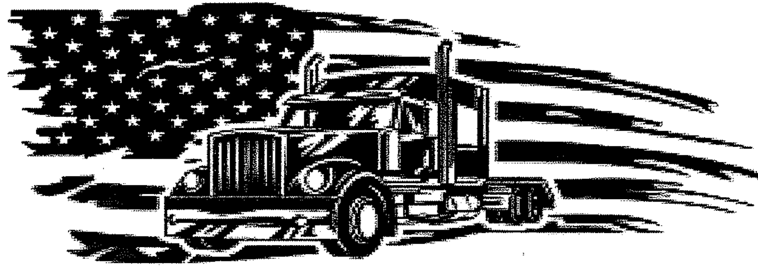


A&B Logistics LLC

Local Haul Employee Package

Incentives:

- Ascension Tri State Clinic offers free for employees and family beginning the first day of employment.
- Referral Bonus: $500 if hired
- Uniform rental through Aramark (optional)
- After 6 months of employment, you receive paid holidays. An employee must work the day before/after to be eligible and maintain a 90% attendance.
- One week vacation after an employee has been employed for one year and maintained a 90% attendance.
- Weekly Health Insurance Contributions and Simple IRA plan after 90 days of employment. (A&B matches up to $50 weekly)

Pay Options:

- Weekly pay with direct deposit.
- A&B Contracting load rates change after one year, five years and ten years. It is your responsibility to inform the office of your anniversary date. Load rate sheet is enclosed.

This is an example driver employment application. Carriers do not need to use this exact form, but must have a completed and signed employment application for all drivers that contains the information listed in 49 CFR 391.21.

DRIVER EMPLOYMENT APPLICATION

[COMPANY NAME, ADDRESS, PHONE NUMBER, AND EMAIL]
An Equal Opportunity Employer

COMPLETE IN FULL OR IT WILL NOT BE CONSIDERED.

APPLICANT INFORMATION

FIRST NAME		MIDDLE NAME		LAST NAME	
PHONE		EMAIL			
DATE OF BIRTH		SOCIAL SECURITY #			
DATE OF APPLICATION		POSITION APPLIED FOR		DATE AVAILABLE FOR WORK	

Do you have legal right to work in the United States? ☐ YES ☐ NO

PREVIOUS THREE YEARS RESIDENCY

Attach additional sheet if more space is needed

	STREET	CITY	STATE	ZIP CODE	# OF YEARS AT ADDRESS
CURRENT					
MAILING					
PREVIOUS					
PREVIOUS					
PREVIOUS					

LICENSE INFORMATION

No person who operates a commercial motor vehicle shall at any time have more than one driver's license (49 CFR 383.21). I certify that I do not have more than one motor vehicle license, the information for which is listed below. Include all licenses held for the past 3 years; attach additional sheets if needed.

STATE	LICENSE #	TYPE/CLASS	ENDORSEMENTS	EXPIRATION DATE
PREVOIUSLY HELD LICENSES				

DRIVING EXPERIENCE

CLASS OF EQUIPMENT	TYPE OF EQUIPMENT (VAN, TANK, FLAT, ETC.)	DATE FROM	DATE TO	APPROX # OF MILES (TOTAL)
STRAIGHT TRUCK				
TRACTOR & SEMI-TRAILER				
TRACTOR & 2 TRAILERS				
TRACTOR & TANKER				
OTHER				

ACCIDENT RECORD FOR THE PAST 3 YEARS

Attach additional sheet if more space is needed. Check this box if none ☐

DATES (List most recent first)	NATURE OF ACCIDENT (Head-on, rear-end, upset, etc.)	# FATALITIES	# INJURIES	CHEMICAL SPILLS (Y/N)

TRAFFIC CONVICTIONS AND FORFEITURES FOR THE PAST 3 YEARS (OTHER THAN PARKING VIOLATIONS)

Attach additional sheet if more space is needed. Check this box if none ☐

DATE CONVICTED (Month/Year)	VIOLATION	STATE OF VIOLATION	PENALTY (Forfeited bond, collateral and/or points)

Have you ever been denied a license, permit, or privilege to operate a motor vehicle? ☐ YES ☐ NO

If yes, explain

Has any license, permit, or privilege ever been suspended or revoked? ☐ YES ☐ NO

If yes, explain

EMPLOYMENT HISTORY

The Federal Motor Carrier Safety Regulations (49 CFR 391.21) require that all applicants wishing to drive a commercial vehicle list all employment for the last three (3) years. ***In addition, if you have driven a commercial vehicle previously, you must provide employment history for an additional seven (7) years (for a total of ten (10) years). Any gaps in employment in excess of one (1) month must be explained.***

Start with the last or current position, including any military experience, and work backwards (attach separate sheets if necessary). You are required to list the complete mailing address, including street number, city, state, zip; and complete all other information.

CURRENT (MOST RECENT) EMPLOYER					
NAME				PHONE	
ADDRESS					
POSITION HELD		FROM MO/YR		TO MO/YR	
REASON FOR LEAVING				SALARY	
EXPLAIN ANY GAPS IN EMPLOYMENT (Include month/year & reason)					

While employed here, were you subject to the Federal Motor Carrier Safety Regulations? ☐ YES ☐ NO

Was the job designated as a safety-sensitive function in any Department of Transportation-regulated mode subject to alcohol and controlled substances testing as required by 49 CFR, part 40? ☐ YES ☐ NO

SECOND (MOST RECENT) EMPLOYER

NAME		PHONE			
ADDRESS					
POSITION HELD		FROM MO/YR		TO MO/YR	
REASON FOR LEAVING				SALARY	
EXPLAIN ANY GAPS IN EMPLOYMENT (Include month/year & reason)					

While employed here, were you subject to the Federal Motor Carrier Safety Regulations? ☐ YES ☐ NO

Was the job designated as a safety-sensitive function in any Department of Transportation-regulated mode subject to alcohol and controlled substances testing as required by 49 CFR, part 40? ☐ YES ☐ NO

THIRD (MOST RECENT) EMPLOYER

NAME		PHONE			
ADDRESS					
POSITION HELD		FROM MO/YR		TO MO/YR	
REASON FOR LEAVING				SALARY	
EXPLAIN ANY GAPS IN EMPLOYMENT (Include month/year & reason)					

While employed here, were you subject to the Federal Motor Carrier Safety Regulations? ☐ YES ☐ NO

Was the job designated as a safety-sensitive function in any Department of Transportation-regulated mode subject to alcohol and controlled substances testing as required by 49 CFR, part 40? ☐ YES ☐ NO

EDUCATION

SCHOOL	NAME & LOCATION	COURSE OF STUDY	YEARS COMPLETED	GRADUATE Y	GRADUATE N	DETAILS
High School				☐	☐	
College				☐	☐	
Other				☐	☐	

OTHER QUALIFICATIONS

Please list any other qualifications that you have and which you believe should be considered.

TO BE READ AND SIGNED BY APPLICANT

I authorize you to make investigations (including contacting current and prior employers) into my personal, employment, financial, medical history, and other related matters as may be necessary in arriving at an employment decision. I hereby release employers, schools, health care providers, and other persons from all liability in responding to inquiries and releasing information in connection with my application.

In the event of employment, I understand that false or misleading information given in my application or interview(s) may result in discharge. I also understand that I am required to abide by all rules and regulations of the Company.

I understand that the information I provide regarding my current and/or prior employers may be used, and those employer(s) will be contacted for the purpose of investigating my safety performance history as required by 49 CFR 391.23. I understand that I have the right to:

- Review information provided by current/previous employers;
- Have errors in the information corrected by previous employers, and for those previous employers to resend the corrected information to the prospective employer; and
- Have a rebuttal statement attached to the alleged erroneous information, if the previous employer(s) and I cannot agree on the accuracy of the information.

This certifies that I completed this application, and that all entries on it and information in it are true and complete to the best of my knowledge. Note: A motor carrier may require an applicant to provide more information than that required by the Federal Motor Carrier Safety Regulations.

Applicant Signature		Date	
Applicant Name (printed)			

A&B Logistics LLC

PO Box 61
1705 East Broadway
Princeton Indiana 47670
Office Phone: (812)385-3530
Fax: (812) 635-0172

Date Faxed: ________________ Date Mailed: _____________

PREVIOUS EMPLOYMENT VERIFICATION FORM

Applicant Name:___________________________ Social Security Number: _______________
Business Name: __________________________ Phone Number: __________ Fax: ________
Address: ____

The above applicant has listed your company as a previous employer. Please complete as much information as possible on the verification form below.

Date of Employment:
From: _______________ To: ________________
Position: _____________________________ Full Time: __________ Part Time: __________
Over The Road: _______ Local Driver: ______ Solot Driver:________ Team Driver: _______
Tractor/ Trailer: _________ Straight Truck:_________ Van: __________ Tanker: __________
Reefer: _________ Flatbed: _________ Other: ____________________________________

Was the driver involved in any accidents while employed? Yes_________ No___________

Date	Nature of Accident	Preventable	Injuries/Fatalities	Amount of Damage

Has the employee tested positive for drugs/alcohol within the last 3 months?_______________
Has the employee had a BAC of 0.04 or greater within the last 3 months? _________________
Has the employee refused a test for drugs/ alcohol within the last 3 months? _______________
Has the employee violated any DOT drug/alcohol regulations within the last 3 months? ______
If yes, please provide documentation of the employee's successful completion of DOT Return To Duty requirements. (Include Follow Up Drug/Alcohol Results)

Was the employee's general conduct and performance satisfactory? Yes________ No_______
Comments:____
Is the employee eligible for rehire: Yes__________ No__________Reasoning: _____________

I hereby authorize you to release information to A&B Contracting for the purpose of investigations as required by Sec. 391.33 and 383.413 of Federal Carriers Safety regulations. You are released from any and all liability, which may result from furnishing information.

Applicant Signature: _________________________________ Date: _________________________
Completed By: ______________________________________ Date: _________________________

A&B Logistics LLC

PO Box 61
1705 East Broadway
Princeton Indiana 47670
Office Phone: (812)385-3530
Fax: (812) 635-0172

Date Faxed: ________________ Date Mailed: _____________

PREVIOUS EMPLOYMENT VERIFICATION FORM

Applicant Name:___________________________ Social Security Number: _______________
Business Name: __________________________ Phone Number: __________ Fax: ________
Address: ____

The above applicant has listed your company as a previous employer. Please complete as much information as possible on the verification form below.

Date of Employment:
From: _______________ To: ________________
Position: ____________________________ Full Time: __________ Part Time: __________
Over The Road: _______ Local Driver: ______ Solot Driver:________ Team Driver: _______
Tractor/ Trailer: _________ Straight Truck:_________ Van: __________ Tanker: __________
Reefer: _________ Flatbed: _________ Other: ____________________________________

Was the driver involved in any accidents while employed? Yes_________ No___________

Date	Nature of Accident	Preventable	Injuries/Fatalities	Amount of Damage

Has the employee tested positive for drugs/alcohol within the last 3 months?_______________
Has the employee had a BAC of 0.04 or greater within the last 3 months? _________________
Has the employee refused a test for drugs/ alcohol within the last 3 months? _______________
Has the employee violated any DOT drug/alcohol regulations within the last 3 months? ______
If yes, please provide documentation of the employee's successful completion of DOT Return To Duty requirements. (Include Follow Up Drug/Alcohol Results)

Was the employee's general conduct and performance satisfactory? Yes________ No_______
Comments:____
Is the employee eligible for rehire: Yes__________ No__________Reasoning: _____________

I hereby authorize you to release information to A&B Contracting for the purpose of investigations as required by Sec. 391.33 and 383.413 of Federal Carriers Safety regulations. You are released from any and all liability, which may result from furnishing information.

Applicant Signature: ________________________________ Date: ________________________
Completed By: _____________________________________ Date: ________________________

DMV REPORT AUTHORIZATION

I, ______________________________ hereby give my written consent to obtain a "Motor Vehicle Report" from the Department of Motor Vehicles in the State in which I am currently a licensed driver. I understand that A&B Contracting LLC will request the DMV report only after an employment offer has been made and that this requirement is based on the driving and/ or transportation responsibilities contained in the position description for which I am applying.

This authorization extends to future requests for updated DMV reports for the duration of my employment with the center in my position which includes responsibilities for driving or transportation duties.

Signature: _________________________
Date: _____________________________
Social Security #: ____________________
License Number: ____________________
D.O.B.: ____________________________
Phone Number: ______________________
Address: ___________________________
____

WITNESSED BY:

A&B Logistics LLC
1705 East Broadway Street
PO Box 62
Princeton IN 47670
Office: (812)385-3530
Fax: (812) 635-0172

Please list equipment that you have experience operating below:

____

____

____

____

This form is an example only. Requirements for the annual driver's certification of violations can be found in 49 CFR 391.27.

ANNUAL DRIVER'S CERTIFICATION OF VIOLATIONS

MOTOR CARRIER INSTRUCTIONS: Each motor carrier must at least once every 12 months, require each driver to prepare a list of all violations of motor vehicle traffic laws and ordinances (other than violations involving only parking) of which the driver has been convicted, or of which he/she has forfeited bond or collateral during the preceding 12 months (49 CFR 391.27). Drivers who have provided information required by 49 CFR 383.31 need not repeat that information on this form.

DRIVER REQUIREMENTS: Each driver will provide the list as required by the motor carrier above. If the driver has not been convicted of, or forfeited bond or collateral on account of, any violation which must be listed, he/she shall so certify (49 CFR 391.27).

COMPLETED BY DRIVER - CERTIFICATION OF VIOLATIONS

DRIVER NAME: LAST, FIRST, MI   SOCIAL SECURITY NUMBER   DATE OF EMPLOYMENT

HOME TERMINAL (CITY AND STATE)   DRIVER'S LICENSE NUMBER   STATE   EXPIRATION DATE

I certify that the following is a true and complete list of traffic violations required to be listed (other than those I have provided under 49 CFR 383) for which I have been convicted or forfeited bond or collateral during the past 12 months.

☐ Check this box if you have had no violations in the past 12 months.

DATE	OFFENSE	LOCATION	TYPE OF VEHICLE OPERATED

If no violations are listed above, I certify that I have not been convicted or forfeited bond or collateral on account of any violation required to be listed during the past 12 months.

DATE   DRIVER'S SIGNATURE

MOTOR CARRIER NAME   MOTOR CARRIER ADDRESS

REVIEWER PRINTED NAME   REVIEWER SIGNATURE   TITLE   DATE

CERTIFICATION OF COMPLIANCE WITH DRIVER LICENSE REQUIREMENTS

MOTOR CARRIER INSTRUCTIONS: The requirements in Part 383 apply to every driver who operates in intrastate, interstate, or foreign commerce and operates a vehicle weighing or rated at 26,001 pounds or more, can transport more than 15 people, or transports hazardous materials that require placarding.

The requirements in Part 391 apply to every driver who operates in interstate commerce and operates a vehicle weighing or rated 10,001 pounds or more, can transport hazardous materials that require placarding.

DRIVER REQUIREMENTS: Pats 383 and 391 of the Federal Motor Carrier Safety Regulations contain certain driver licensing requirements that you as a driver must comply with including the following:

1. **POSSESS ONLY ONE LICENSE:** You, as a commercial vehicle driver, may not possess more than one motor vehicle operator's license.

2. **NOTIFICATION OF LICENSE SUSPENSION, REVOCATION OR CANCELLATION:** Sections 391.15(b)(2) and 383.33 of the Federal Motor Carrier Safety Regulations require that you notify your employer the NEXT BUSINESS DAY of any revocation, suspension, cancellation, or disqualification of your driver's license or driving privilege. In addition, Section 383.31 requires that any time you are convicted of violating a state or local traffic law (other than parking); you must report it within 30 days to your employing motor carrier. The notification must be in writing.

3. **CDL DOMICILE REQUIREMENT:** Section 383.23(a)(2) requires that your commercial driver's license be issued by your legal state of domicile, where you have your true, fixed, and permanent home or principal residence and to which you have the intention of returning whenever you are absent. If you establish a new domicile in another state, you must apply to transfer your DCL within 30 days.

The following license is the only one I possess:

Driver's License Number: ______________________________ State: _____ Expiration Date: ________

DRIVER CERTIFICATION: I certify that I have read and understood the above requirements.

Driver's Name (Printed): ____

Driver's Signature: ______________________________________ Date: ______________

Notes: ____

State of Indiana
Pre-Employment Applicant Testing Form (DOT/CDL)

I understand that applicants covered under the State Personnel Department Standardized Policy for Drug and Alcohol Testing under DOT Regulations for Commercial Driver's License (CDL) Holders must be tested for controlled substances as a precondition for employment in performing the duties of ______________________________.

I understand that a urine specimen will be collected and tested for controlled substances.

I understand that a positive test result for controlled substances will disqualify me for a position with the State of Indiana. I also understand a report that my urine sample was adulterated or substituted will also disqualify me for a position with State of Indiana.

I understand that if my urine sample is reported as diluted, I may be required to provide another sample for testing.

A Medical Review Officer will review my test result from the laboratory and report a final result to the State of Indiana. The results will not be released to any other parties without my written authorization.

FMCSA Clearinghouse Limited Query Consent Form

I hereby provide consent to the State of Indiana to conduct a limited query of the FMCSA CDL Drug and Alcohol Clearinghouse (Clearinghouse) to determine whether drug or alcohol violation information about me exists in the Clearinghouse. The FMCSA requires annual limited queries to be run through the Clearinghouse for all employees required to maintain a CDL as a part of their position with the State of Indiana.

I understand I am giving my consent to the State of Indiana to run a limited query, a minimum of one (1) time per calendar year, for the duration of my employment.

I understand if the limited query conducted by the State of Indiana states drug or alcohol violation information about me exists in the Clearinghouse, FMCSA will not disclose further information to the State of Indiana without first obtaining additional specific consent from me. If the limited query indicates a violation exists, I understand that I must give authorization electronically within the Clearinghouse for a full query to be completed.

I further understand if I refuse to provide consent for the State of Indiana to conduct a limited query of the Clearinghouse, the State of Indiana must prohibit me from performing safety-sensitive functions, including driving a commercial motor vehicle, as required by FMCSA's drug and alcohol program regulations and may impose discipline up to and including dismissal.

I understand the above conditions and hereby agree to comply with them.

Name:______________________________ ______________________________

(Printed Name) (Signature)

Date:____________________ CDL #:______________________________

Revised 12/15/2019

State of Indiana
Pre-Employment Applicant Testing Form

I understand that applicants covered under the State Personnel Department Standardized Policy for Drug and Alcohol Testing must be tested for controlled substances as a precondition for employment in the job classification of ______________________.

I understand that a urine specimen will be collected and tested for controlled substances.

I understand that a positive test result for controlled substances will disqualify me for a position with the State of Indiana. I also understand a report that my urine sample was adulterated or substituted will also disqualify me for a position with State of Indiana.

I understand that if my urine sample is reported as diluted, I may be required to provide another sample for testing.

A Medical Review Officer will review my test result from the laboratory and report a final result to the State of Indiana. The results will not be released to any other parties without my written authorization.

I understand the above conditions and hereby agree to comply with them.

Name:______________________________ ______________________________
(Printed Name) (Signature)

Date:__________________

Revised 1/14/14

EMPLOYEE EMERGENCY CONTACT FORM

Should you incur serious illness or injury during work hours, do you give permission to transport you to the nearest medical facility?

☐ **Yes** ☐ **No**

DETAILS		
	Name	
	Home Address	
	City, State, ZIP	
	Home Phone Number	
	Cell Phone #	
	Email Address	

Please list the details of two people to be contacted in the event of an emergency.

EMERGENCY CONTACT 1		
	Name	
	Home Address	
	City, State, ZIP	
	Home Phone Number	
	Cell Phone #	
	Email Address	

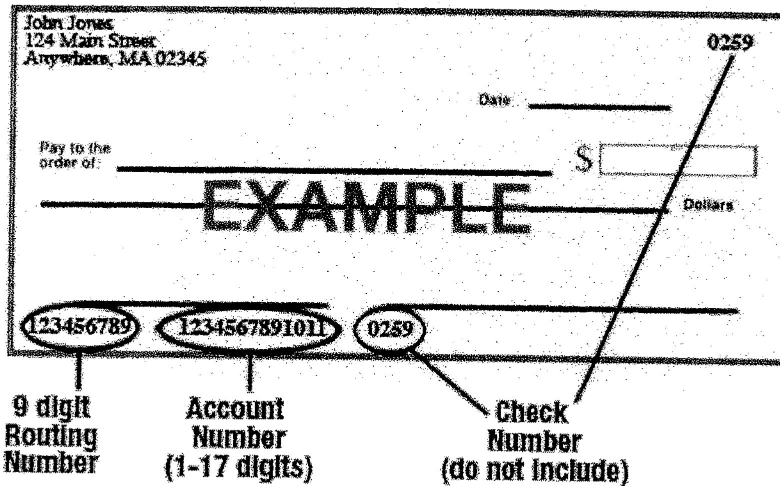
DIRECT DEPOSIT AUTHORIZATION

Please print and complete ALL the information below.

Name: ______________________________

Address: ______________________________

City, State, Zip: ______________________________



Name of Bank: ______________________________

Account #: ______________________________

9-Digit Routing #: ______________________________

Amount: ☐ $ __________ ☐ __________% or ☐ Entire Paycheck

Type of Account: ☐ Checking ☐ Savings (Check One)

Attach a voided check for each bank account to which funds should be deposited (if necessary)

__________________ (*Company Name*) is hereby authorized to directly deposit my pay to the account listed above. This authorization will remain in effect until I modify or cancel it in writing.

Employee's Signature: ______________________________

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

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)					
Document Title 2 (if any)			**Additional Information**		
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)			☐ 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

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 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)