



Employment Application

REFERRED BY: _____

Applicant Information

Full Name: _____ Date: _____

Last First M.I.

Address: _____
Street Address Apartment/Unit #

City State ZIP Code

Phone: _____ Email: _____

Position Interested in: _____

When can you start work? _____

Do you have reliable transportation or need assistance? _____
YES NO If no, are you authorized to work in the U.S.? YES NO

Are you a citizen of the United States?

Have you ever been convicted of a felony? YES NO

If yes, explain: _____

Education

High School: _____ Address: _____

From: _____ To: _____ Did you graduate? YES NO Diploma: _____

Previous Employment

Job Titles: _____
Responsibilities: _____

Military Service

Branch: _____ From: _____ To: _____

Disclaimer and Signature

*I certify that my answers are true and complete to the best of my knowledge.
If this application leads to employment, I understand that false or misleading information in my application or interview may result in my release.*

Signature: _____ Date: _____



NEW CANDIDATE CONTROL FORM

Please Print

Last Name: _____ First Name: _____ Middle: _____

Hire Status: Indirect Direct Rehire: Yes No

SSN: _____ D.O.B.: _____

Disability Code: _____ Ethnic Origin: _____ Gender: _____

Full Address: _____

City: _____ State: _____ Zip Code: _____

Phone #1: _____ Phone #2: _____

Email Address: _____

Emergency Contact Name: _____

Emergency Contact Phone#: _____

Emergency Contact Relationship: _____

To be Completed by: Innovative Workforce Development LLC. Administration/Manager

Department#: _____ Company: _____

Job Title: _____

Hire Date/Start Date: _____ FT PT

Supervisor: _____

Pay Rate: _____ Direct Deposit: Yes No (defaults to Aline Card)

Filing Status: _____ State: _____

Documentation of Disability: Yes No



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

USCIS
Form I-9
 OMB No.1615-0047
 Expires 07.31.2026

START HERE: Employers must ensure the form instructions are available to employees when completing this form. Employers are liable for failing to comply with the requirements for completing this form. See below and the **Instructions**.

ANTI-DISCRIMINATION NOTICE: All employees can choose which acceptable documentation to present for Form I-9. Employers cannot ask employees for documentation to verify information in Section 1, or specify which acceptable documentation employees must present for Section 2 or Supplement B, Reverification and Rehire. Treating employees differently based on their citizenship, immigration status, or national origin may be illegal.

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

Last Name (Family Name)		First Name (Given Name)		Middle Initial (if any)	Other Last Names Used (if any)	
Address (Street Number and Name)			Apt. Number (if any)	City or Town		State ZIP Code
Date of Birth (mm/dd/yyyy)	U.S. Social Security Number		Employee's Email Address		Employee's Telephone Number	
I am aware that federal law provides for imprisonment and/or fines for false statements, or the use of false documents, in connection with the completion of this form. I attest, under penalty of perjury, that this information, including my selection of the box attesting to my citizenship or immigration status, is true and correct.	Check one of the following boxes to attest to your citizenship or immigration status (See page 2 and 3 of the instructions):					
	<input type="checkbox"/> 1. A citizen of the United States					
	<input type="checkbox"/> 2. A noncitizen national of the United States (See instructions.)					
	<input type="checkbox"/> 3. A lawful permanent resident (Enter USCIS or A-Number.)					
<input type="checkbox"/> 4. A noncitizen (other than Item Numbers 2. and 3. above) authorized to work until (exp. date, if any)						
If you check Item Number 4., enter one of these:						
USCIS A-Number		OR		Form I-94 Admission Number		Foreign Passport Number and Country of Issuance
Signature of Employee					Today's Date (mm/dd/yyyy)	

If a preparer and/or translator assisted you in completing Section 1, that person MUST complete the **Preparer and/or Translator Certification on Page 3.**

Section 2. Employer Review and Verification: Employers or their authorized representative must complete and sign Section 2 within three business days after the employee's first day of employment, and must physically examine, or examine consistent with an alternative procedure authorized by the Secretary of DHS, documentation from List A OR a combination of documentation from List B and List C. Enter any additional documentation in the Additional Information box; see Instructions.

List A	OR	List B	AND	List C
Document Title 1				
Issuing Authority				
Document Number (if any)				
Expiration Date (if any)				
Document Title 2 (if any)		Additional Information <input type="checkbox"/> Check here if you used an alternative procedure authorized by DHS to examine documents		
Issuing Authority				
Document Number (if any)				
Expiration Date (if any)				
Document Title 3 (if any)				
Issuing Authority				
Document Number (if any)				
Expiration Date (if any)				
Certification: I attest, under penalty of perjury, that (1) I have examined the documentation presented by the above-named employee, (2) the above-listed documentation appears to be genuine and to relate to the employee named, and (3) to the best of my knowledge, the employee is authorized to work in the United States.				First Day of Employment (mm/dd/yyyy):
Last Name, First Name and Title of Employer or Authorized Representative		Signature of Employer or Authorized Representative		Today's Date (mm/dd/yyyy)
Employer's Business or Organization Name		Employer's Business or Organization Address, City or Town, State, ZIP Code		
Signature Staff Resources		1460 T.L Townsend Drive, Suite # 104 / Rockwall, TX 75032		

For reverification or rehire, complete **Supplement B, Reverification and Rehire on Page 4.**

Employee's Withholding Certificate

Department of the Treasury
Internal Revenue Service

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.

2024

Step 1: Enter Personal Information	(a) First name and middle initial	Last name	(b) Social security number
	Address		Does your name match the name on your social security card? If not, to ensure you get credit for your earnings, contact SSA at 800-772-1213 or go to www.ssa.gov .
	City or town, state, and ZIP code		
	(c) <input type="checkbox"/> Single or Married filing separately <input type="checkbox"/> Married filing jointly or Qualifying surviving spouse <input type="checkbox"/> Head of household (Check only if you're unmarried and pay more than half the costs of keeping up a home for yourself and a qualifying individual.)		

Complete Steps 2-4 ONLY if they apply to you; otherwise, skip to Step 5. See page 2 for more information on each step, who can claim exemption from withholding, and when to use the estimator at www.irs.gov/W4App.

Step 2: 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.

Multiple Jobs or Spouse Works Do only one of the following.

(a) Use the estimator at www.irs.gov/W4App for most accurate withholding for this step (and Steps 3-4). If you or your spouse have self-employment income, use this option; or

(b) Use the Multiple Jobs Worksheet on page 3 and enter the result in Step 4(c) below; or

(c) If there are only two jobs total, you may check this box. Do the same on Form W-4 for the other job. This option is generally more accurate than (b) if pay at the lower paying job is more than half of the pay at the higher paying job. Otherwise, (b) is more accurate

Complete Steps 3-4(b) on Form W-4 for only ONE of these jobs. Leave those steps blank for the other jobs. (Your withholding will be most accurate if you complete Steps 3-4(b) on the Form W-4 for the highest paying job.)

Step 3: Claim Dependent and Other Credits	<p>If your total income will be \$200,000 or less (\$400,000 or less if married filing jointly):</p> <p>Multiply the number of qualifying children under age 17 by \$2,000 \$ _____</p> <p>Multiply the number of other dependents by \$500 \$ _____</p> <p>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</p>	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: Under penalties of perjury, I declare that this certificate, to the best of my knowledge and belief, is true, correct, and complete.

Sign Here

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)
	Signature Staff Resources 1460 T.L. Townsend Drive, Suite # 104 Rockwall, TX 75032		41-2192213



2211004013

STATE OF GEORGIA EMPLOYEE'S WITHHOLDING ALLOWANCE CERTIFICATE

1a. YOUR FULL NAME 1b. YOUR SOCIAL SECURITY NUMBER
2a. HOME ADDRESS (Number, Street, or Rural Route) 2b. CITY, STATE AND ZIP CODE

PLEASE READ INSTRUCTIONS ON REVERSE SIDE BEFORE COMPLETING LINES 3 - 8

3. MARITAL STATUS

(If you do not wish to claim an allowance, enter "0" in the brackets beside your marital status.)

- A. Single: Enter 0 or 1 []
B. Married Filing Joint, both spouses working: Enter 0 or 1 []
C. Married Filing Joint, one spouse working: Enter 0 or 1 or 2 []
D. Married Filing Separate: Enter 0 or 1 []
E. Head of Household: Enter 0 or 1 []

4. DEPENDENT ALLOWANCES []

5. ADDITIONAL ALLOWANCES []
(worksheet below must be completed)

6. ADDITIONAL WITHHOLDING \$ _____

WORKSHEET FOR CALCULATING ADDITIONAL ALLOWANCES

(Must be completed in order to enter an amount on step 5)

1. COMPLETE THIS LINE ONLY IF USING STANDARD DEDUCTION:
Yourself: [] Age 65 or over [] Blind
Spouse: [] Age 65 or over [] Blind Number of boxes checked _____ x 1300.....\$ _____
2. ADDITIONAL ALLOWANCES FOR DEDUCTIONS:
A. Federal Estimated Itemized Deductions (If Itemizing Deductions).....\$ _____
B. Georgia Standard Deduction (enter one): Single/Head of Household \$4,600
Each Spouse \$3,000 \$ _____
C. Subtract Line B from Line A (If zero or less, enter zero).....\$ _____
D. Allowable Deductions to Federal Adjusted Gross Income.....\$ _____
E. Add the Amounts on Lines 1, 2C, and 2D.....\$ _____
F. Estimate of Taxable Income not Subject to Withholding.....\$ _____
G. Subtract Line F from Line E (if zero or less, stop here).....\$ _____
H. Divide the Amount on Line G by \$3,000. Enter total here and on Line 5 above.....\$ _____

(This is the maximum number of additional allowances you can claim. If the remainder is over \$1,500 round up)

7. LETTER USED (Marital Status A, B, C, D, or E) _____ TOTAL ALLOWANCES (Total of Lines 3 - 5) _____
(Employer: The letter indicates the tax tables in Employer's Tax Guide)

8. EXEMPT: (Do not complete Lines 3 - 7 if claiming exempt) Read the Line 8 instructions on page 2 before completing this section.

- a) I claim exemption from withholding because I incurred no Georgia income tax liability last year and I do not expect to have a Georgia income tax liability this year. Check here []
b) I certify that I am not subject to Georgia withholding because I meet the conditions set forth under the Servicemembers Civil Relief Act as provided on page 2. My state of residence is _____. My spouse's (servicemember) state of residence is _____. The states of residence must be the same to be exempt. Check here []

I certify under penalty of perjury that I am entitled to the number of withholding allowances or the exemption from withholding status claimed on this Form G-4. Also, I authorize my employer to deduct per pay period the additional amount listed above.

Employee's Signature _____ Date _____

Employer: Complete Line 9 and mail entire form only if the employee claims over 14 allowances or exempt from withholding. If necessary, mail form to: Georgia Department of Revenue, Taxpayer Services Division, P.O. Box 105499, Atlanta, GA 30359

9. EMPLOYER'S NAME AND ADDRESS: _____ EMPLOYER'S FEIN: _____

EMPLOYER'S WH#: _____

Do not accept forms claiming additional allowances unless the worksheet has been completed. Do not accept forms claiming exempt if numbers are written on Lines 3 - 7.



Georgia Information

We are thrilled you are joining Signature Staff Resources in Georgia.

Below are **benefits** that are specific to you as a Georgia resident.

- Workers' Compensation Doctors
- Worker's Compensation

Below are **employment posters** that are specific to you as a Georgia resident.

- Equal Pay
- Hazardous Chemical Protection
- Unemployment

Please sign below to acknowledge receipt of this information.

Employee Name

Date

EEO-1 Voluntary Self Identification Form

The Equal Employment Opportunity Commission (EEOC) requires all private employers with 00 or more employees must invite employees to self-identify gender and race for this report. Completion of this form is voluntary and will not affect your opportunity for employment, or the terms or conditions of your employment. This form will be used for EE)-1 reporting purposes only and will be kept separate from all other personnel records only access by the Human Resources department.

If you choose not to self-identify your race/ethnicity at this time, the federal government requires Signature Staff Resource LLC to determine this information by visual survey and or other available information.

Name: _____

Gender: (Please check one) _____ Male _____ Woman _____ Non-Binary

Race/Ethnicity:

___ Hispanic or Latino: A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin regardless of race.

___ White: A person having origins in any of the original peoples of Europe, the Middle East or North Africa.

___ Black or African American: A person having origins in any of the black racial groups of Africa.

___ Native Hawaiian or Pacific Islander: A person having origins in any of the peoples of Hawaii, Guam, Samoa or other Pacific Islands.

___ Asian: A person having origins in any of the original peoples of the Far East, Southeast Asia or the Indian Subcontinent, including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.

Native American or Alaska Native: A person having origins in any of the original peoples of North and South America (including Central America) and who maintains tribal affiliation or community attachment.

___ Two or more races: All persons who identify with more than one of the above five races.

___ I do not wish to disclose.



Direct Deposit Authorization

New Revision Cancellation
(Circle one)

Name: _____ SS# _____

Worksite: _____

I authorize Signature Staff Resources to make credit entries and, if necessary, debit entries and adjustments for any credit entries in error to my account at the Depository indicated above. The Depository is authorized to credit and/or debit the same to my account. This authorization is to remain in effect until Signature has received written notification of termination from me, and until Signature and the Depository have had a reasonable opportunity to act. I UNDERSTAND THAT MY ACCOUNT MAY NOT BE CREDITED FOR 2 BUSINESS DAYS FROM CHECK DATE, DEPENDING ON THE FINANCIAL INSTITUTION.

Name: _____
(name must appear exactly as shown on account)

Account Type: Checking or Savings (check one)

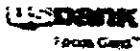
Name of Bank or Institution: _____

Account Number: _____ Routing Number: _____
(1st 9 digits on lower left of check)

Amount: \$ _____ or Percent % _____

Signature: _____ Date: _____

Please email a voided check OR some sort of
backup from your bank to
newhires@signaturebackoffice.com



CFR Prepaid Visa Debit Card Application Form

Please enter completed applications into
www.cfrcard.org.



If you have questions, e-mail support@cfrcard.org.

Financial institutions must authenticate the identity of people applying for bank accounts or prepaid debit cards. Usually this process requires nothing more than a Social Security number. Some applicants do not have sufficient personal data on public databases that can be used to complete electronic authentication. These applicants must submit additional documentation to complete the card activation process. CFR will notify your site if you have card enrollees that need to provide additional ID. If needed, refer to the ID Verification Instructions.

Items marked in RED are required fields. Please write neatly and provide all required information.

*Enrollment Date: _____

*Applicant's Name: _____
(First) (Last)

Applicant Residence/Physical Address: (no PO Boxes)

*Address (line 1): _____

(line 2-optional): _____

*City/State/Zip: _____
(City) (State) (Zip Code)

Mail-to Address: (provide only if different from physical residence address OR if card is to be sent to organization/employer, leave blank and check here _____)

Address (line 1): _____

(line 2-optional): _____

City/State/Zip: _____
(City) (State) (Zip Code)

* Home or Cell phone Number: _____
(Area code & Number)

Work Phone _____

* Email: _____

*Social Security Number: _____ - _____ - _____ *Date of Birth: ____ / ____ / ____
(MM) (DD) (YYYY)

(To be completed by enrollment sponsor)

Record Direct Deposit Account Information: _____ (*Bank Acct Number – 13 digits)

Rules for Van Pool Riders

1. You must give a 24 hour notice 912-446-3603 to cancel a ride, if not, you'll still be charged for the ride.
2. Van Rides are not on a per ride basis. Charges are only deducted if you have an excused absence (If you work for IWD, the employer excuses it and/or you called off on our call off line). Non-employees must have employer excused verification.
3. To request additional rides, routes, or changes in times, and/or additional times, you must get approval from IWD management by calling 912-446-3603.
4. Routes are pre- established. You must get approval to change rides, routes, changes in times, and/or additional times, 24 hours before this change goes into effect.
5. If are running at least 10 minutes after any pick up times, notify your driver by text or call to inform them you are running late. You are expected to be at your designated pick-up at the designated time, **ON TIME**.
6. You can be denied a ride for any reason.
7. Do not distract the driver while the vehicle is in motion. This includes talking to the Driver.
8. Be courteous to others in the van. No loud music, yelling, or arguing.
9. The driver is your supervisor while in the van. Please follow his/her directions for everyone's safety.
10. You must sign a payment agreement before you are permitted a ride.
11. No violence, harassment, or intimidation of any kind is allowed. This will lead to immediate cancellation of service.

"I understand and agree to the rules of conduct outlined in this document and agree to its terms"

Van Rider

Date

Management

Date

\$ _____ PER WEEK (PAYROLL DEDUCTED)



Deduction Authorization Agreement

I, _____ authorize a deduction of \$15 a week for meals provided by DIRT Environmental Solutions. This agreement is valid only as long as the employee is assigned to work by Innovative Workforce Development to DIRT Environmental Solutions.

Employee Signature

Date

Company Representative

Date
