# Impact Logistics, Inc.

# California

## New Hire Employee Checklist

Employee Name _____

Employee # _____

Date of Hire _____

- ☐ ID’s
- ☐ PAN
- ☐ W-4
- ☐ State Specific Forms
- ☐ I-9
- ☐ Paycard
- ☐ Direct Deposit
- ☐ Background Check
- ☐ Kronos Proxy Card
- ☐ Pay Policy
- ☐ Employee Application
- ☐ Affirmative Action
- ☐ Handbook Acknowledgment
- ☐ Health Insurance Coverage Forms
- ☐ Sick Leave Policy Forms

New Hire File Audit Completed By: _____ Hiring Manager (Please Print)

Contact (Cell): _____

Date: _____

# Impact Logistics, Inc.

Personal Action Notice (PAN)

Social Security # _____

Employee ID _____

Accounting Code _____

First Day Worked _____

☐ New Hire ☐ Position Change

☐ Rehire ☐ Data Change

☐ Transfer

☐ Other _____

| Personal Information (Required) | | |
|---|---|---|
| Last Name: | First Name: | MI: |
| Mailing Address: | Apt/Lot #: | |
| City: | State: | Zip: |
| Phone Number: | Date of Birth: | |

| Pay Information | |
|---|---|
| Primary Kronos Job: _____ | Proxy Card Number: _____ |
| Choose **ONE** Option Below: | |
| **Option 1:** ☐ Straight Hourly: $ _____ | **Option 2:** ☐ Hourly + Bonus |

| Transfer |
|---|
| To _____ From_____ Effective Date: ____/____/____ |

Filled Out By (Please Print): _____

Signature: _____ Date: _____

# Form W-4 (2017)

**Purpose.** Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay. Consider completing a new Form W-4 each year and when your personal or financial situation changes.

**Exemption from withholding.** If you are exempt, complete **only** lines 1, 2, 3, 4, and 7 and sign the form to validate it. Your exemption for 2017 expires February 15, 2018. See Pub. 505, Tax Withholding and Estimated Tax.

**Note:** If another person can claim you as a dependent on his or her tax return, you can't claim exemption from withholding if your total income exceeds $1,050 and includes more than $350 of unearned income (for example, interest and dividends).

***Exceptions***. An employee may be able to claim exemption from withholding even if the employee is a dependent, if the employee:

- Is age 65 or older,
- Is blind, or
- Will claim adjustments to income; tax credits; or itemized deductions, on his or her tax return.

The exceptions don't apply to supplemental wages greater than $1,000,000.

**Basic instructions.** If you aren't exempt, complete the **Personal Allowances Worksheet** below. The worksheets on page 2 further adjust your withholding allowances based on itemized deductions, certain credits, adjustments to income, or two-earners/multiple jobs situations.

Complete all worksheets that apply. However, you may claim fewer (or zero) allowances. For regular wages, withholding must be based on allowances you claimed and may not be a flat amount or percentage of wages.

**Head of household.** Generally, you can claim head of household filing status on your tax return only if you are unmarried and pay more than 50% of the costs of keeping up a home for yourself and your dependent(s) or other qualifying individuals. See Pub. 501, Exemptions, Standard Deduction, and Filing Information, for information.

**Tax credits.** You can take projected tax credits into account in figuring your allowable number of withholding allowances. Credits for child or dependent care expenses and the child tax credit may be claimed using the **Personal Allowances Worksheet** below. See Pub. 505 for information on converting your other credits into withholding allowances.

**Nonwage income.** If you have a large amount of nonwage income, such as interest or dividends, consider making estimated tax payments using Form 1040-ES, Estimated Tax for Individuals. Otherwise, you may owe additional tax. If you have pension or annuity income, see Pub. 505 to find out if you should adjust your withholding on Form W-4 or W-4P.

**Two earners or multiple jobs.** If you have a working spouse or more than one job, figure the total number of allowances you are entitled to claim on all jobs using worksheets from only one Form W-4. Your withholding usually will be most accurate when all allowances are claimed on the Form W-4 for the highest paying job and zero allowances are claimed on the others. See Pub. 505 for details.

**Nonresident alien.** If you are a nonresident alien, see Notice 1392, Supplemental Form W-4 Instructions for Nonresident Aliens, before completing this form.

**Check your withholding.** After your Form W-4 takes effect, use Pub. 505 to see how the amount you are having withheld compares to your projected total tax for 2017. See Pub. 505, especially if your earnings exceed $130,000 (Single) or $180,000 (Married).

**Future developments.** Information about any future developments affecting Form W-4 (such as legislation enacted after we release it) will be posted at *www.irs.gov/w4*.

## Personal Allowances Worksheet (Keep for your records.)

| | | |
|---|---|---|
| **A** | Enter "1" for **yourself** if no one else can claim you as a dependent | **A** _____ |
| **B** | Enter "1" if: • You're single and have only one job; or • You're married, have only one job, and your spouse doesn't work; or • Your wages from a second job or your spouse's wages (or the total of both) are $1,500 or less. | **B** _____ |
| **C** | Enter "1" for your **spouse.** But, you may choose to enter "-0-" if you are married and have either a working spouse or more than one job. (Entering "-0-" may help you avoid having too little tax withheld.) | **C** _____ |
| **D** | Enter number of **dependents** (other than your spouse or yourself) you will claim on your tax return | **D** _____ |
| **E** | Enter "1" if you will file as **head of household** on your tax return (see conditions under **Head of household** above) | **E** _____ |
| **F** | Enter "1" if you have at least $2,000 of **child or dependent care expenses** for which you plan to claim a credit (**Note:** Do **not** include child support payments. See Pub. 503, Child and Dependent Care Expenses, for details.) | **F** _____ |
| **G** | **Child Tax Credit** (including additional child tax credit). See Pub. 972, Child Tax Credit, for more information. • If your total income will be less than $70,000 ($100,000 if married), enter "2" for each eligible child; then **less** "1" if you have two to four eligible children or **less** "2" if you have five or more eligible children. • If your total income will be between $70,000 and $84,000 ($100,000 and $119,000 if married), enter "1" for each eligible child. | **G** _____ |
| **H** | Add lines A through G and enter total here. (**Note:** This may be different from the number of exemptions you claim on your tax return.) ► | **H** _____ |

**For accuracy, complete all worksheets that apply.**

- If you plan to **itemize** or **claim adjustments to income** and want to reduce your withholding, see the **Deductions and Adjustments Worksheet** on page 2.
- If you are **single and have more than one job** or are **married and you and your spouse both work** and the combined earnings from all jobs exceed $50,000 ($20,000 if married), see the **Two-Earners/Multiple Jobs Worksheet** on page 2 to avoid having too little tax withheld.
- If **neither** of the above situations applies, **stop here** and enter the number from line H on line 5 of Form W-4 below.

---------- **Separate here and give Form W-4 to your employer. Keep the top part for your records.** ----------

Form **W-4**
Department of the Treasury
Internal Revenue Service

## Employee's Withholding Allowance Certificate

► **Whether you are entitled to claim a certain number of allowances or exemption from withholding is subject to review by the IRS. Your employer may be required to send a copy of this form to the IRS.**

OMB No. 1545-0074

**2017**

| | | |
|---|---|---|
| **1** Your first name and middle initial / Last name | | **2 Your social security number** |
| Home address (number and street or rural route) | **3** ☐ Single ☐ Married ☐ Married, but withhold at higher Single rate. **Note:** If married, but legally separated, or spouse is a nonresident alien, check the "Single" box. | |
| City or town, state, and ZIP code | **4 If your last name differs from that shown on your social security card, check here. You must call 1-800-772-1213 for a replacement card.** ► ☐ | |
| **5** Total number of allowances you are claiming (from line **H** above **or** from the applicable worksheet on page 2) | **5** | |
| **6** Additional amount, if any, you want withheld from each paycheck | **6** $ | |
| **7** I claim exemption from withholding for 2017, and I certify that I meet **both** of the following conditions for exemption. • Last year I had a right to a refund of **all** federal income tax withheld because I had **no** tax liability, **and** • This year I expect a refund of **all** federal income tax withheld because I expect to have **no** tax liability. If you meet both conditions, write "Exempt" here ► | **7** | |

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

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

| **8** Employer's name and address (Employer: Complete lines 8 and 10 only if sending to the IRS.) | **9** Office code (optional) | **10** Employer identification number (EIN) |
|---|---|---|
| Impact Logistics, Inc 7980 N Brother Blvd Memphis, TN 38133 | | 62-1519198 |

## Deductions and Adjustments Worksheet

**Note:** Use this worksheet *only* if you plan to itemize deductions or claim certain credits or adjustments to income.

| | | | |
|---|---|---|---|
| 1 | Enter an estimate of your 2017 itemized deductions. These include qualifying home mortgage interest, charitable contributions, state and local taxes, medical expenses in excess of 10% of your income, and miscellaneous deductions. For 2017, you may have to reduce your itemized deductions if your income is over $313,800 and you're married filing jointly or you're a qualifying widow(er); $287,650 if you're head of household; $261,500 if you're single, not head of household and not a qualifying widow(er); or $156,900 if you're married filing separately. See Pub. 505 for details | 1 | $ |
| 2 | Enter: { $12,700 if married filing jointly or qualifying widow(er); $9,350 if head of household; $6,350 if single or married filing separately } | 2 | $ |
| 3 | **Subtract** line 2 from line 1. If zero or less, enter "-0-" | 3 | $ |
| 4 | Enter an estimate of your 2017 adjustments to income and any additional standard deduction (see Pub. 505) | 4 | $ |
| 5 | **Add** lines 3 and 4 and enter the total. (Include any amount for credits from the *Converting Credits to Withholding Allowances for 2017 Form W-4* worksheet in Pub. 505.) | 5 | $ |
| 6 | Enter an estimate of your 2017 nonwage income (such as dividends or interest) | 6 | $ |
| 7 | **Subtract** line 6 from line 5. If zero or less, enter "-0-" | 7 | $ |
| 8 | **Divide** the amount on line 7 by $4,050 and enter the result here. Drop any fraction | 8 | |
| 9 | Enter the number from the **Personal Allowances Worksheet,** line H, page 1 | 9 | |
| 10 | **Add** lines 8 and 9 and enter the total here. If you plan to use the **Two-Earners/Multiple Jobs Worksheet,** also enter this total on line 1 below. Otherwise, **stop here** and enter this total on Form W-4, line 5, page 1 | 10 | |

## Two-Earners/Multiple Jobs Worksheet (See *Two earners or multiple jobs* on page 1.)

**Note:** Use this worksheet *only* if the instructions under line H on page 1 direct you here.

| | | | |
|---|---|---|---|
| 1 | Enter the number from line H, page 1 (or from line 10 above if you used the **Deductions and Adjustments Worksheet**) | 1 | |
| 2 | Find the number in **Table 1** below that applies to the **LOWEST** paying job and enter it here. **However,** if you are married filing jointly and wages from the highest paying job are $65,000 or less, do not enter more than "3" | 2 | |
| 3 | If line 1 is **more than or equal to** line 2, subtract line 2 from line 1. Enter the result here (if zero, enter "-0-") and on Form W-4, line 5, page 1. **Do not** use the rest of this worksheet | 3 | |

**Note:** If line 1 is **less than** line 2, enter "-0-" on Form W-4, line 5, page 1. Complete lines 4 through 9 below to figure the additional withholding amount necessary to avoid a year-end tax bill.

| | | | |
|---|---|---|---|
| 4 | Enter the number from line 2 of this worksheet | 4 | |
| 5 | Enter the number from line 1 of this worksheet | 5 | |
| 6 | **Subtract** line 5 from line 4 | 6 | |
| 7 | Find the amount in **Table 2** below that applies to the **HIGHEST** paying job and enter it here | 7 | $ |
| 8 | **Multiply** line 7 by line 6 and enter the result here. This is the additional annual withholding needed | 8 | $ |
| 9 | Divide line 8 by the number of pay periods remaining in 2017. For example, divide by 25 if you are paid every two weeks and you complete this form on a date in January when there are 25 pay periods remaining in 2017. Enter the result here and on Form W-4, line 6, page 1. This is the additional amount to be withheld from each paycheck | 9 | $ |

### Table 1

| Married Filing Jointly | | All Others | |
|---|---|---|---|
| If wages from **LOWEST** paying job are— | Enter on line 2 above | If wages from **LOWEST** paying job are— | Enter on line 2 above |
| $0 - $7,000 | 0 | $0 - $8,000 | 0 |
| 7,001 - 14,000 | 1 | 8,001 - 16,000 | 1 |
| 14,001 - 22,000 | 2 | 16,001 - 26,000 | 2 |
| 22,001 - 27,000 | 3 | 26,001 - 34,000 | 3 |
| 27,001 - 35,000 | 4 | 34,001 - 44,000 | 4 |
| 35,001 - 44,000 | 5 | 44,001 - 70,000 | 5 |
| 44,001 - 55,000 | 6 | 70,001 - 85,000 | 6 |
| 55,001 - 65,000 | 7 | 85,001 - 110,000 | 7 |
| 65,001 - 75,000 | 8 | 110,001 - 125,000 | 8 |
| 75,001 - 80,000 | 9 | 125,001 - 140,000 | 9 |
| 80,001 - 95,000 | 10 | 140,001 and over | 10 |
| 95,001 - 115,000 | 11 | | |
| 115,001 - 130,000 | 12 | | |
| 130,001 - 140,000 | 13 | | |
| 140,001 - 150,000 | 14 | | |
| 150,001 and over | 15 | | |

### Table 2

| Married Filing Jointly | | All Others | |
|---|---|---|---|
| If wages from **HIGHEST** paying job are— | Enter on line 7 above | If wages from **HIGHEST** paying job are— | Enter on line 7 above |
| $0 - $75,000 | $610 | $0 - $38,000 | $610 |
| 75,001 - 135,000 | 1,010 | 38,001 - 85,000 | 1,010 |
| 135,001 - 205,000 | 1,130 | 85,001 - 185,000 | 1,130 |
| 205,001 - 360,000 | 1,340 | 185,001 - 400,000 | 1,340 |
| 360,001 - 405,000 | 1,420 | 400,001 and over | 1,600 |
| 405,001 and over | 1,600 | | |

**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. Internal Revenue Code sections 3402(f)(2) and 6109 and their regulations require you to provide this information; your employer uses it to determine your federal income tax withholding. Failure to provide a properly completed form will result in your being treated as a single person who claims no withholding allowances; 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; to cities, states, the District of Columbia, and U.S. commonwealths and possessions for use in administering their tax laws; and to the Department of Health and Human Services for use in the National Directory of New Hires. 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 Code 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 Development Department
State of California

This form can be used to manually compute your withholding allowances, or you can electronically compute them at **www.taxes.ca.gov/de4.pdf.**

# EMPLOYEE'S WITHHOLDING ALLOWANCE CERTIFICATE

| Type or Print Your Full Name | Your Social Security Number |
|---|---|
| Home Address (Number and Street or Rural Route) | Filing Status Withholding Allowances<br>☐ SINGLE or MARRIED (with two or more incomes)<br>☐ MARRIED (one income)<br>☐ HEAD OF HOUSEHOLD |
| City, State, and ZIP Code | |

1. Number of allowances for Regular Withholding Allowances, Worksheet A _____
   Number of allowances from the Estimated Deductions, Worksheet B _____
   Total Number of Allowances (A + B) when using the California Withholding Schedules for 2015 _____
   OR
2. Additional amount of state income tax to be withheld each pay period (if employer agrees), Worksheet C _____
   OR
3. I certify under penalty of perjury that I am not subject to California withholding. I meet the conditions set forth under the Service Member Civil Relief Act, as amended by the Military Spouses Residency Relief Act. (Check box here) ☐

***Under the penalties of perjury, I certify that the number of withholding allowances claimed on this certificate does not exceed the number to which I am entitled or, if claiming exemption from withholding, that I am entitled to claim the exempt status.***

Signature _____ Date _____

| Employer's Name and Address | California Employer Account Number |
|---|---|
| | |

cut here

Give the top portion of this page to your employer and keep the remainder for your records.

## YOUR CALIFORNIA PERSONAL INCOME TAX MAY BE UNDERWITHHELD IF YOU DO NOT FILE THIS DE 4 FORM.

***IF YOU RELY ON THE FEDERAL FORM W-4 FOR YOUR CALIFORNIA WITHHOLDING ALLOWANCES, YOUR CALIFORNIA STATE PERSONAL INCOME TAX MAY BE UNDERWITHHELD AND YOU MAY OWE MONEY AT THE END OF THE YEAR.***

**PURPOSE**: This certificate, DE 4, is for **California Personal Income Tax (PIT) withholding** purposes only. The DE 4 is used to compute the amount of taxes to be withheld from your wages, by your employer, to accurately reflect your state tax withholding obligation.

You should complete this form if either:

(1) You claim a different marital status, number of regular allowances, or different additional dollar amount to be withheld for California PIT withholding than you claim for federal income tax withholding or,

(2) You claim additional allowances for estimated deductions.

THIS FORM WILL NOT CHANGE YOUR FEDERAL WITHHOLDING ALLOWANCES.

The federal Form W-4 is applicable for California withholding purposes if you wish to claim the same marital status, number of regular allowances, and/or the same additional dollar amount to be withheld for state and federal purposes. However, federal tax brackets and withholding methods do not reflect state PIT withholding tables. **If you rely on the number of withholding allowances you claim on your Form W-4 withholding allowance certificate for your state income tax withholding, you may be significantly underwithheld.** This is particularly true if your household income is derived from more than one source.

**CHECK YOUR WITHHOLDING:** After your Form W-4 and/or DE 4 takes effect, compare the state income tax withheld with your estimated total annual tax. For state withholding, use the worksheets on this form.

**EXEMPTION FROM WITHHOLDING:** If you wish to claim exempt, complete the federal Form W-4. You may claim exempt from withholding California income tax if you did not owe any federal income tax last year and you do not expect to owe any federal income tax this year. The exemption is good for one year. If you continue to qualify for the exempt filing status, a new Form W-4 designating EXEMPT must be submitted by February 15 each year to continue your exemption. If you are not having federal income tax withheld this year but expect to have a tax liability next year, you are reuired to give your employer a new Form W-4 by December 1.

**EXEMPTION FROM WITHHOLDING** (continued): Under the Service Member Civil Relief Act, as amended by the Military Spouses Residency Relief Act, you may be exempt from California income tax on your wages if (i) your spouse is a member of the armed forces present in California in compliance with military orders; (ii) you are present in California solely to be with your spouse; and (iii) you maintain your domicile in another state. If you claim exemption under this act, check the box on Line 3. You may be required to provide proof of exemption upon request.

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**IF YOU NEED MORE DETAILED INFORMATION, SEE THE INSTRUCTIONS THAT CAME WITH YOUR LAST CALIFORNIA INCOME TAX RETURN OR CALL THE FRANCHISE TAX BOARD (FTB).**

| | |
|---|---|
| IF YOU ARE CALLING FROM WITHIN THE UNITED STATES | 800-852-5711 (voice)<br>800-822-6268 (TTY) |
| IF YOU ARE CALLING FROM OUTSIDE THE UNITED STATES (Not Toll Free) | 916-845-6500 |

The *California Employer's Guide* (DE 44) provides the income tax withholding tables. This publication may be found on the Employment Development Department (EDD) website at **www.edd.ca.gov/Payroll_Taxes/Forms_and_Publications.htm**. To assist you in calculating your tax liability, please visit the Franchise Tax Board website at **www.ftb.ca.gov/individuals/index.shtml**.

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**NOTIFICATION:** Your employer is required to send a copy of your DE 4 to the FTB if it meets either of the following two conditions:

- You claim more than 10 withholding allowances.
- You claim exemption from state or federal income tax withholding and your employer expects your usual weekly wages to exceed $200 per week.

IF THE IRS INSTRUCTS YOUR EMPLOYER TO WITHHOLD FEDERAL INCOME TAX BASED ON A CERTAIN WITHHOLDING STATUS, YOUR EMPLOYER IS REQUIRED TO USE THE SAME WITHHOLDING STATUS FOR STATE INCOME TAX WITHHOLDING IF YOUR WITHHOLDING ALLOWANCES FOR STATE PURPOSES MEET THE REQUIREMENTS LISTED UNDER "NOTIFICATION." IF YOU FEEL THAT THE FEDERAL DETERMINATION IS NOT CORRECT FOR STATE WITHHOLDING PURPOSES, YOU MAY REQUEST A REVIEW.

To do so, write to:

W-4 Unit
Franchise Tax Board MS F180
P.O. Box 2952
Sacramento, CA 95812-2952
Fax: 916-843-1094

Your letter should contain the basis of your request for review. You will have the burden of showing that the federal determination is incorrect for state withholding purposes. The FTB will limit its review to that issue. The FTB will notify both you and your employer of its findings. Your employer is then required to withhold state income tax as instructed by the FTB. In the event the FTB or the IRS finds there is no reasonable basis for the number of withholding exemptions that you claimed on your Form W-4/DE 4, you may be subject to a penalty.

**PENALTY:** You may be fined $500 if you file, with no reasonable basis, a DE 4 that results in less tax being withheld than is properly allowable. In addition, criminal penalties apply for willfully supplying false or fraudulent information or failing to supply information requiring an increase in withholding. This is provided for by Section 13101 of the California Unemployment Insurance Code.

## INSTRUCTIONS — 1 — ALLOWANCES*

When determining your withholding allowances, you must consider your personal situation:
— Do you claim allowances for dependents or blindness?
— Will you itemize your deductions?
— Do you have more than one income coming into the household?

**TWO-EARNER/TWO-JOBS:** When earnings are derived from more than one source, underwithholding may occur. If you have a working spouse or more than one job, it is best to check the box "SINGLE or MARRIED (with two or more incomes)." Figure the total number of allowances you are entitled to claim on all jobs using only one DE 4 form. Claim allowances with one employer. Do not claim the same allowances with more than one employer. Your withholding will usually be most accurate when all allowances are claimed on the DE 4 or Form W-4 filed for the highest paying job and zero allowances are claimed for the others.

**MARRIED BUT NOT LIVING WITH YOUR SPOUSE:** You may check the "Head of Household" marital status box if you meet all of the following tests:
(1) Your spouse will not live with you at any time during the year;
(2) You will furnish over half of the cost of maintaining a home for the entire year for yourself and your child or stepchild who qualifies as your dependent; and
(3) You will file a separate return for the year.

**HEAD OF HOUSEHOLD:** To qualify, you must be unmarried or legally separated from your spouse and pay more than 50% of the costs of maintaining a home for the entire year for yourself and your dependent(s) or other qualifying individuals. Cost of maintaining the home includes such items as rent, property insurance, property taxes, mortgage interest, repairs, utilities, and cost of food. It does not include the individual's personal expenses or any amount which represents value of services performed by a member of the household of the taxpayer.

## WORKSHEET A — REGULAR WITHHOLDING ALLOWANCES

| | | |
|---|---|---|
| (A) | Allowance for yourself — enter 1 | (A) _____ |
| (B) | Allowance for your spouse (if not separately claimed by your spouse) — enter 1 | (B) _____ |
| (C) | Allowance for blindness — yourself — enter 1 | (C) _____ |
| (D) | Allowance for blindness — your spouse (if not separately claimed by your spouse) — enter 1 | (D) _____ |
| (E) | Allowance(s) for dependent(s) — do not include yourself or your spouse | (E) _____ |
| (F) | Total — add lines (A) through (E) above | (F) _____ |

## INSTRUCTIONS — 2 — ADDITIONAL WITHHOLDING ALLOWANCES

If you expect to itemize deductions on your California income tax return, you can claim additional withholding allowances. Use Worksheet B to determine whether your expected estimated deductions may entitle you to claim one or more additional withholding allowances. Use last year's FTB Form 540 as a model to calculate this year's withholding amounts.

Do not include deferred compensation, qualified pension payments, or flexible benefits, etc., that are deducted from your gross pay but are not taxed on this worksheet.

You may reduce the amount of tax withheld from your wages by claiming one additional withholding allowance for each $1,000, or fraction of $1,000, by which you expect your estimated deductions for the year to exceed your allowable standard deduction.

## WORKSHEET B — ESTIMATED DEDUCTIONS

| | | | |
|---|---|---|---|
| 1. | Enter an estimate of your itemized deductions for California taxes for this tax year as listed in the schedules in the FTB Form 540 | | 1. _____ |
| 2. | Enter $7,984 if married filing joint with two or more allowances, unmarried head of household, or qualifying widow(er) with dependent(s) or $3,992 if single or married filing separately, dual income married, or married with multiple employers | – | 2. _____ |
| 3. | Subtract line 2 from line 1, enter difference | = | 3. _____ |
| 4. | Enter an estimate of your adjustments to income (alimony payments, IRA deposits) | + | 4. _____ |
| 5. | Add line 4 to line 3, enter sum | = | 5. _____ |
| 6. | Enter an estimate of your nonwage income (dividends, interest income, alimony receipts) | – | 6. _____ |
| 7. | If line 5 is greater than line 6 (if less, see below); Subtract line 6 from line 5, enter difference | = | 7. _____ |
| 8. | Divide the amount on line 7 by $1,000, round any fraction to the nearest whole number Enter this number on line 1 of the DE 4. Complete Worksheet C, if needed. | | 8. _____ |
| 9. | If line 6 is greater than line 5; Enter amount from line 6 (nonwage income) | | 9. _____ |
| 10. | Enter amount from line 5 (deductions) | | 10. _____ |
| 11. | Subtract line 10 from line 9, enter difference Complete Worksheet C | | 11. _____ |

*Wages paid to registered domestic partners will be treated the same for state income tax purposes as wages paid to spouses for California Personal Income Tax (PIT) withholding and PIT wages. This law does not impact federal income tax law. A registered domestic partner means an individual partner in a domestic partner relationship within the meaning of Section 297 of the Family Code. For more information, please call our Taxpayer Assistance Center at 888-745-3886.

## WORKSHEET C — TAX WITHHOLDING AND ESTIMATED TAX

1. Enter estimate of total wages for tax year 2015 . . . . . 1. _____
2. Enter estimate of nonwage income (line 6 of Worksheet B) . . . . . 2. _____
3. Add line 1 and line 2. Enter sum . . . . . 3. _____
4. Enter itemized deductions or standard deduction (line 1 or 2 of Worksheet B, whichever is largest) . . . . . 4. _____
5. Enter adjustments to income (line 4 of Worksheet B) . . . . . 5. _____
6. Add line 4 and line 5. Enter sum . . . . . 6. _____
7. Subtract line 6 from line 3. Enter difference . . . . . 7. _____
8. Figure your tax liability for the amount on line 7 by using the 2015 tax rate schedules below . . . . . 8. _____
9. Enter personal exemptions (line F of Worksheet A x $118.80) . . . . . 9. _____
10. Subtract line 9 from line 8. Enter difference . . . . . 10. _____
11. Enter any tax credits. (See FTB Form 540) . . . . . 11. _____
12. Subtract line 11 from line 10. Enter difference. This is your total tax liability . . . . . 12. _____
13. Calculate the tax withheld and estimated to be withheld during 2015. Contact your employer to request the amount that will be withheld on your wages based on the marital status and number of withholding allowances you will claim for 2015. Multiply the estimated amount to be withheld by the number of pay periods left in the year. Add the total to the amount already withheld for 2015 . . . . . 13. _____
14. Subtract line 13 from line 12. Enter difference. If this is less than zero, you do not need to have additional taxes withheld . . . . . 14. _____
15. Divide line 14 by the number of pay periods remaining in the year. Enter this figure on line 2 of the DE 4 . . . 15. _____

**NOTE:** Your employer is not required to withhold the additional amount requested on line 2 of your DE 4. If your employer does not agree to withhold the additional amount, you may increase your withholdings as much as possible by using the "single" status with "zero" allowances. If the amount withheld still results in an underpayment of state income taxes, you may need to file quarterly estimates on Form 540-ES with the FTB to avoid a penalty.

*THESE TABLES ARE FOR CALCULATING WORKSHEET C AND FOR 2015 ONLY*

**SINGLE OR MARRIED WITH DUAL EMPLOYERS**

| IF THE TAXABLE INCOME IS | | COMPUTED TAX IS | | |
|---|---|---|---|---|
| OVER | BUT NOT OVER | OF AMOUNT OVER . . . | | PLUS* |
| $0 | $7,749 ... | 1.100% | $0 | $0.00 |
| $7,749 | $18,371 ... | 2.200% | $7,749 | $85.24 |
| $18,371 | $28,995 ... | 4.400% | $18,371 | $318.92 |
| $28,995 | $40,250 ... | 6.600% | $28,995 | $786.38 |
| $40,250 | $50,869 ... | 8.800% | $40,250 | $1,529.21 |
| $50,869 | $259,844 ... | 10.230% | $50,869 | $2,463.68 |
| $259,844 | $311,812 ... | 11.330% | $259,844 | $23,841.82 |
| $311,812 | $519,687 ... | 12.430% | $311,812 | $29,729.79 |
| $519,687 | $1,000,000 ... | 13.530% | $519,687 | $55,568.65 |
| $1,000,000 | and over | 14.630% | $1,000,000 | $120,555.00 |

**MARRIED FILING JOINT OR QUALIFYING WIDOW(ER) TAXPAYERS**

| IF THE TAXABLE INCOME IS | | COMPUTED TAX IS | | |
|---|---|---|---|---|
| OVER | BUT NOT OVER | OF AMOUNT OVER . . . | | PLUS* |
| $0 | $15,498 ... | 1.100% | $0 | $0.00 |
| $15,498 | $36,742 ... | 2.200% | $15,498 | $170.48 |
| $36,742 | $57,990 ... | 4.400% | $36,742 | $637.85 |
| $57,990 | $80,500 ... | 6.600% | $57,990 | $1,572.76 |
| $80,500 | $101,738 ... | 8.800% | $80,500 | $3,058.42 |
| $101,738 | $519,688 ... | 10.230% | $101,738 | $4,927.36 |
| $519,688 | $623,624 ... | 11.330% | $519,688 | $47,683.65 |
| $623,624 | $1,000,000 ... | 12.430% | $623,624 | $59,459.60 |
| $1,000,000 | $1,039,374 ... | 13.530% | $1,000,000 | $106,243.14 |
| $1,039,374 | and over | 14.630% | $1,039,374 | $111,570.44 |

**UNMARRIED HEAD OF HOUSEHOLD TAXPAYERS**

| IF THE TAXABLE INCOME IS | | COMPUTED TAX IS | | |
|---|---|---|---|---|
| OVER | BUT NOT OVER | OF AMOUNT OVER . . . | | PLUS* |
| $0 | $15,508 ... | 1.100% | $0 | $0.00 |
| $15,508 | $36,743 ... | 2.200% | $15,508 | $170.59 |
| $36,743 | $47,366 ... | 4.400% | $36,743 | $637.76 |
| $47,366 | $58,621 ... | 6.600% | $47,366 | $1,105.17 |
| $58,621 | $69,242 ... | 8.800% | $58,621 | $1,848.00 |
| $69,242 | $353,387 ... | 10.230% | $69,242 | $2,782.65 |
| $353,387 | $424,065 ... | 11.330% | $353,387 | $31,850.68 |
| $424,065 | $706,774 ... | 12.430% | $424,065 | $39,858.50 |
| $706,774 | $1,000,000 ... | 13.530% | $706,774 | $74,999.23 |
| $1,000,000 | and over | 14.630% | $1,000,000 | $114,672.71 |

*marginal tax

IF YOU NEED MORE DETAILED INFORMATION, SEE THE INSTRUCTIONS THAT CAME WITH YOUR LAST CALIFORNIA INCOME TAX RETURN OR CALL THE FTB:

IF YOU ARE CALLING FROM WITHIN THE UNITED STATES — 800-852-5711 (voice), 800-822-6268 (TTY)

IF YOU ARE CALLING FROM OUTSIDE THE UNITED STATES (Not Toll Free) — 916-845-6500

The DE 4 information is collected for purposes of administering the PIT law and under the authority of Title 22, California Code of Regulations, and the Revenue and Taxation Code, including Section 18624. The Information Practices Act of 1977 requires that individuals be notified of how information they provide may be used. Further information is contained in the instructions that came with your last California income tax return.

Employee ID

# FIRST MEAL BREAK WAIVER

1. I understand that if I work more than five (5) hours in a work day, I am entitled to a thirty minute (30) uninterrupted meal break without pay and that Impact will provide me with this meal break (this meal break shall be referred to as “first meal break”).

2. On days when I work more than five (5) hours but less than six (6) hours, I may elect to waive this first meal break. I understand that in waiving this first meal break, I will be paid for the number of hours actually worked.

3. I agree that when I have worked a shift of more than five (5) hours but less than six (6) hours, I voluntarily elect to waive my right to take my first 30-minute meal break in all such instances. This waiver does not prevent me from taking a first meal break if I so choose. If I do choose to take a first meal break, I agree to clock out and in when I do take a first meal break, according to company policy.

4. I understand a first meal break waiver applies only to days where I work less than six (6) hours in a day. It is recognized that unforeseen circumstances may occur and in such cases where I did not receive a first meal break and my total hours are more than six (6) hours, I must notify my Impact supervisor/manager that I was unable to take a first meal break. In cases where this issue arises, a meal break will be provided to me or, if it is impossible to take a first meal break, the premium for a missed break will automatically be paid in accordance with the law.

5. In order for this waiver to be valid, and authorized company official must approve my request by signing below.

6. I am aware that I may revoke this agreement at any time by signing this form as indicated below.

Employee Signature Date

Authorized Company Signature Date

Revocation: I hereby revoke this waiver.

Employee Signature Date

Authorized Company Representative Signature Date

Employee ID

# SECOND MEAL BREAK WAIVER

1. I understand that if I work more than five (5) hours in a work day, I am entitled to a thirty minute (30) uninterrupted meal break without pay and that Impact will provide me with this meal break. I also understand that if I work more than ten (10) hours in a work day, I am entitled to a second thirty (30) minute uninterrupted meal break without pay and that Impact will provide me with this meal break.

2. On days when I work more than ten (10) hours but less than twelve (12) hours, and have taken my first meal break, I may elect to waive this second meal break. I understand that in waiving this meal break, I will be paid for the number of hours actually worked.

3. I agree that when I have worked a shift of more than ten (10) hours but less than twelve (12) hours, I voluntarily elect to waive my right to take my second thirty-minute meal period in all such instances.

4. I understand a second meal break waiver applies only to days where I work less than twelve (12) hours in a day. It is recognized that unforeseen circumstances may occur that require the workday to be extended beyond twelve hours. In such cases where I did not receive a second meal break, and my total hours are twelve (12) hours or more, I must notify my Impact supervisor/manager that I was unable to take a second meal break. In cases where this issue arises, a meal period premium will automatically be paid in accordance with the law.

5. In order for this waiver to be valid, and authorized company official must approve my request by signing below.

6. I am aware that I may revoke this agreement at any time by signing this form as indicated below.

Employee Signature Date

Authorized Company Signature Date

Revocation: I hereby revoke this waiver.

Employee Signature Date

Authorized Company Representative Signature Date

# NOTICE REGARDING BACKGROUND INVESTIGATION PURSUANT TO CALIFORNIA LAW

Employer ("the Company") may obtain information about you from a consumer reporting agency for employment purposes. Thus, you can expect to be the subject of "investigative consumer reports" and "consumer credit reports" obtained for employment purposes. Such reports may include information about your character, general reputation, personal characteristics, and mode of living. With respect to any investigative consumer report from an investigative consumer reporting agency ("ICRA"), the Company may investigate the information contained in your employment application and other background information about you, including, but not limited to obtaining a criminal record report, verifying references, work history, your social security number, your educational achievements, licensure, and certifications, your driving record, and other information about you, and interviewing the people who are knowledgeable about you. The results of this report may be used as a factor in making employment decisions. The source of any investigative consumer report (as that term is defined under California Law) will be Corporate Screening Services, Inc., 16530 Commerce Court, Cleveland, OH 44130, Phone 800-229-8606, Fax: (440) 243-4204.

The company agrees to provide you with a copy of an investigative consumer report when required to do so under California Law.

Under California Civil Code section 1786.22, you are entitled to find out from ICRA what is in the ICRA's file on you with proper identification as follows:

- In person, by visual inspection of your file during normal business hours and on reasonable notice. You may also request a copy of the information in person. The ICRA may not charge you more than the actual copying costs for providing you with a copy of your file.

- A summary of all information contained in the ICRA file on you that is required to be provided by the California Civil Code will be provided to you via telephone, if you have made a written request, with proper identification, for telephone disclosure, and the toll charge, if any, for the telephone call is prepaid by or charged directly to you.

- By requesting a copy be sent to a specified address by certified mail. ICRAs complying with requests for certified mailing shall not be liable for disclosures to third parties caused by mishandling of mail after such mailing leave the ICRA.

"Proper Identification" includes documents such as a valid US Driver's License, social security account number, military identification card, and credit cards. Only if you cannot identify yourself with such information may the ICRA require additional information concerning your employment and personal and family history to identify your identity.

The ICRA will provide trained personnel to explain any information furnished to you and will provide a written explanation of any coded information contained in files maintained on you. This written explanation will be provided whenever a file is provided to you for visual inspection.

You may be accompanied by one other person of your choosing, who must furnish reasonable identification. An ICRA may require you to furnish a written statement granting permission to the ICRA to discuss your file in such person's presence.

# Employment Eligibility Verification

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

**USCIS**
**Form I-9**
OMB No. 1615-0047
Expires 08/31/2019

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

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

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

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

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

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

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

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

☐ 1. A citizen of the United States

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

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

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

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

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

QR Code - Section 1
Do Not Write In This Space

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

## Preparer and/or Translator Certification (check one):

☐ I did not use a preparer or translator. ☐ A preparer(s) and/or translator(s) assisted the employee in completing Section 1.
*(Fields below must be completed and signed when preparers and/or translators assist an employee in completing Section 1.)*

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

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

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

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

STOP *Employer Completes Next Page* STOP

# Employment Eligibility Verification

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

**USCIS**
**Form I-9**
OMB No. 1615-0047
Expires 08/31/2019

## Section 2. Employer or Authorized Representative Review and Verification

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

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

| List A<br>Identity and Employment Authorization | OR | List B<br>Identity | AND | List C<br>Employment Authorization |
|---|---|---|---|---|
| Document Title | | Document Title | | Document Title |
| Issuing Authority | | Issuing Authority | | Issuing Authority |
| Document Number | | Document Number | | Document Number |
| Expiration Date *(if any)(mm/dd/yyyy)* | | Expiration Date *(if any)(mm/dd/yyyy)* | | Expiration Date *(if any)(mm/dd/yyyy)* |
| Document Title | | | | |
| Issuing Authority | | | | |
| Document Number | | | | |
| Expiration Date *(if any)(mm/dd/yyyy)* | | | | |
| Document Title | | | | |
| Issuing Authority | | | | |
| Document Number | | | | |
| Expiration Date *(if any)(mm/dd/yyyy)* | | | | |

Additional Information

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

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

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

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

| Last Name of Employer or Authorized Representative | First Name of Employer or Authorized Representative | Employer's Business or Organization Name |
|---|---|---|
| | | Impact Logisitics |

| Employer's Business or Organization Address (Street Number and Name) | City or Town | State | ZIP Code |
|---|---|---|---|
| 7980 N Brother Blvd | Memphis | TN | 38133 |

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

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

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

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

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

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

## LISTS OF ACCEPTABLE DOCUMENTS
## All documents must be UNEXPIRED

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

| LIST A<br>Documents that Establish Both Identity and Employment Authorization | OR | LIST B<br>Documents that Establish Identity | AND | LIST C<br>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:<br>(1) NOT VALID FOR EMPLOYMENT<br>(2) VALID FOR WORK ONLY WITH INS AUTHORIZATION<br>(3) VALID FOR WORK ONLY WITH DHS AUTHORIZATION |
| **2.** Permanent Resident Card or Alien Registration Receipt Card (Form I-551) | | **2.** ID card issued by federal, state or local government agencies or entities, provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address | | **2.** Certification of report of birth issued by the Department of State (Forms DS-1350, FS-545, FS-240) |
| **3.** Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa | | **3.** School ID card with a photograph | | **3.** Original or certified copy of birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal |
| **4.** Employment Authorization Document that contains a photograph (Form I-766) | | **4.** Voter's registration card | | **4.** Native American tribal document |
| **5.** For a nonimmigrant alien authorized to work for a specific employer because of his or her status:<br>**a.** Foreign passport; and<br>**b.** Form I-94 or Form I-94A that has the following:<br>(1) The same name as the passport; and<br>(2) An endorsement of the alien's nonimmigrant status as long as that period of endorsement has not yet expired and the proposed employment is not in conflict with any restrictions or limitations identified on the form. | | **5.** U.S. Military card or draft record | | **5.** U.S. Citizen ID Card (Form I-197) |
| | | **6.** Military dependent's ID card | | **6.** Identification Card for Use of Resident Citizen in the United States (Form I-179) |
| | | **7.** U.S. Coast Guard Merchant Mariner Card | | **7.** Employment authorization document issued by the Department of Homeland Security |
| **6.** Passport from the Federated States of Micronesia (FSM) or the Republic of the Marshall Islands (RMI) with Form I-94 or Form I-94A indicating nonimmigrant admission under the Compact of Free Association Between the United States and the FSM or RMI | | **8.** Native American tribal document | | |
| | | **9.** Driver's license issued by a Canadian government authority | | |
| | | **For persons under age 18 who are unable to present a document listed above:** | | |
| | | **10.** School record or report card | | |
| | | **11.** Clinic, doctor, or hospital record | | |
| | | **12.** Day-care or nursery school record | | |

**Examples of many of these documents appear in Part 13 of the Handbook for Employers (M-274).**

**Refer to the instructions for more information about acceptable receipts.**

| Employee ID Number |
| --- |
| |

# TransCard Prepaid MasterCard Enrollment Form

I hereby authorize Impact Logistics, Inc., to deposit my payroll into a TransCard Prepaid Master Card account and to credit or debit my account as necessary to place the correct net payroll amount into my account. I further authorize TransCard to debit or credit my account for transactions initiated by Impact Logistics, Inc. Your initial card will be provided free of charge. Any replacement cards will be deducted from your paycheck in the amount of $10.00 per card.

To Be Completed by Employee

| Name | | |
| --- | --- | --- |
| Street Address | | Apt # |
| City | State | Zip |
| Social Security Number | | Date of Birth |

I hereby acknowledge receipt of the above mentioned TransCard Prepaid MasterCard for payroll disbursement, Cardholder Agreement and Disclosure, and instructions.

| Employee Signature | Date |
| --- | --- |
| | |

To Be Completed by Employer

| Card Number Issued (please print clearly; must have 16 digits) | Date |
| --- | --- |
| | |

| Employee ID Number |
| --- |
| |

# Authorization Agreement for Direct Deposit of Payroll

I hereby authorize Impact Logistics, Inc. to initiate Direct Deposit of my payroll and to credit or debit my account as necessary to place the correct net payroll amount into my account as indicated below. I further authorize the depository named on this form to debit or credit to my account the transactions initiated by Impact Logistics, Inc.

This authority is to remain in full force and effect until Impact Logistics, Inc. has received written notification from me of its termination an in such manner as to afford Impact Logistics, Inc. a reasonable opportunity to act upon it.

Printed Name_____

Social Security Number_____

Signature_____ Date_____

**THIS AUTHORIZATION IS NOT VALID UNLESS ACCOMPANIED BY:**

**1) A VOIDED CHECK FROM YOUR CHECKING ACCOUNT**

**2) A DIRECT DEPOSIT ENROLLMENT REQUEST FORM FROM THE ACCOUNT CHOSEN TO RECEIVE THE DIRECT DEPOSIT.**

**PHOTOCOPIES OF A CHECK OR DEPOSIT TICKETS ARE NOT ACCEPTABLE.**

**Please staple the voided check or attach the direct deposit enrollment form from your bank account (where you want your wages to be deposited) to this form below the line and return it to:**

Impact Logistics, Inc.
7980 N. Brother Blvd.
Memphis, TN 38133

(STAPLE THE VOIDED CHECK HERE)

| Employee ID Number |
| --- |
| |

# NOTICE REGARDING BACKGROUND INVESTIGATION
## [IMPORTANT – PLEASE READ CAREFULLY BEFORE SIGNING ACKNOWLEDGEMENT]

Impact Logistics, Inc. ("the Company") may obtain information about you from a consumer reporting agency for employment purposes. Thus, you may be the subject of a "consumer report" and/or an "investigative consumer report" which may include information about your character, general reputation, personal characteristics, and/or mode of living, and which can involve personal interviews with sources such as your neighbors, friends, or associates. These reports may be obtained at any time after receipt of your authorization and, if you are hired, throughout your employment. You have the right, upon written request made within a reasonable time after receipt of this notice, to request disclosure of the nature and scope of any investigative consumer report obtained with regards to applicants for employment is an investigation into your education and/or employment history conducted by Data Facts, PO Box 4276, Cordova, TN, 38088, Phone: 800-264-4110, Fax: 901-685-7351 or another outside organization. The scope of this notice and authorization is all-encompassing, however, allowing Employer to obtain from any outside organization all manner of consumer reports and investigative consumer reports now, and if you are hired, throughout the course of your employment to the extent permitted by law. As a result, you should carefully consider whether to exercise your right to request disclosure of the nature and scope of any investigative consumer report.

**New York applicants or employees only**: You have the right to inspect and receive a copy of any investigative consumer report requested by Employer by contacting the consumer reporting agency identified above directly.

## ACKNOWLEDGMENT AND AUTHORIZATION

I acknowledge receipt of the NOTICE REGARDING BACKGROUND INVESTIGATION and A SUMMARY OF YOUR RIGHTS UNDER THE FAIR CREDIT REPORTING ACT and certify that I have read and understand both of those documents. I hereby authorize the obtaining of "consumer reports" and/or "investigative consumer reports" at any time after receipt of this authorization and, if I am hired, throughout my employment. To this end, I hereby authorize, without reservation, any law enforcement agency, administrator, state or federal agency, institution, school or university (public or private), information service bureau, employer, or insurance company to furnish any and all background information requested by Corporate Screening Services, Inc., another outside organization acting on behalf of Employer, and/or Employer itself. I agree that a facsimile (fax) or photographic copy of this Authorization shall be as valid as the original.

**Minnesota and Oklahoma applicants or employees only**: Please check this box if you would like to receive a copy of a consumer report if one is obtained by the Company. ☐

**California applicants or employees only**: By signing below, you also acknowledge receipt of the NOTICE REGARDING BACKGROUND INVESTIGATION PURSUANT TO CALIFORNIA LAW. Please check this box if you would like to receive a copy of an investigative consumer report or consumer credit report if one is obtained by the Company at no charge whenever you have a right to receive such a copy under California law.

Name_____
Please Print

Social Security Number_____DOB**_____

Current Address_____

City_____/State_____/Zip_____

Drivers License Number_____State_____

Signature_____Date_____

**Date of Birth is being requested in order to obtain accurate retrieval of records.

| Employee ID Number |
| --- |
| |

TO: All Impact Logistics, Inc. Associates
FROM: Impact Logistics, Inc. Management
RE: Kronos Proxy Card Acknowledgement
DATE: January 10, 2013

In the course of your employment with Impact Logistics, Inc., you will be provided a proximity (Proxy) card to be used for the automated recording of time and attendance. With the assignment of this card come expectations; including, but not limited to the following:

1. I understand and acknowledge that I am responsible for using my assigned card for the daily entry of time and activities into the automated system. I understand and acknowledge that I am to clock in prior to performing any work or work-related duties. I understand and acknowledge that I am not to perform any work or work-related duties after I have clocked out. I have been advised that Impact Logistics, Inc. does NOT allow me to work while not clocked in for work.
2. I understand and acknowledge that I am responsible for the entry of time and activities only for myself and at NO TIME am I authorized to enter time or activities for another person.
3. The first Proxy card will be provided to me; if lost, I am responsible for the $10.00 cost for the replacement of the card.
4. On terminating my employment with Impact Logistics, Inc. I agree to return my assigned Proxy card. If not returned, I authorize Impact Logistics, Inc. to deduct the $10.00 cost of the card from my final pay.

By signing this document, I acknowledge my understanding of its content and agree to the terms outlined above. Thank you for choosing Impact Logistics, Inc. as your employer; we are committed to your well-being and look forward to a strong future together.

_____ _____

Employee (Sign) Date

CONFIDENTIAL

7980 N. Brother Blvd
Memphis, TN 38133
Phone/901.377.5298 Fax/901.377.9307
www.impact-logistics.com

Impact Logistics, Inc.

| Employee ID Number |
| --- |
| |

TO: All Impact Logistics, Inc. Associates
FROM: Impact Logistics, Inc. Corporate
RE: Pay Policy
DATE: January 10, 2013

As many of you are aware, over the past few months we have been reviewing and updating our Employee Handbook to ensure that we properly communicate with each person employed with Impact Logistics, Inc. In so doing, we are also updating our Pay Stubs which you receive weekly to include an hourly wage and bonus based on performance. I want to make you aware that each pay period you will be receiving two documents: an Earnings Statement and a Pay Stub.

The Earnings Statement will identify your gross wages, deductions and withholdings, such as state and federal taxes and your net wages earned.

The Pay Stub identifies in detail your work completed for the pay period and associated pay. Specifically it identifies the following:

1. The name and address of the employer.
2. The pay date and pay period.
3. Hourly rates of pay earned.
4. Total pay for each hourly activity completed.
5. Total pay for regular overtime hours worked.
6. Bonus pay calculation.
7. Overtime calculation on Bonus pay.
8. A detailed breakdown of each container loaded/unloaded.
9. Total earnings for the pay period.
10. Employee information.

If you should have any questions, please do not hesitate to contact your Supervisor or Director, who will address any questions that may arise. I want to thank you for your hard work and commitment to Impact Logistics, Inc.; you are very much appreciated and we look forward to a strong future together.

_____ _____

Associate (Sign) Date

CONFIDENTIAL

7980 N. Brother Blvd
Memphis, TN 38133
Phone/901.377.5298 Fax/901.377.9307
www.impact-logistics.com

Impact Logistics

# Application for Employment

**An Equal Opportunity Employer**

**Please provide complete information to all requests.**

**Date Application Completed:_____ Location Applied For: _____**

| **Last Name** | **First Name** | **Middle Name** | **Social Security Number** |
|---|---|---|---|
| **Street address** | | | **Phone Number** **(  )** |
| **City, State, Zip** | | | |

| | |
|---|---|
| **Emergency Contact:** | **Do you understand the requirements of the Position you have applied for?** **Yes ☐ No ☐** **Can you perform the physical requirements with or without reasonable accommodation?** **Yes ☐ No ☐** **Will you work Overtime if needed? Yes ☐ No☐** |
| **Emergency Phone Number:** **(  )** | |
| **Position Applied For:** | **Pay Expected:** |

Only those U.S. Citizens or Aliens who have a legal right to work in the United States are eligible for employment. Can you, upon employment, provide documentation verifying your legal right to work in the United States and your identity? Yes ☐ No ☐

| **Name & Location of Schools Attended** | **Graduated (Yes/No)** | **Type of Degree Awarded** | **Major Area of Study** |
|---|---|---|---|
| **High School** | | | |
| **College** | | | |
| **Other** | | | |

If you did not graduate from High School, circle the last year of school you completed.

5 6 7 8 9 10 11

List any other education, certifications, or trade skills that you have which relate to this job.

_____

_____

Are you 18 years of age or older? Yes ☐ No ☐

**A record of conviction does not necessarily disqualify you from employment consideration.** Have you ever been convicted of a felony or misdemeanor, other than traffic violations? Yes ☐ No ☐ If yes, list only convictions and dates: _____

_____

## Employment History

Please provide accurate, complete full-time and part-time employment history for your last four positions. Start with your most recent employer.

| | |
|---|---|
| #1 Co. Name | Telephone ( ) |
| Address | Employed From to |
| Supervisor's Name | Starting Pay Ending Pay |
| Your Title | Reason for Leaving |

| | |
|---|---|
| #2 Co. Name | Telephone ( ) |
| Address | Employed From to |
| Supervisor's Name | Starting Pay Ending Pay |
| Your Title | Reason for Leaving |

| | |
|---|---|
| #3 Co. Name | Telephone ( ) |
| Address | Employed From to |
| Supervisor's Name | Starting Pay Ending Pay |
| Your Title | Reason for Leaving |

| | |
|---|---|
| #4 Co. Name | Telephone ( ) |
| Address | Employed From to |
| Supervisor's Name | Starting Pay Ending Pay |
| Your Title | Reason for Leaving |

**IMPORTANT-READ CAREFULLY BEFORE SIGNING**

I certify that the information provided in this Application for Employment is true, correct and complete. If employed, any misstatement or omission of material fact on this application will result in my immediate dismissal. I understand and agree that the fact that Impact Logistics, Inc. has or has not made an investigation or the fact that I performed my work satisfactorily for any period of time prior to this termination, shall not constitute a waiver, abandonment or bar of the right of Impact Logistics, Inc. to take such disciplinary action. I authorize all persons, schools, companies, corporations, credit bureaus, government agencies, or any other party to release information concerning my background which may include, but is not limited to, criminal, credit, driver's records, so long as not prohibited by law and the requests are job related.

I further agree to submit to alcohol and /or drug screening tests, if requested of me, at any time prior to (only drug screens will be administered pre-employment), or during my employment in accordance with applicable law, and I further understand and consent to the results of said tests being communicated to Impact Logistics, Inc. and to my worksite employer. I further understand that no one, other than the President of Impact Logistics, Inc. in writing, has the authority to enter into an employment agreement with me that differs from that which is outlined here, and that if I should become employed by Impact Logistics, Inc. that the employment relationship is "at will" and can be terminated by either party without cause.

I further understand that this application for employment will remain "active" for thirty (30) days from today's date. If I still desire a position with Impact Logistics, Inc., it will be my responsibility to fill out a new application and file it with Impact Logistics, Inc. after that period expires.

Signature of Applicant_____ Date_____

# Affirmative Action

# Voluntary Information

It is the policy of this organization to provide equal employment opportunity to all qualified applicants for employment without regard to race, color, religion, national origin, sex, age, veteran status or disability. Various agencies of the government require employers to invite applicants to identify themselves as indicated below.

COMPLETION OF THIS FORM IS VOLUNTARY AND IN NO WAY AFFECTS THE DECISION REGARDING YOUR APPLICATION FOR EMPLOYMENT. THIS FORM IS CONFIDENTIAL AND WILL BE MAINTAINED SEPARATELY FROM YOUR APPLICATION FORM. YOU COOPERATION IS APPRECIATED.

**Please Print**

**Referral Source**

☐ Walk In ☐ Government Employment Agency ☐ Private Employment Agency

☐ Employee ☐ Relative ☐ School

☐ Advertisement-Source_____ ☐ Other_____

Name of Person who referred you (if applicable) _____

Name:_____ Date:_____

Address:_____

Telephone Number:_____

Position Applied For: (List Only One)_____

☐ Male ☐ Female

**Please Check One of the Following Equal Employment Opportunity Identification Groups:**

☐ White (Not of Hispanic Origin)
☐ Hispanic
☐ American Indian/Alaskan Native
☐ Black (Not of Hispanic Origin)
☐ Asian or Pacific Islander

For Administrative Use Only

Position(s) Applied For ☐ Available ☐ Not Available

Other Positions Considered For _____

Hired ☐ Yes ☐ No

Position Hired For _____ Date of Hire ____/___/_____

From the EEO Job Classification Listed Below, Which One Best Describes the Position Filled?

☐ Officials & Managers ☐ Sales Workers ☐ Operatives (Semi-Skilled)

☐ Professionals ☐ Office & Clerical ☐ Laborers (Unskilled)

☐ Technicians ☐ Craft Workers (Skilled) ☐ Service Workers

Completed By: _____ Date: ___/___/_____

| Employee ID Number |
| --- |
| |

## HANDBOOK ACKNOWLEDGMENT FORM

I acknowledge that a copy of this Handbook was made available to me at the local Impact office and through Impact's intranet site: http://impact-logistics.com/caemployeehandbook.pdf

I understand that I am responsible for knowing and adhering to the policies set forth in the Handbook during my employment with Impact. I understand that the policies contained in the Handbook are not intended to create any contractual rights or obligations, with the exception of Impact's at---will employment and arbitration policies. I further understand that Impact reserves the right to amend, interpret, modify, or withdraw any portion of this Handbook at any time. I understand and agree that if the terms of this Acknowledgment are inconsistent with any policy or practice of Impact now or in the future, the terms of this Acknowledgment shall control.

I further understand and agree that my relationship with Impact is "at will," which means that my employment is for no definite period and may be terminated by me or by Impact at any time and for any reason with or without cause or advance notice. I also understand that Impact may demote or discipline me or alter the terms of my employment at any time at its discretion, with or without cause or advance notice. I understand that no policy, statement, conduct, or action on the part of Impact or any company personnel may alter or waive the at---will nature of my employment at any time or under any circumstances. I understand that in the absence of a writing signed by me and by the President or Chief Operating Officer, which expressly provides for employment for a specified term, no policy, practice, procedure, statement, or action of or any individual at may alter, modify, or waive the at---will nature of employment with in any way or at any time.

I further understand that in the event of a dispute arising between Impact and me regarding my employment or termination from employment, such dispute will be resolved in accordance with the arbitration provisions set forth in the separate Mutual Agreement to Arbitrate Claims, and without a jury trial in the event I pursue litigation. I further understand that both Impact and I expressly waive any constitutional or statutory right Impact or I may possess to have employment---related disputes decided in a court of law or equity before a jury.

Finally, I agree that this Acknowledgment contains a full and complete statement of the agreements and understandings that it recites, and I agree that this Acknowledgment supersedes all previous agreements, whether written or oral, express or implied, relating to the subjects covered in this Acknowledgment.

_____ _____

Employee Signature Date

EMPLOYEE COPY

# New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 1-31-2017)

## PART A: General Information

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by your employer.

### What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

### Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

### Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.[1]

**Note:** If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution –as well as your employee contribution to employer-offered coverage– is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

### How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact Ashley Yarbro @ (901) 377-5298.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

I have received a copy of this notice.

Employee Signature: _____ Date: _____

[1] An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

EMPLOYEE COPY

## PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

| | | |
|---|---|---|
| 3. Employer name<br>Impact Logistics, Inc. | | 4. Employer Identification Number (EIN)<br>62-1519198 |
| 5. Employer address<br>7980 N Brother Blvd | | 6. Employer phone number<br>(901) 377-5298 |
| 7. City<br>Memphis | 8. State<br>TN | 9. ZIP code<br>38133 |
| 10. Who can we contact about employee health coverage at this job?<br>Ashley Yarbro | | |
| 11. Phone number (if different from above)<br>(901) 377-5298 | 12. Email address<br>ayarbro@impact-logistics.com | |

Here is some basic information about health coverage offered by this employer:

- As your employer, we offer a health plan to:
  - ☐ All employees. Eligible employees are:
  - ☑ Some employees. Eligible employees are:

    FULL-TIME ACTIVE EMPLOYEES
    (WORKING AT LEAST 130 HOURS PER MONTH FOR 3 CONSECUTIVE MONTHS.)
    Note: There is a 90 day waiting period before health insurance coverage can begin
- With respect to dependents:
  - ☑ We do offer coverage. Eligible dependents are:
  - ☐ We do not offer coverage.

☑ If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, HealthCare.gov will guide you through the process. Here's the employer information you'll enter when you visit HealthCare.gov to find out if you can get a tax credit to lower your monthly premiums.

I have received a copy of this notice.

Employee Signature: _____ Date: _____

# EMPLOYEE COPY

The information below corresponds to the Marketplace Employer Coverage Tool. Completing this section is optional for employers, but will help ensure employees understand their coverage choices.

13. **Is the employee currently eligible for coverage offered by this employer, or will the employee be eligible in the next 3 months?**

☐ **Yes** (Continue)
13a. If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage?_____ (mm/dd/yyyy) (Continue)
☐ **No** (STOP and return this form to employee)

14. Does the employer offer a health plan that meets the minimum value standard*?
☑ Yes (Go to question 15) ☐ No (STOP and return form to employee)

15. For the lowest-cost plan that meets the minimum value standard* **offered only to the employee** (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/ she received the maximum discount for any tobacco cessation programs, and didn't receive any other discounts based on wellness programs.
a. How much would the employee have to pay in premiums for this plan? $_____
b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

If the plan year will end soon and you know that the health plans offered will change, go to question 16. If you don't know, STOP and return form to employee.

16. What change will the employer make for the new plan year?_____
☐ Employer won't offer health coverage
☐ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)
a. How much would the employee have to pay in premiums for this plan? $_____
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**Note:** If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution –as well as your employee contribution to employer-offered coverage– is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

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    FULL-TIME ACTIVE EMPLOYEES
    (WORKING AT LEAST 130 HOURS PER MONTH FOR 3 CONSECUTIVE MONTHS.)
    Note: There is a 90 day waiting period before health insurance coverage can begin
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** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

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# NOTICE TO EMPLOYEE

***Labor Code section 2810.5***

## EMPLOYEE

Employee Name: _____

Start Date: _____

## EMPLOYER

Legal Name of Hiring Employer: Impact Logistics, Inc.

Is hiring employer a staffing agency/business (e.g., Temporary Services Agency; Employee Leasing Company; or Professional Employer Organization [PEO])? ☐ Yes ☑ No

Other Names Hiring Employer is "doing business as" (if applicable):

N/A

Physical Address of Hiring Employer's Main Office:

7980 N Brother Blvd, Memphis, TN 38133

Hiring Employer's Mailing Address (if different than above):

N/A

Hiring Employer's Telephone Number: 901-377-5298

If the hiring employer is a staffing agency/business (above box checked "Yes"), the following is the other entity for whom this employee will perform work:

Name: N/A

Physical Address of Main Office: N/A

Mailing Address: N/A

Telephone Number: N/A

## WAGE INFORMATION

Rate(s) of Pay: _____ Overtime Rate(s) of Pay: _____

Rate by (check box): ☐ Hour ☐ Shift ☐ Day ☐ Week ☐ Salary ☐ Piece rate ☐ Commission

☒ Other (provide specifics): Employee paid Hourly + Production Pay. Total pay varies weekly based on volume and other factors.

Does a written agreement exist providing the rate(s) of pay? (check box) ☐ Yes ☒ No

If yes, are all rate(s) of pay and bases thereof contained in that written agreement? ☐ Yes ☐ No

Allowances, if any, claimed as part of minimum wage (including meal or lodging allowances):

_____

(If the employee has signed the acknowledgment of receipt below, it does not constitute a "voluntary written agreement" as required under the law between the employer and employee in order to credit any meals or lodging against the minimum wage. Any such voluntary written agreement must be evidenced by a separate document.)

Regular Payday: Every Friday

## WORKERS' COMPENSATION

Insurance Carrier's Name: Zurich Insurance Company/Gallagher Bassett Services
Address: P.O. Box 14260 Orange California 92863
Telephone Number: 1 (800) 297-0866
Policy No.: WC3888671
☐ Self-Insured (Labor Code 3700) and Certificate Number for Consent to Self-Insure: _____

## PAID SICK LEAVE

Unless exempt, the employee identified on this notice is entitled to minimum requirements for paid sick leave under state law which provides that an employee:

a. May accrue paid sick leave and may request and use up to 3 days or 24 hours of accrued paid sick leave per year;
b. May not be terminated or retaliated against for using or requesting the use of accrued paid sick leave; and
c. Has the right to file a complaint against an employer who retaliates or discriminates against an employee for
   1. requesting or using accrued sick days;
   2. attempting to exercise the right to use accrued paid sick days;
   3. filing a complaint or alleging a violation of Article 1.5 section 245 et seq. of the California Labor Code;
   4. cooperating in an investigation or prosecution of an alleged violation of this Article or opposing any policy or practice or act that is prohibited by Article 1.5 section 245 et seq. of the California Labor Code.

The following applies to the employee identified on this notice: *(Check one box)*

☒ 1. Accrues paid sick leave only pursuant to the minimum requirements stated in Labor Code §245 et seq. with no other employer policy providing additional or different terms for accrual and use of paid sick leave.
☐ 2. Accrues paid sick leave pursuant to the employer's policy which satisfies or exceeds the accrual, carryover, and use requirements of Labor Code §246.
☐ 3. Employer provides no less than 24 hours (or 3 days) of paid sick leave at the beginning of each 12-month period.
☐ 4. The employee is exempt from paid sick leave protection by Labor Code §245.5. (State exemption and specific subsection for exemption):_____

## ACKNOWLEDGEMENT OF RECEIPT

(*Optional*)

_____ _____
(PRINT NAME of Employer representative) (PRINT NAME of Employee)

_____ _____
(SIGNATURE of Employer Representative) (SIGNATURE of Employee)

_____ _____
(Date) (Date)

The employee's signature on this notice merely constitutes acknowledgement of receipt.

Labor Code section 2810.5(b) requires that the employer notify you in writing of any changes to the information set forth in this Notice within seven calendar days after the time of the changes, unless one of the following applies: (a) All changes are reflected on a timely wage statement furnished in accordance with Labor Code section 226; (b) Notice of all changes is provided in another writing required by law within seven days of the changes.

# Employee's Copy

**Division of Labor Standards Enforcement** **Office of the Labor Commissioner**

**THIS POSTER MUST BE DISPLAYED WHERE EMPLOYEES CAN EASILY READ IT**

*(Poster may be printed on 8 ½" x 11" letter size paper)*

## HEALTHY WORKPLACES/HEALTHY FAMILIES ACT OF 2014
## PAID SICK LEAVE

**Entitlement:**

- An employee who, on or after July 1, 2015, works in California for 30 or more days within a year from the beginning of employment is entitled to paid sick leave.
- Paid sick leave accrues at the rate of one hour per every 30 hours worked, paid at the employee's regular wage rate. Accrual shall begin on the first day of employment or July 1, 2015, whichever is later.
- Accrued paid sick leave shall carry over to the following year of employment and may be capped at 48 hours or 6 days. However, subject to specified conditions, if an employer has a paid sick leave, paid leave or paid time off policy (PTO) that provides no less than 24 hours or three days of paid leave or paid time off, no accrual or carry over is required if the full amount of leave is received at the beginning of each year in accordance with the policy.

**Usage**:

- An employee may use accrued paid sick days beginning on the 90th day of employment.
- An employer shall provide paid sick days upon the oral or written request of an employee for themselves or a family member for the diagnosis, care or treatment of an existing health condition or preventive care, or specified purposes for an employee who is a victim of domestic violence, sexual assault, or stalking.
- An employer may limit the use of paid sick days to 24 hours or three days in each year of employment.

Retaliation or discrimination against an employee who requests paid sick days or uses paid sick days or both is prohibited. An employee can file a complaint with the Labor Commissioner against an employer who retaliates or discriminates against the employee.

For additional information you may contact your employer or the local office of the Labor Commissioner. Locate the office by looking at the list of offices on our website http://www.dir.ca.gov/dlse/DistrictOffices.htm using the alphabetical listing of cities, locations, and communities. Staff is available in person and by telephone.

Employee's Copy

Within the guidelines of the Healthy Workplace Healthy Family Act of 2014 (AB 1522) also known as the California Sick Leave Law, Impact Logistics has implemented the following policies:

1. Employees are limited to 24 hours of Sick Leave pay within each year of employment.
    a. A qualifying employee begins to accrue paid sick leave beginning on July 1, 2015, or if hired after that date, on the first day of employment.
2. Employees are limited to 48 hours of accrued Sick Leave each year.
    a. Unused Sick Leave Hours can be carried over from one year to the next.
3. Employees must use at least 2 Hours of their accrued Sick Leave per request.
4. The hourly rate for each employee's sick leave will be determined by dividing the previous 90 days of pay (excluding overtime premiums) by the number of hours worked.

CONFIDENTIAL

7980 N. Brother Blvd
Memphis, TN 38133
Phone/901.377.5298 Fax/901.377.9307
www.impact-logistics.com

Impact Logistics, Inc.

Employer's Copy

Employee ID Number

Within the guidelines of the Healthy Workplace Healthy Family Act of 2014 (AB 1522) also known as the California Sick Leave Law, Impact Logistics, Inc. has implemented the following policies:

1. Employees are limited to 24 hours of Sick Leave pay within each year of employment.
    a. A qualifying employee begins to accrue paid sick leave beginning on July 1, 2015, or if hired after that date, on the first day of employment.
2. Employees are limited to 48 hours of accrued Sick Leave each year.
    a. Unused Sick Leave Hours can be carried over from one year to the next.
3. Employees must use at least 2 Hours of their accrued Sick Leave per request.
4. The hourly rate for each employee's sick leave will be determined by dividing the previous 90 days of pay (excluding overtime premiums) by the number of hours worked.

_____ _____

Associate (Sign) Date

CONFIDENTIAL

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Impact Logistics, Inc.