration, timing, context, modifying factors, associated signs &symptoms)

Problem 1:	New	Established	stable	evolving
Problem 2:	New	Established	stable	evolving
Problem3:	New	Established	stable	evolving

o GENERAL APPERANCE AND DEVELOPMENT: Good Fair Poor

VISION: For distance Right/20 Left/20 Both/20 Without corrective lenses
With corrective lenses
Evidence of diseases or injury:: Right_____ Left_____
Color test: Right_____ Left_____
Horizontal Field of vision: Right_____ Left_____

HEARING: Right ear_____ Left ear_____
Evidence of diseases or injury: Right ear_____ Left ear_____

AUDIOMETRIC TEST: 500HZ 1000HZ 2000HZ 3000HZ 4000HZ
5000HZ 6000HZ 7000HZ 8000HZ

THROAT: _____

THORAX: Heart:_____
If organic disease is present, is it fully compensated?_____
Blood pressure: systolic_____ Diastolic_____
Pulse: Before exercise_____ Immediately after_____
Lungs:_____

ABDOMEN: Scars_____ Abdominal Masses_____ Tenderness_____

_____ _____ _____
Signature of Physician, Certified Nurse Practitioner or Registered Assistant | Date | Print or Stamp Name

AFFECTIONATE HOME HEALTH CARE, LLC
14 South Lansdowne Ave, Lansdowne PA. 19050
o Phone 484-461-4369 Fax: 484-461-4598

Employee Mantoux Tuberculin Skin Test (TST) Record

I _____ give permission to administer the Mantoux Tuberculin Skin Test (TST) for the detection of Tuberculosis (TB) exposure.

The MantouxTuberculin Skin Test (TST) is required to be given annually to assist in the detection of TB exposure. The Mantoux Tuberculin Skin Test (TST) is not given as a vaccine. A positive exposure will indicate further evaluation, such as, Chest X-ray. After receiving the Mantoux Tuberculin Skin Test (TST), the results will be read in 72-hours by licensed health professional.

_____ _____

Employee Name (Please print) Employee Signature

_____

Date

_____ _____

Health Professional Name (please print) Health Professional Signature

_____

Date

2-STEP: NEW EMPLOYEES ONLY							
Date Admin	Site	Lot #	EXP Date Of Lot	Given by:	Date Read	MM Indur.	Read By:

ANNUAL							
Date Admin	Site	Lot #	EXP Date Of Lot	Given by:	Date Read	MM Indur.	Read By:

CHEST X-RAY*

Date	Result

*If an employee has a history of a positive Tuberculin Skin Test (TST), a chest x-ray taken no longer than 60 days prior to his hire must be kept on file. In addition the employee must have documented annual monitoring of symptoms of TB.

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

2020

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 widow(er))
☐ 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, when to use the online estimator, and privacy.

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); or

(b) Use the Multiple Jobs Worksheet on page 3 and enter the result in Step 4(c) below for roughly accurate withholding; 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 accurate for jobs with similar pay; otherwise, more tax than necessary may be withheld . . . . . ▶ ☐

TIP: To be accurate, submit a 2020 Form W-4 for all other jobs. If you (or your spouse) have self-employment income, including as an independent contractor, use the estimator.

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 Dependents

If your 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 and 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)

Employment Eligibility Verification
Department of Homeland Security
U.S. Citizenship and Immigration Services

USCIS
Form I-9
OMB No. 1615-0047
Expires 10/31/2022

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

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

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

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

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

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

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

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

☐ 1. A citizen of the United States

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

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

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

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

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

QR Code - Section 1
Do Not Write In This Space

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

Preparer and/or Translator Certification (check one):

☐ I did not use a preparer or translator. ☐ A preparer(s) and/or translator(s) assisted the employee in completing Section 1.

(Fields below must be completed and signed when preparers and/or translators assist an employee in completing Section 1.)

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

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

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

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

STOP *Employer Completes Next Page* STOP

Employment Eligibility Verification

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

USCIS
Form I-9
OMB No. 1615-0
Expires 10/31/20

Section 2. Employer or Authorized Representative Review and Verification

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

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

List A Identity and Employment Authorization	OR	List B Identity	AND	List C Employment Authorizatio

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

Additional Information

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

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

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

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

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

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

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

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

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

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

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

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

AFFECTIONATE HOME HEALTH CARE LLC.

14 South Lansdowne Ave,
Lansdowne, PA. 29050

Criminal Record Check:

All employees of Affectionate Home Health Care are required to have a criminal background checks. The fee is twenty ($23) dollars and will be deducted from your pay roll. An employee is prohibited from employment through AHHC if results reveal a conviction specified in the waiver's respective regulation. You as an employer may decide to move forward with a potential employee if other convictions are revealed in those results.

However, family members are required to sign at the bottom, agreeing that they want their family members to work with them, regardless of their criminal history. Non family member can indicate N/A on this section.

I _____ agreed that, (_____) will work for me as a Home Health Aide, regardless of their criminal history.

_____ _____

Consumer Signature *Administrative Signature*

_____ _____

Employee Signature Administrative Signature

Assigned Employee Confidentiality and Privacy Agreement

Date: _____

As a condition of my assignment by Affectionate Home Health Care, LLC with any assigned Care, I hereby acknowledge and agree as follows:

I will not use, disclose, or in any way reveal or disseminate to unauthorized parties any information I gain through contact with materials or documents that are made available through my assignment at Client or that I learn about during such assignment.

I will not disclose or in any way reveal or disseminate any information pertaining to Client or its operating methods and procedures that comes to my attention as a result of this assignment.

Under no circumstances shall I remove copies or documents from the premises of Client.

I have read the attached "Summary of HIPAA Privacy Rules for Personnel" and understand it. During my assignment with at Client, I will abide by the principles described in this attached summary as well as any privacy policy provided to me by the Client. In particular, I will not use, disclose or in any way reveal or disseminate any protected health information that I learn in connection with any assignment, except in accordance with such principles and privacy policy.

I understand that I shall be responsible for any direct or consequential damages resulting from any violation of this Agreement. This obligation of this Agreement shall remain in effect even after my employment by Affectionate Home Health Care has ended.

Assigned Employee	Witness
_____	_____
Printed Name	Printed Name
_____	_____
Signature	Signature
_____	_____
Date	Date

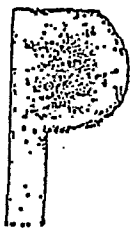
LISTS OF ACCEPTABLE DOCUMENTS
All documents must be UNEXPIRED

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

LIST A Documents that Establish Both Identity and Employment Authorization	OR	LIST B Documents that Establish Identity	AND	LIST C Documents that Establish Employment Authorization
1. U.S. Passport or U.S. Passport Card		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		1. A Social Security Account Number card, unless the card includes one of the following restrictions: (1) NOT VALID FOR EMPLOYMENT (2) VALID FOR WORK ONLY WITH INS AUTHORIZATION (3) VALID FOR WORK ONLY WITH DHS AUTHORIZATION
2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551)		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		2. Certification of report of birth issued by the Department of State (Forms DS-1350, FS-545, FS-240)
3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa		3. School ID card with a photograph		3. Original or certified copy of birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal
4. Employment Authorization Document that contains a photograph (Form I-766)		4. Voter's registration card		4. Native American tribal document
5. For a nonimmigrant alien authorized to work for a specific employer because of his or her status: a. Foreign passport; and b. Form I-94 or Form I-94A that has the following: (1) The same name as the passport; and (2) An endorsement of the alien's nonimmigrant status 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.		5. U.S. Military card or draft record		5. U.S. Citizen ID Card (Form I-197)
		6. Military dependent's ID card		6. Identification Card for Use of Resident Citizen in the United States (Form I-179)
		7. U.S. Coast Guard Merchant Mariner Card		7. Employment authorization document issued by the Department of Homeland Security
6. 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 and the FSM or RMI		8. Native American tribal document		
		9. Driver's license issued by a Canadian government authority		
		For persons under age 18 who are unable to present a document listed above:		
		10. School record or report card		
		11. Clinic, doctor, or hospital record		
		12. Day-care or nursery school record		

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

Refer to the instructions for more information about acceptable receipts.



CORPORATE
PAYROLL SERVICES
2 Neshaminy Interplex Suite 104
Trevose, PA 19053
(215) 244-2580
www.corpay.com

DATE: ___/___/___ CUSTID: ___ ___ ___ ___ ___ ___

Company Name: _____

Employee ID/Name: _____ _____

Employee Bank Routing Number: _____

Employee Bank Account Number: _____

This letter confirms the above listed Company and Employee accept full liability for Corporate Payroll Services providing direct deposit service to the above listed Employee bank routing and account number. This bank account only allows money to be deposited into it, not drafted from it. Therefore, it is considered a non-transaction bank account. If a payroll error occurs that results in the Employee being overpaid, regardless of who is at fault, the Company understands Corporate Payroll Services will be unable to retrieve any funds from this bank account. As a result, the Company cannot be reimbursed by Corporate Payroll Services for any money erroneously paid to the Employee.

Agreed and understood,

_____	_____	_____
Authorized Payroll Contact	Employee	Corporate Payroll Services

Corporate Payroll Services

Authorization Agreement For Direct Deposit Employees

For direct deposit employees, this Authorization Agreement along with voided check(s) or deposit ticket(s) must be received a minimum of 5 banking days before the first direct deposit pay date. This Authorization Agreement may be initially faxed along with a copy of voided check(s) or deposit ticket(s) to (215) 244-2581. Originals must be received by us within 5 business days.

Employee Name _____ Employee ID # _____

Company Name _____ Cust. ID # _____

Corporate Payroll Services cannot set up direct deposits for "credit only" accounts. These accounts do not allow debit entries, which are necessary for voiding and reissuing checks.

Corporate Payroll Services does not offer direct deposit of funds to either a foreign bank or a U.S. financial institution where the entire amount will be forwarded to a bank account in another country. If this situation applies to you, please do not complete this form.

If you only have one account, simply write 100 next to the % sign in the first row. You may choose up to 4 accounts into which your net pay is deposited. Please enter either a dollar amount or a percentage for all accounts. If you choose the dollar amount, the remaining amounts will be directed to the first account listed below. If using the % method, the total of the percentages must equal 100%.

$ All Remaining OR _____ % * Bank Name: _____ Checking ___ Savings ___

Routing: _____ Acct# _____

$ _____ OR _____ % * Bank Name _____ Checking ___ Savings ___

Routing _____ Acct# _____

$ _____ OR _____ % * Bank Name _____ Checking ___ Savings ___

Routing _____ Acct# _____

$ _____ OR _____ % * Bank Name _____ Checking ___ Savings ___

*Total for ALL % amounts must = 100 Routing _____ Acct# _____

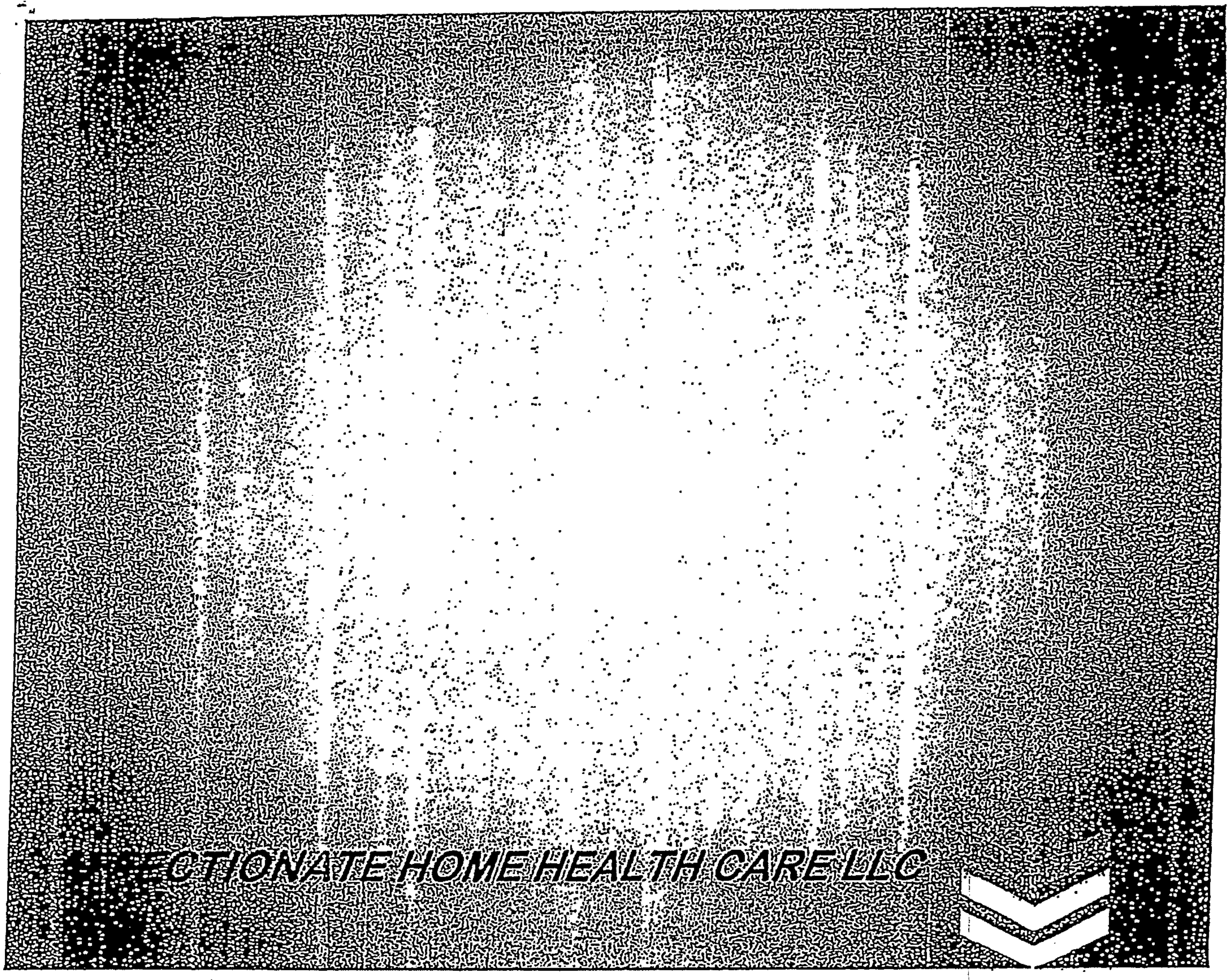
I hereby authorize Corporate Payroll Services, its agents and the bank named above to initiate credit and any necessary adjusting debit entries to my account(s) indicated above. This Authority is to remain in effect until Corporate Payroll Services and the bank have received written notice from me of its termination in such time and manner as to afford Corporate Payroll Services and the bank a reasonable opportunity to act on it.

Signature: _____ Date ___/___/___

*Please email my direct deposit stub to : _____

Staple copy of voided check(s) to this form when sending originals

For office use only: Entered by _____ Date _____ Email entered? Y N Notes: _____
Verified by _____ Date _____ Email verified? Y N Notes: _____



[illegible]

Employee Confi[illegible] Information and Agre[illegible]

[illegible] for Employee [illegible]

a. Agreement

[illegible] Practices

[illegible]nowledgement and Consent