

Form W-4 (2018)

Future developments. For the latest information about any future developments related to Form W-4, such as legislation enacted after it was published, go to www.irs.gov/FormW4.

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. You may claim exemption from withholding for 2018 if **both** of the following apply.

- For 2017 you had a right to a refund of **all** federal income tax withheld because you had **no** tax liability, **and**
- For 2018 you expect a refund of **all** federal income tax withheld because you expect to have **no** tax liability.

If you're exempt, complete **only** lines 1, 2, 3, 4, and 7 and sign the form to validate it. Your exemption for 2018 expires February 15, 2019. See Pub. 505, Tax Withholding and Estimated Tax, to learn more about whether you qualify for exemption from withholding.

General Instructions

If you aren't exempt, follow the rest of these instructions to determine the number of withholding allowances you should claim for withholding for 2018 and any additional amount of tax to have withheld. For regular wages, withholding must be based on allowances you claimed and may not be a flat amount or percentage of wages.

You can also use the calculator at www.irs.gov/W4App to determine your tax withholding more accurately. Consider

using this calculator if you have a more complicated tax situation, such as if you have a working spouse, more than one job, or a large amount of nonwage income outside of your job. After your Form W-4 takes effect, you can also use this calculator to see how the amount of tax you're having withheld compares to your projected total tax for 2018. If you use the calculator, you don't need to complete any of the worksheets for Form W-4.

Note that if you have too much tax withheld, you will receive a refund when you file your tax return. If you have too little tax withheld, you will owe tax when you file your tax return, and you might owe a penalty.

Filers with multiple jobs or working spouses. If you have more than one job at a time, or if you're married and your spouse is also working, read all of the instructions including the instructions for the Two-Earners/Multiple Jobs Worksheet before beginning.

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 might owe additional tax. Or, you can use the Deductions, Adjustments, and Other Income Worksheet on page 3 or the calculator at www.irs.gov/W4App to make sure you have enough tax withheld from your paycheck. If you have pension or annuity income, see Pub. 505 or use the calculator at www.irs.gov/W4App to find out if you should adjust your withholding on Form W-4 or W-4P.

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

Specific Instructions

Personal Allowances Worksheet

Complete this worksheet on page 3 first to determine the number of withholding allowances to claim.

Line C. Head of household please note: Generally, you can claim head of household filing status on your tax return only if you're unmarried and pay more than 50% of the costs of keeping up a home for yourself and a qualifying individual. See Pub. 501 for more information about filing status.

Line E. Child tax credit. When you file your tax return, you might be eligible to claim a credit for each of your qualifying children. To qualify, the child must be under age 17 as of December 31 and must be your dependent who lives with you for more than half the year. To learn more about this credit, see Pub. 972, Child Tax Credit. To reduce the tax withheld from your pay by taking this credit into account, follow the instructions on line E of the worksheet. On the worksheet you will be asked about your total income. For this purpose, total income includes all of your wages and other income, including income earned by a spouse, during the year.

Line F. Credit for other dependents. When you file your tax return, you might be eligible to claim a credit for each of your dependents that don't qualify for the child tax credit, such as any dependent children age 17 and older. To learn more about this credit, see Pub. 505. To reduce the tax withheld from your pay by taking this credit into account, follow the instructions on line F of the worksheet. On the worksheet, you will be asked about your total income. For this purpose, total income includes all of

----- Separate here and give Form W-4 to your employer. Keep the worksheet(s) for your records. -----

Form W-4 Department of the Treasury Internal Revenue Service		Employee's Withholding Allowance Certificate		OMB No. 1545-0074
		▶ Whether you're 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.		2018
1 Your first name and middle initial		Last name		2 Your social security number
Home address (number and street or rural route)		3 <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Married, but withhold at higher Single rate. Note: If married filing separately, check "Married, but withhold at higher Single rate."		
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 800-772-1213 for a replacement card. ▶ <input type="checkbox"/>		
5 Total number of allowances you're claiming (from the applicable worksheet on the following pages)		5		
6 Additional amount, if any, you want withheld from each paycheck		6 \$		
7 I claim exemption from withholding for 2018, 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 boxes 8 and 10 if sending to IRS and complete boxes 8, 9, and 10 if sending to State Directory of New Hires.)		9 First date of employment	10 Employer identification number (EIN)	



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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.....\$ _____
B. Georgia Standard Deduction (enter one): Single/Head of Household \$2,300
Each Spouse \$1,500 \$ _____
C. Subtract Line B from Line A.....\$ _____
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 amended by the Military Spouses Residency 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, Withholding Tax Unit, P.O. Box 49432, 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.

TOOMBS COUNTY BOARD OF EDUCATION DIRECT DEPOSIT AGREEMENT

This agreement is made this _____ day of _____, _____

by and between Toombs County Board of Education (Employer) and

_____ (Employee's signature)

The employee hereby requests the Toombs County Board of Education to initiate electronic signals for paperless entries to accounts maintained at financial institutions by means of the Automated Clearing House (the "ACH").

*The employee agrees to furnish the necessary account information to the Employer for the electronic transfer.

*If the employee decides to change financial institutions, a termination notice must be submitted in writing to the Toombs County Board of Education Payroll Department by the tenth (10th) day of the month and a new agreement will have to be signed furnishing the necessary account information if direct deposit is to be continued.

*The employee agrees that should he or she decide to discontinue direct deposit (not a change of bank) that a notice of termination will be submitted in writing to the Toombs County Board of Education Payroll Department by the tenth (10th) day of the month in which termination is desired and that the employee will not be permitted to enter into another agreement for direct deposit until the next open enrollment which will be during September of each fiscal year.

*A "new hire" will be given the opportunity for direct deposit at the time of employment.

In order to initiate the transfer, the following information is necessary:

Employee Number _____

Name _____

Bank Account Number _____

Bank Routing Number _____

Bank Account Type (checking or savings) _____

ATTACH VOIDED CHECK

Descriptor Term:	Descriptor Code:	Issued Date:
Employee Alcohol & Drugs Drug Free Work Place	GAMB	05/14/91
	Rescinds:	Issued:

An employee shall not possess, sell, use, transmit, or be under the influence of any controlled substance, except as prescribed for the individual by a licensed physician, narcotic drug, hallucinogenic drug, amphetamine, barbiturate, marijuana, alcoholic beverage or intoxicant in any kind, nor shall he represent any substance as a drug for sale or use:

- a. On the school grounds at any time.
- b. Off the school grounds at a school function, activity, or event.

Any employee suspected of violating this code of conduct shall be suspended with pay for a period not to exceed 10 working days. During this ten-day period, the superintendent, or his designee, shall conduct an investigation to determine the facts in the matter. After such investigation as the superintendent or his designee deems appropriate, the superintendent shall make a recommendation for the resolution of the matter to the Board of Education. This recommendation may include, but is not limited to:

- a. Full reinstatement of employment without penalty.
- b. Extended suspension with pay.
- c. Extended suspension without pay.
- d. Termination of employment.
- e. Referral for possible prosecution.

Information regarding treatment program and facilities will be made available upon request from the Superintendent's office or First District Regional Educational Service Agency.

A copy of this policy shall be given to every employee. The provision of this policy shall be mandatory.

Consent

I have carefully and thoroughly read the Toombs County Board of Education's Alcohol and Drug Abuse Policy. I agree, without reservation, to follow that policy.

Date: _____
Employee's Signature

Witness _____
Employee's Name (Printed)

In order to show our compliance with all standards, state and federal rules and regulations, employees are required to sign at the bottom of this page in the space indicated. (Each employee is directed to duplicate a copy of this page and give the copy to his/her supervisor.)

***EMPLOYEE SIGNATURE: _____ DATE: _____**

***If you require further explanation of any policies and procedures as set forth by the Georgia Department of Education and/or the Toombs County Board of Education, please contact your direct supervisor prior to signing this document.**

EMPLOYEE MEDICAL HISTORY QUESTIONNAIRE

Completion of this report is requested to assist your employee in meeting the knowledge requirement for the Georgia Subsequent Injury Trust Fund.

To the best of your knowledge do you have, or have had, any of the following medical conditions? Answer YES or NO (please fill in blanks as indicated and use "Remarks" section to explain in detail if needed)

- Epilepsy
- Diabetes
- Arthritis – state body part affected _____
- Amputated foot, leg, arm, or hand
- Loss of sight of one or both eyes or a partial loss of uncorrected vision of more than 75 % bilaterally
- Residual disability from polio
- Cerebral Palsy
- Multiple sclerosis
- Parkinson's disease
- Cardiovascular disorders (cardiac/heart disease)
- Tuberculosis
- Mental retardation
- Psychoneurotic disability following confinement for treatment in a recognized medical or mental institution for a period in excess of six months.
- Hemophilia
- Sickle cell anemia
- Chronic osteomyelitis
- Ankylosis of major weight-bearing joints (frozen Joint)
- Hyperinsulism (excessive insulin – low blood sugar)
- Muscular dystrophy
- Total occupational loss of hearing/deafness
- Compressed air sequelae (the bends; problems produced by flying at high altitudes; Exposure to high atmospheric pressure as in scuba diving)
- Ruptured intervertebral disc (slipped/herniated disc)
- Back surgery
- Prior back injury – state and impairment rating _____
- Degenerative back problems
- Knee surgery (arthroscopic surgery)
- Asthma
- Cancer
- Pulmonary disease
- Any other preexisting disease, condition, or impairment which is permanent in nature, or for which your doctor has indicated physical limitations or restrictions

Remarks (including any other conditions not listed above)

Employee Signature _____ Date _____

**PUBLIC SCHOOL EMPLOYMENT
OATH OF ALLEGIANCE**

**STATE OF GEORGIA
COUNTY OF TOOMBS**

I, _____, a citizen of the United States of America and being an employee of **Toombs County Board of Education** and the recipient of public funds for services rendered as such employee, do hereby swear and affirm that I will support the Constitution of the United States and the Constitution of Georgia.

Employee Signature

Sworn to and subscribed before me this _____ day of _____,
20_____.

Notary Public

STAFF RACE/ETHNICITY INFORMATION

DATE: _____

NAME: _____ DATE OF BIRTH: _____

SCHOOL LOCATION: _____

Part A. Are you Hispanic/Latino (Choose only one)

No, not Hispanic/Latino

Yes, Hispanic/Latino (A person of Cuban, Mexican, Puerto Rican, Cuban, South or Central American, or other Spanish cultures or origin, regardless of race.)

The above part of the question is about ethnicity, not race. No matter what you selected above **please continue to answer the following** by marking one or more boxes to indicate what you consider your race to be.

Part B. What is your race? (choose one or more)

American Indian 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.)

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.)

Black or African American (A person having origins in any of the black racial groups of Africa)

Native Hawaiian or Other Pacific Islander (A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.)

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

WORKER'S COMPENSATION POLICY & INFORMATION LETTER

Dear Employee:

The purpose of this policy is to provide you with information about on the job accidents and workers compensation insurance coverage which is provided to you, should you have a work-related injury.

Management believes that on the job accidents are preventable, and expects each employee, regardless of his/her position within the organization to cooperate with the Company's safety program in every respect.

1. Each employee has the responsibility for his/her own safety, as well as the safety of his/her fellow employees. It is only by your becoming familiar with the hazards of your job and doing what is necessary to ensure safety, that our Company can achieve the safe working conditions deserved by all employees.
2. If you should become injured while on the job, *you must report your injury to your immediate supervisor immediately*. The supervisor is responsible for completing an accident report and an accident investigation report for all work related injuries.
3. Your employer is required by State law to post a list of at least four doctors (see attached list); this list is called a Panel of Physicians list. If you need or desire to seek medical care, you may choose from any of these listed physicians from the Panel of Physicians list. In an emergency you may get temporary medical care from any doctor (or emergency room) until the emergency is over then you must get a treatment from a doctor on the posted panel.
4. You may make one change to another doctor on the panel list without the permission of the employer: however, additional changes in medical care require the permission of your employer/insurer, or the State Board of Workers' Compensation.
5. In the event that you cannot return to your normal duty, please inform your supervisor immediately. All work related accidents must be reported to the insurance company within 14 hours, especially when an employee cannot go back to normal duty.
6. Every employee who is out of work due to a work-related injury will be encouraged and given the opportunity to return to work as soon as medical clearance outlining the employee's limitations is received. Temporary and progressive modified duty is a policy of this Company.

One attachment accompanies this policy/memo:

- (1) a Panel of physicians list for our Company

Please read and review this attachment, then sign below, acknowledging that you understand your rights and responsibilities as explained in this policy, and that you will comply with all policies and procedures in this document.

I _____ acknowledge that I have read the policies and procedures as explained in this policy/memo. That I have reviewed the Panel of Physicians list and I agree to comply with all rules and regulations outlined above.

EMPLOYEE: _____ DATE: _____