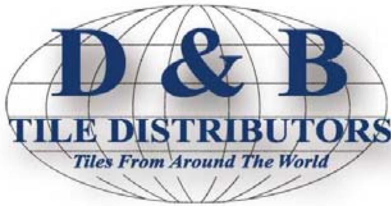
NEW HIRE CHECKLIST

- ☐ APPLICATION
- ☐ COMPLETED PRE-HIRE DRUG TEST
- ☐ EMPLOYMENT ELIGIBILITY VERFICATION (I-9)
- ☐ TWO VALID IDENTIFICATIONS
  (SEE ATTACHED LIST OF ACCEPTABLE DOCUMENTS)
- ☐ CURRENT YEAR W-4 FORM
- ☐ POST-HIRE MEDICAL QUESTIONNAIRE
- ☐ EMPLOYEE ACKNOWLEDGEMENT/WORKMAN'S COMPENSATION
- ☐ CONSENT TO DRUG TESTING AND RELEASE
- ☐ EMPLOYEE ACKNOWLEDGEMENT OF PROBATION
- ☐ USE OF PERSONAL PROTECTIVE EQUIPMENT
- ☐ EMPLOYEE ACKNOWLEDGEMENT OF POLICY
  REGARDING ACCEPTANCE OF CHECKS FOR PURCHASES
- ☐ CELL PHONE POLICY
- ☐ CONSENT FORM (PERSONAL USE OF OFFICE EQUIPMENT, ETC.)
- ☐ DRESS CODE
- ☐ EMPLOYEE ACKNOWLEDGEMENT OF RECEIPT
  OF EMPLOYEE MANUAL
- ☐ CONFIDENTIAL EMPLOYEE HISTORY
- ☐ DIRECT DEPOSIT FORM
- ☐ EMPLOYEE CHANGE OF RECORD



We are proud to be a Drug-Free Workplace

E-Mail: root@dbtile.com
Home Page: www.dbtile.com

D & B OF HOLLYWOOD INC 1685 STATE RD 7 HOLLYWOOD, FL 33023 Ph: 954-983-6373	D & B TILE OF MIAMI 8369 NW 36 STREET MIAMI, FL 33166 Ph: 305-592-9340	D & B TILE OF PALM BEACH 3346 45 STREET W PALM BEACH, FL 33407 Ph: 561-478-4242
D & B OF POMPANO INC 1551 N POWERLINE ROAD POMPANO BEACH, FL 33069 Ph: 954-979-2066	D & B OF KENDALL INC 17911 SOUTH DIXIE HIGHWAY MIAMI, FL 33157 Ph: 305-238-8492	D & B TILE OF DELRAY 781 SOUTH CONGRESS AVE DELRAY BEACH, FL 33445 Ph: 561-278-7022
D & B OF SAWGRASS 14200 NW 4 STREET SUNRISE, FL 33325 Ph: 954-846-2660	D & B OF ORLANDO INC 4420 N ORANGE BLOSSOM TR ORLANDO, FL 32808 Ph: 407-298-6677	D & B TILE OF PT ST LUCIE 321 NW PEACOCK BLVD PT ST LUCIE, FL 34986 Ph: 772-873-8556

APPLICATION FOR EMPLOYMENT

Pre-Employment Questionnaire

PERSONAL INFORMATION

LAST NAME______________________________ FIRST NAME_____________________________ MIDDLE INITIAL ________

PRESENT ADDRESS ____

CITY ____ STATE______________________________ ZIP ________________

SOCIAL SECURITY# ____ PHONE ____

ARE YOU 18 YEARS OF AGE OR OLDER? _________________________

EDUCATION

SCHOOL LEVEL	NAME & LOCATION OF SCHOOL	DATE ATTENDED	DID YOU GRADUATE
GRAMMAR			
HIGH SCHOOL			
COLLEGE			
TRADE/BUSINESS			

GENERAL

SPECIAL TRAINING ____

SPECIAL SKILLS ____

ENTER BELOW THE NAMES OF THREE PERSONS YOU ARE NOT RELATED TO, WHOM YOU HAVE KNOWN AT LEAST THREE YEARS

NAME	ADDRESS	PHONE #	YEARS KNOWN

HAVE YOU EVER BEEN CHARGED WITH OR CONVICTED OF A CRIME WITHIN THE LAST FIVE YEARS? ___________________

IF, SO EXPLAIN ____

DESIRED EMPLOYMENT

POSITION ___________________________ DATE YOU CAN START ________________ SALARY DESIRED_________________

ARE YOU EMPLOYED NOW? __________ MAY WE CONTACT YOUR PRESENT EMPLOYER? _________________________

HAVE YOU EVER APPLIED TO D & B BEFORE? ______________ WHERE AND WHEN ? _____________________________

HAVE YOU EVER WORKED FOR D & B BEFORE? _____________ WHERE AND WHEN ? _____________________________

NAME OF LAST SUPERVISOR ____

REASON FOR LEAVING ____

WHO REFERRED YOU TO D & B TILE? (CIRCLE ONE)

EMPLOYMENT AGENCY NEWSPAPER AD FRIEND STATE AGENCY OTHER

FORMER EMPLOYERS

LIST BELOW YOUR LAST THREE EMPLOYERS, STARTING WITH THE MOST RECENT.

NAME OF PRESENT OR MOST RECENT EMPLOYER ____

ADDRESS ________________________________ CITY ___________________________ ST_______ ZIP ____________

TELEPHONE ____________________ SUPERVISOR __________________________ TITLE _______________________

STARTING DATE __________________ LEAVING DATE __________________ JOB TITLE _______________________

WEEKLY STARTING SALARY _________________________ WEEKLY ENDING SALARY ________________________

YOUR JOB DESCRIPTION ____

____

YOUR REASON FOR LEAVING ____

____

NAME OF NEXT MOST RECENT EMPLOYER ____

ADDRESS ________________________________ CITY ___________________________ ST_______ ZIP ____________

TELEPHONE ____________________ SUPERVISOR __________________________ TITLE _______________________

STARTING DATE __________________ LEAVING DATE __________________ JOB TITLE _______________________

WEEKLY STARTING SALARY _________________________ WEEKLY ENDING SALARY ________________________

YOUR JOB DESCRIPTION ____

____

YOUR REASON FOR LEAVING ____

____

NAME OF NEXT MOST RECENT EMPLOYER ____

ADDRESS ________________________________ CITY ___________________________ ST_______ ZIP ____________

TELEPHONE ___________________ SUPERVISOR __________________________ TITLE _______________________

STARTING DATE _________________ LEAVING DATE _________________ JOB TITLE _______________________

WEEKLY STARTING SALARY _________________________ WEEKLY ENDING SALARY ________________________

YOUR JOB DESCRIPTION ____

____

YOUR REASON FOR LEAVING ____

____

NOTICE TO APPLICANTS

D & B Tile complies with the Americans with Disabilities Act of 1990. During the interview process, you may be asked questions concerning your ability to perform job-related functions. If you are given a conditional offer of employment, you may be required to complete a post-job offer medical questionnaire and/or undergo a medical examination. If required, all new employees in the same job category will be subject to the same medical questionnaire and/or undergo a medical examination, and all information will be kept confidential in separate files.

D & B Tile is an equal opportunity employer. We adhere to a policy of making employment decisions without regard to race, color, sex, religion, national origin, or marital status. We assure you that your opportunity for employment with D & B Tile depends solely upon your qualifications.

STATEMENT OF APPLICANT

The information which I have entered on this application is correct, to the best of my knowledge. I understand that D & B Tile may perform a background check to verify any of the information that I have included on this application.

Further, I agree, that if I am hired, any employment dispute or grievance whatsoever which may arise during, or as a result of, my employment or Application For Employment, which cannot be resolved between myself and D & B Tile Distributors or any of its affiliated companies, shall be resolved or settled by binding arbitration, rather than by a State or Federal Court, by the American Arbitration Association and its arbitration rules, and arbitration shall take place in Broward County, Florida. I understand that by agreeing to this binding arbitration provision, both myself and the Company give up their rights to trial by jury.

____

Signature of Applicant

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

Form I-9, Employment Eligibility Verification

Instructions

Read all instructions carefully before completing this form.

Anti-Discrimination Notice. It is illegal to discriminate against any individual (other than an alien not authorized to work in the United States) in hiring, discharging, or recruiting or referring for a fee because of that individual's national origin or citizenship status. It is illegal to discriminate against work-authorized individuals. Employers **CANNOT** specify which document(s) they will accept from an employee. The refusal to hire an individual because the documents presented have a future expiration date may also constitute illegal discrimination. For more information, call the Office of Special Counsel for Immigration Related Unfair Employment Practices at 1-800-255-8155.

What Is the Purpose of This Form?

The purpose of this form is to document that each new employee (both citizen and noncitizen) hired after November 6, 1986, is authorized to work in the United States.

When Should Form I-9 Be Used?

All employees, citizens, and noncitizens hired after November 6, 1986, and working in the United States must complete Form I-9.

Filling Out Form I-9

Section 1, Employee

This part of the form must be completed no later than the time of hire, which is the actual beginning of employment. Providing the Social Security Number is voluntary, except for employees hired by employers participating in the USCIS Electronic Employment Eligibility Verification Program (E-Verify). **The employer is responsible for ensuring that Section 1 is timely and properly completed.**

Noncitizen Nationals of the United States

Noncitizen nationals of the United States are persons born in American Samoa, certain former citizens of the former Trust Territory of the Pacific Islands, and certain children of noncitizen nationals born abroad.

Employers should note the work authorization expiration date (if any) shown in **Section 1**. For employees who indicate an employment authorization expiration date in **Section 1**, employers are required to reverify employment authorization for employment on or before the date shown. Note that some employees may leave the expiration date blank if they are aliens whose work authorization does not expire (e.g., asylees, refugees, certain citizens of the Federated States of Micronesia or the Republic of the Marshall Islands). For such employees, reverification does not apply unless they choose to present in Section 2 evidence of employment authorization that contains an expiration date (e.g., Employment Authorization Document (Form I-766)).

Preparer/Translator Certification

The Preparer/Translator Certification must be completed if **Section 1** is prepared by a person other than the employee. A preparer/translator may be used only when the employee is unable to complete **Section 1** on his or her own. However, the employee must still sign **Section 1** personally.

Section 2, Employer

For the purpose of completing this form, the term "employer" means all employers including those recruiters and referrers for a fee who are agricultural associations, agricultural employers, or farm labor contractors. Employers must complete **Section 2** by examining evidence of identity and employment authorization within three business days of the date employment begins. However, if an employer hires an individual for less than three business days, **Section 2** must be completed at the time employment begins. Employers cannot specify which document(s) listed on the last page of Form I-9 employees present to establish identity and employment authorization. Employees may present any List A document **OR** a combination of a List B and a List C document.

If an employee is unable to present a required document (or documents), the employee must present an acceptable receipt in lieu of a document listed on the last page of this form. Receipts showing that a person has applied for an initial grant of employment authorization, or for renewal of employment authorization, are not acceptable. Employees must present receipts within three business days of the date employment begins and must present valid replacement documents within 90 days or other specified time.

Employers must record in Section 2:

1. Document title;
2. Issuing authority;
3. Document number;
4. Expiration date, if any; and
5. The date employment begins.

Employers must sign and date the certification in **Section 2**. Employees must present original documents. Employers may, but are not required to, photocopy the document(s) presented. If photocopies are made, they must be made for all new hires. Photocopies may only be used for the verification process and must be retained with Form I-9. **Employers are still responsible for completing and retaining Form I-9.**

For more detailed information, you may refer to the *USCIS Handbook for Employers* (Form M-274). You may obtain the handbook using the contact information found under the header "USCIS Forms and Information."

Section 3, Updating and Reverification

Employers must complete **Section 3** when updating and/or reverifying Form I-9. Employers must reverify employment authorization of their employees on or before the work authorization expiration date recorded in **Section 1** (if any). Employers **CANNOT** specify which document(s) they will accept from an employee.

A. If an employee's name has changed at the time this form is being updated/reverified, complete Block A.

B. If an employee is rehired within three years of the date this form was originally completed and the employee is still authorized to be employed on the same basis as previously indicated on this form (updating), complete Block B and the signature block.

C. If an employee is rehired within three years of the date this form was originally completed and the employee's work authorization has expired **or** if a current employee's work authorization is about to expire (reverification), complete Block B; and:

1. Examine any document that reflects the employee is authorized to work in the United States (see List A **or** C);
2. Record the document title, document number, and expiration date (if any) in Block C; and
3. Complete the signature block.

Note that for reverification purposes, employers have the option of completing a new Form I-9 instead of completing **Section 3.**

What Is the Filing Fee?

There is no associated filing fee for completing Form I-9. This form is not filed with USCIS or any government agency. Form I-9 must be retained by the employer and made available for inspection by U.S. Government officials as specified in the Privacy Act Notice below.

USCIS Forms and Information

To order USCIS forms, you can download them from our website at www.uscis.gov/forms or call our toll-free number at 1-800-870-3676. You can obtain information about Form I-9 from our website at www.uscis.gov or by calling 1-888-464-4218.

Information about E-Verify, a free and voluntary program that allows participating employers to electronically verify the employment eligibility of their newly hired employees, can be obtained from our website at www.uscis.gov/e-verify or by calling 1-888-464-4218.

General information on immigration laws, regulations, and procedures can be obtained by telephoning our National Customer Service Center at 1-800-375-5283 or visiting our Internet website at www.uscis.gov.

Photocopying and Retaining Form I-9

A blank Form I-9 may be reproduced, provided both sides are copied. The Instructions must be available to all employees completing this form. Employers must retain completed Form I-9s for three years after the date of hire or one year after the date employment ends, whichever is later.

Form I-9 may be signed and retained electronically, as authorized in Department of Homeland Security regulations at 8 CFR 274a.2.

Privacy Act Notice

The authority for collecting this information is the Immigration Reform and Control Act of 1986, Pub. L. 99-603 (8 USC 1324a).

This information is for employers to verify the eligibility of individuals for employment to preclude the unlawful hiring, or recruiting or referring for a fee, of aliens who are not authorized to work in the United States.

This information will be used by employers as a record of their basis for determining eligibility of an employee to work in the United States. The form will be kept by the employer and made available for inspection by authorized officials of the Department of Homeland Security, Department of Labor, and Office of Special Counsel for Immigration-Related Unfair Employment Practices.

Submission of the information required in this form is voluntary. However, an individual may not begin employment unless this form is completed, since employers are subject to civil or criminal penalties if they do not comply with the Immigration Reform and Control Act of 1986.

Paperwork Reduction Act

An agency may not conduct or sponsor an information collection and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. The public reporting burden for this collection of information is estimated at 12 minutes per response, including the time for reviewing instructions and completing and submitting the form. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to: U.S. Citizenship and Immigration Services, Regulatory Management Division, 111 Massachusetts Avenue, N.W., 3rd Floor, Suite 3008, Washington, DC 20529-2210. OMB No. 1615-0047. **Do not mail your completed Form I-9 to this address.**

OMB No. 1615-0047; Expires 06/30/09

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

Form I-9, Employment Eligibility Verification

Read instructions carefully before completing this form. The instructions must be available during completion of this form.

ANTI-DISCRIMINATION NOTICE: It is illegal to discriminate against work-authorized individuals. Employers CANNOT specify which document(s) they will accept from an employee. The refusal to hire an individual because the documents have a future expiration date may also constitute illegal discrimination.

Section 1. Employee Information and Verification *(To be completed and signed by employee at the time employment begins.)*

Print Name: Last | First | Middle Initial | Maiden Name

Address *(Street Name and Number)* | Apt. # | Date of Birth *(month/day/year)*

City | State | Zip Code | Social Security #

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):

- ☐ A citizen of the United States
- ☐ A noncitizen national of the United States (see instructions)
- ☐ A lawful permanent resident (Alien #) ______
- ☐ An alien authorized to work (Alien # or Admission #) ______ until (expiration date, if applicable - *month/day/year*)

Employee's Signature | Date *(month/day/year)*

Preparer and/or Translator Certification *(To be completed and signed if Section 1 is prepared by a person other than the employee.) I attest, under penalty of perjury, that I have assisted in the completion of this form and that to the best of my knowledge the information is true and correct.*

Preparer's/Translator's Signature | Print Name

Address *(Street Name and Number, City, State, Zip Code)* | Date *(month/day/year)*

Section 2. Employer Review and Verification *(To be completed and signed by employer. Examine one document from List A OR examine one document from List B and one from List C, as listed on the reverse of this form, and record the title, number, and expiration date, if any, of the document(s).)*

	List A	OR	List B	AND	List C
Document title:					
Issuing authority:					
Document #:					
Expiration Date *(if any)*:					
Document #:					
Expiration Date *(if any)*:					

CERTIFICATION: I attest, under penalty of perjury, that I have examined the document(s) presented by the above-named employee, that the above-listed document(s) appear to be genuine and to relate to the employee named, that the employee began employment on *(month/day/year)* ______ **and that to the best of my knowledge the employee is authorized to work in the United States. (State employment agencies may omit the date the employee began employment.)**

Signature of Employer or Authorized Representative | Print Name | Title

Business or Organization Name and Address *(Street Name and Number, City, State, Zip Code)* | Date *(month/day/year)*

Section 3. Updating and Reverification *(To be completed and signed by employer.)*

A. New Name *(if applicable)* | B. Date of Rehire *(month/day/year) (if applicable)*

C. If employee's previous grant of work authorization has expired, provide the information below for the document that establishes current employment authorization.

Document Title: ______ Document #: ______ Expiration Date *(if any)*: ______

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 | Date *(month/day/year)*

LISTS OF ACCEPTABLE DOCUMENTS

All documents must be unexpired

LIST A

Documents that Establish Both Identity and Employment Authorization

1. U.S. Passport or U.S. Passport Card
2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551)
3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa
4. Employment Authorization Document that contains a photograph (Form I-766)
5. In the case of a nonimmigrant alien authorized to work for a specific employer incident to status, a foreign passport with Form I-94 or Form I-94A bearing the same name as the passport and containing an endorsement of the alien's nonimmigrant status, as long as the period of endorsement has not yet expired and the proposed employment is not in conflict with any restrictions or limitations identified on the form
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

OR

LIST B

Documents that Establish Identity

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
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
3. School ID card with a photograph
4. Voter's registration card
5. U.S. Military card or draft record
6. Military dependent's ID card
7. U.S. Coast Guard Merchant Mariner Card
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

AND

LIST C

Documents that Establish Employment Authorization

1. Social Security Account Number card other than one that specifies on the face that the issuance of the card does not authorize employment in the United States
2. Certification of Birth Abroad issued by the Department of State (Form FS-545)
3. Certification of Report of Birth issued by the Department of State (Form DS-1350)
4. Original or certified copy of birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal
5. Native American tribal document
6. U.S. Citizen ID Card (Form I-197)
7. Identification Card for Use of Resident Citizen in the United States (Form I-179)
8. Employment authorization document issued by the Department of Homeland Security

Illustrations of many of these documents appear in Part 8 of the Handbook for Employers (M-274)

Initial Drug Screen Result Form

Specimen ID Number ________________________

Collection Test Date ___________________________

Company Information: *(Information about the Company doing the testing)*

Company ____

Address ____

City ______________________ State ______________ Postal Code ______________

Collector's Name ____

Specimen Temperature: (90-100 F.) In Range ☐ Other ______________ Fax ______________________

Donor Information: *(Information about the person being tested)*

Donor's Name ____

ID # or SSN ____

Identification Type ____ Expiration __________________

Notes ____

____

Employee ID # or Last Name:

Certificate Information: *(Must be signed by both Donor and Collector)*

I hereby certify that the specimen provided is my own and has not been substituted or adulterated. I further agree and grant permission for the testing of my specimen for drug metabolites and/or alcohol.

Donor's Signature ____________________ *Date* ____________________

I hereby certify that I collected the specimen provided by the aforementioned Donor and that it was not substituted or adulterated to the best of my knowledge. The specimen temperature and color were acceptable.

Collector's Signature ____________________ *Date* ____________________

Initial Screen Results: *(All "Confirm" or non-negative results must be confirmed using GC/MS)*

Drug Name	Device Code	Negative	Confirm	Not Tested
Cocaine	*COC*	☐	☐	☐
Marijuana	*THC*	☐	☐	☐
Opiates/Morphine	*OPI/MOR*	☐	☐	☐
Amphetamines	*AMP*	☐	☐	☐
Methamphetamine	*mAMP*	☐	☐	☐
Phencyclidine	*PCP*	☐	☐	☐
Benzodiazepine	*BZO*	☐	☐	☐
Barbiturates	*BAR*	☐	☐	☐
Methadone	*MTD*	☐	☐	☐
Tricyclic Antidepressants	*TCA*	☐	☐	☐
Oxycodone	*OXY*	☐	☐	☐
Propoxyphene	*PPX*	☐	☐	☐
Methylenedioxymethamphetamine	*MDMA*	☐	☐	☐
ALCOHOL SCREEN	*ALC*	*Level* ____________________		

Last Name ____________ First Name ____________

Form W-4 (2009)

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 2009 expires February 16, 2010. See Pub. 505, Tax Withholding and Estimated Tax.

Note. You cannot claim exemption from withholding if (a) your income exceeds $950 and includes more than $300 of unearned income (for example, interest and dividends) and (b) another person can claim you as a dependent on their tax return.

Basic instructions. If you are not 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-earner/multiple job 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 may 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. 919, How Do I Adjust My Tax Withholding, 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. 919 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. 919 for details.

Nonresident alien. If you are a nonresident alien, see the Instructions for Form 8233 before completing this Form W-4.

Check your withholding. After your Form W-4 takes effect, use Pub. 919 to see how the amount you are having withheld compares to your projected total tax for 2009. See Pub. 919, especially if your earnings exceed $130,000 (Single) or $180,000 (Married).

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 are single and have only one job; or
- You are married, have only one job, and your spouse does not 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 $1,800 of **child or dependent care expenses** for which you plan to claim a credit . . **F** ______
(**Note.** Do **not** include child support payments. See Pub. 503, Child and Dependent Care Expenses, for details.)

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 $61,000 ($90,000 if married), enter "2" for each eligible child; then **less** "1" if you have three or more eligible children.
- If your total income will be between $61,000 and $84,000 ($90,000 and $119,000 if married), enter "1" for each eligible child plus "1" **additional** if you have six or more eligible children.

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 have **more than one job** or are **married and you and your spouse both work** and the combined earnings from all jobs exceed $40,000 ($25,000 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.

Cut 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

2009

1 Type or print 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 2009, 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
(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)

Deductions and Adjustments Worksheet

Note. Use this worksheet *only* if you plan to itemize deductions, claim certain credits, adjustments to income, or an additional standard deduction.

1 Enter an estimate of your 2009 itemized deductions. These include qualifying home mortgage interest, charitable contributions, state and local taxes, medical expenses in excess of 7.5% of your income, and miscellaneous deductions. (For 2009, you may have to reduce your itemized deductions if your income is over $166,800 ($83,400 if married filing separately). See *Worksheet 2* in Pub. 919 for details.) . . . **1** $ ______

2 Enter: { $11,400 if married filing jointly or qualifying widow(er); $ 8,350 if head of household; $ 5,700 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 2009 adjustments to income and any additional standard deduction. (Pub. 919) . . . **4** $ ______

5 **Add** lines 3 and 4 and enter the total. (Include any amount for credits from *Worksheet 8* in Pub. 919.) . **5** $ ______

6 Enter an estimate of your 2009 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 $3,500 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 $50,000 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 4–9 below to calculate 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 2009. For example, divide by 26 if you are paid every two weeks and you complete this form in December 2008. 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: If wages from **LOWEST** paying job are—	Enter on line 2 above	All Others: If wages from **LOWEST** paying job are—	Enter on line 2 above
$0 - $4,500	0	$0 - $6,000	0
4,501 - 9,000	1	6,001 - 12,000	1
9,001 - 18,000	2	12,001 - 19,000	2
18,001 - 22,000	3	19,001 - 26,000	3
22,001 - 26,000	4	26,001 - 35,000	4
26,001 - 32,000	5	35,001 - 50,000	5
32,001 - 38,000	6	50,001 - 65,000	6
38,001 - 46,000	7	65,001 - 80,000	7
46,001 - 55,000	8	80,001 - 90,000	8
55,001 - 60,000	9	90,001 - 120,000	9
60,001 - 65,000	10	120,001 and over	10
65,001 - 75,000	11		
75,001 - 95,000	12		
95,001 - 105,000	13		
105,001 - 120,000	14		
120,001 and over	15		

Table 2

Married Filing Jointly: If wages from **HIGHEST** paying job are—	Enter on line 7 above	All Others: If wages from **HIGHEST** paying job are—	Enter on line 7 above
$0 - $65,000	$550	$0 - $35,000	$550
65,001 - 120,000	910	35,001 - 90,000	910
120,001 - 185,000	1,020	90,001 - 165,000	1,020
185,001 - 330,000	1,200	165,001 - 370,000	1,200
330,001 and over	1,280	370,001 and over	1,280

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. The Internal Revenue Code requires this information under sections 3402(f)(2)(A) and 6109 and their regulations. 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 also 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 using it 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.

POST-HIRE MEDICAL QUESTIONNAIRE

The State of Florida has developed a program to encourage employers to hire employees with disabilities. The program is called "The Special Disability Trust Fund". This medical questionnaire is necessary for qualification to the trust fund, and must only be completed after an offer of employment is made. The questionnaire is not being used as the basis for deciding whether to employ you.

IMPORTANT NOTICE: Under Florida law, any employee who falsely represents his condition in writing at the time of entering into the employment relationship with the employer may be denied workers' compensation benefits.

EMPLOYEE NAME: ______________________________ HEIGHT: ___________ WEIGHT: _______________
SOCIAL SECURITY:______________________________ DRIVERS LICENSE # __________________________
TELEPHONE: ___________________________________

Answer YES or NO, YES answers must be followed by approximate date of injury or treatment	YES or NO	WHEN
1. Have you ever had a back injury?		
2. Have you ever had a herniated intervertebral disk in your back?		
3. Have you ever had back surgery for removal of a disk?		
4. Have you ever had a neck injury?		
5. Have you have had a herniated disk in your neck?		
6. Have you ever had neck surgery for removal of a disk?		
7. Have you ever had a knee injury? Which Knee? ___________		
8. Have you ever had surgery on either of your knees?		
9. Have you ever had a shoulder injury? Which shoulder? ___________ . .		
10. Have you ever had surgery on either shoulder? Which shoulder? ___________		
11. Have you ever had an elbow injury? Which elbow? _________		
12. Have you ever had surgery on either elbow? Which elbow? _________		
13. Do you have, or ever had an amputation of your foot, leg, arm, or hand?		
14. Do you have epilepsy?		
15. Do you have, or did you ever have diabetes?		
16. Do you have, or have you ever had cardiac disease?		

Answer YES or NO, YES answers must be followed by approximate date of injury or treatment	YES or NO	WHEN
17. Do you have or have you ever had Marie-Strumple Disease (Ankylosing Spondylitis)?		
18. Do you have or have you ever had total loss of sight of one or both eyes or a partial loss corrected vision of more than 75% bilaterally?		
19. Do you have or have you ever had residual disability from poliomyelitis?		
20. Do you have or have you ever had Cerebral Palsy?		
21. Do you have or have you ever had Multiple Sclerosis?		
22. Do you have or have you ever had Parkinson's Disease?		
23. Do you have or have you ever had a Vascular Disorder?		
24. Do you have or have you ever had Psychoneurotic Disability following treatment in a recognized medical or mental institution for a period in excess of 6 months?		
25. Do you have or have you ever had Hemophilia?		
26. Do you have or have you ever had Chronic Osteomyelitis?		
27. Do you have or have you ever had Ankylosis of a major weight-bearing joint?		
28. Do you have or have you ever had Hyperinsulism?		
29. Do you have or ever had Muscular Dystrophy?		
30. Do you have or have you ever had Thrombophlebitis?		
31. Do you have or have you ever had Total Deafness?		
32. Do you have or have you ever had mental retardation?		
33. Do you have or have you ever had a permanent physical condition Which constitutes a 20% impairment of a member of the body as a whole?		
34. Are you now or have you ever been obese? (30% or more over normal body weight)		
35. Do you have or have you ever had Rheumatic Fever?		
36. Do you have or have you ever had High Blood Pressure?		

ADDITIONAL NOTES

Answer YES or NO, YES answers must be followed by approximate date of injury or treatment	YES or NO	WHEN
37. Do you have or have you ever had Varicose Veins or a Leg Ulcer?		
38. Do you have or have you ever had Tuberculosis?		
39. Do you have or have you ever had allergies or asthma?		
40. Do you have or have you ever had skin trouble?		
41. Do you have or have you ever had reaction to a serum drug?		
42. Do you have or have you ever had kidney or bladder trouble.		
43. Do you have or have you ever had ulcers?		
44. Do you have or have you ever had a head injury?		
45. Do you have or have you ever had Cancer?		
46. Do you have or have you ever had Arthritis or Rheumatism? What part of the body? ____________________________		
47. Have you ever been ruptured (hernia)? On which side was surgery performed? ____________________		
48. Have you ever had an injury, operation, or disability not covered by the above questions?		
49. Are there any questions you don't understand? Which question?____________________________________		

PLEASE DETAIL ALL YES ANSWERS

____

____

____

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

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

Name of Applicant (printed): _________________________________

Name of Applicant (signed): _________________________________ Date: ___________________

TO BE COMPLETED BY EMPLOYER

Reviewed By: ______________________________________ Title:______________________________

Date: _________________________

Employee Acknowledgement

YOUR EMPLOYER has agreed to provide workers' compensation coverage for work-related injuries and illness through a Managed care Arrangement (MCA) pursuant to Section 440.134, Florida Statutes.

As an employee of ________________________________ you must follow
(Employer/Company Name)
the procedures and guidelines of your workers' compensation MCA.

The attached employee brochure entitled, "Facts for Injured Workers" sets forth your rights and responsibilities under your employer's workers' compensation MCA.

BE ADVISED:

Your failure to comply with the procedures, terms and conditions of the MCA could result in loss of benefits, and personal responsibility for the payment of medical and hospital charges.

ACKNOWLEDGEMENT OF EMPLOYEE:

I, _____________________ an employee of _________________________
(Employee Name) (Employer Name)
do hereby agree o comply with the procedures, terms and conditions of my employer's Workers' Compensation MCA. I acknowledge and understand that my failure or refusal to comply with the procedures, terms and conditions of this MCA could result in the loss of benefits to me and responsibility for the payment of medical and hospital charges.

______________________________ ______________________________
(Employee Name) (Date)

____
(Witness Signature)

CONSENT TO DRUG TESTING AND RELEASE

This form is to be completed when employee is given a conditional job offer.

Pursuant to my application for employment (including contract for services) with D&B TILE DISTRIBUTORS, I understand that all job offers are expressly conditioned upon submitting to and passing a drug test to detect the presence of illegal drugs and/or alcohol use. I have carefully and thoroughly read the company's Drug-Free Workplace Policy and I understand my rights and obligations contained in that policy. I also understand that it is a condition of my continued employment that I agree to follow, without reservation, that policy, which includes my consent to submit to all drug testing required by the Company. I also understand that the Company's Drug-Free Workplace Policy applies to me by virtue of my continued employment with the company.

I hereby consent to submit to a urinalysis or other tests as required by D&B TILE DISTRIBUTORS, their respective employees and agents, at a time and place specified by D&B TILE DISTRIBUTORS, for the purposes of testing for the presence of illegal drugs and/or alcohol abuse. I agree that Concentra Medical Centers may perform the drug tests in accordance with my employment with D&B TILE DISTRIBUTORS. I further agree to authorize the release of the results of these tests to the Medical Review Officer employed or retained by Concentra Medical Centers, to the Director of Operations of D&B TILE DISTRIBUTORS, and to such other management personnel as may require this information on a need to know basis. My understanding is that any information derived from these tests will be confidential between the laboratory, the Director of Operations of the Company, and the Medical Review Officer, except as otherwise provided by law, or if I place the test or its results in issue in any administrative, legal or other proceeding.

I further agree to release and hold D&B TILE DISTRIBUTORS and its agents, employees and assigns, including the laboratory collecting and conducting these tests, harmless from any liability arising in whole or in part out of the collection or testing of the specimens I provide or from the use of the information derived from these tests in consideration of my employment application.

I have carefully read this Consent and Release Form and understand it completely. I also understand that execution of this Consent and Release is a condition of employment with D&B TILE DISTRIBUTORS and my refusal to sign will result in withdrawal of any offer of employment I may receive. I am signing this form voluntarily and have not been coerced or placed under duress by any person.

____________________________________ (Signature of employee/applicant)

____________________________________ (Print name of employee/applicant)

Date signed: __________________________

____________________________________ (Witness)

____________________________________ (Print name of Witness)

Date: ________________________________

EMPLOYEE ACKNOWLEDGMENT OF INTRODUCTORY PERIOD

I UNDERSTAND THAT I AM ON PROBATION AS AN EMPLOYEE FOR THE FIRST NINETY DAYS OF MY EMPLOYMENT, WHICH STARTED ON ____________. I UNDERSTAND THAT DURING THIS PERIOD OF EVALUATION, I WILL NOT BE ENTITLED TO ANY BENEFITS. FURTHER, I UNDERSTAND THAT, IF MY EMPLOYER DISCHARGES ME FOR UNSATISFACTORY WORK PERFORMANCE, UNDER THE FLORIDA UMEMPLOYMENT COMPENSATION LAW THE EMPLOYER WILL NOT HAVE HIS ACCOUNT CHARGED FOR ANY UNEMPLOYMENT BENEFITS I MIGHT BE ELIGIBLE FOR IN THE FUTURE.

AT THE END OF THE PROBATIONARY PERIOD, MY PERFORMANCE WILL BE REVIEWED AND, PROVIDED MY PERFORMANCE HAS BEEN SATISFACTORY TO MY EMPLOYER, I WILL BECOME A REGULAR EMPLOYEE AND ELIGIBLE FOR ALL THE BENEFITS AS SET FORTH IN THIS MANUAL AND ACCRUED FROM THE INITIAL DATE OF EMPLOYMENT.

I FURTHER ACKNOWLEDGE THAT I HAVE SIGNED THIS FORM WITHIN SEVEN (7) DAYS OF MY EMPLOYMENT.

____
(Signature)

____
(Social Security)

____
(Date)

USE OF PERSONAL PROTECTIVE EQUIPMENT

I, THE UNDERSIGNED, UNDERSTAND AND AGREE THAT AS A CONDITION OF EMPLOYMENT, I AM REQUIRED TO WEAR/USE THE FOLLOWING PERSONAL PROTECTIVE EQUIPMENT SUPPLIED AND/OR REQUIRED BY MY EMPLOYER:

COMPANY SUPPLIED: BACK SUPPORTS
FIRST-AID KITS
SAFETY GLASSES/GOGGLES

SUPPLIED BY EMPLOYEE: SAFETY SHOES
HARD HATS

I AGREE TO INFORM MY EMPLOYER IMMEDIATELY UPON THE FAILURE OF ANY OF THE ABOVE LISTED EQUIPMENT SO THAT THE EQUIPMENT CAN BE PROMPTLY REPAIRED OR REPLACED.

IN THE EVENT THAT I SUSTAIN AN ON-THE-JOB INJURY AS A DIRECT RESULT OF MY FAILURE TO WEAR/USE THE PERSONAL PROTECTIVE EQUIPMENT LISTED ABOVE, MY WORKERS' COMPENSATION BENEFITS COULD BE SUBSTANTIALLY REDUCED.

______________________________ ______________________
(Employee Signature) (Date)

______________________________ ______________________
(Manager or Company Representative) (Date)

______________________________ ______________________
(Witness) (Date)

EMPLOYEE ACKNOWLEDGMENT OF POLICY REGARDING ACCEPTANCE OF CHECKS FOR PURCHASES

THE FOLLOWING STEPS ARE MANDATORY FOR ALL CHECKS (NO EXCEPTIONS):

(1) All checks must be preprinted by the bank with:

- (A) NAME
- (B) ADDRESS (If it is a P.O. Box, handwrite the street address)

(2) Other information to be preprinted or handwritten on the face of the check:

- (A) TELEPHONE NUMBER (Work and/or home)
- (B) DRIVER'S LICENSE NUMBER (of the individual signing the check)
  Make sure signature on check matches I.D.
- (C) OUR ORDER/INVOICE NUMBER
- (D) YOUR INITIALS

(3) Make a photocopy of the check and driver's license and attach it to your store copy of the invoice.

As stated above, these procedures are for all checks, including those checks that we submit through our electronic processor.

The following steps must be followed when processing checks electronically:
(This will GUARANTEE the check)

(4) The receipt must be signed by the check writer and,
(5) A printed name and current phone number must be written on the receipt.

IF A CHECK IS RETURNED BY THE BANK AND ANY OF THE ABOVE INFORMATION IS MISSING, YOU WILL NOT RECEIVE ANY COMMISSION ON THE RELATED SALE. IF THE COMMISSION HAS ALREADY BEEN PAID TO YOU, IT WILL BE DEDUCTED FROM YOUR FUTURE COMMISSIONS.

ADDITIONALLY, IF THE CHECK CAN NOT BE RE-DEPOSITED FOR ANY REASON, THE AMOUNT OF THE CHECK WILL ALSO BE DEDUCTED FROM YOUR FUTURE COMMISSIONS.

(Employee's signature) ____________________________ (Date) ___________

(Social Security Number) ______-______-______

D & B TILE DISTRIBUTORS

MEMO

Date: May 15, 2004

To: All personnel

From: Harold Yarborough

Subject: CELL PHONES

You are not to carry a personal cell phone while on company time. The only exception to this is managers, drivers and sales people that have a Nextel for company business. Managers, drivers, sales people allowed to have a cell/Nextel for business are never to use while in the warehouse for **safety** reasons.

Warehouse personnel are never to have a cell phone while in the warehouse on duty.

All cell phones are to be left in your vehicle.

The concern is for everyone's **safety.**

If you are caught with a cell phone on or off, you will be sent home for the day. The next time you will be terminated.

Sign here that you understand ______________________________Date____________

CONSENT FORM

I have reviewed the Company's policy on personal use of office equipment and supplies and cell phone usage and agree to abide by all of its terms. I understand that all Systems and all communications and information transmitted by, received from, or stored in those Systems are the property of the Company. Accordingly, I have no expectation of privacy in connection with the use of that equipment or the transmission, receipt, or storage of information in such equipment.

I understand and agree not to use any unauthorized code or an encryption key to access a file, voice-mailbox, or other data, nor will I use an unauthorized code or encryption key to store any communication, file, or other data unless authorized. I understand and agree not to distribute or provide access to any access code or encryption key unless expressly authorized by the Company.

I acknowledge and consent to the Company's monitoring of my use of all the Company-provided electronic and telephonic systems. Such monitoring may include, but is not limited to, reading, listening to, recording, and transcribing all incoming, outgoing, or stored e-mail and voicemail.

____
(Employee Signature)
Name:___________________________
Date:____________________________

EMPLOYEE ACKNOWLEDGEMENT OF DRESS CODE GUIDELINES

This will acknowledge that I have read and understand the Company's dress code entitled "DRESS FOR SUCCESS-GUIDELINES".

Date: ______________________________

Employee's Name: _________________________________

Signed: ____

(Employee Signature)

ACKNOWLEDGMENT

PLEASE READ THE D&B TILE DISTRIBUTORS' EMPLOYMENT POLICIES MANUAL AND FILL OUT AND RETURN THIS PORTION TO THE PERSONNEL DEPARTMENT [WITHIN ONE WEEK OF EMPLOYMENT]

Employee Name: ________________________________.

This will acknowledge that I have been given a copy of the Company's current Employment Policies Manual for my review summarizing the Company's personnel guidelines and have read and understood all the contents therein, including, but not limited to, the Company's policies dealing with Drug-Free Workplace and Harassment (including sexual harassment). I understand the statements contained in the Policies Manual are not intended to create any contractual or other legal obligations. I also understand that the Company may modify or rescind any policies, benefits, or practices described in the Employee Policies Manual at any time without prior notice to me. I also acknowledge that I have been informed of where and how I can locate and review copies of the company's Employment Policies Manual that being either "online" on the company's website or from management.

I further agree that any claim, dispute or controversy between myself and the Company shall be submitted to and determined exclusively by binding arbitration and not by a state or federal court in accordance with D&B Tile Distributors' policy described in the handbook. I understand that by agreeing to the arbitration provision of the handbook, both myself and the Company give up rights to a trial by jury.

Date: ______________________________.

Signed: ______________________________
(Employee Signature)

CONFIDENTIAL

EMPLOYEE HISTORY

Employee Name		Employment Status ___Full Time ___Part Time			
Social Security No.	Date of Birth	Marital Status	Sex	Employment Date	Prior Employment
Address	City	State	Zip	Telephone	

IN CASE OF EMERGENCY

Name	Relationship	Telephone No.	Address
Name	Relationship	Telephone No.	Address
Doctor	Telephone No.		Address
Doctor	Telephone No.		Address

EDUCATION AND TRAINING

Elem	Jr. H.S.	High School 1 | 2 | 3 | 4	College Major 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8	Specialization
Other Special Skills and Training				

DEPENDENTS

Name	Relationship	Sex	Date of Birth	Social Security Number
Name	Relationship	Sex	Date of Birth	Social Security Number
Name	Relationship	Sex	Date of Birth	Social Security Number
Name	Relationship	Sex	Date of Birth	Social Security Number
Name	Relationship	Sex	Date of Birth	Social Security Number
Name	Relationship	Sex	Date of Birth	Social Security Number
Name	Relationship	Sex	Date of Birth	Social Security Number

RELATIVES AND FRIENDS EMPLOYED AT THIS COMPANY

Name	Relationship	Name	Relationship
Name	Relationship	Name	Relationship
Name	Relationship	Name	Relationship
Name	Relationship	Name	Relationship

Employee Direct Deposit Enrollment Form

Payroll Manager—Please complete this section and enter data into your ADP Payroll system for employee enrollment. Then contact your CSR or AE for further instructions on how to update your employee's direct deposit information to ADP. NOTE: YOUR COMPANY NAME MUST BE FILLED IN BEFORE DISTRIBUTING THIS FORM TO YOUR EMPLOYEE FOR COMPLETION. (Please print.)

Company Code: ______ Company Name:__________________________ Employee File Number: ____________
(referred to herein as "Employer")

Payroll Mgr. Name: _______________________________ Payroll Mgr. Signature: __________________________

To enroll in Full Service Direct Deposit, simply fill out this form and give it to your payroll manager. Attach a voided check for each checking account – not a deposit slip. If depositing to a savings account, ask your bank to give you the Routing/Transit Number for your account. It isn't always the same as the number on a savings deposit slip. This will help ensure that you are paid correctly.

Below is a sample check MICR line, detailing where the information necessary to complete this form can be found.

Routing/Transit #
(A 9-digit number always between these two marks)

Checking Account #

Check #
(this number matches the number in the upper right corner of the check—not needed for sign-up)

Important! Please read and sign before completing and submitting.

I hereby authorize Employer, either directly or through its payroll service provider, to deposit any amounts owed me, by initiating credit entries to my account at the financial institution (hereinafter "Bank") indicated on this form. Further, I authorize Bank to accept and to credit any credit entries indicated by Employer, either directly or through its payroll service provider, to my account. In the event that Employer deposits funds erroneously into my account, I authorize Employer, either directly or through its payroll service provider, to debit my account for an amount not to exceed the original amount of the erroneous credit.

This authorization is to remain in full force and effect until Employer and Bank have received written notice from me of its termination in such time and in such manner as to afford Employer and Bank reasonable opportunity to act on it.

Employee Name: _______________________________ Social Security #: __ __ __ - __ __ - __ __ __ __

Employee Signature: ___________________________ Date: ___________________________

Account Information

The last item must be for the remaining amount owed to you. To distribute to more accounts, please complete another form.

Make sure to indicate what kind of account, along with amount to be deposited, if less than your total net paycheck.

1. Bank Name/City/State: ____

   Routing/Transit #: __ __ __ __ __ __ __ __ __ Account Number: ______________________

   ☐ Checking ☐ Savings ☐ Other I wish to deposit: $ _______ . ____ or ☐ Entire Net Amount

2. Bank Name/City/State: ____

   Routing/Transit #: __ __ __ __ __ __ __ __ __ Account Number: ______________________

   ☐ Checking ☐ Savings ☐ Other I wish to deposit: $ _______ . ____ or ☐ Entire Net Amount

3. Bank Name/City/State: ____

   Routing/Transit #: __ __ __ __ __ __ __ __ __ Account Number: ______________________

   ☐ Checking ☐ Savings ☐ Other I wish to deposit: $ _______ . ____ or ☐ Entire Net Amount

ATTENTION PAYROLL MANAGER:
Employers must keep each original employee enrollment form on file as long as the employee is using FSDD, and for two years thereafter.

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EMPLOYEE CHANGE OF RECORD

DATE: ____/____/____

NAME: ______________________________ ADDRESS: ____________________________

CITY/TOWN: ________________________ STATE: _________ ZIP CODE: __________

S / S: _____________________________ D.O.B.: ______/______/______

PHONE #:____________________________ POSITION: __________________________

START DATE: ______/______/______ END DATE: ______/______/______

PUT (X)

____ QUIT ____ DISCHARGED ____ RESIGNED

____ NEW POSITION ____ RETIRED ____ TEMP /LEAVE

____ NEW EMPLOYEE ____ SICK LEAVE ____ OTHER

COMPENSATION

RATE OF PAY: _____________________ PER /HR _____________________ PER /WK

____ FULL TIME ____ PART TIME ____ TEMP

COMMISSION RATE: ____

____

MILEAGE: ____YES ____ NO

GAS EXPENSE: ____YES ____NO

CELL ALLOWANCE: ____ YES ____ NO AMOUNT: $ _____________

BEEPER: ____ YES ____ NO

ADDITIONAL COMMENTS: ____

____

____

EMPLOYEE: _______________________________________ DATE: __________________

SUPERVISOR: _____________________________________ DATE: __________________

REVISED 3/29/2005