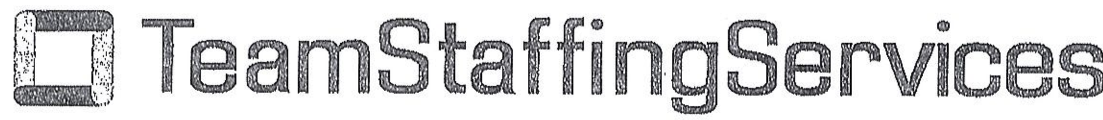



LAST NAME: FIRST NAME:

ADDRESS: CITY: STATE:

ZIP: PHONE #: ALTERNATE #:

SOCIAL SECURITY #: DRIVERS LICENSE #:

STATE: EXPIRATION: EMAIL ADDRESS:

HOURLY RATE EXPECTED: TEMP: PERM: HOURS AVAIL: TO:

DAYS AVAILABLE TO WORK: S M T W T F S SHIFT: 1ST 2ND 3RD LAST MINUTE: YES NO

**EMPLOYMENT HISTORY:**

COMPANY NAME: POSITION HELD:
FROM: TO: COMPANY ADDRESS:
SUPERVISOR AND PHONE #:

COMPANY NAME: POSITION HELD:
FROM: TO: COMPANY ADDRESS:
SUPERVISOR AND PHONE #:

COMPANY NAME: POSITION HELD:
FROM: TO: COMPANY ADDRESS:
SUPERVISOR AND PHONE #:

**PLEASE CIRCLE SKILLS:**

ASSEMBLERS MACHINIST WAREHOUSE FOOD/CHEF UPHOLSTERY DRAFTING CDL
HOSPITALITY HOUSEKEEPING DRIVER FORK LIFT PRINTING SECRETERIAL GENERAL LABORER
OTHER:

**PLEASE CIRCLE:**

TRANSPORTATION: OWN CAR BUS OTHER:
DRIVER LICENSE: YES NO CLASS: A B E DRIVERS LICENSE VALID: YES NO
STEEL TOE SHOES: YES NO CAPABLE OF LIFTING: 30LBS. 50LBS. 80LBS.
FORKLIFT CERTIFIED: YES NO ARE YOU ELIGIBLE FOR EMPLOYMENT IN THIS COUNTRY? YES NO
IS THERE ANY REASON YOU MIGHT BE UNABLE TO PERFORM DUTIES? YES NO
HAVE YOU BEEN CONVITED OF A FELONY IN THE LAST (7) YEARS? YES NO

**APPLICANT'S SIGNATURE:** **DATE:**

I HEREBY CERTIFY THAT THE INFORMATION ON THIS APPLICATION FORM AND ANY ATTACHMENTS LISTED BELOW (HEREAFTER MADE A PART OF THIS APPLICATION) IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND AGREE TO HAVE ANY STATEMENTS CHECKED BY TEAM STAFFING SERVICES UNLESS I HAVE INDICATED TO THE CONTRARY. I AUTHORIZE THE REFERENCES LISTED ABOVE TO PROVIDE TSS ANY AND ALL INFORMATION CONCERNING MY PREVIOUS EMPLOYMENT AND ANY PERTINENT INFORMATION THAT THEY MY HAVE FURTHER, I RELEASE ALL PARTIES AND PERSONS FROM ANY AND ALL LIABILITY FOR ANY CHANGES THAT MAY RESULT FROM FURNISHING SUCH INFORMATION TO TSS AS WELL AS FROM USE OR DISCLOSESURE OF SUCH INFORMATION BY TSS OR ANY OF ITS AGENTS, EMPLOYEES AND REPRESENTATIVES. I UNDERSTAND ANY MISREPRESENTATION, FALSIFICATION OR MATERIAL OMMISSION OF INFORMATION MAY RESULT IN MY FAILURE TO RECEIVE A JOB OR IF I AM HIRED IN MY DISMISSAL FROM EMPLOYMENT.

6220 South O.B.T., Ste. 511 ▪ Orlando, FL 32809 ▪ P: 407.888.4746 ▪ F: 407.888.3441

# 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) | | | | | |
| **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.**

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

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

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

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

**Instructions:** This supplement must be completed by any preparer and/or translator who assists an employee in completing Section 1 of Form I-9. The preparer and/or translator must enter the employee's name in the spaces provided above. Each preparer or translator must complete, sign, and date a separate certification area. Employers must retain completed supplement sheets with the employee's completed Form I-9.

**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 | | | Date *(mm/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 |

**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 | | | Date *(mm/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 |

**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 | | | Date *(mm/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 |

**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 | | | Date *(mm/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 |

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) |
|---|---|---|
| | | |

# TEAM STAFFING SERVICES

**Join the Winning Team**

**Medical Questionnaire**

Name: ______________________ Social Security # ______________________

Address: ______________________

City: ______________ State: ______________ Zip: ______________

**Please answer each question by checking YES or NO.** ****ALL questions must be answered.**

| HAVE YOU EVER? | Y | N |
|---|---|---|
| Received worker's compensation (in any state) | | |
| Receive or have received a pension or disability for injury | | |
| Had any prolonged hospitalization | | |
| Had any serious medical illness | | |
| Been advised to have an operation | | |
| Been rejected for the military service | | |
| Been in an automobile accident | | |
| Been given a prescription for back support or brace | | |
| Been refused life insurance | | |
| Had a hernia or rupture | | |
| Worn a truss | | |
| Sprained or injured your back | | |
| Had surgery to your back | | |
| Had to wear a back support or brace | | |
| Do you or have you ever received physical therapy | | |
| Do you use medication regularly, prescription or OTC | | |
| Had surgery or injury to your neck | | |
| Had an injury to your knee | | |
| Worn a knee brace | | |
| Had surgery on your knee | | |
| Had an injury to your ankle | | |
| Had surgery on your ankle | | |
| Had an injury to your feet or heels | | |
| Had surgery to your feet or heels | | |
| Had a fracture of any bones | | |
| Had an injury to your wrist or hand | | |
| Do you use a hearing aid | | |
| Do you have hearing loss | | |
| Had an injury to your head | | |
| Had an injury to your shoulder or elbow | | |

| HAVE YOU EVER HAD? | Y | N |
|---|---|---|
| Tuberculosis | | |
| Hay Fever | | |
| Paralysis | | |
| Polio | | |
| Allergic Reaction to drugs | | |
| Swelling of legs/ankle/feet | | |
| Nerve trouble | | |
| Foot/Leg/Arm/Hand amputation | | |
| Partial/total loss of one or both eyes | | |
| Uncontrolled bleeding (hemophilia) | | |
| Muscular dystrophy | | |
| Nervous breakdown | | |
| Frequent headaches | | |
| Diabetes | | |
| High Blood pressure | | |
| Back pain while lifting | | |
| Fainting and/or dizzy spells | | |
| Epilepsy | | |
| Seizures or Convulsions | | |
| Heart trouble | | |
| Dislocations | | |
| Arthritis or Rheumatism | | |
| Skin rashes or eczema | | |
| Stomach ulcer | | |
| Cerebral palsy | | |
| Multiple Sclerosis | | |
| Parkinson's Disease | | |
| Bone Inflammation (osteomyelitis) | | |
| Blood Clots (thrombophlebitis) | | |
| Asthma | | |

The information on this form will not be used to discriminate against a qualified individual with a disability, due to the existence of the disability regarding the following: job application procedures, hiring, advancement or discharge of the employee, employee compensation, job training and other terms, conditions or privileges of employment.

Under penalty of perjury, I declare that the foregoing and that all facts alleged are true to the best of my knowledge and belief.

**Employee Signature** ______________________ **Date** ______________

**Employer Signature** ______________________ **Position** ______________ **Date** ______________

# TeamStaffingServices

JOIN THE WINNING TEAM

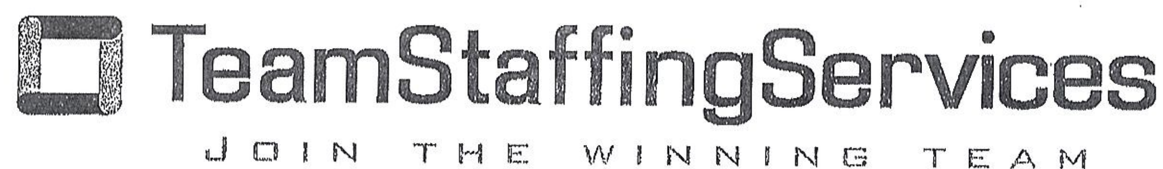
Team Staffing Services Employees,

Please be advised that it is your responsibility to contact our office for work. When you are on an assignment that is ending it is your responsibility to contact our office for a new assignment. Failure to do so may result in denial of unemployment benefits.

Print Name: ______________________________

Signature: ______________________________

Date: ____________________




# AUTHORIZATION TO RELEASE CRIMINAL BACKGROUND AND PERSONAL INFORMATION

I, ________________________________________ give TEAM STAFFING SERVICES my permission to run my driving record and conduct a criminal background check using my name and personal information.

I also give permission to check employment and personal references.

I understand that this information will be given to 3rd party potential employers.

I understand that the information given and received will be kept confidential.

Signature of Applicant: ________________________________

Date Signed: ___________________________

6220 South O.B.T., Ste. 511 ◻ Orlando, FL 32809 ◻ P: 407.888.4746 ◻ F: 407.888.3441

# TeamStaffingServices

JOIN THE WINNING TEAM

Team Staffing Services Employees,

We are proud to announce that we are a Drug-Free Workplace. Because we wish to provide you with a safe working environment we will adhere to all guidelines established for a Drug-Free Workplace.

In signing this letter, you are stating that, if we choose, you will submit to random drug testing at our expense. If you test positive you will be immediately terminated. Also, if you are injured on the job we will automatically require an immediate drug test. If your results are positive your injury will not be covered under our insurance and you will be held liable for all expenses.

In partnership with you, we can help keep your work environment a safe environment. Thank you for your cooperation.

Print Name: ______________________________

Signature: ______________________________

Date: ______________________

# TeamStaffingServices

JOIN THE WINNING TEAM

## COURTESY POLICY

***We depend on everyone to show up for work on time as scheduled. On your first day or on any day after, in the event you cannot report to work we ask for the courtesy of a phone call letting us know you will not be able to report to work. The statements below explain our policy in place to prevent "NO CALL & NO SHOWS" from happening. We are available 24 hours a day by calling (407) 888-4746. If there is no answer, please leave a message and a representative will call you back.***

Upon accepting a short-term position with Team Staffing Services, we ask if for any reason you will not be able to complete your position to notify a Team Staffing Services representative within 4 hours of your start time. If you do not notify a Team Staffing Services representative within the 4-hour time frame your pay rate for that day or week will revert from what it was originally quoted to minimum wage ($11.00 per hour), which is required by law.

____________________________
Applicant Initials

Upon accepting a long-term and/or temp-to-hire position with Team Staffing Services, we ask if for any reason you will not be able to complete your position to notify a Team Staffing Services representative giving 24 hours advance notice to cancel your position. If you do not notify a Team Staffing Services representative within the 24-hour notice, your pay rate for that week will revert from what it was originally quoted to minimum wage ($11.00 per hour), which is required by law.

____________________________
Applicant Initials

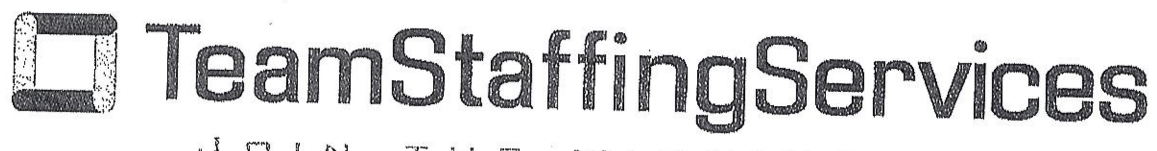
I ______________________________ understand the above policy and courtesy statement.

____________________________
Applicant Signature

____________________
Date

____________________________
Team Staffing Representative

____________________
Date




## TEAM STAFFING SERVICES DRUG SCREEN RESULTS

**COMPANY INFORMATION**

COMPANY NAME: TEAM STAFFING SERVICES

ADDRESS: 6220 SOUTH ORANGE BLOSSOM TRAIL, SUITE 511, ORLANDO, FL 32809

NAME OF COLLECTOR: ______________________________

PHONE: 407-888-4746 FAX: 407-888-3441

**DONOR INFORMATION**

LAST NAME: ______________________ FIRST NAME: ______________________

DRIVERS LICENSE #: ______________________ GOVERNMENT ISSUED I.D.: ______________________

**SCREEN RESULTS**

TIME COLLECTED: ______________________ TIME INTERPRETED: ______________________

TEMPERATURE: ______________ NORMAL (90-100) ______________ OTHER ______________

| DRUG NAME | SYMBOL | NEGATIVE | CONFIRM |
| --- | --- | --- | --- |
| COCAINE | (COC) | | |
| MARIJUANA | (THT) | | |
| OPIATES | (OPI) | | |
| AMPHETAMINES | (AMP) | | |
| PHENCYCLIDINE | (PCP) | | |
| BENZODIAZEPINE | (BZD) | | |
| BARBITURATE | (BAR) | | |
| METHODONE | (MTD) | | |
| METHAMPHETAMINE | (MET) | | |
| ECSTASY | (MDMA) | | |

**CERTIFICATION**

I HEREBY AGREE TO SUBMIT TO A URINALYSIS FOR THE PURPOSE OF TESTING FOR DRUG METABOLITES. THIS SPECIMEN IS MY OWN AND HAS NOT BEEN SUBSTITUTED OR ADULTERED.

DONOR SIGNATURE ______________________________ DATE ______________________

I HEREBY CERTIFY THE SPECIMEN HAS BEEN PROVIDED BY THE DONORIDENTIFIED ABOVE.

COLLECTOR SIGNATURE ______________________________ DATE ______________________

I HEREBY CERTIFY THAT A SECURE SAMPLE WAS RECEIVED FOR CONFIRMATION

## Employee Direct Deposit

No More Extra Trips To The Bank!

To request Direct Deposit of your paycheck, read and complete the following authorization agreement and give it to your payroll department. If you are eligible to participate, they'll set you up on Direct Deposit.

Please deposit my entire net pay into the account specified below.

Circle One: Checking Savings

Bank Name: ______________________

Account #: ______________________

Routing / Transit #: ______________________

Attach a voided check, bank letter or specification sheet. Deposit tickets are NOT accepted.

If you are splitting your deposit, please select the second account and mark the percentage or the correct dollar amount to be deposited.

Circle One: Checking Savings

Bank Name: ______________________

Account #: ______________________

Routing / Transit #: ______________________

Split amount Percentage to this account % or flat dollar amount $

Attach a voided check, bank letter or specification sheet. Deposit tickets are NOT accepted.

## EMPLOYEE INFORMATION

Name: ______________________

Social Security #: ______________________

Home Address: ______________________

City: ______________________

State: ______________________ Zip: ______________________

### Responsibility of Employee

Upon enrolling in the direct deposit program, the Employee will affirm whether the entire payment amount, is or is not, subject to being forwarded to a bank in another country. Should the employee's IAT status change at any time in the future, the employee should notify the state or the inquiring agency. Should the employee receive payroll via direct deposit at a U.S. financial institution and then have the entire payroll amount forwarded to a bank in another country, the employee should advise Team Staffing Services (hereinafter client name), client name may provide a general notice regarding the IAT rules, or it may make a specific inquiry of you. If the employee does not advise client name that the employee meets the definition of an IAT payee, the employee will be presumed to be a non-IAT payee. Should the Employee's IAT status change at any time in the future, the Employee should notify client name.

Please indicate if the Employee is an IAT payee by placing a check here: [ ]

### Authorization

I authorize my employer, Team Staffing Services (hereinafter client name) to deposit my net pay each payday directly into my account. In the event that client name deposits funds erroneously into my account, I hereby authorize client name to debit my account for an amount not to exceed the original amount of erroneous credit. Any dispute arising out of or in correction with this agreement, if not otherwise resolved, shall be determined by arbitration in Cleveland, Ohio, in accordance with the rules of the American Arbitration Association, and it's the expressed desire of both parties that the prevailing party be awarded the costs and attorney's fees and that the award be entered as a judgment in any jurisdiction in which the non-prevailing party does business. This authorization will remain in full force and effect until client name and the bank have received written notice from me of its termination in such time and in such manner as to afford client name and Bank a reasonable opportunity to act on it.

Employee Signature: ______________________ Date: ______________________