

Baptist Health Employment Information Sheet

Please Print All Information

Employee's Name _____
Last First Middle Initial

Address _____

City _____ State _____ Zip Code _____

Phone # _____ Social Security # _____

Automobile Tag # _____

In case of emergency, who should be contacted? _____
Relationship _____

Address _____ City _____ State _____ Zip Code _____ Telephone Number _____

Spouse _____ Spouse's Date of Birth _____

To Help Us Comply with Federal and State Equal Employment Opportunity Record Keeping, Reporting and Other Legal Requirements, Please Answer the Questions Below:

Date of Birth: _____
Month./Day/Year

Marital Status: ___ Single ___ Married ___ Separated ___ Divorced ___ Widowed
(Check One)

EEOC (Check One)

- | | |
|---|---|
| <input type="checkbox"/> M Female/American Indian or Alaska Native | <input type="checkbox"/> G Male/American Indian or Alaska Native |
| <input type="checkbox"/> L Female/Asian | <input type="checkbox"/> F Male/Asian |
| <input type="checkbox"/> J Female/Black or African American | <input type="checkbox"/> D Male/Black or African American |
| <input type="checkbox"/> B Female/Hispanic or Latino | <input type="checkbox"/> A Male/Hispanic or Latino |
| <input type="checkbox"/> K Female/Native Hawaiian/Pacific Islander | <input type="checkbox"/> E Male/Native Hawaiian/Pacific Islander |
| <input type="checkbox"/> N Female/Two or More Races (Not Hispanic/Latino) | <input type="checkbox"/> H Male/Two or More Races (Not Hispanic/Latino) |
| <input type="checkbox"/> I Female/White (Not Hispanic/Latino) | <input type="checkbox"/> C Male/White (Not Hispanic/Latino) |

For Human Resources Only – Do Not Write Below This Line

East/Prattville Facilities

Federal Tax: ___ Marital Status State Tax: ___ Marital Status
___ Exemptions ___ Exemptions
___ Additional Dollars ___ Additional Dollars

Emp # _____ Dept # _____ Hire Date _____ Job Class # _____ Job Title _____

ALABAMA DEPARTMENT OF REVENUE
Employee's Withholding Exemption Certificate

FULL NAME _____ SOCIAL SECURITY NO. _____ CITY _____ STATE _____ ZIP CODE _____
HOME ADDRESS _____

MSRRA - Military Spouses Residency Relief Act. An exemption from Alabama withholding tax may be claimed if your spouse is a member of the US Armed Services and their state of legal residence is not Alabama. Employees claiming this exemption may skip lines 1-6 and check the box below.

Form DD-2058 must be attached to Form A-4. See instructions on the back of Form A-4 before checking this box.

HOW TO CLAIM YOUR WITHHOLDING EXEMPTIONS

- If you claim no personal exemption for yourself, write the figure "0", sign and date the bottom of Form A-4. (Note: if you claim no personal exemption you cannot claim dependent exemptions on Line 4.)
- IF YOU ARE SINGLE or MARRIED FILING SEPARATELY**, a \$1,500 personal exemption is allowed.
 - if you are **SINGLE** and claim personal exemption for yourself (\$1,500) write a letter "S"
 - if you are **MARRIED FILING SEPARATELY** and claim personal exemption for "yourself only" (\$1,500), write the letters "MS"
- IF YOU ARE MARRIED or SINGLE CLAIMING HEAD OF FAMILY**, a \$3,000 personal exemption is allowed.
 - if you are **MARRIED** and claim exemption for both yourself and your spouse (\$3,000), write the letter "M"
 - if you are **SINGLE** with dependents and claim **HEAD OF FAMILY** exemption (\$3,000), write the letter "H"
 - if you are married and wish to withhold at the higher single rate (\$1,500), write the letter "S"
- If during the year you will provide more than one-half of the support of persons closely related to you (other than spouse) write the number of such dependents. _____
Additional amount, if any, you want deducted each pay period. _____ \$
- THIS LINE TO BE COMPLETED BY EMPLOYER:**
- TOTAL EXEMPTIONS** (Example: Employee claims "M" on Line 3 and "1" on Line 4. Employer should use column headed M-1 in Withholding Tables.) _____

DATE _____ SIGNED _____

CHANGES IN EXEMPTIONS

You may file a new certificate at any time if the number of your exemptions INCREASES.

You must file a new certificate within 10 days if the number of exemptions previously claimed by you DECREASES for any of the following reasons:

- Your spouse for whom you have been claiming exemption is divorced, legally separated, or claims her or his own exemption on a separate certificate.
- The support of a dependent for whom you claimed exemption is taken over by someone else and you no longer expect to furnish more than half of this dependent's support for the year.

OTHER DECREASES in exemption, such as the death of a spouse or dependent, do not affect your withholding until the next year, but require the filing of a new certificate by December 1 of the year in which this occurs.

Any correspondence concerning this form should be sent to the Alabama Department of Revenue, Individual and Corporate Tax Division, Withholding Tax Section, P.O. Box 327480, Montgomery, AL 36132-7480 or telephone (334) 242-1300 (fax (334) 242-0112).

EXCLUSION FROM WITHHOLDING TAX (EXEMPT STATUS)

This exemption applies to a spouse of a US Armed Services member whose state of legal residence is not Alabama. You must provide Form DD-2058 to your employer

with Form A-4 to qualify. All wages will be reported to your state of legal residence by your employer. This exemption may also be used by individuals who 1.) filed an Alabama Income Tax Return last year and 2.) had a zero tax liability on that return. Zero tax liability means if you had any tax withheld, 100% of this tax was refunded to you. If not, you will not qualify for exemption and should complete the front of Form A-4.

DEPENDENTS

To qualify as your dependent (Line 4 on other side), a person must receive more than one-half of his or her support from you for the year and must be related to you as follows:

- Your son or daughter (including legally adopted children), grandchild, stepson, stepdaughter, son-in-law, or daughter-in-law;
- Your father, mother, grandparent, stepfather, stepmother, father-in-law, or mother-in-law;
- Your brother, sister, stepbrother, stepsister, half brother, half sister, brother-in-law, or sister-in-law;
- Your uncle, aunt, nephew, or niece (but only if related by blood).

PENALTIES

Penalties are imposed for willfully supplying false information. If an employee is believed to have claimed too many exemptions, this information should be reported to the Alabama Department of Revenue, Withholding Tax Section.

Baptist Health Direct Deposit Form

Employee Name (Please Print):	Employee ID#:	Date:
Facility Name:	Dept#:	Dept Name:

Authorization Agreement

I hereby authorize Baptist Health and the financial institution(s) listed below to electronically deposit monies to the specific account number(s) I have listed below. I acknowledge that I am responsible for immediately notifying my manager and the Payroll Department in the event that any funds are deposited to my account(s) in error. I further acknowledge that I am personally responsible for the immediate repayment of any funds deposited to my account(s) in error. If monies, to which I am not entitled, are deposited to my account(s) in error, I hereby authorize Baptist Health to request and the financial institution(s) to return said funds to Baptist Health.

I understand this agreement will remain in effect until I provide written notification of any requested changes to the Baptist Health Human Resources Department. I further understand that I must allow Baptist Health and the financial institution(s) a reasonable opportunity to act upon my requested changes.

By signing below, I acknowledge that I have read and understand this authorization and agree to comply with the terms and conditions set forth herein.

Primary Account Information for NET PAY DEPOSIT ONLY

Name of Financial Institution:		
Routing Number:	Enroll / Change <input type="checkbox"/> <input type="checkbox"/>	Cancel <input type="checkbox"/>
Account Number:	Credit Card / Checking / Savings <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	% of Net Pay 100%

Alternate Account Information for Direct Deposit (Optional)

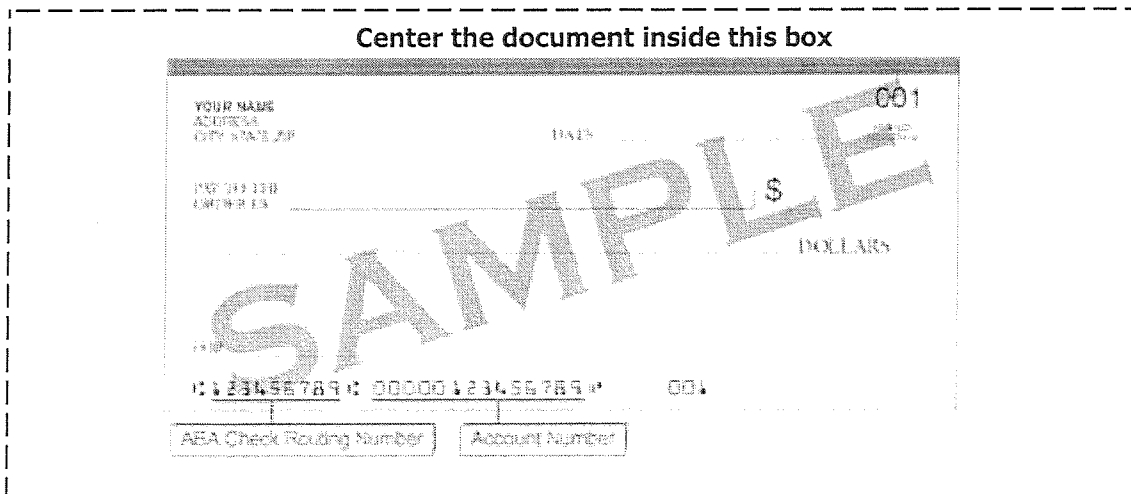
Name of Financial Institution:		
Routing Number:	Enroll / Change <input type="checkbox"/> <input type="checkbox"/>	Cancel <input type="checkbox"/>
Account Number:	Credit Card / Checking / Savings <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Fixed Amount \$

Signature

Employee Signature:	Date:
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You must attach a voided check or document from your financial institution that reflects your account number and Transit / ABA routing number for each direct deposit account Prior to submitting this form to the HR Department.

*** do not attach a deposit slip ***



For Use By Human Resources Only

Entity: _____	Employee Number: _____
Verified By: _____	Date: _____

EMPLOYER FEIN 203204949 00010

EMPLOYER NAME THE HEALTH CARE AUTHORITY

MARK ONE OF THE FOLLOWING BOXES: New Hire

Recall

Job Refusal

Mark box like this

NOT like this

SOCIAL SECURITY NUMBER

FIRST DAY OF WORK (OR DATE OF REFUSAL)

EMPLOYER REPRESENTATIVE PHONE NUMBER (Only in case of job refusal)

E - -

() -

1 LAST NAME

FIRST NAME

MI

2 STREET NUMBER

STREET NAME OR RURAL ROUTE AND NUMBER

OR P.O. BOX NUMBER

3 CITY

STATE

ZIP CODE

THE ABOVE INFORMATION IS TRUE AND CORRECT

EMPLOYEE Signature _____ Date _____

EMPLOYER Representative Signature _____ Date _____