Application for Employment

Date of Application _____

Please Print (Fully complete both pages)

Last four digits of SSN	Last Name	First Name	Middle Name
Address (street number and name)		City	County
State	Zip Code	Phone (home or where you can be reached)	Business Phone

Position Applied For: _____

Date of Birth: _____ N. C. Driver's License Number _____
(month) (day) (year)

Have you ever been convicted of breaking a law other than a minor traffic violation? YES____ NO____ If yes, give the date and explain fully. Use an additional piece of paper if more space is needed: _____

_____

Have you ever had an abuse or neglect or child maltreatment substantiation? YES____ NO____ If yes, list county/State and give the date and explain fully. Use an additional piece of paper if more space is needed: _____

_____

(The offense(s) and how recently you were convicted will be evaluated in relation to the job for which you are applying.)

Education

Circle the highest grade completed: 1 2 3 4 5 6 7 8 9 10 11 12 GED College 1 2 3 4

Schools	Name and Location	Dates Attended	Coursed of Study	Degree/Diploma
High School		to		
College or University		to		
		to		
		to		
		to		
Graduate or Professional				
Educational, Vocational Schools, etc.				

Child care training completed in the last three years (such as First Aid, CPR, Health and Safety Training, ITS-SIDS, CDA etc.):

_____

References

List the names, addresses, and phone numbers of people we may contact as references:

_____

_____

_____

Work History

(List child care/early childhood experience first.)

Current or Last Employer			Address		
Job Title			Supervisor's Name		No. Supervised by you
Date Employed (mo/yr)	Starting Salary $ Per		Ending Salary $ Per	Reason for leaving	May we contact employer? yes no
Date Separated (mo/yr)			Duties:		
Full Time	Years	Months			
Part Time	Years	Months			
If part time, number of hours per week					

Current or Last Employer			Address		
Job Title			Supervisor's Name		No. Supervised by you
Date Employed (mo/yr)	Starting Salary $ Per		Ending Salary $ Per	Reason for leaving	May we contact employer? yes no
Date Separated (mo/yr)			Duties:		
Full Time	Years	Months			
Part Time	Years	Months			
If part time, number of hours per week					

I certify that I have given true, accurate, and complete information on this form to the best of my knowledge. In the event confirmation is needed in connection with my work, I authorize educational institutions, associations, registration, and licensing boards, and others to furnish whatever detail is available concerning my qualifications. I authorize investigations of all statements made in this application and understand that false information of documentation, or a failure to disclose relevant information may be grounds for rejection of my application, disciplinary action, or dismissal if I am employed, and (or) criminal action. I further understand that dismissal on unemployment shall be mandatory if fraudulent disclosures are given to meet position qualifications.

Signature of Applicant_____ Date_____

Emergency Information – Staff

10A NCAC 09 .0701(a)

Child care providers, including the director, uncompensated providers, substitute providers, and volunteers must provide this information on or before the first day of work. Emergency information must be updated as changes occur and at least annually.

Date completed:	
Full name of individual:	
Home address:	
Phone number:	Email:

Person(s) to be contacted in case of an emergency:

Primary contact
Name:
Address:
Phone number:
Secondary contact
Name:
Address:
Phone number:

Choice of health care professional:
Address:
Telephone number:

Health Questionnaire – Child Care Centers

10A NCAC 09 .0701(a)

All staff, including the director, must complete a health questionnaire annually following the initial medical report. Substitute providers and volunteers must complete a health questionnaire on or before the first day of work and annually thereafter.

Full name of individual:	
Home address:	
Phone number:	Email:

I certify that I am emotionally and physically fit to care for children.

Signature:
Date:

This portion of the form to be completed by the Child Care Center Director

As the director, I understand that I may request another evaluation of a staff member's emotional and physical fitness to care for children when there is reason to believe that there has been deterioration in the staff member's emotional or physical fitness to care for children. This request may be made based upon factors such as observations of myself or other staff members, reports of concern from family, reports from law enforcement, or reports from medical personal. Child Care Rule 10A NCAC 09 .0701(b).

Director's Signature:
Date:

*This information must be included in the staff member's medical file, which must be maintained separately from the staff member's individual personnel file in the center. Child Care Rule 10A NCAC 09 .0701(d)

EPR and EMCP Review
Acknowledgment Form

I have received and reviewed the following:

- Emergency Preparedness and Response Plan
- Emergency Medical Care Plan

Staff Signature _____ Date _____

Director Signature _____ Date _____

Tuberculosis Screening Form

10A NCAC 09 .0701 (a) (Centers)

This questionnaire must be administered to all child care providers, by a licensed health care professional, before coming into contact with children. Directors, substitutes, and individuals who volunteer more than once a week must be screened. Testing should only be performed if the individual answers "yes" to one of the screening questions. Both screening and testing are available at the local health department.

Note to health care professionals: A negative risk and symptom screen should be considered a negative tuberculosis test in such individuals, and no further testing is required. An Interferon Gamma Release Assay is preferred over a tuberculin skin test for otherwise low-risk individuals with a positive response to the risk or symptom screening questionnaires. (See page 2.)

Last name (print clearly)	First name	Middle	Date of Birth

Tuberculosis Risk Questionnaire

1) Were you born outside the USA in one of the following parts of the world: Africa, Asia, Central America, South America, or Eastern Europe?	YES	NO
2) Have you traveled outside the USA and lived for more than one month in one of the following parts of the world: Africa, Asia, Central America, South America, or Eastern Europe?	YES	NO
3) Do you have a compromised immune system such as from any of the following conditions: HIV/AIDS, organ or bone marrow transplantation, diabetes, immunosuppressive medicines (e.g. prednisone, Remicade), leukemia, lymphoma, cancer of the head or neck, gastrectomy or jejeunal bypass, end-stage renal disease (on dialysis), or silicosis?	YES	NO
4) Have you ever done one of the following: used crack cocaine, injected illegal drugs, worked or resided in jail or prison, worked or resided at a homeless shelter, or worked as a healthcare worker in direct contact with patients?	YES	NO
5) Have you ever been exposed to anyone with infectious tuberculosis?	YES	NO

Tuberculosis Symptom Questionnaire

Do you currently have any of the following symptoms?		
1) Unexplained cough lasting more than 3 weeks?	YES	NO
2) Unexplained fever lasting more than 3 weeks?	YES	NO
3) Night sweats (sweating that leaves the bedclothes and sheets wet)?	YES	NO
4) Shortness of breath?	YES	NO
5) Chest pain?	YES	NO
6) Unintentional weight loss?	YES	NO
7) Unexplained fatigue (very tired for no reason)?	YES	NO

The above health statement is accurate to the best of my knowledge. I will contact my health care professional and/or the health department if my health status changes.

Signature:	Date:

Screening administered by licensed health care professional:

Printed name and location:	
Signature:	Date:

Tuberculosis Testing Form

10A NCAC 09 .0701 (a) (Centers), .1702 (b)(4) and .1729 (a)(5) & (b) (Family Child Care Homes)

Record of Tuberculosis Test

Last name (print clearly)	First name	Middle	Date of birth

Type of test:

☐ Tuberculin

Date given	
Date read	
Results	MM reading: _____ ☐ Negative ☐ Positive

☐ Interferon Gamma Release Assay

Date	
Results	

Comments:

Signature of Authorized Health Professional	Date	Location

*This information must be included in the operator or staff member's medical file, which must be maintained separately from the operator or staff member's individual personnel file that is kept on site.

Staff Health Assessment/Medical Report

10A NCAC 09 .0701 (Child Care Centers)

This document, completed by a health care professional prior to employment, indicates that the individual listed is emotionally and physically fit to care for children. This form must have been completed within the last twelve months.

Full name of individual:	
Home address:	
Phone number:	Email:

To be completed by a health care professional

Date of assessment:

Does this applicant have any physical condition that would limit their ability to work with children?
☐ Yes ☐ No
If yes, please describe:

Is this applicant currently under treatment that would limit their ability to work with children?
☐ Yes ☐ No
If yes, please describe:

Is this applicant currently taking any medication that would affect his/her work with children?
☐ Yes ☐ No
If yes, please describe:

In your opinion, is this applicant emotionally and physically capable to care for children on a daily basis?
☐ Yes ☐ No

Name of health care professional:	Date:
Signature of health care professional:	
Address:	
Phone number:	

*This information must be included in the staff member's medical file, which must be maintained separately from the staff member's individual personnel file in the center. Child Care Rule 10A NCAC 09 .0701(d).

APPLICANT INFORMATION for CHILD CARE

Please print name as shown on photo Identification Card you will take to Law Enforcement Agency.

*Name: Last:*_____ *Date of Birth:*_____

*First:*_____ *Place of Birth:*_____

*Middle:*_____ *Residence:*_____

Maiden Name: _____ _____

Aliases: _____

_____

Employer and Address:
DOCD
2201 Mail Service Center
Raleigh, NC 27699

Sex: Male___Female_____

*Race:*_____
(Write the appropriate letter in the space provided)

W -White B -Black I -American Indian

A -Asian or Pacific Islander U -Unknown

Reason Fingerprinted:
State and Federal Check
NC Day Care Provider
NCGS 114-9.5, 110-90.1 to 110.91

*Height:*_____

*Social Security Number:*_____

*Weight:*_____

*Eye Color:*_____
(Write the appropriate letters in the space provided)

BLK -Black GRY -Gray MAR -Maroon

BLU -Blue BRO -Brown GRN -Green

HAZ -Hazel PNK -Pink XXX -Unknown

Your Case NO. (OCA): DOCD000000

Type of Transaction: Non-Federal User Fee

NCFP Card Type: Child Care Provider

*Hair Color:*_____
(Write the appropriate letters in the space provided)

BAL -Bald BLK -Black BLN -Blond or strawberry

BRO -Brown GRY -Gray or partially

RED -Red or Auburn SDY -Sandy

This form is to be taken to the Law Enforcement Agency when you visit to be fingerprinted.
Do NOT send this form to the SBI.

YOUR NAME MUST MATCH ON ALL FORMS

NC DEPARTMENT OF
HEALTH AND
HUMAN SERVICES
Division of Child Development and Early Education

ROY COOPER • Governor
KODY KINSLEY • Secretary
ARIEL FORD • Director

OUT OF STATE BACKGROUND CHECK CERTIFICATION

I understand that North Carolina law and the federal Child Care Development Block Grant (CCDBG) Act of 2014, 42 U.S.C. § 9858f, require me to obtain background checks and child abuse registry checks from other states I have resided in at any time in the preceding five (5) years. **I understand if I fail to request information from other states, I may be disqualified from providing child care in the State of North Carolina in accordance with N.C.G.S. § 110-90.2(c).**

Fill out this form completely. Incomplete forms will not be processed. If a question does not apply to you, put "N/A".

I hereby certify that I have requested criminal record information (if applicable) and a search of the child abuse and neglect registry for the state(s) of _____ _____.

I further certify I made this request/these requests on _____ (date(s)).

North Carolina General Statute 110-90.2 states "Any child care provider who intentionally falsifies any information required to be furnished to conduct the criminal history shall be guilty of a Class 2 misdemeanor".

Applicant Name (*please print*) _____

_____ _____
Applicant's Signature Date

10A NCAC .2703(g) Within five days of applying for provisional status through the Division's online portal, the applicant shall complete and submit any documents specific to their former state(s) of residence that are necessary to complete the out-of-state portion of their background check. The applicant shall also certify in writing within five days to the Division that they have made the required requests. When requested by the Division, the applicant shall submit a copy and proof of submission of the documents necessary to complete the out-of-state portion of their background check.

Once completed, scan and email this form to DCDEE.CBC.OOR@dhhs.nc.gov or mail to: 2201 Mail Service Center, Raleigh, NC 27699-2200. You may fax to 919.715.0987

FINGERPRINT SUBMISSION RELEASE OF INFORMATION

I authorize the submission or transmission of my fingerprints to the State Bureau of Investigation (SBI). I authorize the North Carolina Department of Public Safety through the State Bureau of Investigation to perform a national criminal history record check in connection with my fitness to be a child care provider/employee, or other household member of a child care program regulated by the Department of Health and Human Services, Division of Child Development and Early Education pursuant to N.C.G.S. §§NCGS 114-19.5, 110-90.1 to 110-91.

I understand that the North Carolina State Bureau of Investigation, Criminal Information and Identification Section, the Federal Bureau of Investigation, and its officials and employees shall not be held legally accountable in any way for providing this information to the above named agency, and I hereby release said agency and persons from any and all liability which may be incurred as a result of furnishing such information.

Applicant's Name: _____ DOB: _____

(Please print name clearly – as it appears on your photo Identification Card you will present to Agent)

Date: _____ Applicant's Signature: _____

Parent/Legal Guardian's Signature *(if applicant is under age 18)* _____

Please check appropriate box for type of submission:

☐ **ELECTRONIC SUBMISSION**

The Division of Child Development & Early Education (DCDEE) authorizes the above named subject to be fingerprinted and nave the fingerprints submitted to the SBI electronically.

Law Enforcement Agent

I certify that I have taken the fingerprints of the above named subject and forwarded them electronically to the SBI/Criminal Information and Identification Section.

Date: _____ Signature of Official Taking Fingerprints: _____

☐ **MANUAL submission** *(Prints Were Not Transmitted Electronically)*

Card must be mailed to DCDEE by applicant

The completed fingerprint card is attached. _____ (initials of Law Enforcement Agent)

This completed form is to be mailed **with other CBC items to:**
DCDEE CBC, 2201 Mail Service Center, Raleigh, NC 27699.
*Include manual card if received from LEA. Do NOT send this form to the SBI.

THE NAME ON YOUR FINGERPRINT CARD MUST MATCH WITH THE OTHER ITEMS SUBMITTED TO THE DIVISION.

☐ By checking this box, I understand my rights to complete or challenge the accuracy of the information contained in the FBI identification record. The procedure for obtaining a change, correction, or updating an FBI identification record are set forth in Title 28, CFR, 16.34.

POLICY TITLE: CALL OUTS, TARDINESS, RESPECT, JOB RESPONSIBILITIES, CELL PHONE USE.

PROCEDURES:

EMPLOYEES- Please note that all call outs and tardiness must affect you directly.

1. Employees will make their supervisor aware at least 24 hours before their shift or as soon as possible if they are unable to make it to work with **supported documentation.**
2. Employees will try to make alternate arrangements to complete at least half of their shift, if possible.
3. Unless it's an EMERGENCY, employees are responsible for making contact with their supervisor by phone. If you cannot make contact by phone, Employees must send their Supervisor a text message explaining the nature of the call out. Employees must provide **documentation** to support their emergency prior to working their next shift.
4. Employees ***MUST*** follow the steps above BEFORE they have someone call the job for them.
5. Employees are aware that calling out after their shift is considered a no call no show.
6. 3 Call Outs within a month period will result in termination.
7. Employees will make sure they call their supervisor immediately if they are running late with a time of arrival. Excessive tardiness will result in disciplinary action.
8. Employees will respect everyone in the building at all times and report any knowledge of disrespect immediately.
9. Employees will adhere to all job responsibilities explained in orientation and make the supervisor aware of any misunderstandings or additional training they feel are needed.

Cell Phone Use:

The use of personal cell phones at work is PROHIBITED in the classroom. Therefore, employees who bring personal cell phones to work are required to leave them either in their cars or anywhere away from the classroom, with the ringer shut off/vibrate mode. When using your cell phone in the center, please keep it confined to lunchbreak. During your shift, if you must use your cell phone for an emergency purpose, please ask for someone to cover your classroom. Such action should not take more than five minutes. If you have to spend more than 5 mins on a call, please clock out until your call is finished and your cell phone is put away properly. Conversations should be held away from areas where other employees are working.

If you are seen on your cell phone in the classroom:
First, you will get a verbal warning. Second will be written notice. Any violation after that will result in termination of employment.

Please understand that not abiding by the above Policy and Procedures will result in disciplinary action. 1st you will receive a verbal warning, 2nd you will receive a written warning and the 3rd time may lead to possible termination

POLICY ACKNOWLEDGEMENT

(Call out, Tardiness, Respect, Job Responsibilities, cell phone use)

DATE: _____

By signing this document, you are acknowledging that you've received a copy of the Discipline Policy.

You must read over this policy and let your Supervisor know of any questions or concerns you have about this policy.

I _____ have read and understood the ***Discipline Policy***.

_____ EMPLOYEE PRINT NAME

_____ SUPERVISOR PRINT NAME

_____ EMPLOYEE SIGNATURE

_____ SUPERVISOR SIGNATURE

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, other details, 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) Reserved for future use.

(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 . . . . . ☐

TIP: If you have self-employment income, see page 2.

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)

General Instructions

Section references are to the Internal Revenue Code.

Future developments. For the latest information about any future developments related to Form W-4P, such as legislation enacted after it was published, go to *www.irs.gov/FormW4P*.

Purpose of form. Complete Form W-4P to have payers withhold the correct amount of federal income tax from your periodic pension, annuity (including commercial annuities), profit-sharing and stock bonus plan, or IRA payments. Federal income tax withholding applies to the taxable part of these payments. Periodic payments are made in installments at regular intervals (for example, annually, quarterly, or monthly) over a period of more than 1 year. Don't use Form W-4P for a nonperiodic payment (note that distributions from an IRA that are payable on demand are treated as nonperiodic payments) or an eligible rollover distribution (including a lump-sum pension payment). Instead, use Form W-4R, Withholding Certificate for Nonperiodic Payments and Eligible Rollover Distributions, for these payments/distributions. For more information on withholding, see Pub. 505, Tax Withholding and Estimated Tax.

Choosing not to have income tax withheld. You can choose not to have federal income tax withheld from your payments by writing "No Withholding" on Form W-4P in the space below Step 4(c). Then, complete Steps 1a, 1b, and 5. Generally, if you are a U.S. citizen or a resident alien, you are not permitted to elect not to have federal income tax withheld on payments to be delivered outside the United States and its territories.

Caution: If you have too little tax withheld, you will generally owe tax when you file your tax return and may owe a penalty unless you make timely payments of estimated tax. If too much tax is withheld, you will generally be due a refund when you file your tax return. If your tax situation changes, or you chose not to have federal income tax withheld and you now want withholding, you should submit a new Form W-4P.

Self-employment. Generally, you will owe both income and self-employment taxes on any self-employment income you (or you and your spouse) receive. If you do not have a job and want to pay these taxes through withholding from your payments, you should enter the self-employment income in Step 4(a). Then compute your self-employment tax, divide that tax by the number of payments remaining in the year, and include that resulting amount per payment in Step 4(c). You can also add half of the annual amount of self-employment tax to Step 4(b) as a deduction. To calculate self-employment tax, you generally multiply the self-employment income by 14.13% (this rate is a quick way to figure your self-employment tax and equals the sum of the 12.4% social security tax and the 2.9% Medicare tax multiplied by 0.9235). See Pub. 505 for more information, especially if your self-employment income multiplied by 0.9235 is over $160,200.

Payments to nonresident aliens and foreign estates. Do not use Form W-4P. See Pub. 515, Withholding of Tax on Nonresident Aliens and Foreign Entities, and Pub. 519, U.S. Tax Guide for Aliens, for more information.

Tax relief for victims of terrorist attacks. If your disability payments for injuries incurred as a direct result of a terrorist attack are not taxable, write "No Withholding" in the space below Step 4(c). See Pub. 3920, Tax Relief for Victims of Terrorist Attacks, for more details.

Specific Instructions

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

Step 2. Use this step if you have at least one of the following: income from a job, income from more than one pension/annuit and/or a spouse (if married filing jointly) that receives income from a job/pension/annuity. The following examples will assist you in completing Step 2.

Example 1. Bob, a single filer, is completing Form W-4P for a pension that pays $50,000 a year. Bob also has a job that pays $25,000 a year. Bob has no other pensions or annuities. Bob w enter $25,000 in Step 2(b)(i) and in Step 2(b)(iii).

If Bob also has $1,000 of interest income, which he entered on Form W-4, Step 4(a), then he will instead enter $26,000 in Step 2(b)(i) and in Step 2(b)(iii). He will make no entries in Step 4(a) o this Form W-4P.

Example 2. Carol, a single filer, is completing Form W-4P for a pension that pays $50,000 a year. Carol does not have a job, but she also receives another pension for $25,000 a year (which pays less annually than the $50,000 pension). Carol will enter $25,000 in Step 2(b)(ii) and in Step 2(b)(iii).

If Carol also has $1,000 of interest income, then she will enter $1,000 in Step 4(a) of this Form W-4P.

Example 3. Don, a single filer, is completing Form W-4P for a pension that pays $50,000 a year. Don does not have a job, but he receives another pension for $75,000 a year (which pays more annually than the $50,000 pension). Don will not enter any amounts in Step 2.

If Don also has $1,000 of interest income, he won't enter that amount on this Form W-4P because he entered the $1,000 on the Form W-4P for the higher paying $75,000 pension.

Example 4. Ann, a single filer, is completing Form W-4P for a pension that pays $50,000 a year. Ann also has a job that pays $25,000 a year and another pension that pays $20,000 a year. Ann will enter $25,000 in Step 2(b)(i), $20,000 in Step 2(b)(ii), and $45,000 in Step 2(b)(iii).

If Ann also has $1,000 of interest income, which she entered on Form W-4, Step 4(a), she will instead enter $26,000 in Step 2(b)(i), leave Step 2(b)(ii) unchanged, and enter $46,000 in Step 2(b)(iii). She will make no entries in Step 4(a) of this Form W-4P.

If you are married filing jointly, the entries described above do not change if your spouse is the one who has the job or the other pension/annuity instead of you.

CAUTION *Multiple sources of pensions/annuities or jobs. If you (or if married filing jointly, you and/or your spouse) have a job(s), do NOT complete Steps 3 through 4(b) on Form W-4P. Instead, complete Steps 3 through 4(b) on the Form W-4 for the job. If you (or if married filing jointly, you and your spouse) do not have a job, complete Steps 3 through 4(b) on Form W-4P for only the pension/annuity that pays the most annually. Leave those steps blank for the other pensions/ annuities.*

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

Specific Instructions *(continued)*

Step 4 (optional).

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

Step 4(b). Enter in this step the amount from the Deductions Worksheet, line 6, if you expect to claim deductions other than the basic standard deduction on your 2023 tax return and want to reduce your withholding to account for these deductions. This includes itemized deductions, the additional standard deduction for those 65 and over, and other deductions such as for student loan interest and IRAs.

Step 4(c). Enter in this step any additional tax you want withheld from **each payment.** Entering an amount here will reduce your payments and will either increase your refund or reduce any amount of tax that you owe.

Note: If you don't give Form W-4P to your payer, you don't provide an SSN, or the IRS notifies the payer that you gave an incorrect SSN, then the payer will withhold tax from your payments as if your filing status is single with no adjustments in Steps 2 through 4. For payments that began before 2023, your current withholding election (or your default rate) remains in effect unless you submit a new Form W-4P.

Step 4(b)—Deductions Worksheet *(Keep for your records.)*



1	Enter an estimate of your 2023 itemized deductions (from Schedule A (Form 1040)). Such deductions may include qualifying home mortgage interest, charitable contributions, state and local taxes (up to $10,000), and medical expenses in excess of 7.5% of your income	1	$
2	Enter: • $27,700 if you're married filing jointly or a qualifying surviving spouse • $20,800 if you're head of household • $13,850 if you're single or married filing separately	2	$
3	If line 1 is greater than line 2, subtract line 2 from line 1 and enter the result here. If line 2 is greater than line 1, enter "-0-"	3	$
4	If line 3 equals zero, and you (or your spouse) are 65 or older, enter: • $1,850 if you're single or head of household. • $1,500 if you're married filing separately. • $1,500 if you're a qualifying surviving spouse or you're married filing jointly and one of you is under age 65. • $3,000 if you're married filing jointly and both of you are age 65 or older. Otherwise, enter "-0-". See Pub. 505 for more information	4	$
5	Enter an estimate of your student loan interest, deductible IRA contributions, and certain other adjustments (from Part II of Schedule 1 (Form 1040)). See Pub. 505 for more information	5	$
6	Add lines 3 through 5. Enter the result here and in **Step 4(b)** on Form W-4P	6	$

Privacy Act and Paperwork Reduction Act Notice. We ask for the information on this form to carry out the Internal Revenue laws of the United States. You are required to provide this information only if you want to (a) request federal income tax withholding from pension or annuity payments based on your filing status and adjustments; (b) request additional federal income tax withholding from your pension or annuity payments; (c) choose not to have federal income tax withheld, when permitted; or (d) change a previous Form W-4P. To do any of the aforementioned, you are required by sections 3405(e) and 6109 and their regulations to provide the information requested on this form. Failure to provide this information may result in inaccurate withholding on your payment(s). Failure to provide a properly completed form will result in your being treated as a single person with no other entries on the form; providing fraudulent information may subject you to penalties.

Routine uses of this information include giving it to the Department of Justice for civil and criminal litigation, and to cities, states, the District of Columbia, and U.S. commonwealths and territories for use in administering their tax laws. We may also disclose this information to other countries under a tax treaty, to federal and state agencies to enforce federal nontax criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism.

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

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

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

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

LISTS OF ACCEPTABLE DOCUMENTS

All documents containing an expiration date must be unexpired.

* Documents extended by the issuing authority are considered unexpired.

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

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

LIST A 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 an individual temporarily authorized to work for a specific employer because of his or her status or parole: 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 individual's status or parole as long as that period of endorsement has not yet expired and the proposed employment is not in conflict with any restrictions or limitations identified on the form.		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 For examples, see Section 7 and Section 13 of the M-274 on uscis.gov/i-9-central The Form I-766, Employment Authorization Document, is a List A, Item Number 4, document, not a List C document
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		

Acceptable Receipts

May be presented in lieu of a document listed above for a temporary period.

For receipt validity dates, see the M-274.

• Receipt for a replacement of a lost, stolen, or damaged List A document. • Form I-94 issued to a lawful permanent resident that contains an I-551 stamp and a photograph of the individual. • Form I-94 with "RE" notation or refugee stamp issued to a refugee.	OR	Receipt for a replacement of a lost, stolen, or damaged List B document.	Receipt for a replacement of a lost, stolen, or damaged List C document.

*Refer to the Employment Authorization Extensions page on I-9 Central for more information.

EMPLOYEE ACKNOWLEDGMENT FORM

I have received and read the Trinity Hearts Learning Center KDHNC, LLC Employee Policy and Procedures Handbook. I expect to be guided by the rules and policies contained therein. I understand that any or all of the provisions contained in the Employee Policy and Procedures Handbook may be modified, amended, or eliminated by Trinity Hearts Learning Center KDH at any time with or without notice. **I also understand ignorance of the policies does not preclude me from being responsible for them.**

I further understand and agree that my employment with Trinity Hearts Learning Center KDHNC, LLC is at will and may be terminated by the Director/Owner of the Trinity Hearts Learning Center KDHNC, LLC at any time for any reason or without reason. I understand that nothing in the Personnel Policies and Procedures handbook or in any oral statement or representation by any employee or representative of Trinity Hearts Learning Center shall be deemed to create a contract of employment or any other modification of the at-will employment relationship. **I understand that if I leave before my 6 months time period I will be responsible for my CPR and all other training costs incurred. If I fail to give 2 weeks written notice of voluntary termination of my employment with Trinity Hearts Learning Center KDHNC LLC, I will be responsible for all training fees paid on my behalf by Trinity Hearts Learning Center KDH, LLC within the past year.** (initial each policy)

TH **Discipline policy**_____
TH **Shaken Baby**_____
TH **Biting Policy**_____
TH **Supervision Policy**_____
TH **Infant Toddler Safe Sleep**_____
TH **NC Smoking and Vaping Policy**_____
TH **Cell Phone Policy**_____
TH **Employee conduct Policy**_____
TH **Non Solicitation and Non Compete Clause**_____
TH **NDA Confidentiality Policy**_____

I pledge that I will not discuss or otherwise communicate any form of information concerning the care or condition of any child with unauthorized individuals, parents, staff or volunteers. All communication about children and families in our care along with proprietary information about the business, staff or volunteers (medical files, assessments or reports, scheduling, procedures, protected confidential information about business and staff etc)

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shall be considered confidential and shall not be disclosed to or discussed with anyone other than those authorized to receive such information unless disclosure is authorized by law. Failure to abide by this agreement could result in immediate termination, written warning, and or . This applies to all communications about children, parents, staff or volunteers. Breach of this policy and any other will be punishable under North Carolina law to the fullest extent. I confirm that I have read and understand the above and will comply with above directive on Confidentiality and above policies._____

_____

Employee Name Date

_____

Employee Signature Date

_____

Director/Assistant Director Name Date

_____

Director/Assistant Director Signature Date

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Instructions for Accessing Moodle for 2024 H&S Trainings

Here are instructions for accessing Moodle to do your Health & Safety (H&S) Trainings which are due within 12 months of hire.
*CPR/First Aid due within 3 months of hire.
*Recognizing and Responding to Suspicions of Child Maltreatment due within 3 months of hire.

H&S Training in most of the required topic areas is available at no cost on Moodle on the DCDEE Website.

1. Go to DCDEE website https://ncchildcare.ncdhhs.gov/ . Hover cursor over Provider tab
2. Move cursor down one to Training and Professional Development
3. Slide over and down to DCDEE Moodle. (There is a tutorial for navigating Moodle. Review if needed.)
4. Use your NCID to sign in in the top right corner.
5. View picture carousel and click on the one that reads "View Early Childhood Professional Development"
6. Scroll down to "Regulatory" and click
7. Click on "Year 2024 Medication in Child Care" to complete that module.
8. Click on "Year 2024 Health & Safety Training" to complete other modules
9. Read the instructions under "Start Here". There is a link to contact someone if you need help.
10. You do not have to complete all modules at one time but complete each module in one sitting.
11. Depending on your program, you may not have to complete all modules.
    a. If your facility is not licensed to serve infants (Birth – 12 months), you do not have to complete "Prevention of Sudden Infant Death Syndrome and Use of Safe Sleep Practices".
    b. If your facility does not offer routine transportation or transportation for field trips, you do not have to complete "Precautions in Transporting Children".
    c. If your facility only serves school-age children, you do not have to complete "Prevention of Shaken Baby Syndrome, Abusive Head Trauma and Child Maltreatment".
12. Once you have completed these training modules and print your certificates, you are done with Moodle.
13. Complete ***"Recognizing and Responding to Suspicions of Child Maltreatment"*** on the Prevent Child Abuse NC website... www.preventchildabusenc.org **(due 3 months of hire)**
    *For five-year renewal you can choose to complete any approved training related to child maltreatment. Prevent Child Abuse NC also has an approved training called ***"What is Prevention?"***
14. Complete Adult and Pediatric CPR/First Aid **(due 3 months of hire)**
15. Complete the Health & Safety Training Log and attach certificates. Repeat every five years. (CPR/FA every 2 years)

For assistance with Moodle, email DCDEE_Moodle_Support@dhhs.nc.gov or call (919) 814-6326.