FORMS

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AFFIDAVIT – LIST OF CHURCH'S BANK AND INVESTMENT ACCOUNTS

We, the Pastor and the Church Treasurer, hereby affirm that this report lists all the bank and investment accounts that held funds of the ________________________________ Seventh-day Adventist Church during the audit period from ______________, 20 ______ through ________________, 20______.

Name of Bank or Institution	Account Name	Account Number

______________________________ ______________________________
Pastor Church Treasurer

______________________________ ______________________________
Date Date

ϖ ϖ ϖ

Note: Attach invoice, disbursement voucher, or other evidence of authorization for payment to the upper portion of this form and fill in information called for on the blank lines below.

If no invoice is available (which will be the case for such items as rent and loan payments) fill in the requested information below and place this form in the disbursement voucher file in regular numerical order according to check number.

DO NOT ATTACH THE CANCELED CHECK TO THIS SHEET.

DATE ____________________ AMOUNT $ ____________________

PAID TO ____

FOR ____

CHARGE TO ____ CHECK NO. ________________

CHECK REQUEST

Requested by: ______________________________
(Print Name)

Date: ______________

Pay to: ______________________________
(Print Name)

Amount: $______________

Purpose: ______________________________

Charge to: ______________________________

Approved: ______________________________

CHECK REQUEST

Requested by: ______________________________
(Print Name)

Date: ______________

Pay to: ______________________________
(Print Name)

Amount: $______________

Purpose: ______________________________

Charge to: ______________________________

Approved: ______________________________

CHECK REQUEST

Requested by: ____
(Print Name)

Date: ______________

Pay to: ____
(Print Name)

Amount: $______________

Purpose: ____

Charge to: ____

Approved: ____

DATE:_________________AMOUNT:__________________

PAID TO:____

FOR____

CHARGE TO_______________________________________ CHECK NO.____________

SUPPLY ORDER FORM

NAME OF CHURCH ______________________________

Please send the following order of supplies to:

Name ____

Address ____

City_________________________________ Zip _________________

NUMBER	DESCRIPTION
	Tithe Envelope — ***English***
	Tithe Envelope — **Spanish**
	Envelope Front Pad — ***English***
	Envelope Front Pad — **Spanish**
	Disbursement Voucher Form D-2
	Weekly Mailing Envelopes — Small (4 ½ x 10 ½)
	Weekly Mailing Envelopes — Large (7 x 10)

Date Received_______________________ Date Sent ______________________

How to Apply for an EIN

Español

Applying for an EIN is a free service offered by the Internal Revenue Service. Beware of websites on the Internet that charge for this free service.

If you are a home-care service recipient who has a previously assigned EIN either as a sole proprietor or as a household employer, do not apply for a new EIN. Use the EIN previously provided. If you can not locate your EIN for any reason, follow the instructions on the Lost or Misplaced Your EIN? Web page.

Apply Online

The Internet EIN application is the preferred method for customers to apply for and obtain an EIN. Once the application is completed, the information is validated during the online session, and an EIN is issued immediately. The online application process is available for all entities whose principal business, office or agency, or legal residence (in the case of an individual), is located in the United States or U.S. Territories. The principal officer, general partner, grantor, owner, trustor etc. must have a valid Taxpayer Identification Number (Social Security Number, Employer Identification Number, or Individual Taxpayer Identification Number) in order to use the online application.

Apply by Fax

Taxpayers can fax the completed Form SS-4 (PDF) application to their state fax number (see Where to File Your Taxes (for Form SS-4)), after ensuring that the Form SS-4 contains all of the required information. If it is determined that the entity needs a new EIN, one will be assigned using the appropriate procedures for the entity type. If the taxpayer's fax number is provided, a fax will be sent back with the EIN within four (4) business days.

Apply by Mail

The processing timeframe for an EIN application received by mail is four weeks. Ensure that the Form SS-4 (PDF) contains all of the required information. If it is determined that the entity needs a new EIN, one will be assigned using the appropriate procedures for the entity type and mailed to the taxpayer. Find out where to mail Form SS-4 on the Where to File Your Taxes (for Form SS-4) page.

Apply by Telephone – International Applicants

International applicants may call 267-941-1099 (not a toll-free number) 6:00 a.m. to 11:00 p.m. (Eastern Time) Monday through Friday to obtain their EIN. The person making the call must be authorized to receive the EIN and answer questions concerning the Form SS-4 (PDF), *Application for Employer Identification Number*. Complete the Third Party Designee section only if you want to authorize the named individual to receive the entity's EIN and answer questions about the completion of Form SS-4. The designee's authority terminates at the time the EIN is assigned and released to the designee. You must complete the signature area for the authorization to be valid.

Other Important Information

Daily Limitation of an Employer Identification Number

Effective May 21, 2012, to ensure fair and equitable treatment for all taxpayers, the Internal Revenue Service will limit Employer Identification Number (EIN) issuance to one per responsible party per day. This limitation is applicable to all requests for EINs whether online or by fax or mail. We apologize for any inconvenience this may cause.

Responsible Party

In order to identify the correct individuals and entities applying for EINs, language changes have been made to the EIN process. Refer to Responsible Parties and Nominees to learn about these important changes before applying for an EIN.

Third Party Authorization

The Third Party Designee section must be completed at the bottom of the Form SS-4. The Form SS-4 must also be signed by the taxpayer for the third party designee authorization to be valid. The Form SS-4 must be mailed or faxed to the appropriate service center. The third party designee's authority terminates at the time the EIN is assigned and released to the designee.

Rate the Small Business and Self-Employed Website

Page Last Reviewed or Updated: 13-Jan-2015

Form **SS-4**

(Rev. January 2010)

Department of the Treasury
Internal Revenue Service

Application for Employer Identification Number

(For use by employers, corporations, partnerships, trusts, estates, churches, government agencies, Indian tribal entities, certain individuals, and others.)

► See separate instructions for each line. ► Keep a copy for your records.

OMB No. 1545-0003

EIN

Type or print clearly.

1 Legal name of entity (or individual) for whom the EIN is being requested

2 Trade name of business (if different from name on line 1)

3 Executor, administrator, trustee, "care of" name

4a Mailing address (room, apt., suite no. and street, or P.O. box)

5a Street address (if different) (Do not enter a P.O. box.)

4b City, state, and ZIP code (if foreign, see instructions)

5b City, state, and ZIP code (if foreign, see instructions)

6 County and state where principal business is located

7a Name of responsible party

7b SSN, ITIN, or EIN

8a Is this application for a limited liability company (LLC) (or a foreign equivalent)? . . . . ☐ **Yes** ☐ **No**

8b If 8a is "Yes," enter the number of LLC members . . . . ►

8c If 8a is "Yes," was the LLC organized in the United States? . . . . ☐ **Yes** ☐ **No**

9a **Type of entity** (check only one box). **Caution.** If 8a is "Yes," see the instructions for the correct box to check.

- ☐ Sole proprietor (SSN) ________
- ☐ Partnership
- ☐ Corporation (enter form number to be filed) ► ________
- ☐ Personal service corporation
- ☐ Church or church-controlled organization
- ☐ Other nonprofit organization (specify) ► ________
- ☐ Other (specify) ►
- ☐ Estate (SSN of decedent) ________
- ☐ Plan administrator (TIN) ________
- ☐ Trust (TIN of grantor) ________
- ☐ National Guard
- ☐ State/local government
- ☐ Farmers' cooperative
- ☐ Federal government/military
- ☐ REMIC
- ☐ Indian tribal governments/enterprises

Group Exemption Number (GEN) if any ►

9b If a corporation, name the state or foreign country (if applicable) where incorporated | State | Foreign country

10 **Reason for applying** (check only one box)

- ☐ Started new business (specify type) ► ________
- ☐ Hired employees (Check the box and see line 13.)
- ☐ Compliance with IRS withholding regulations
- ☐ Other (specify) ►
- ☐ Banking purpose (specify purpose) ► ________
- ☐ Changed type of organization (specify new type) ► ________
- ☐ Purchased going business
- ☐ Created a trust (specify type) ► ________
- ☐ Created a pension plan (specify type) ► ________

11 Date business started or acquired (month, day, year). See instructions.

12 Closing month of accounting year

13 Highest number of employees expected in the next 12 months (enter -0- if none).
If no employees expected, skip line 14.

Agricultural	Household	Other

14 If you expect your employment tax liability to be $1,000 or less in a full calendar year **and** want to file Form 944 annually instead of Forms 941 quarterly, check here. (Your employment tax liability generally will be $1,000 or less if you expect to pay $4,000 or less in total wages.) If you do not check this box, you must file Form 941 for every quarter. ☐

15 First date wages or annuities were paid (month, day, year). **Note.** If applicant is a withholding agent, enter date income will first be paid to nonresident alien (month, day, year) . . . . ►

16 Check **one** box that best describes the principal activity of your business.

- ☐ Health care & social assistance
- ☐ Wholesale-agent/broker
- ☐ Construction
- ☐ Rental & leasing
- ☐ Transportation & warehousing
- ☐ Accommodation & food service
- ☐ Wholesale-other
- ☐ Retail
- ☐ Real estate
- ☐ Manufacturing
- ☐ Finance & insurance
- ☐ Other (specify)

17 Indicate principal line of merchandise sold, specific construction work done, products produced, or services provided.

18 Has the applicant entity shown on line 1 ever applied for and received an EIN? ☐ **Yes** ☐ **No**
If "Yes," write previous EIN here ►

Third Party Designee

Complete this section **only** if you want to authorize the named individual to receive the entity's EIN and answer questions about the completion of this form.

Designee's name

Designee's telephone number (include area code) ( )

Address and ZIP code

Designee's fax number (include area code) ( )

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

Applicant's telephone number (include area code) ( )

Name and title (type or print clearly) ►

Applicant's fax number (include area code) ( )

Signature ► Date ►

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions. Cat. No. 16055N Form **SS-4** (Rev. 1-2010)

Do I Need an EIN?

File Form SS-4 if the applicant entity does not already have an EIN but is required to show an EIN on any return, statement, or other document.[1] See also the separate instructions for each line on Form SS-4.

IF the applicant...	AND...	THEN...
Started a new business	Does not currently have (nor expect to have) employees	Complete lines 1, 2, 4a–8a, 8b–c (if applicable), 9a, 9b (if applicable), and 10–14 and 16–18.
Hired (or will hire) employees, including household employees	Does not already have an EIN	Complete lines 1, 2, 4a–6, 7a–b (if applicable), 8a, 8b–c (if applicable), 9a, 9b (if applicable), 10–18.
Opened a bank account	Needs an EIN for banking purposes only	Complete lines 1–5b, 7a–b (if applicable), 8a, 8b–c (if applicable), 9a, 9b (if applicable), 10, and 18.
Changed type of organization	Either the legal character of the organization or its ownership changed (for example, you incorporate a sole proprietorship or form a partnership) [2]	Complete lines 1–18 (as applicable).
Purchased a going business [3]	Does not already have an EIN	Complete lines 1–18 (as applicable).
Created a trust	The trust is other than a grantor trust or an IRA trust [4]	Complete lines 1–18 (as applicable).
Created a pension plan as a plan administrator [5]	Needs an EIN for reporting purposes	Complete lines 1, 3, 4a–5b, 9a, 10, and 18.
Is a foreign person needing an EIN to comply with IRS withholding regulations	Needs an EIN to complete a Form W-8 (other than Form W-8ECI), avoid withholding on portfolio assets, or claim tax treaty benefits [6]	Complete lines 1–5b, 7a–b (SSN or ITIN optional), 8a, 8b–c (if applicable), 9a, 9b (if applicable), 10, and 18.
Is administering an estate	Needs an EIN to report estate income on Form 1041	Complete lines 1–6, 9a, 10–12, 13–17 (if applicable), and 18.
Is a withholding agent for taxes on non-wage income paid to an alien (i.e., individual, corporation, or partnership, etc.)	Is an agent, broker, fiduciary, manager, tenant, or spouse who is required to file Form 1042, Annual Withholding Tax Return for U.S. Source Income of Foreign Persons	Complete lines 1, 2, 3 (if applicable), 4a–5b, 7a–b (if applicable), 8a, 8b–c (if applicable), 9a, 9b (if applicable), 10, and 18.
Is a state or local agency	Serves as a tax reporting agent for public assistance recipients under Rev. Proc. 80-4, 1980-1 C.B. 581 [7]	Complete lines 1, 2, 4a–5b, 9a, 10, and 18.
Is a single-member LLC	Needs an EIN to file Form 8832, Classification Election, for filing employment tax returns and excise tax returns, or for state reporting purposes [8]	Complete lines 1–18 (as applicable).
Is an S corporation	Needs an EIN to file Form 2553, Election by a Small Business Corporation [9]	Complete lines 1–18 (as applicable).

[1] For example, a sole proprietorship or self-employed farmer who establishes a qualified retirement plan, or is required to file excise, employment, alcohol, tobacco, or firearms returns, must have an EIN. A partnership, corporation, REMIC (real estate mortgage investment conduit), nonprofit organization (church, club, etc.), or farmers' cooperative must use an EIN for any tax-related purpose even if the entity does not have employees.

[2] However, do not apply for a new EIN if the existing entity only (a) changed its business name, (b) elected on Form 8832 to change the way it is taxed (or is covered by the default rules), or (c) terminated its partnership status because at least 50% of the total interests in partnership capital and profits were sold or exchanged within a 12-month period. The EIN of the terminated partnership should continue to be used. See Regulations section 301.6109-1(d)(2)(iii).

[3] Do not use the EIN of the prior business unless you became the "owner" of a corporation by acquiring its stock.

[4] However, grantor trusts that do not file using Optional Method 1 and IRA trusts that are required to file Form 990-T, Exempt Organization Business Income Tax Return, must have an EIN. For more information on grantor trusts, see the Instructions for Form 1041.

[5] A plan administrator is the person or group of persons specified as the administrator by the instrument under which the plan is operated.

[6] Entities applying to be a Qualified Intermediary (QI) need a QI-EIN even if they already have an EIN. See Rev. Proc. 2000-12.

[7] See also *Household employer* on page 4 of the instructions. **Note.** State or local agencies may need an EIN for other reasons, for example, hired employees.

[8] See *Disregarded entities* on page 4 of the instructions for details on completing Form SS-4 for an LLC.

[9] An existing corporation that is electing or revoking S corporation status should use its previously-assigned EIN.

Form **W-9**
(Rev. December 2014)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

Give Form to the requester. Do not send to the IRS.

Print or type
See **Specific Instructions** on page 2.

1 Name (as shown on your income tax return). Name is required on this line; do not leave this line blank.

2 Business name/disregarded entity name, if different from above

3 Check appropriate box for federal tax classification; check only **one** of the following seven boxes:

☐ Individual/sole proprietor or single-member LLC ☐ C Corporation ☐ S Corporation ☐ Partnership ☐ Trust/estate

☐ Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=partnership) ▶ ________

Note. For a single-member LLC that is disregarded, do not check LLC; check the appropriate box in the line above for the tax classification of the single-member owner.

☐ Other (see instructions) ▶

4 Exemptions (codes apply only to certain entities, not individuals; see instructions on page 3):

Exempt payee code (if any) ________

Exemption from FATCA reporting code (if any) ________

(Applies to accounts maintained outside the U.S.)

5 Address (number, street, and apt. or suite no.)

Requester's name and address (optional)

6 City, state, and ZIP code

7 List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on line 1 to avoid backup withholding. For individuals, this is generally your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 3. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN* on page 3.

Note. If the account is in more than one name, see the instructions for line 1 and the chart on page 4 for guidelines on whose number to enter.

Social security number

☐☐☐ – ☐☐ – ☐☐☐☐

or

Employer identification number

☐☐ – ☐☐☐☐☐☐☐

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me); and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding; and
3. I am a U.S. citizen or other U.S. person (defined below); and
4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions on page 3.

Sign Here **Signature of U.S. person ▶** **Date ▶**

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Future developments. Information about developments affecting Form W-9 (such as legislation enacted after we release it) is at *www.irs.gov/fw9*.

Purpose of Form

An individual or entity (Form W-9 requester) who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) which may be your social security number (SSN), individual taxpayer identification number (ITIN), adoption taxpayer identification number (ATIN), or employer identification number (EIN), to report on an information return the amount paid to you, or other amount reportable on an information return. Examples of information returns include, but are not limited to, the following:

- Form 1099-INT (interest earned or paid)
- Form 1099-DIV (dividends, including those from stocks or mutual funds)
- Form 1099-MISC (various types of income, prizes, awards, or gross proceeds)
- Form 1099-B (stock or mutual fund sales and certain other transactions by brokers)
- Form 1099-S (proceeds from real estate transactions)
- Form 1099-K (merchant card and third party network transactions)
- Form 1098 (home mortgage interest), 1098-E (student loan interest), 1098-T (tuition)
- Form 1099-C (canceled debt)
- Form 1099-A (acquisition or abandonment of secured property)

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN.

If you do not return Form W-9 to the requester with a TIN, you might be subject to backup withholding. See *What is backup withholding?* on page 2.

By signing the filled-out form, you:

1. Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),

2. Certify that you are not subject to backup withholding, or

3. Claim exemption from backup withholding if you are a U.S. exempt payee. If applicable, you are also certifying that as a U.S. person, your allocable share of any partnership income from a U.S. trade or business is not subject to the withholding tax on foreign partners' share of effectively connected income, and

4. Certify that FATCA code(s) entered on this form (if any) indicating that you are exempt from the FATCA reporting, is correct. See *What is FATCA reporting?* on page 2 for further information.

Note. If you are a U.S. person and a requester gives you a form other than Form W-9 to request your TIN, you must use the requester's form if it is substantially similar to this Form W-9.

Definition of a U.S. person. For federal tax purposes, you are considered a U.S. person if you are:

- An individual who is a U.S. citizen or U.S. resident alien;
- A partnership, corporation, company, or association created or organized in the United States or under the laws of the United States;
- An estate (other than a foreign estate); or
- A domestic trust (as defined in Regulations section 301.7701-7).

Special rules for partnerships. Partnerships that conduct a trade or business in the United States are generally required to pay a withholding tax under section 1446 on any foreign partners' share of effectively connected taxable income from such business. Further, in certain cases where a Form W-9 has not been received, the rules under section 1446 require a partnership to presume that a partner is a foreign person, and pay the section 1446 withholding tax. Therefore, if you are a U.S. person that is a partner in a partnership conducting a trade or business in the United States, provide Form W-9 to the partnership to establish your U.S. status and avoid section 1446 withholding on your share of partnership income.

In the cases below, the following person must give Form W-9 to the partnership for purposes of establishing its U.S. status and avoiding withholding on its allocable share of net income from the partnership conducting a trade or business in the United States:

- In the case of a disregarded entity with a U.S. owner, the U.S. owner of the disregarded entity and not the entity;
- In the case of a grantor trust with a U.S. grantor or other U.S. owner, generally, the U.S. grantor or other U.S. owner of the grantor trust and not the trust; and
- In the case of a U.S. trust (other than a grantor trust), the U.S. trust (other than a grantor trust) and not the beneficiaries of the trust.

Foreign person. If you are a foreign person or the U.S. branch of a foreign bank that has elected to be treated as a U.S. person, do not use Form W-9. Instead, use the appropriate Form W-8 or Form 8233 (see Publication 515, Withholding of Tax on Nonresident Aliens and Foreign Entities).

Nonresident alien who becomes a resident alien. Generally, only a nonresident alien individual may use the terms of a tax treaty to reduce or eliminate U.S. tax on certain types of income. However, most tax treaties contain a provision known as a "saving clause." Exceptions specified in the saving clause may permit an exemption from tax to continue for certain types of income even after the payee has otherwise become a U.S. resident alien for tax purposes.

If you are a U.S. resident alien who is relying on an exception contained in the saving clause of a tax treaty to claim an exemption from U.S. tax on certain types of income, you must attach a statement to Form W-9 that specifies the following five items:

1. The treaty country. Generally, this must be the same treaty under which you claimed exemption from tax as a nonresident alien.
2. The treaty article addressing the income.
3. The article number (or location) in the tax treaty that contains the saving clause and its exceptions.
4. The type and amount of income that qualifies for the exemption from tax.
5. Sufficient facts to justify the exemption from tax under the terms of the treaty article.

Example. Article 20 of the U.S.-China income tax treaty allows an exemption from tax for scholarship income received by a Chinese student temporarily present in the United States. Under U.S. law, this student will become a resident alien for tax purposes if his or her stay in the United States exceeds 5 calendar years. However, paragraph 2 of the first Protocol to the U.S.-China treaty (dated April 30, 1984) allows the provisions of Article 20 to continue to apply even after the Chinese student becomes a resident alien of the United States. A Chinese student who qualifies for this exception (under paragraph 2 of the first protocol) and is relying on this exception to claim an exemption from tax on his or her scholarship or fellowship income would attach to Form W-9 a statement that includes the information described above to support that exemption.

If you are a nonresident alien or a foreign entity, give the requester the appropriate completed Form W-8 or Form 8233.

Backup Withholding

What is backup withholding? Persons making certain payments to you must under certain conditions withhold and pay to the IRS 28% of such payments. This is called "backup withholding." Payments that may be subject to backup withholding include interest, tax-exempt interest, dividends, broker and barter exchange transactions, rents, royalties, nonemployee pay, payments made in settlement of payment card and third party network transactions, and certain payments from fishing boat operators. Real estate transactions are not subject to backup withholding.

You will not be subject to backup withholding on payments you receive if you give the requester your correct TIN, make the proper certifications, and report all your taxable interest and dividends on your tax return.

Payments you receive will be subject to backup withholding if:

1. You do not furnish your TIN to the requester,
2. You do not certify your TIN when required (see the Part II instructions on page 3 for details),
3. The IRS tells the requester that you furnished an incorrect TIN,
4. The IRS tells you that you are subject to backup withholding because you did not report all your interest and dividends on your tax return (for reportable interest and dividends only), or
5. You do not certify to the requester that you are not subject to backup withholding under 4 above (for reportable interest and dividend accounts opened after 1983 only).

Certain payees and payments are exempt from backup withholding. See *Exempt payee code* on page 3 and the separate Instructions for the Requester of Form W-9 for more information.

Also see *Special rules for partnerships* above.

What is FATCA reporting?

The Foreign Account Tax Compliance Act (FATCA) requires a participating foreign financial institution to report all United States account holders that are specified United States persons. Certain payees are exempt from FATCA reporting. See *Exemption from FATCA reporting code* on page 3 and the Instructions for the Requester of Form W-9 for more information.

Updating Your Information

You must provide updated information to any person to whom you claimed to be an exempt payee if you are no longer an exempt payee and anticipate receiving reportable payments in the future from this person. For example, you may need to provide updated information if you are a C corporation that elects to be an S corporation, or if you no longer are tax exempt. In addition, you must furnish a new Form W-9 if the name or TIN changes for the account; for example, if the grantor of a grantor trust dies.

Penalties

Failure to furnish TIN. If you fail to furnish your correct TIN to a requester, you are subject to a penalty of $50 for each such failure unless your failure is due to reasonable cause and not to willful neglect.

Civil penalty for false information with respect to withholding. If you make a false statement with no reasonable basis that results in no backup withholding, you are subject to a $500 penalty.

Criminal penalty for falsifying information. Willfully falsifying certifications or affirmations may subject you to criminal penalties including fines and/or imprisonment.

Misuse of TINs. If the requester discloses or uses TINs in violation of federal law, the requester may be subject to civil and criminal penalties.

Specific Instructions

Line 1

You must enter one of the following on this line; **do not** leave this line blank. The name should match the name on your tax return.

If this Form W-9 is for a joint account, list first, and then circle, the name of the person or entity whose number you entered in Part I of Form W-9.

a. **Individual.** Generally, enter the name shown on your tax return. If you have changed your last name without informing the Social Security Administration (SSA) of the name change, enter your first name, the last name as shown on your social security card, and your new last name.

Note. ITIN applicant: Enter your individual name as it was entered on your Form W-7 application, line 1a. This should also be the same as the name you entered on the Form 1040/1040A/1040EZ you filed with your application.

b. **Sole proprietor or single-member LLC.** Enter your individual name as shown on your 1040/1040A/1040EZ on line 1. You may enter your business, trade, or "doing business as" (DBA) name on line 2.

c. **Partnership, LLC that is not a single-member LLC, C Corporation, or S Corporation.** Enter the entity's name as shown on the entity's tax return on line 1 and any business, trade, or DBA name on line 2.

d. **Other entities.** Enter your name as shown on required U.S. federal tax documents on line 1. This name should match the name shown on the charter or other legal document creating the entity. You may enter any business, trade, or DBA name on line 2.

e. **Disregarded entity.** For U.S. federal tax purposes, an entity that is disregarded as an entity separate from its owner is treated as a "disregarded entity." See Regulations section 301.7701-2(c)(2)(iii). Enter the owner's name on line 1. The name of the entity entered on line 1 should never be a disregarded entity. The name on line 1 should be the name shown on the income tax return on which the income should be reported. For example, if a foreign LLC that is treated as a disregarded entity for U.S. federal tax purposes has a single owner that is a U.S. person, the U.S. owner's name is required to be provided on line 1. If the direct owner of the entity is also a disregarded entity, enter the first owner that is not disregarded for federal tax purposes. Enter the disregarded entity's name on line 2, "Business name/disregarded entity name." If the owner of the disregarded entity is a foreign person, the owner must complete an appropriate Form W-8 instead of a Form W-9. This is the case even if the foreign person has a U.S. TIN.

Line 2

If you have a business name, trade name, DBA name, or disregarded entity name, you may enter it on line 2.

Line 3

Check the appropriate box in line 3 for the U.S. federal tax classification of the person whose name is entered on line 1. Check only one box in line 3.

Limited Liability Company (LLC). If the name on line 1 is an LLC treated as a partnership for U.S. federal tax purposes, check the “Limited Liability Company” box and enter “P” in the space provided. If the LLC has filed Form 8832 or 2553 to be taxed as a corporation, check the “Limited Liability Company” box and in the space provided enter “C” for C corporation or “S” for S corporation. If it is a single-member LLC that is a disregarded entity, do not check the “Limited Liability Company” box; instead check the first box in line 3 “Individual/sole proprietor or single-member LLC.”

Line 4, Exemptions

If you are exempt from backup withholding and/or FATCA reporting, enter in the appropriate space in line 4 any code(s) that may apply to you.

Exempt payee code.

- Generally, individuals (including sole proprietors) are not exempt from backup withholding.
- Except as provided below, corporations are exempt from backup withholding for certain payments, including interest and dividends.
- Corporations are not exempt from backup withholding for payments made in settlement of payment card or third party network transactions.
- Corporations are not exempt from backup withholding with respect to attorneys' fees or gross proceeds paid to attorneys, and corporations that provide medical or health care services are not exempt with respect to payments reportable on Form 1099-MISC.

The following codes identify payees that are exempt from backup withholding. Enter the appropriate code in the space in line 4.

1—An organization exempt from tax under section 501(a), any IRA, or a custodial account under section 403(b)(7) if the account satisfies the requirements of section 401(f)(2)

2—The United States or any of its agencies or instrumentalities

3—A state, the District of Columbia, a U.S. commonwealth or possession, or any of their political subdivisions or instrumentalities

4—A foreign government or any of its political subdivisions, agencies, or instrumentalities

5—A corporation

6—A dealer in securities or commodities required to register in the United States, the District of Columbia, or a U.S. commonwealth or possession

7—A futures commission merchant registered with the Commodity Futures Trading Commission

8—A real estate investment trust

9—An entity registered at all times during the tax year under the Investment Company Act of 1940

10—A common trust fund operated by a bank under section 584(a)

11—A financial institution

12—A middleman known in the investment community as a nominee or custodian

13—A trust exempt from tax under section 664 or described in section 4947

The following chart shows types of payments that may be exempt from backup withholding. The chart applies to the exempt payees listed above, 1 through 13.

IF the payment is for . . .	THEN the payment is exempt for . . .
Interest and dividend payments	All exempt payees except for 7
Broker transactions	Exempt payees 1 through 4 and 6 through 11 and all C corporations. S corporations must not enter an exempt payee code because they are exempt only for sales of noncovered securities acquired prior to 2012.
Barter exchange transactions and patronage dividends	Exempt payees 1 through 4
Payments over $600 required to be reported and direct sales over $5,000[1]	Generally, exempt payees 1 through 5[2]
Payments made in settlement of payment card or third party network transactions	Exempt payees 1 through 4

[1] See Form 1099-MISC, Miscellaneous Income, and its instructions.

[2] However, the following payments made to a corporation and reportable on Form 1099-MISC are not exempt from backup withholding: medical and health care payments, attorneys' fees, gross proceeds paid to an attorney reportable under section 6045(f), and payments for services paid by a federal executive agency.

Exemption from FATCA reporting code. The following codes identify payees that are exempt from reporting under FATCA. These codes apply to persons submitting this form for accounts maintained outside of the United States by certain foreign financial institutions. Therefore, if you are only submitting this form for an account you hold in the United States, you may leave this field blank. Consult with the person requesting this form if you are uncertain if the financial institution is subject to these requirements. A requester may indicate that a code is not required by providing you with a Form W-9 with “Not Applicable” (or any similar indication) written or printed on the line for a FATCA exemption code.

A—An organization exempt from tax under section 501(a) or any individual retirement plan as defined in section 7701(a)(37)

B—The United States or any of its agencies or instrumentalities

C—A state, the District of Columbia, a U.S. commonwealth or possession, or any of their political subdivisions or instrumentalities

D—A corporation the stock of which is regularly traded on one or more established securities markets, as described in Regulations section 1.1472-1(c)(1)(i)

E—A corporation that is a member of the same expanded affiliated group as a corporation described in Regulations section 1.1472-1(c)(1)(i)

F—A dealer in securities, commodities, or derivative financial instruments (including notional principal contracts, futures, forwards, and options) that is registered as such under the laws of the United States or any state

G—A real estate investment trust

H—A regulated investment company as defined in section 851 or an entity registered at all times during the tax year under the Investment Company Act of 1940

I—A common trust fund as defined in section 584(a)

J—A bank as defined in section 581

K—A broker

L—A trust exempt from tax under section 664 or described in section 4947(a)(1)

M—A tax exempt trust under a section 403(b) plan or section 457(g) plan

Note. You may wish to consult with the financial institution requesting this form to determine whether the FATCA code and/or exempt payee code should be completed.

Line 5

Enter your address (number, street, and apartment or suite number). This is where the requester of this Form W-9 will mail your information returns.

Line 6

Enter your city, state, and ZIP code.

Part I. Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. If you are a resident alien and you do not have and are not eligible to get an SSN, your TIN is your IRS individual taxpayer identification number (ITIN). Enter it in the social security number box. If you do not have an ITIN, see *How to get a TIN* below.

If you are a sole proprietor and you have an EIN, you may enter either your SSN or EIN. However, the IRS prefers that you use your SSN.

If you are a single-member LLC that is disregarded as an entity separate from its owner (see *Limited Liability Company (LLC)* on this page), enter the owner’s SSN (or EIN, if the owner has one). Do not enter the disregarded entity’s EIN. If the LLC is classified as a corporation or partnership, enter the entity’s EIN.

Note. See the chart on page 4 for further clarification of name and TIN combinations.

How to get a TIN. If you do not have a TIN, apply for one immediately. To apply for an SSN, get Form SS-5, Application for a Social Security Card, from your local SSA office or get this form online at *www.ssa.gov*. You may also get this form by calling 1-800-772-1213. Use Form W-7, Application for IRS Individual Taxpayer Identification Number, to apply for an ITIN, or Form SS-4, Application for Employer Identification Number, to apply for an EIN. You can apply for an EIN online by accessing the IRS website at *www.irs.gov/businesses* and clicking on Employer Identification Number (EIN) under Starting a Business. You can get Forms W-7 and SS-4 from the IRS by visiting IRS.gov or by calling 1-800-TAX-FORM (1-800-829-3676).

If you are asked to complete Form W-9 but do not have a TIN, apply for a TIN and write “Applied For” in the space for the TIN, sign and date the form, and give it to the requester. For interest and dividend payments, and certain payments made with respect to readily tradable instruments, generally you will have 60 days to get a TIN and give it to the requester before you are subject to backup withholding on payments. The 60-day rule does not apply to other types of payments. You will be subject to backup withholding on all such payments until you provide your TIN to the requester.

Note. Entering “Applied For” means that you have already applied for a TIN or that you intend to apply for one soon.

Caution: *A disregarded U.S. entity that has a foreign owner must use the appropriate Form W-8.*

Part II. Certification

To establish to the withholding agent that you are a U.S. person, or resident alien, sign Form W-9. You may be requested to sign by the withholding agent even if items 1, 4, or 5 below indicate otherwise.

For a joint account, only the person whose TIN is shown in Part I should sign (when required). In the case of a disregarded entity, the person identified on line 1 must sign. Exempt payees, see *Exempt payee code* earlier.

Signature requirements. Complete the certification as indicated in items 1 through 5 below.

1. Interest, dividend, and barter exchange accounts opened before 1984 and broker accounts considered active during 1983. You must give your correct TIN, but you do not have to sign the certification.

2. Interest, dividend, broker, and barter exchange accounts opened after 1983 and broker accounts considered inactive during 1983. You must sign the certification or backup withholding will apply. If you are subject to backup withholding and you are merely providing your correct TIN to the requester, you must cross out item 2 in the certification before signing the form.

3. Real estate transactions. You must sign the certification. You may cross out item 2 of the certification.

4. Other payments. You must give your correct TIN, but you do not have to sign the certification unless you have been notified that you have previously given an incorrect TIN. "Other payments" include payments made in the course of the requester's trade or business for rents, royalties, goods (other than bills for merchandise), medical and health care services (including payments to corporations), payments to a nonemployee for services, payments made in settlement of payment card and third party network transactions, payments to certain fishing boat crew members and fishermen, and gross proceeds paid to attorneys (including payments to corporations).

5. Mortgage interest paid by you, acquisition or abandonment of secured property, cancellation of debt, qualified tuition program payments (under section 529), IRA, Coverdell ESA, Archer MSA or HSA contributions or distributions, and pension distributions. You must give your correct TIN, but you do not have to sign the certification.

What Name and Number To Give the Requester

For this type of account:	Give name and SSN of:
1. Individual	The individual
2. Two or more individuals (joint account)	The actual owner of the account or, if combined funds, the first individual on the account[1]
3. Custodian account of a minor (Uniform Gift to Minors Act)	The minor[2]
4. a. The usual revocable savings trust (grantor is also trustee)	The grantor-trustee[1]
b. So-called trust account that is not a legal or valid trust under state law	The actual owner[1]
5. Sole proprietorship or disregarded entity owned by an individual	The owner[3]
6. Grantor trust filing under Optional Form 1099 Filing Method 1 (see Regulations section 1.671-4(b)(2)(i)(A))	The grantor*
For this type of account:	**Give name and EIN of:**
7. Disregarded entity not owned by an individual	The owner
8. A valid trust, estate, or pension trust	Legal entity[4]
9. Corporation or LLC electing corporate status on Form 8832 or Form 2553	The corporation
10. Association, club, religious, charitable, educational, or other tax-exempt organization	The organization
11. Partnership or multi-member LLC	The partnership
12. A broker or registered nominee	The broker or nominee
13. Account with the Department of Agriculture in the name of a public entity (such as a state or local government, school district, or prison) that receives agricultural program payments	The public entity
14. Grantor trust filing under the Form 1041 Filing Method or the Optional Form 1099 Filing Method 2 (see Regulations section 1.671-4(b)(2)(i)(B))	The trust

[1] List first and circle the name of the person whose number you furnish. If only one person on a joint account has an SSN, that person's number must be furnished.

[2] Circle the minor's name and furnish the minor's SSN.

[3] You must show your individual name and you may also enter your business or DBA name on the "Business name/disregarded entity" name line. You may use either your SSN or EIN (if you have one), but the IRS encourages you to use your SSN.

[4] List first and circle the name of the trust, estate, or pension trust. (Do not furnish the TIN of the personal representative or trustee unless the legal entity itself is not designated in the account title.) Also see *Special rules for partnerships* on page 2.

***Note.** Grantor also must provide a Form W-9 to trustee of trust.

Note. If no name is circled when more than one name is listed, the number will be considered to be that of the first name listed.

Secure Your Tax Records from Identity Theft

Identity theft occurs when someone uses your personal information such as your name, SSN, or other identifying information, without your permission, to commit fraud or other crimes. An identity thief may use your SSN to get a job or may file a tax return using your SSN to receive a refund.

To reduce your risk:

- Protect your SSN,
- Ensure your employer is protecting your SSN, and
- Be careful when choosing a tax preparer.

If your tax records are affected by identity theft and you receive a notice from the IRS, respond right away to the name and phone number printed on the IRS notice or letter.

If your tax records are not currently affected by identity theft but you think you are at risk due to a lost or stolen purse or wallet, questionable credit card activity or credit report, contact the IRS Identity Theft Hotline at 1-800-908-4490 or submit Form 14039.

For more information, see Publication 4535, Identity Theft Prevention and Victim Assistance.

Victims of identity theft who are experiencing economic harm or a system problem, or are seeking help in resolving tax problems that have not been resolved through normal channels, may be eligible for Taxpayer Advocate Service (TAS) assistance. You can reach TAS by calling the TAS toll-free case intake line at 1-877-777-4778 or TTY/TDD 1-800-829-4059.

Protect yourself from suspicious emails or phishing schemes. Phishing is the creation and use of email and websites designed to mimic legitimate business emails and websites. The most common act is sending an email to a user falsely claiming to be an established legitimate enterprise in an attempt to scam the user into surrendering private information that will be used for identity theft.

The IRS does not initiate contacts with taxpayers via emails. Also, the IRS does not request personal detailed information through email or ask taxpayers for the PIN numbers, passwords, or similar secret access information for their credit card, bank, or other financial accounts.

If you receive an unsolicited email claiming to be from the IRS, forward this message to *phishing@irs.gov*. You may also report misuse of the IRS name, logo, or other IRS property to the Treasury Inspector General for Tax Administration (TIGTA) at 1-800-366-4484. You can forward suspicious emails to the Federal Trade Commission at: *spam@uce.gov* or contact them at *www.ftc.gov/idtheft* or 1-877-IDTHEFT (1-877-438-4338).

Visit IRS.gov to learn more about identity theft and how to reduce your risk.

Privacy Act Notice

Section 6109 of the Internal Revenue Code requires you to provide your correct TIN to persons (including federal agencies) who are required to file information returns with the IRS to report interest, dividends, or certain other income paid to you; mortgage interest you paid; the acquisition or abandonment of secured property; the cancellation of debt; or contributions you made to an IRA, Archer MSA, or HSA. The person collecting this form uses the information on the form to file information returns with the IRS, reporting the above information. Routine uses of this information include giving it to the Department of Justice for civil and criminal litigation and to cities, states, the District of Columbia, and U.S. commonwealths and possessions for use in administering their laws. The information also may be disclosed to other countries under a treaty, to federal and state agencies to enforce civil and criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism. You must provide your TIN whether or not you are required to file a tax return. Under section 3406, payers must generally withhold a percentage of taxable interest, dividend, and certain other payments to a payee who does not give a TIN to the payer. Certain penalties may also apply for providing false or fraudulent information.

Southeastern California Conference
New Employee Checklist

Employee Name: ____ Date: ____________________________

Place of Employment: ____

Please follow the directions stated for each document and submit these documents, with this checklist to ***the Human Resources Department***. Keep a copy of all forms for your records until the employee is processed through payroll. ***All documents must be completed prior to the employee's first day of work***.

□ **PERSONNEL ACTION REQUEST**
Who: To be completed by church pastor or authorized representative.
Where: Original to Human Resources (all copies)
Processing: Completed and signed by pastor or church administrator. Must include name of employee, status, rate, hours of work per week, starting date, church name, and signature of church official.

□ **APPLICATION FOR EMPLOYMENT**
Who: All employees
Where: Original to Human Resources. Keep a copy on site.
Processing: Completed by employee, and signed at the bottom of the second page.

□ **W-4 FORM**
Who: All employees
Where: Human Resources
Processing: Be sure items 1, 2, 3, and 4 are complete. Then, either item 5 **OR** 7 should be completed but **NOT BOTH**. This document must also be signed and dated by the employee.

□ **EMPLOYMENT ELIGIBILITY (I-9 FORM)**
Who: All employees
Where: Original to Human Resources. Keep a copy on site.
Processing: Employee completes and signs Section 1. Section 2 is completed by an employee of the church that witnesses the employee's actual identification, chosen from the back of the I-9 form (one item from list A, or one item from list B **AND** one from list C), and signs the certification. **Please note that this must be done on site as the actual identification must be witnessed and certified.**

□ **NEW EMPLOYEE DATA COLLECTION**
Who: All employees
Where: Original to Human Resources. Keep a copy on site.
Processing: Completed and **signed** by the employee.

□ **CONFLICT OF INTEREST FORM**
Who: All employees
Where: Original to Human Resources
Processing: Completed and signed by the employee.

□ **SERVICE RECORD FORM**
Who: All employees
Where: Original to Human Resources.
Processing: Completed by employees. **Please list last denominational service only under the Employment section.**

□ **SOCIAL SECURITY CARD COPY**
Who: All employees
Where: Copy of card to Human Resources.
Processing: A copy of the employee's Social Security Card is **REQUIRED** to issue payroll checks. Checks will be issued in the name printed on the card. If there is a discrepancy or if the employee has lost their card, refer them immediately to the Social Security office to apply for a replacement card.

□ **BACKGROUND CHECK AUTHORIZATION**
Who: All employees
Where: Original to Human Resources.
Processing: Completed and signed by the employee.

□ **Church Membership Check Form**
Who: All employees
Where: Original to Human Resources.
Processing: Completed and signed by the employee.

If you have any questions or need information or assistance in completing any of these forms, please contact the Human Resources Department at 951.509.2354.

PERSONNEL ACTION REQUEST

Southeastern California Conference of Seventh-day Adventists

(office use)

Emp.#: ____________________

Base Accrual Date:

EMPLOYEE INFO

Employee Name: ______________________________

☐ New position (include job description)

Supervisory position: YES ☐ **NO** ☐

NEW ☐ REHIRE ☐ ADDITIONAL ASSIGNMENT ☐

☐ Full-Time ☐ Regular ☐ Student ☐ Biweekly Salary: ____________

☐ Part-Time ☐ Temporary ☐ On-Call ☐ Hourly Rate: ____________

Job Title: ____________________ Name of Supervisor: ____________________

Place of Work: ____________________ Date Voted by Local Board: ____________________

Hours/Week or FTE: ____________ Starting Date: ____________ Ending Date: ____________

In addition to the wages, there are other employment expenses. HR assumes no responsibility for budget calculations.

Comments: ______________________________

____

____

CHANGE ☐ TRANSFER ☐

Current Work Location: ____________________ Effective Date: ____________________

☐ New Work Location: ____________________ ☐ Hours/Week or FTE: ____________________

☐ Job Title: ____________________ ☐ Bi-Weekly Salary/Hourly Rate: ____________

☐ Status Change: ☐ Full-Time ☐ Part-Time ☐ Regular ☐ Temporary ☐ On-Call ☐ LTD (DI 42022)

Comments: ______________________________

____

TERMINATION ☐ LEAVE OF ABSENCE ☐

Effective Date: ____________ Work Location: ____________________

☐ Resignation (attach letter) ☐ Layoff/Reduction-In Force ☐ Dismissal ☐ Retirement

☐ Other: ____________________ ☐ Leave of Absence Begin: ________ End: ________

Vacation/Paid Leave Due: ____________________

Comments: ______________________________

____

Initiating Supervisor ____________________ ____________________ Date ________
(signature) (print)

Department Head ____________________ ____________________ Date ________
(signature) (print)

TO BE COMPLETED BY HUMAN RESOURCES:

☐ Approved ☐ Not Approved Date: ____________________

Qualifies for: ☐ LTD (DI 42022)

☐ Medical ☐ Auto ☐ Retirement ☐ Paid Leave ☐ Parsonage

Remuneration ____________ Cost Area ____________ FTE ____________ Travel ____________

EEOC Number ____________ Worker's Comp Title/Code ____________________ Credential ____________________

Charge to ______________________________

Comments: ______________________________

____

Audited by: ____________ **Date:** ____________

FTE Audit by: ____________ **Date:** ____________

____
Human Resources Director (sign) **Date**

10/2011 White - Human Resources Blue - Payroll Green - Insurance Yellow - Department Head Pink - Employee Goldenrod - Service Records

Southeastern California Conference
of Seventh-day Adventists

EMPLOYMENT APPLICATION

11330 Pierce Street
Riverside, CA 92515

Phone: (951) 509-2352 • Fax: (951) 509-2395

Equal Employment Opportunity Employer

(OFFICE USE ONLY)
NAME ______
Date ______
Position Applied for: ______
Test Scores: ______

Southeastern California Conference is a religiously-qualified Equal Opportunity Employer, with the right to prefer Seventh-day Adventists in hiring. It is the policy of Southeastern California Conference to recruit and promote for all job classifications on the basis of merit, qualification, competence, attitude and spiritual commitment. No aspect of employment shall be influenced by race, color, national origin, sex, age or handicap.

TYPE or PRINT — Complete all sections, even if a resume is submitted.

Position applied for: ______ Location: ______ Date ______

PERSONAL DATA: **New Hire** ______ **Rehire** ______ **Original hire date** ______

Name ______

Address ______ Telephone (______) ______

City ______ State ______ Zip ______ Other Contact Number ______

Birth date (if under 18) ______

Are you a member of the Seventh-day Adventist Church? Yes____, No____. Number of years, if member ______

Location/Name of Church ______ Pastor ______

Have you ever been convicted of a criminal offense? Yes_______, No_______. (If yes, attach a detailed explanation.)
(The existence of a criminal record does not constitute an automatic bar to employment.)

Have you ever been terminated, dismissed or asked to resign? Yes_______, No_______. (If yes, attach a detailed explanation.)

EDUCATION: **Complete the following for each school attended. (High school and above)**

School (City & State)	Curriculum or Major	Degree or Hours Completed

Trade, Technical or Business School	Course of Study	Certificate and Year

LICENSES OR CREDENTIALS:

☐ Ministerial License ☐ Missionary Credential ☐ Other ______

OTHER SKILLS:

If applicable to position — which of the following do you have knowledge of?

☐ Adobe Acrobat Professional ☐ Microsoft Access ☐ Typing — wpm ______
☐ Adobe Designer ☐ Microsoft Excel ☐ Adding machine
☐ Adobe Illustrator ☐ Microsoft Powerpoint ☐ PBX / Switchboard
☐ Adobe InDesign ☐ Microsoft Word ☐ Other ______
☐ Adobe Photoshop ☐ WordPerfect ______
______

Do you speak, read or write any languages other than English? ______

APPLICATION MUST BE SIGNED, DATED AND COMPLETED ON BOTH SIDES

EMPLOYMENT RECORD: List most recent first.

DATES FROM	DATES TO	EMPLOYER ADDRESS AND PHONE	INDICATE YOUR JOB AND MAJOR DUTIES:	REASON FOR LEAVING
			TITLE:	
			DUTIES:	
				IMMEDIATE SUPERV:
			TITLE:	
			DUTIES:	
				IMMEDIATE SUPERV:
			TITLE:	
			DUTIES:	
				IMMEDIATE SUPERV:

PERMISSION TO REFER APPLICATION:

Southeastern California Conference has my permission to refer my application to any Seventh-day Adventist denominational entity, with a job opening for which I appear to be qualified and competitive.

☐ YES ☐ NO

ADDITIONAL INFORMATION: List any other experience or skill that you believe contributes to your qualifications for this position:

____

____

____

REFERENCES: List below three persons other than relatives who can provide both character and employment references:

Name	Position	Complete Address	Zip Code	Phone

If hired, can you provide, satisfactory proof of identity and legal authority to work in the U.S. as required by the U.S. Department of Homeland Security. (I-9 Form)? Yes ___________ **No**_____________

VERIFICATION OF APPLICATION INFORMATION

I hereby certify that all of the information on this employment application and any resume or exhibit is true, correct and complete. I have not withheld any information requested on this application. I understand that false, misleading, incomplete or omitted information on this application or my resume will result in disqualification for employment or, if I am hired, dismissal from employment. I authorize the employing organization and its agents to confirm information supplied on this application and my resume and to investigate my suitability for employment. I agree to furnish additional information if requested. I release all parties and persons from any claims, liabilities and damages that may result from requesting or furnishing information about me to the employing organization, as well as from using such information in considering my employment application. I am a member in good and regular standing of the Seventh-day Adventist church, and abide by its teachings. I understand that if I receive a conditional employment offer, I may be asked to take a job-related medical examination with a physician selected by the employing organization. The results of this examination will be communicated to the employing organization and considered in evaluating my application. If I refuse to take such a medical examination, I understand that I will be disqualified from employment. I understand that if employed I must complete an I-9 form and provide satisfactory proof of my identity and legal authority to work in the United States. If employed, I agree to conform to the policies and standards of the employing organization. I understand that no one other than the conference administrator or designee is authorized to enter into any employment agreement for any specific time period, or to make any agreement contrary to the foregoing.

____ ____

Signature of Applicant Date

Form W-4 (2015)

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 2015 expires February 16, 2016. See Pub. 505, Tax Withholding and Estimated Tax.

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

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

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

The exceptions do not apply to supplemental wages greater than $1,000,000.

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-earners/multiple jobs situations.

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

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

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

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

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

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

Check your withholding. After your Form W-4 takes effect, use Pub. 505 to see how the amount you are having withheld compares to your projected total tax for 2015. See Pub. 505, especially if your earnings exceed $130,000 (Single) or $180,000 (Married).

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

Personal Allowances Worksheet (Keep for your records.)

A Enter "1" for **yourself** if no one else can claim you as a dependent . . . . **A** ______

B Enter "1" if:
- You 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 $2,000 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 $65,000 ($100,000 if married), enter "2" for each eligible child; then **less** "1" if you have two to four eligible children or **less** "2" if you have five or more eligible children.
- If your total income will be between $65,000 and $84,000 ($100,000 and $119,000 if married), enter "1" for each eligible child . . . **G** ______

H Add lines A through G and enter total here. (**Note.** This may be different from the number of exemptions you claim on your tax return.) ▶ **H** ______

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

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

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

Employee's Withholding Allowance Certificate

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

OMB No. 1545-0074
2015

1 Your first name and middle initial	Last name	2 **Your social security number**
Home address (number and street or rural route)	3 ☐ Single ☐ Married ☐ Married, but withhold at higher Single rate. **Note.** If married, but legally separated, or spouse is a nonresident alien, check the "Single" box.	
City or town, state, and ZIP code	4 **If your last name differs from that shown on your social security card, check here. You must call 1-800-772-1213 for a replacement card.** ▶ ☐	

5 Total number of allowances you are claiming (from line **H** above **or** from the applicable worksheet on page 2) **5** ______

6 Additional amount, if any, you want withheld from each paycheck . . . . **6** $ ______

7 I claim exemption from withholding for 2015, and I certify that I meet **both** of the following conditions for exemption.
- Last year I had a right to a refund of **all** federal income tax withheld because I had **no** tax liability, **and**
- This year I expect a refund of **all** federal income tax withheld because I expect to have **no** tax liability.

If you meet both conditions, write "Exempt" here . . . . ▶ **7** ______

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

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

8 Employer's name and address (Employer: Complete lines 8 and 10 only if sending to the IRS.)	9 Office code (optional)	10 Employer identification number (EIN)

For Privacy Act and Paperwork Reduction Act Notice, see page 2. Cat. No. 10220Q Form **W-4** (2015)

Deductions and Adjustments Worksheet

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

1	Enter an estimate of your 2015 itemized deductions. These include qualifying home mortgage interest, charitable contributions, state and local taxes, medical expenses in excess of 10% (7.5% if either you or your spouse was born before January 2, 1951) of your income, and miscellaneous deductions. For 2015, you may have to reduce your itemized deductions if your income is over $309,900 and you are married filing jointly or are a qualifying widow(er); $284,050 if you are head of household; $258,250 if you are single and not head of household or a qualifying widow(er); or $154,950 if you are married filing separately. See Pub. 505 for details	1	$
2	Enter: { $12,600 if married filing jointly or qualifying widow(er); $9,250 if head of household; $6,300 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 2015 adjustments to income and any additional standard deduction (see Pub. 505)	4	$
5	**Add** lines 3 and 4 and enter the total. (Include any amount for credits from the *Converting Credits to Withholding Allowances for 2015 Form W-4* worksheet in Pub. 505.)	5	$
6	Enter an estimate of your 2015 nonwage income (such as dividends or interest)	6	$
7	**Subtract** line 6 from line 5. If zero or less, enter "-0-"	7	$
8	**Divide** the amount on line 7 by $4,000 and enter the result here. Drop any fraction	8	
9	Enter the number from the **Personal Allowances Worksheet,** line H, page 1	9	
10	**Add** lines 8 and 9 and enter the total here. If you plan to use the **Two-Earners/Multiple Jobs Worksheet,** also enter this total on line 1 below. Otherwise, **stop here** and enter this total on Form W-4, line 5, page 1	10	

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

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

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

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

4	Enter the number from line 2 of this worksheet . . . . 4 ______		
5	Enter the number from line 1 of this worksheet . . . . 5 ______		
6	**Subtract** line 5 from line 4	6	
7	Find the amount in **Table 2** below that applies to the **HIGHEST** paying job and enter it here	7	$
8	**Multiply** line 7 by line 6 and enter the result here. This is the additional annual withholding needed . .	8	$
9	Divide line 8 by the number of pay periods remaining in 2015. For example, divide by 25 if you are paid every two weeks and you complete this form on a date in January when there are 25 pay periods remaining in 2015. 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				Table 2			
Married Filing Jointly		All Others		Married Filing Jointly		All Others	
If wages from **LOWEST** paying job are—	Enter on line 2 above	If wages from **LOWEST** paying job are—	Enter on line 2 above	If wages from **HIGHEST** paying job are—	Enter on line 7 above	If wages from **HIGHEST** paying job are—	Enter on line 7 above
$0 - $6,000	0	$0 - $8,000	0	$0 - $75,000	$600	$0 - $38,000	$600
6,001 - 13,000	1	8,001 - 17,000	1	75,001 - 135,000	1,000	38,001 - 83,000	1,000
13,001 - 24,000	2	17,001 - 26,000	2	135,001 - 205,000	1,120	83,001 - 180,000	1,120
24,001 - 26,000	3	26,001 - 34,000	3	205,001 - 360,000	1,320	180,001 - 395,000	1,320
26,001 - 34,000	4	34,001 - 44,000	4	360,001 - 405,000	1,400	395,001 and over	1,580
34,001 - 44,000	5	44,001 - 75,000	5	405,001 and over	1,580		
44,001 - 50,000	6	75,001 - 85,000	6				
50,001 - 65,000	7	85,001 - 110,000	7				
65,001 - 75,000	8	110,001 - 125,000	8				
75,001 - 80,000	9	125,001 - 140,000	9				
80,001 - 100,000	10	140,001 and over	10				
100,001 - 115,000	11						
115,001 - 130,000	12						
130,001 - 140,000	13						
140,001 - 150,000	14						
150,001 and over	15						

Privacy Act and Paperwork Reduction Act Notice. We ask for the information on this form to carry out the Internal Revenue laws of the United States. Internal Revenue Code sections 3402(f)(2) and 6109 and their regulations require you to provide this information; your employer uses it to determine your federal income tax withholding. Failure to provide a properly completed form will result in your being treated as a single person who claims no withholding allowances; providing fraudulent information may subject you to penalties. Routine uses of this information include giving it to the Department of Justice for civil and criminal litigation; to cities, states, the District of Columbia, and U.S. commonwealths and possessions for use in administering their tax laws; and to the Department of Health and Human Services for use in the National Directory of New Hires. We may also disclose this information to other countries under a tax treaty, to federal and state agencies to enforce federal nontax criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism.

You are not required to provide the information requested on a form that is subject to the Paperwork Reduction Act unless the form displays a valid OMB control number. Books or records relating to a form or its instructions must be retained as long as their contents may become material in the administration of any Internal Revenue law. Generally, tax returns and return information are confidential, as required by Code section 6103.

The average time and expenses required to complete and file this form will vary depending on individual circumstances. For estimated averages, see the instructions for your income tax return.

If you have suggestions for making this form simpler, we would be happy to hear from you. See the instructions for your income tax return.

Instructions for Employment Eligibility Verification

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

USCIS
Form I-9
OMB No. 1615-0047
Expires 03/31/2016

Read all instructions carefully before completing this form.

Anti-Discrimination Notice. It is illegal to discriminate against any work-authorized individual in hiring, discharge, recruitment or referral for a fee, or in the employment eligibility verification (Form I-9 and E-Verify) process based on that individual's citizenship status, immigration status or national origin. Employers **CANNOT** specify which document(s) they will accept from an employee. The refusal to hire an individual because the documentation presented has a future expiration date may also constitute illegal discrimination. For more information, call the Office of Special Counsel for Immigration-Related Unfair Employment Practices (OSC) at 1-800-255-7688 (employees), 1-800-255-8155 (employers), or 1-800-237-2515 (TDD), or visit www.justice.gov/crt/about/osc.

What Is the Purpose of This Form?

Employers must complete Form I-9 to document verification of the identity and employment authorization of each new employee (both citizen and noncitizen) hired after November 6, 1986, to work in the United States. In the Commonwealth of the Northern Mariana Islands (CNMI), employers must complete Form I-9 to document verification of the identity and employment authorization of each new employee (both citizen and noncitizen) hired after November 27, 2011. Employers should have used Form I-9 CNMI between November 28, 2009 and November 27, 2011.

General Instructions

Employers are responsible for completing and retaining Form I-9. 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.

Form I-9 is made up of three sections. Employers may be fined if the form is not complete. Employers are responsible for retaining completed forms. Do not mail completed forms to U.S. Citizenship and Immigration Services (USCIS) or Immigration and Customs Enforcement (ICE).

Section 1. Employee Information and Attestation

Newly hired employees must complete and sign Section 1 of Form I-9 **no later than the first day of employment**. Section 1 should never be completed before the employee has accepted a job offer.

Provide the following information to complete Section 1:

Name: Provide your full legal last name, first name, and middle initial. Your last name is your family name or surname. If you have two last names or a hyphenated last name, include both names in the last name field. Your first name is your given name. Your middle initial is the first letter of your second given name, or the first letter of your middle name, if any.

Other names used: Provide all other names used, if any (including maiden name). If you have had no other legal names, write "N/A."

Address: Provide the address where you currently live, including Street Number and Name, Apartment Number (if applicable), City, State, and Zip Code. Do not provide a post office box address (P.O. Box). Only border commuters from Canada or Mexico may use an international address in this field.

Date of Birth: Provide your date of birth in the mm/dd/yyyy format. For example, January 23, 1950, should be written as 01/23/1950.

U.S. Social Security Number: Provide your 9-digit Social Security number. Providing your Social Security number is voluntary. However, if your employer participates in E-Verify, you must provide your Social Security number.

E-mail Address and Telephone Number (Optional): You may provide your e-mail address and telephone number. Department of Homeland Security (DHS) may contact you if DHS learns of a potential mismatch between the information provided and the information in DHS or Social Security Administration (SSA) records. You may write "N/A" if you choose not to provide this information.

EMPLOYERS MUST RETAIN COMPLETED FORM I-9
DO NOT MAIL COMPLETED FORM I-9 TO ICE OR USCIS

All employees must attest in Section 1, under penalty of perjury, to their citizenship or immigration status by checking one of the following four boxes provided on the form:

1. **A citizen of the United States**
2. **A noncitizen national 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.
3. **A lawful permanent resident:** A lawful permanent resident is any person who is not a U.S. citizen and who resides in the United States under legally recognized and lawfully recorded permanent residence as an immigrant. The term "lawful permanent resident" includes conditional residents. If you check this box, write either your Alien Registration Number (A-Number) or USCIS Number in the field next to your selection. At this time, the USCIS Number is the same as the A-Number without the "A" prefix.
4. **An alien authorized to work:** If you are not a citizen or national of the United States or a lawful permanent resident, but are authorized to work in the United States, check this box.

   If you check this box:

   a. Record the date that your employment authorization expires, if any. Aliens whose employment authorization does not expire, such as refugees, asylees, and certain citizens of the Federated States of Micronesia, the Republic of the Marshall Islands, or Palau, may write "N/A" on this line.

   b. Next, enter your Alien Registration Number (A-Number)/USCIS Number. At this time, the USCIS Number is the same as your A-Number without the "A" prefix. If you have not received an A-Number/USCIS Number, record your Admission Number. You can find your Admission Number on Form I-94, "Arrival-Departure Record," or as directed by USCIS or U.S. Customs and Border Protection (CBP).

   (1) If you obtained your admission number from CBP in connection with your arrival in the United States, then also record information about the foreign passport you used to enter the United States (number and country of issuance).

   (2) If you obtained your admission number from USCIS *within the United States*, or you entered the United States without a foreign passport, you must write "N/A" in the Foreign Passport Number and Country of Issuance fields.

Sign your name in the "Signature of Employee" block and record the date you completed and signed Section 1. By signing and dating this form, you attest that the citizenship or immigration status you selected is correct and that you are aware that you may be imprisoned and/or fined for making false statements or using false documentation when completing this form. To fully complete this form, you must present to your employer documentation that establishes your identity and employment authorization. Choose which documents to present from the Lists of Acceptable Documents, found on the last page of this form. You must present this documentation no later than the third day after beginning employment, although you may present the required documentation before this date.

Preparer and/or Translator Certification

The Preparer and/or Translator Certification must be completed if the employee requires assistance to complete Section 1 (e.g., the employee needs the instructions or responses translated, someone other than the employee fills out the information blocks, or someone with disabilities needs additional assistance). The employee must still sign Section 1.

Minors and Certain Employees with Disabilities (Special Placement)

Parents or legal guardians assisting minors (individuals under 18) and certain employees with disabilities should review the guidelines in the *Handbook for Employers: Instructions for Completing Form I-9 (M-274)* on www.uscis.gov/I-9Central before completing Section 1. These individuals have special procedures for establishing identity if they cannot present an identity document for Form I-9. The special procedures include **(1)** the parent or legal guardian filling out Section 1 and writing "minor under age 18" or "special placement," whichever applies, in the employee signature block; and **(2)** the employer writing "minor under age 18" or "special placement" under List B in Section 2.

Section 2. Employer or Authorized Representative Review and Verification

Before completing Section 2, employers must ensure that Section 1 is completed properly and on time. Employers may not ask an individual to complete Section 1 before he or she has accepted a job offer.

Employers or their authorized representative must complete Section 2 by examining evidence of identity and employment authorization within 3 business days of the employee's first day of employment. For example, if an employee begins employment on Monday, the employer must complete Section 2 by Thursday of that week. However, if an employer hires an individual for less than 3 business days, Section 2 must be completed no later than the first day of employment. An employer may complete Form I-9 before the first day of employment if the employer has offered the individual a job and the individual has accepted.

Employers cannot specify which document(s) employees may present from the Lists of Acceptable Documents, found on the last page of Form I-9, to establish identity and employment authorization. Employees must present one selection from List A **OR** a combination of one selection from List B and one selection from List C. List A contains documents that show both identity and employment authorization. Some List A documents are combination documents. The employee must present combination documents together to be considered a List A document. For example, a foreign passport and a Form I-94 containing an endorsement of the alien's nonimmigrant status must be presented together to be considered a List A document. List B contains documents that show identity only, and List C contains documents that show employment authorization only. If an employee presents a List A document, he or she should **not** present a List B and List C document, and vice versa. If an employer participates in E-Verify, the List B document must include a photograph.

In the field below the Section 2 introduction, employers must enter the last name, first name and middle initial, if any, that the employee entered in Section 1. This will help to identify the pages of the form should they get separated.

Employers or their authorized representative must:

1. Physically examine each original document the employee presents to determine if it reasonably appears to be genuine and to relate to the person presenting it. The person who examines the documents must be the same person who signs Section 2. The examiner of the documents and the employee must both be physically present during the examination of the employee's documents.
2. Record the document title shown on the Lists of Acceptable Documents, issuing authority, document number and expiration date (if any) from the original document(s) the employee presents. You may write "N/A" in any unused fields.

   If the employee is a student or exchange visitor who presented a foreign passport with a Form I-94, the employer should also enter in Section 2:

   a. The student's Form I-20 or DS-2019 number (Student and Exchange Visitor Information System-SEVIS Number); **and** the program end date from Form I-20 or DS-2019.
3. Under Certification, enter the employee's first day of employment. Temporary staffing agencies may enter the first day the employee was placed in a job pool. Recruiters and recruiters for a fee do not enter the employee's first day of employment.
4. Provide the name and title of the person completing Section 2 in the Signature of Employer or Authorized Representative field.
5. Sign and date the attestation on the date Section 2 is completed.
6. Record the employer's business name and address.
7. Return the employee's documentation.

Employers may, but are not required to, photocopy the document(s) presented. If photocopies are made, they should be made for **ALL** new hires or reverifications. Photocopies must be retained and presented with Form I-9 in case of an inspection by DHS or other federal government agency. Employers must always complete Section 2 even if they photocopy an employee's document(s). Making photocopies of an employee's document(s) cannot take the place of completing Form I-9. Employers are still responsible for completing and retaining Form I-9.

Unexpired Documents

Generally, only unexpired, original documentation is acceptable. The only exception is that an employee may present a certified copy of a birth certificate. Additionally, in some instances, a document that appears to be expired may be acceptable if the expiration date shown on the face of the document has been extended, such as for individuals with temporary protected status. Refer to the *Handbook for Employers: Instructions for Completing Form I-9 (M-274)* or I-9 Central (www.uscis.gov/I-9Central) for examples.

Receipts

If an employee is unable to present a required document (or documents), the employee can present an acceptable receipt in lieu of a document from the Lists of Acceptable Documents 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. Employers cannot accept receipts if employment will last less than 3 days. Receipts are acceptable when completing Form I-9 for a new hire or when reverification is required.

Employees must present receipts within 3 business days of their first day of employment, or in the case of reverification, by the date that reverification is required, and must present valid replacement documents within the time frames described below.

There are three types of acceptable receipts:

1. A receipt showing that the employee has applied to replace a document that was lost, stolen or damaged. The employee must present the actual document within 90 days from the date of hire.
2. The arrival portion of Form I-94/I-94A with a temporary I-551 stamp and a photograph of the individual. The employee must present the actual Permanent Resident Card (Form I-551) by the expiration date of the temporary I-551 stamp, or, if there is no expiration date, within 1 year from the date of issue.
3. The departure portion of Form I-94/I-94A with a refugee admission stamp. The employee must present an unexpired Employment Authorization Document (Form I-766) or a combination of a List B document and an unrestricted Social Security card within 90 days.

When the employee provides an acceptable receipt, the employer should:

1. Record the document title in Section 2 under the sections titled List A, List B, or List C, as applicable.
2. Write the word "receipt" and its document number in the "Document Number" field. Record the last day that the receipt is valid in the "Expiration Date" field.

By the end of the receipt validity period, the employer should:

1. Cross out the word "receipt" and any accompanying document number and expiration date.
2. Record the number and other required document information from the actual document presented.
3. Initial and date the change.

See the *Handbook for Employers: Instructions for Completing Form I-9 (M-274)* at www.uscis.gov/I-9Central for more information on receipts.

Section 3. Reverification and Rehires

Employers or their authorized representatives should complete Section 3 when reverifying that an employee is authorized to work. When rehiring an employee within 3 years of the date Form I-9 was originally completed, employers have the option to complete a new Form I-9 or complete Section 3. When completing Section 3 in either a reverification or rehire situation, if the employee's name has changed, record the name change in Block A.

For employees who provide an employment authorization expiration date in Section 1, employers must reverify employment authorization on or before the date provided.

Some employees may write "N/A" in the space provided for the expiration date in Section 1 if they are aliens whose employment authorization does not expire (e.g., asylees, refugees, certain citizens of the Federated States of Micronesia, the Republic of the Marshall Islands, or Palau). Reverification does not apply for such employees unless they chose to present evidence of employment authorization in Section 2 that contains an expiration date and requires reverification, such as Form I-766, Employment Authorization Document.

Reverification applies if evidence of employment authorization (List A or List C document) presented in Section 2 expires. However, employers should not reverify:

1. U.S. citizens and noncitizen nationals; or
2. Lawful permanent residents who presented a Permanent Resident Card (Form I-551) for Section 2.

Reverification does not apply to List B documents.

If both Section 1 and Section 2 indicate expiration dates triggering the reverification requirement, the employer should reverify by the earlier date.

For reverification, an employee must present unexpired documentation from either List A or List C showing he or she is still authorized to work. Employers CANNOT require the employee to present a particular document from List A or List C. The employee may choose which document to present.

To complete Section 3, employers should follow these instructions:

1. Complete Block A if an employee's name has changed at the time you complete Section 3.
2. Complete Block B with the date of rehire if you rehire an employee within 3 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. Also complete the "Signature of Employer or Authorized Representative" block.
3. Complete Block C if:
   - **a.** The employment authorization or employment authorization document of a current employee is about to expire and requires reverification; or
   - **b.** You rehire an employee within 3 years of the date this form was originally completed and his or her employment authorization or employment authorization document has expired. (Complete Block B for this employee as well.)

   To complete Block C:
   - **a.** Examine either a List A or List C document the employee presents that shows that the employee is currently authorized to work in the United States; and
   - **b.** Record the document title, document number, and expiration date (if any).
4. After completing block A, B or C, complete the "Signature of Employer or Authorized Representative" block, including the date.

   For reverification purposes, employers may either complete Section 3 of a new Form I-9 or Section 3 of the previously completed Form I-9. Any new pages of Form I-9 completed during reverification must be attached to the employee's original Form I-9. If you choose to complete Section 3 of a new Form I-9, you may attach just the page containing Section 3, with the employee's name entered at the top of the page, to the employee's original Form I-9. If there is a more current version of Form I-9 at the time of reverification, you must complete Section 3 of that version of the form.

What Is the Filing Fee?

There is no 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 **"USCIS Privacy Act Statement"** below.

USCIS Forms and Information

For more detailed information about completing Form I-9, employers and employees should refer to the *Handbook for Employers: Instructions for Completing Form I-9 (M-274).*

You can also obtain information about Form I-9 from the USCIS Web site at www.uscis.gov/I-9Central, by e-mailing USCIS at **I-9Central@dhs.gov**, or by calling **1-888-464-4218**. For TDD (hearing impaired), call **1-877-875-6028**.

To obtain USCIS forms or the *Handbook for Employers*, you can download them from the USCIS Web site at www.uscis.gov/forms. You may order USCIS forms by calling our toll-free number at **1-800-870-3676**. You may also obtain forms and information by contacting the USCIS National Customer Service Center at **1-800-375-5283**. For TDD (hearing impaired), call **1-800-767-1833**.

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 the USCIS Web site at www.dhs.gov/E-Verify, by e-mailing USCIS at **E-Verify@dhs.gov** or by calling **1-888-464-4218**. For TDD (hearing impaired), call **1-877-875-6028.**

Employees with questions about Form I-9 and/or E-Verify can reach the USCIS employee hotline by calling **1-888-897-7781**. For TDD (hearing impaired), call **1-877-875-6028.**

Photocopying and Retaining Form I-9

A blank Form I-9 may be reproduced, provided all sides are copied. The instructions and Lists of Acceptable Documents must be available to all employees completing this form. Employers must retain each employee's completed Form I-9 for as long as the individual works for the employer. Employers are required to retain the pages of the form on which the employee and employer enter data. If copies of documentation presented by the employee are made, those copies must also be kept with the form. Once the individual's employment ends, the employer must retain this form for either 3 years after the date of hire or 1 year after the date employment ended, whichever is later.

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

USCIS Privacy Act Statement

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

PURPOSE: This information is collected by employers to comply with the requirements of the Immigration Reform and Control Act of 1986. This law requires that employers verify the identity and employment authorization of individuals they hire 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.

DISCLOSURE: Submission of the information required in this form is voluntary. However, failure of the employer to ensure proper completion of this form for each employee may result in the imposition of civil or criminal penalties. In addition, employing individuals knowing that they are unauthorized to work in the United States may subject the employer to civil and/or criminal penalties.

ROUTINE USES: 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 employer will keep this form and make it 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.

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 35 minutes per response, including the time for reviewing instructions and completing and retaining 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 Coordination Division, Office of Policy and Strategy, 20 Massachusetts Avenue NW, Washington, DC 20529-2140; OMB No. 1615-0047. **Do not mail your completed Form I-9 to this address.**

Employment Eligibility Verification

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

USCIS
Form I-9
OMB No. 1615-0047
Expires 03/31/2016

►START HERE. 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 documentation presented has a future expiration date may also constitute illegal discrimination.

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

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

Address *(Street Number and Name)*	Apt. Number	City or Town	State	Zip Code

Date of Birth *(mm/dd/yyyy)*	U.S. Social Security Number	E-mail Address	Telephone Number
	___-__-____		

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

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

☐ A citizen of the United States

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

☐ A lawful permanent resident (Alien Registration Number/USCIS Number): ____________________

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

*For aliens authorized to work, provide your Alien Registration Number/USCIS Number **OR** Form I-94 Admission Number:*

1. Alien Registration Number/USCIS Number: ____________________

OR

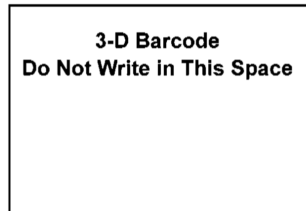
2. Form I-94 Admission Number: ____________________

If you obtained your admission number from CBP in connection with your arrival in the United States, include the following:

Foreign Passport Number: ____________________

Country of Issuance: ____________________

Some aliens may write "N/A" on the Foreign Passport Number and Country of Issuance fields. (*See instructions*)



Signature of Employee:	Date *(mm/dd/yyyy)*:

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.

Signature of Preparer or Translator:	Date *(mm/dd/yyyy)*:

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

Address *(Street Number and Name)*	City or Town	State	Zip Code

Employer Completes Next Page

Section 2. Employer or Authorized Representative Review and Verification

(Employers or their authorized representative must complete and sign Section 2 within 3 business days of the employee's first day of employment. You must physically examine one document from List A OR examine a combination of one document from List B and one document from List C as listed on the "Lists of Acceptable Documents" on the next page of this form. For each document you review, record the following information: document title, issuing authority, document number, and expiration date, if any.)

Employee Last Name, First Name and Middle Initial from Section 1:

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

3-D Barcode
Do Not Write in This Space

Certification

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

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

Signature of Employer or Authorized Representative	Date *(mm/dd/yyyy)*	Title of Employer or Authorized Representative	
Last Name *(Family Name)*	First Name *(Given Name)*	Employer's Business or Organization Name	
Employer's Business or Organization Address *(Street Number and Name)*	City or Town	State	Zip Code

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

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

C. If employee's previous grant of employment authorization has expired, provide the information for the document from List A or List C the employee presented that establishes current employment authorization in the space provided below.

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

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

Signature of Employer or Authorized Representative:	Date *(mm/dd/yyyy)*:	Print Name of Employer or Authorized Representative:

LISTS OF ACCEPTABLE DOCUMENTS
All documents must be UNEXPIRED

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

LIST A **Documents that Establish Both Identity and Employment Authorization**	OR	LIST B **Documents that Establish Identity**	AND	LIST C **Documents that Establish Employment Authorization**
1. U.S. Passport or U.S. Passport Card		**1.** Driver's license or ID card issued by a State or outlying possession of the United States provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		**1.** A Social Security Account Number card, unless the card includes one of the following restrictions: (1) NOT VALID FOR EMPLOYMENT (2) VALID FOR WORK ONLY WITH INS AUTHORIZATION (3) VALID FOR WORK ONLY WITH DHS AUTHORIZATION
2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551)		**2.** ID card issued by federal, state or local government agencies or entities, provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		**2.** Certification of Birth Abroad issued by the Department of State (Form FS-545)
3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa		**3.** School ID card with a photograph		**3.** Certification of Report of Birth issued by the Department of State (Form DS-1350)
4. Employment Authorization Document that contains a photograph (Form I-766)		**4.** Voter's registration card		**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. For a nonimmigrant alien authorized to work for a specific employer because of his or her status: **a.** Foreign passport; and **b.** Form I-94 or Form I-94A that has the following: (1) The same name as the passport; and (2) An endorsement of the alien's nonimmigrant status as long as that period of endorsement has not yet expired and the proposed employment is not in conflict with any restrictions or limitations identified on the form.		**5.** U.S. Military card or draft record		**5.** Native American tribal document
		6. Military dependent's ID card		**6.** U.S. Citizen ID Card (Form I-197)
		7. U.S. Coast Guard Merchant Mariner Card		**7.** Identification Card for Use of Resident Citizen in the United States (Form I-179)
		8. Native American tribal document		**8.** Employment authorization document issued by the Department of Homeland Security
		9. Driver's license issued by a Canadian government authority		
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		**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		

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

Refer to Section 2 of the instructions, titled "Employer or Authorized Representative Review and Verification," for more information about acceptable receipts.

NEW EMPLOYEE DATA COLLECTION FORM

Legal Name: ______________________________

Home Address: ______________________________

____

Mailing Address: ______________________________

____

Home Phone: ____________________ Cell Phone ____________________

E-mail: ______________________________

Birthdate: ____________________ Gender: □ Male □ Female

Marital Status: □ Single □ Married Date of Marriage: ____________________

Ethnicity:

□ American Indian/Alaskan Native	□ Black or African American	□ Asian	□ White
□ Native Hawaiian or Pacific Islander	□ Hispanic or Latino	□ Two or More Races	

Job Title: ______________________________

Work Location: ______________________________

Date Entered Denomination Service: ______________________________

Date Hired: ______________________________

Credential/License Held: ______________________________

Have you previously worked for SECC? □ Yes □ No

Location: ____________________ Dates: ____________________

Are you currently working for SECC? □ Yes □ No

Location: ____________________ Dates: ____________________

______________________________ ____________________

Employee's Signature **Date**

Name of Spouse: ____________________ Date of Birth: ____________________

Names of Children:	Date of Birth:	Gender:
____________________	____________________	____________
____________________	____________________	____________
____________________	____________________	____________
____________________	____________________	____________

Benefits Payroll Service Record

STATEMENT OF ETHICAL FOUNDATIONS FOR THE NORTH AMERICAN DIVISION AND ITS EMPLOYEES

Our Mission

The Seventh-day Adventist Church mission is to proclaim to all peoples the everlasting gospel, in the context of the three angels' messages of Revelation 14:6-12, leading them to accept Jesus as their personal Savior, and encouraging them to unite with His church and prepare for His soon return. Within the scope of this mission, the North American Division office exists to lead the Church in being a worldwide witness for God's kingdom and in making disciples of Jesus Christ.

Our Responsibilities

North American Division employees believe:

We are responsible first to God, our Creator. Individual and collective action must reflect His character and exhibit His love.

We are responsible to the communities in which we work and live and also to the world community. We accept the challenge to be exemplary individuals and corporate citizens. We support good works and charities. We encourage civic improvements, a better quality of life, security, health, and education for all.

We are responsible to our fellow church members. We accept accountability for sound leadership decisions and appropriate stewardship.

We are responsible to each other within the office complex. Every individual deserves to be treated with dignity and respect; to have his or her role and contribution valued and affirmed; to function in a safe working environment; to experience an atmosphere of challenge, open communication, and contentment.

Our Values

We value the *Bible* as the primary reference for life's direction and qualities.

We value *excellence* in all that we do.

We value *ethical and moral conduct* at all times and in all relationships.

We value *creativity and innovation* in the completion of our mission.

We value *honesty, integrity, and courage* as the foundation of all our actions.

We value the *trust* placed in us by colleagues and by the world Church membership.

We value *people* as children of God and therefore brothers and sisters of one family.

Ethical Responsibilities as Employer and Corporate Citizen

In pursuit of its mission, and while maintaining its responsibilities and adhering to its values, the General Conference operates under the following ethical guidelines:

Equal opportunity employment. Within the purview of laws permitting church membership as a condition of employment, and subject to denominational policies on positions requiring ministerial ordination, the North American Division will follow procedures to ensure equal opportunity of employment, remuneration, and advancement on the basis of job qualifications and performance.

Equity, fairness and non-discrimination. The North American Division will treat all individuals and groups with loving justice. It will not practice or condone discrimination with regard to race, national origin, gender, age, marital status, veteran status, or disability that does not prohibit performance of essential job functions.

Compliance with laws of the land. The North American Division will carry on its activities in compliance with the laws of the land provided these are not in contradiction to God's expressed will.

Loyalty and fulfillment of contractual obligations. The North American Division will fulfill the commitments it has entered into through authorized channels. Where misunderstandings arise regarding such commitments, the North American Division shall participate, with the parties concerned, in conflict resolution procedures within the organization before seeking the help of the wider community.

Atmosphere of safety and happiness. The North American Division is committed to providing a work environment that offers physical safety and security. It also strives to encourage and promote genuine happiness through the realization that every employee is valuable and every task, no matter how routine or unnoticed, is a service to God. The North American Division will continue to integrate worship, work, and celebration in a manner that acknowledges wholeness in life and relationships.

Respect for human dignity and individuality. The North American Division affirms and respects the uniqueness of every employee. It recognizes that a person's value surpasses the worth of his or her contribution to the organization. It believes that communal harmony and corporate objectives are enhanced rather than compromised by the broad mosaic of personalities, talents, skills, and viewpoints dedicated to the honor of Jesus Christ. The North American Division shall strive for communication that is timely, truthful, open, candid, and kind.

Ethical Responsibilities as Employees

We recognize that employment in the Seventh-day Adventist Church implies commitment to the organization's mission and concurrence with its responsibilities and values. We affirm that the employer-employee relationship grows within a reciprocity of mutual regard. Our reasonable service as employees includes the following ethical responsibilities:

Life consistent with church message and mission. While in the employ of the North American Division we will live in a manner consistent with the beliefs and values of the Church. We will uphold, in word and conduct, the teachings and principles held and advanced by the Seventh-day Adventist Church.

Respect for Church-owned assets. We will respect the property of our organization, including any intellectual property that is developed in the course of our employment. We will use the property, facilities, and resources solely for the benefit of our organization, unless otherwise permitted or when financial compensation for such use has been arranged.

Respect for colleagues. We will respect and uplift our fellow employees. We will refrain from intentionally placing another in a position of embarrassment, disrespect, or harassment. We will avoid all behavior that may be construed as sexually inappropriate. We will honor the privacy and guard the safety of others.

Efficiency and attention on the job. The hours of our employment shall be devoted to the work assignments entrusted to us. We will not use the employer's time for personal business or the advancement of personal interests unrelated to the work assigned by our supervisors. We will not deprive our employer by entering into other employment or activities which impair our performance for the North American Division while on the job. We will aspire to greater efficiency and the reduction of waste in time, effort, and resources.

Personal integrity in financial matters. We will not engage in theft or embezzlement of any kind including the misuse of expense accounts, falsification of time reports, or the misapplication of resources for which we are responsible.

Avoiding inappropriate influence. We acknowledge that the giving or receiving of business gifts can easily inject ulterior considerations in our work and employment relationships. Therefore the use of gifts, payments, or honoraria as incentives or rewards for a particular course of action is unacceptable. We will not offer gifts, favors, payments, or other forms of reward directly or indirectly in exchange for a specific gain or action.

Maintaining an ethical environment in the workplace. We accept the obligation of maintaining ethical standards in personal life and in the workplace. We believe it is our personal responsibility to report, through established confidential channels, any behavior that is inappropriate or which undermines the ethical environment in the office complex. We are prepared to be held accountable by our supervisors and peers for professional conduct representing the moral and ethical values of the Seventh-day Adventist Church.

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Document voted by the General Conference 1999 Annual Council and at the 1999 North American Division Year-end Meeting.

CONFERENCE EMPLOYEES
SOUTHEASTERN CALIFORNIA CONFERENCE
NORTH AMERICAN DIVISION
P 35 40 STATEMENT OF ACCEPTANCE

THIS DECLARATION applies, to the best of my knowledge, to all members of my immediate family (spouse, children, parents) and its provisions shall protect any organization affiliated with or subsidiary to the Southeastern California Conference hereafter known as SECC. In the event facts change in the future that may create a potential conflict of interest, I agree to notify SECC in writing.

1. I have read the Statement of Ethical Foundations and the policy on Conflict of Interest and/or Commitment.

2. I am in compliance with the SECC policy on conflict of interest and/or commitment as printed above.

3. Except as disclosed below:

    a. Neither I nor my family have a financial interest or business relationship which competes with or conflicts with the interests of SECC.

    b. Neither I nor my family have a financial interest in or have been an employee, officer, director, or trustee of, nor receive/have financial benefits either directly or indirectly from any enterprise (excluding less than five percent (5%) ownership in any entity with publicly traded securities) which is or has been doing business with or is a competitor of SECC.

    c. Neither I nor my family receive/have received any payments or gifts (other than of token value) from other denominational entities, suppliers, or agencies doing business with SECC.

    d. Neither I nor my family serve/have served as an officer, director, trustee, or agent of any organization affiliated with or subsidiary to SECC in any decision making process involving financial or legal interests adverse to SECC.

Disclosures:

1.

2.

3.

____________________	____________________	______________
Signature	Print Name	Date
____________________	____________________	
Job Title	Location	

EMPLOYEE SERVICE RECORD

First Name: ____________________ Social Security Number: ____________________

Middle Name: ____________________ Date of Birth: ____________________

Last Name: ____________________ Birthplace: ____________________

Maiden Name: ____________________ Citizenship: ____________________

Suffix: ____________________ Date of Ordination: ____________________

Address: ____________________ NAD Retirement Date: ____________________

City: ____________________ Date of Marriage: ____________________

State: ____________________ Spouse's Name: ____________________

Postal Code: ____________________ Spouse's Birthdate: ____________________

Phone Number: ____________________ Date Entered Denominational Service: __________

E-Mail Address: ____

Military Service: Country: __________ Branch: __________ Begin: __________ End: __________

Educational Record

Level of Education	Degree/Diploma Held	Institution	Year Received
College:			
Graduate:			
Doctoral:			
Other:			

Denominational Employment

(list the last place of denomination employment only)

Position/Type of Work: ____________________ Beginning Date: ____________________

Employing Organization: ____________________ Ending Date: ____________________

Conference Affiliation: ____

A record shall be maintained for all full-time employees, salaried employees working 50% or more, and hourly employees working 50% or more per year.
Upon completion of this form, please return to the address listed below:

Southeastern California Conference
Human Resources Department
11330 Pierce Street / P. O. Box 8050
Riverside, CA 92515

Revision Date: 09 April 2008

Southeastern California Conference

CONFIDENTIAL

Background Check Authorization for Employment

Print Name: ____
(First) (Middle) (Last)

Former Name(s) and Dates Used: ____

Current Address Since: ____
(Mo/Yr) (Street) (City) (State/Zip)

Telephone Number: ____

Previous Address From: ____
(Mo/Yr) (Street) (City) (State/Zip)

Social Security Number: ____

Date Of Birth: ____

Drivers License Number/State: ____

Place of Employment: ____

The information contained in this application is correct to the best of my knowledge. I authorize Southeastern California Conference and its designated agents and representatives to conduct a comprehensive review of my background causing a consumer report and/or an investigative consumer report to be generated for employment and/or volunteer purposes. I understand that the scope of the consumer report/ investigative consumer report may include, but is not limited to the following areas: verification of social security number; current and previous residences; employment history, education background, character references; drug testing, civil and criminal history records from any criminal justice agency in any or all federal, state, county jurisdictions; driving records, birth records, and any other public records.

I further authorize any individual, company, firm, corporation, or public agency (including the Social Security Administration and law enforcement agencies) to divulge any and all information, verbal or written, pertaining to me, to Southeastern California Conference or its agents. I further authorize the complete release of any records or data pertaining to me which the individual, company, firm, corporation, or public agency may have, to include information or data received from other sources.

NAD Working Policy states for *Driver Record/Qualifications* that "All drivers shall be properly licensed and comply with all Federal, state and/or provincial laws for the class of vehicle being operated. The recommended minimum age for drivers shall be twenty-one (21) years. A minimum allowable age of nineteen (19) years old may be granted with the approval of the conference officers. The driving record (Motor Vehicle Record) of each driver shall be obtained from state/provincial records and reviewed on a regular basis. Drivers shall have an acceptable driving record during the previous three years with not more than two traffic citations and no at-fault accidents while driving any vehicle. When a driver does not meet the above driving standard, he/she shall not be assigned to or retained for a driving position."

***Southeastern California Conference and its designated agents and representatives shall maintain all information received from this authorization in a confidential manner in order to protect the applicants personal information, including, but not limited to, addresses, social security numbers, and dates of birth.

Notice:
If you wish to receive a copy of your Background Check Report, please initial here: ________________

Signature: ____ Date: ____________________

FOR OFFICE USE ONLY:

Check run: ______________________________________ ☐ *CLEARED* ☐ *NOT CLEARED*

Account Number: ________________________________ ☐ *DMV*

Southeastern California Conference
Human Resources Department

Church Membership Verification Form

Name:	
Previous/Maiden Name:	
Address:	
Date of Birth:	
Church Where Membership is Held: *If church is not within SECC, which conference?	
Membership by:	☐ Baptism ☐ Profession of Faith
Pastor's Name:	
Previous Church Membership:	
Form Completed by:	
Date Form Completed:	

*If your membership is not within SECC please have your church provide a letter of verification stating that you are currently a baptized member in good standing.

Office Use Only:

Membership Verified by:	
Date Membership Verified:	

Return this form to:
SECC Human Resources Dept. Attention: Brooke Hess
P.O. Box 79990 Riverside, CA 92513-1990
Brooke.hess@seccsda.org 951-509-2353 (Phone) 951-509-2395 (fax)

Revised 9/11/2014

JOB HAZARD ASSESSMENT SURVEY

Description of Duties

In order to assign appropriate training for the employees at the church or in the department, please complete this form for each position. This form must be completed as part of the New Employee Packet.

Supervising Site Location ____

Position ____

Employee Serving in this Position ____

Essential Duties and Responsibilities

Please provide a list of essential duties and responsibilities for this position. Attach additional sheet as necessary or attach existing job description if available.

1.

2.

3.

4.

5.

6.

7.

8.

9.

10.

Please select and check next to each item listed below that pertains to this position:

- ☐ This position requires, frequent or infrequent use of a ladder.
- ☐ The position requires lifting or moving objects, even if infrequently.
- ☐ This position works with chemicals, such as cleaning products, copy machine toner, paint, paint thinner, etc.
- ☐ This position works with power tools (i.e. lawn mowers, saws, drills, grinders).
- ☐ This position works with installing and/or repairing electrical wiring, or comes into contact with electrical wiring, boxes, etc.
- ☐ This position may come in contact with blood borne pathogens, such as cleaning the restrooms or working with food.
- ☐ This position requires repetitive movement or prolonged positions (i.e. sitting, working primarily with a computer).

Workers’ Compensation Claim Form (DWC 1) & Notice of Potential Eligibility
Formulario de Reclamo de Compensación de Trabajadores (DWC 1) y Notificación de Posible Elegibilidad

If you are injured or become ill, either physically or mentally, because of your job, including injuries resulting from a workplace crime, you may be entitled to workers’ compensation benefits. Attached is the form for filing a workers’ compensation claim with your employer. **You should read all of the information below.** Keep this sheet and all other papers for your records. You may be eligible for some or all of the benefits listed depending on the nature of your claim. If required you will be notified by the claims administrator, who is responsible for handling your claim, about your eligibility for benefits.

To file a claim, complete the “Employee” section of the form, keep one copy and give the rest to your employer. Your employer will then complete the “Employer” section, give you a dated copy, keep one copy and send one to the claims administrator. Benefits can’t start until the claims administrator knows of the injury, so complete the form as soon as possible.

Medical Care: Your claims administrator will pay all reasonable and necessary medical care for your work injury or illness. Medical benefits may include treatment by a doctor, hospital services, physical therapy, lab tests, x-rays, and medicines. Your claims administrator will pay the costs directly so you should never see a bill. There is a limit on some medical services.

The Primary Treating Physician (PTP) is the doctor with the overall responsibility for treatment of your injury or illness. Generally your employer selects the PTP you will see for the first 30 days, however, in specified conditions, you may be treated by your predesignated doctor or medical group. If a doctor says you still need treatment after 30 days, you may be able to switch to the doctor of your choice. Different rules apply if your employer is using a Health Care Organization (HCO) or a Medical Provider Network (MPN). A MPN is a selected network of health care providers to provide treatment to workers injured on the job. You should receive information from your employer if you are covered by an HCO or a MPN. Contact your employer for more information. If your employer has not put up a poster describing your rights to workers’ compensation, you may choose your own doctor immediately.

Within one working day after you file a claim form, your employer shall authorize the provision of all treatment, consistent with the applicable treating guidelines, for the alleged injury and shall continue to be liable for up to $10,000 in treatment until the claim is accepted or rejected.

Disclosure of Medical Records: After you make a claim for workers' compensation benefits, your medical records will not have the same level of privacy that you usually expect. If you don’t agree to voluntarily release medical records, a workers’ compensation judge may decide what records will be released. If you request privacy, the judge may "seal" (keep private) certain medical records.

Payment for Temporary Disability (Lost Wages): If you can't work while you are recovering from a job injury or illness, for most injuries you will receive temporary disability payments for a limited period of time. These payments may change or stop when your doctor says you are able to return to work. These benefits are tax-free. Temporary disability payments are two-thirds of your average weekly pay, within minimums and maximums set by state law. Payments are not made for the first three days you are off the job unless you are hospitalized overnight or cannot work for more than 14 days.

Return to Work: To help you to return to work as soon as possible, you should actively communicate with your treating doctor, claims administrator, and employer about the kinds of work you can do while recovering. They may coordinate efforts to return you to modified duty or other work that is medically appropriate. This modified or other duty may

Si Ud. se lesiona o se enferma, ya sea físicamente o mentalmente, debido a su trabajo, incluyendo lesiones que resulten de un crimen en el lugar de trabajo, es posible que Ud. tenga derecho a beneficios de compensación de trabajadores. Se adjunta el formulario para presentar un reclamo de compensación de trabajadores con su empleador. **Ud. debe leer toda la información a continuación.** Guarde esta hoja y todos los demás documentos para sus archivos. Es posible que usted reúna los requisitos para todos los beneficios, o parte de éstos, que se enumeran, dependiendo de la índole de su reclamo. Si se requiere, el administrador de reclamos, quien es responsable por el manejo de su reclamo, le notificará sobre su elegibilidad para beneficios.

Para presentar un reclamo, llene la sección del formulario designada para el “Empleado,” guarde una copia, y déle el resto a su empleador. Entonces, su empleador completará la sección designada para el “Empleador,” le dará a Ud. una copia fechada, guardará una copia, y enviará una al administrador de reclamos. Los beneficios no pueden comenzar hasta, que el administrador de reclamos se entere de la lesión, así que complete el formulario lo antes posible.

Atención Médica: Su administrador de reclamos pagará toda la atención médica razonable y necesaria, para su lesión o enfermedad relacionada con el trabajo. Es posible que los beneficios médicos incluyan el tratamiento por parte de un médico, los servicios de hospital, la terapia física, los análisis de laboratorio y las medicinas. Su administrador de reclamos pagará directamente los costos, de manera que usted nunca verá un cobro. Hay un límite para ciertos servicios médicos.

El Médico Primario que le Atiende-*Primary Treating Physician PTP* es el médico con la responsabilidad total para tratar su lesión o enfermedad. Generalmente, su empleador selecciona al *PTP* que Ud. verá durante los primeros 30 días. Sin embargo, en condiciones específicas, es posible que usted pueda ser tratado por su médico o grupo médico previamente designado. Si el doctor dice que usted aún necesita tratamiento después de 30 días, es posible que Ud. pueda cambiar al médico de su preferencia. Hay reglas differentes que se aplican cuando su empleador usa una Organización de Cuidado Médico (HCO) o una Red de Proveedores Médicos (MPN). Una MPN es una red de proveedores de asistencia médica seleccionados para dar tratamiento a los trabajadores lesionados en el trabajo. Usted debe recibir información de su empleador si su tratamiento es cubierto por una HCO o una MPN. Hable con su empleador para más información. Si su empleador no ha colocado un cartel describiendo sus derechos para la compensación de trabajadores, Ud. puede seleccionar a su propio médico inmediatamente.

Dentro de un día después de que Ud. Presente un formulario de reclamo, su empleador autorizará todo tratamiento médico de acuerdo con las pautas de tratamiento aplicables a la presunta lesión y será responsable por $10,000 en tratamiento hasta que el reclamo sea aceptado o rechazado.

Divulgación de Expedientes Médicos: Después de que Ud. presente un reclamo para beneficios de compensación de trabajadores, sus expedientes médicos no tendrán el mismo nivel de privacidad que usted normalmente espera. Si Ud. no está de acuerdo en divulgar voluntariamente los expedientes médicos, un juez de compensación de trabajadores posiblemente decida qué expedientes se revelarán. Si Ud. solicita privacidad, es posible que el juez “selle” (mantenga privados) ciertos expedientes médicos.

Pago por Incapacidad Temporal (Sueldos Perdidos): Si Ud. no puede trabajar, mientras se está recuperando de una lesión o enfermedad relacionada con el trabajo, Ud. recibirá pagos por incapacidad temporal para la mayoría de las lesions por un period limitado. Es posible que estos pagos cambien o paren, cuando su médico diga que Ud. está en condiciones de regresar a trabajar. Estos beneficios son libres de impuestos. Los pagos

be temporary or may be extended depending on the nature of your injury or illness.

Payment for Permanent Disability: If a doctor says your injury or illness results in a permanent disability, you may receive additional payments. The amount will depend on the type of injury, your age, occupation, and date of injury.

Supplemental Job Displacement Benefit (SJDB): If you were injured after 1/1/04 and you have a permanent disability that prevents you from returning to work within 60 days after your temporary disability ends, and your employer does not offer modified or alternative work, you may qualify for a nontransferable voucher payable to a school for retraining and/or skill enhancement. If you qualify, the claims administrator will pay the costs up to the maximum set by state law based on your percentage of permanent disability.

Death Benefits: If the injury or illness causes death, payments may be made to relatives or household members who were financially dependent on the deceased worker.

It is illegal for your employer to punish or fire you for having a job injury or illness, for filing a claim, or testifying in another person's workers' compensation case (Labor Code 132a). If proven, you may receive lost wages, job reinstatement, increased benefits, and costs and expenses up to limits set by the state.

You have the right to disagree with decisions affecting your claim. If you have a disagreement, contact your claims administrator first to see if you can resolve it. If you are not receiving benefits, you may be able to get State Disability Insurance (SDI) benefits. Call State Employment Development Department at (800) 480-3287.

You can obtain free information from an information and assistance officer of the State Division of Workers' Compensation (DWC), or you can hear recorded information and a list of local offices by calling **(800) 736-7401**. You may also go to the DWC website at www.dwc.ca.gov.

You can consult with an attorney. Most attorneys offer one free consultation. If you decide to hire an attorney, his or her fee will be taken out of some of your benefits. For names of workers' compensation attorneys, call the State Bar of California at (415) 538-2120 or go to their web site at **www.californiaspecialist.org**.

por incapacidad temporal son dos tercios de su pago semanal promedio, con cantidades mínimas y máximas establecidas por las leyes estatales. Los pagos no se hacen durante los primeros tres días en que Ud. no trabaje, a menos que Ud. sea hospitalizado una noche o no pueda trabajar durante más de 14 días.

Regreso al Trabajo: Para ayudarle a regresar a trabajar lo antes posible, Ud. debe comunicarse de manera activa con el médico que le atienda, el administrador de reclamos y el empleador, con respecto a las clases de trabajo que Ud. puede hacer mientras se recupera. Es posible que ellos coordinen esfuerzos para regresarle a un trabajo modificado, o a otro trabajo, que sea apropiado desde el punto de vista médico. Este trabajo modificado u otro trabajo podría ser temporal o podría extenderse dependiendo de la índole de su lesión o enfermedad.

Pago por Incapacidad Permanente: Si el doctor dice que su lesión o enfermedad resulta en una incapacidad permanente, es posible que Ud. reciba pagos adicionales. La cantidad dependerá de la clase de lesión, su edad, su ocupación y la fecha de la lesión.

Beneficio Suplementario por Desplazamiento de Trabajo: Si Ud. Se lesionó después del 1/1/04 y tiene una incapacidad permanente que le impide regresar al trabajo dentro de 60 días después de que los pagos por incapacidad temporal terminen, y su empleador no ofrece un trabajo modificado o alternativo, es posible que usted reúna los requisitos para recibir un vale no-transferible pagadero a una escuela para recibir un nuevo entrenamiento y/o mejorar su habilidad. Si Ud. reúne los requisitios, el administrador de reclamos pagará los gastos hasta un máximo establecido por las leyes estatales basado en su porcentaje de incapacidad permanente.

Beneficios por Muerte: Si la lesión o enfermedad causa la muerte, es posible que los pagos se hagan a los parientes o a las personas que viven en el hogar y que dependían económicamente del trabajador difunto.

Es ilegal que su empleador le castigue o despida, por sufrir una lesión o enfermedad en el trabajo, por presentar un reclamo o por testificar en el caso de compensación de trabajadores de otra persona. (El Codigo Laboral sección 132a.) De ser probado, usted puede recibir pagos por pérdida de sueldos, reposición del trabajo, aumento de beneficios y gastos hasta los límites establecidos por el estado.

Ud. tiene derecho a no estar de acuerdo con las decisiones que afecten su reclamo. Si Ud. tiene un desacuerdo, primero comuníquese con su administrador de reclamos para ver si usted puede resolverlo. Si usted no está recibiendo beneficios, es posible que Ud. pueda obtener beneficios del Seguro Estatal de Incapacidad (SDI). Llame al Departamento Estatal del Desarrollo del Empleo (EDD) al (800) 480-3287.

Ud. puede obtener información gratis, de un oficial de información y asistencia, de la División Estatal de Compensación de Trabajadores *(Division of Workers' Compensation – DWC)* o puede escuchar información grabada, así como una lista de oficinas locales llamando al **(800) 736-7401**. Ud. también puede consultar con la pagína Web de la DWC en www.dwc.ca.gov**.**

Ud. puede consultar con un abogado. La mayoría de los abogados ofrecen una consulta gratis. Si Ud. decide contratar a un abogado, los honorarios serán tomados de algunos de sus beneficios. Para obtener nombres de abogados de compensación de trabajadores, llame a la Asociación Estatal de Abogados de California *(State Bar)* al (415) 538-2120, ó consulte con la pagína Web en **www.californiaspecialist.org**.

State of California
Department of Industrial Relations
DIVISION OF WORKERS' COMPENSATION

Estado de California
Departamento de Relaciones Industriales
DIVISION DE COMPENSACIÓN AL TRABAJADOR

WORKERS' COMPENSATION CLAIM FORM (DWC 1)

PETITION DEL EMPLEADO PARA DE COMPENSACIÓN DEL TRABAJADOR (DWC 1)

Employee: Complete the **"Employee"** section and give the form to your employer. Keep a copy and mark it **"Employee's Temporary Receipt"** until you receive the signed and dated copy from your employer. You may call the Division of Workers' Compensation and hear recorded information at **(800) 736-7401**. An explanation of workers' compensation benefits is included as the cover sheet of this form.

You should also have received a pamphlet from your employer describing workers' compensation benefits and the procedures to obtain them.

Empleado: *Complete la sección* ***"Empleado"*** *y entregue la forma a su empleador. Quédese con la copia designada* ***"Recibo Temporal del Empleado"*** *hasta que Ud. reciba la copia firmada y fechada de su empleador. Ud. puede llamar a la Division de Compensación al Trabajador al* ***(800) 736-7401*** *para oir información gravada. En la hoja cubierta de esta forma esta la explicatión de los beneficios de compensación al trabajador.*

Ud. también debería haber recibido de su empleador un folleto describiendo los benficios de compensación al trabajador lesionado y los procedimientos para obtenerlos.

Any person who makes or causes to be made any knowingly false or fraudulent material statement or material representation for the purpose of obtaining or denying workers' compensation benefits or payments is guilty of a felony.

Toda aquella persona que a propósito haga o cause que se produzca cualquier declaración o representación material falsa o fraudulenta con el fin de obtener o negar beneficios o pagos de compensación a trabajadores lesionados es culpable de un crimen mayor "felonia".

Employee—complete this section and see note above ***Empleado—complete esta sección y note la notación arriba.***

1. Name. *Nombre.* ____________ Today's Date. *Fecha de Hoy.* ____________
2. Home Address. *Dirección Residencial.* ____________
3. City. *Ciudad.* ____________ State. *Estado.* ____________ Zip. *Código Postal.* ____________
4. Date of Injury. *Fecha de la lesión (accidente).* ____________ Time of Injury. *Hora en que ocurrió.* ________a.m. ________p.m.
5. Address and description of where injury happened. *Dirección/lugar dónde occurió el accidente.* ____________
6. Describe injury and part of body affected. *Describa la lesión y parte del cuerpo afectada.* ____________
7. Social Security Number. *Número de Seguro Social del Empleado.* ____________
8. Signature of employee. *Firma del empleado.* ____________

Employer—complete this section and see note below. ***Empleador—complete esta sección y note la notación abajo.***

9. Name of employer. *Nombre del empleador.* ____________
10. Address. *Dirección.* ____________
11. Date employer first knew of injury. *Fecha en que el empleador supo por primera vez de la lesión o accidente.* ____________
12. Date claim form was provided to employee. *Fecha en que se le entregó al empleado la petición.* ____________
13. Date employer received claim form. *Fecha en que el empleado devolvió la petición al empleador.* ____________
14. Name and address of insurance carrier or adjusting agency. *Nombre y dirección de la compañía de seguros o agencia adminstradora de seguros.* ____________
15. Insurance Policy Number. *El número de la póliza de Seguro.* ____________
16. Signature of employer representative. *Firma del representante del empleador.* ____________
17. Title. *Título.* ____________ 18. Telephone. *Teléfono.* ____________

Employer: You are required to date this form and provide copies to your insurer or claims administrator and to the employee, dependent or representative who filed the claim within **one working day** of receipt of the form from the employee.

SIGNING THIS FORM IS NOT AN ADMISSION OF LIABILITY

Empleador: *Se requiere que Ud. feche esta forma y que provéa copias a su compañía de seguros, administrador de reclamos, o dependiente/representante de reclamos y al empleado que hayan presentado esta petición dentro del plazo de* ***un día hábil*** *desde el momento de haber sido recibida la forma del empleado.*

EL FIRMAR ESTA FORMA NO SIGNIFICA ADMISION DE RESPONSABILIDAD

❑ Employer copy/*Copia del Empleador* ❑ Employee copy/ *Copia del Empleado* ❑ Claims Administrator/*Administrador de Reclamos* ❑ Temporary Receipt/*Recibo del Empleado*

6/10 Rev.

Southeastern California Conference
Of Seventh-Day Adventists

VOLUNTEER SERVICES

Name: ____________________	Date: ____________________
Address: ____________________	Telephone: ____________________
____________________	Location: ____________________
Assignment: ____________________	Ending Date: ____________________
Beginning Date: ____________________	

AS A VOLUNTEER I UNDERSTAND THERE IS NO PAYMENT AND NO EMPLOYMENT RELATIONSHIP

____________________	____________________
Volunteer Signature Date	Supervisor/Pastor Signature Date

STATEMENT OF INTENT TO EMPLOY A MINOR AND REQUEST FOR WORK PERMIT–CERTIFICATE OF AGE

CDE B1-1 (Rev. 07-10)

A "STATEMENT OF INTENT TO EMPLOY A MINOR AND REQUEST FOR WORK PERMIT–CERTIFICATE OF AGE" form (CDE B1-1) shall be completed in accordance with California *Education Code* 49162 and 49163 as notification of intent to employ a minor. This form is also a Certificate of Age pursuant to California *Education Code* 49114.

(Print Information)

Minor's Information

Minor's Name *(First and Last)* ______ Home Phone ______

Birth Date ______ Social Security Number ______ Grade ______ Age ______

Home Address ______ City ______ Zip Code ______

School Information

School Name ______ School Phone ______

School Address ______ City ______ Zip Code ______

To be filled in and signed by employer. (Please review the General Summary of Minors' Work Regulations on reverse.)

Business Name or Agency of Placement ______ Business Phone ______ Supervisor's Name ______

Business Address ______ City ______ Zip Code ______

Describe nature of work to be performed: ______

In compliance with California labor laws, this employee is covered by worker's compensation insurance. This business does not discriminate unlawfully on the basis of race, ethnic background, religion, sex, sexual orientation, color, national origin, ancestry, age, physical handicap, or medical condition. I hereby certify that, to the best of my knowledge, the information herein is correct and true.

Employer's Name *(Print First and Last)* ______ Employer's Signature ______ Date ______

To be filled in and signed by parent or legal guardian

This minor is being employed at the place of work described with my full knowledge and consent. I hereby certify that to the best of my knowledge and belief, the information herein is correct and true. I request that a work permit be issued.

Parent or Legal Guardian's Name *(Print First and Last)* ______ Parent or Legal Guardian's Signature ______ Date ______

For authorized work permit issuer use ONLY

Maximum number of hours of employment when school is in session:

Mon	Tue	Wed	Thu	Fri	Sat	Sun	Total

Proof of Minor's Age *(Evidence Type)* ______

Verifying Authority's Name and Title *(Print)* ______

Verifying Authority's Signature ______

Check Permit Type:

- ☐ *Full-time
- ☐ **Workability
- ☐ Restricted
- ☐ General
- ☐ ***Work Experience Education, Vocational Education, or Personal Attendant

**EC* 49130 | **Permit Type defined by local school | ***Special Education Grant

Copy–District or County Superintendent; Employer; Parent or Legal Guardian **(Over)**

STATEMENT OF INTENT TO EMPLOY A MINOR AND REQUEST FOR WORK PERMIT—CERTIFICATE OF AGE

CDE B1-1 (Rev. 07-10)

General Summary of Minors' Work Regulations

FLSA-Federal Labor Standards Act, CDE-California Department of Education, *EC*-California *Education Code*, *LC*-California *Labor Code, CFR*-California Federal Regulations

- **If federal laws, state laws, and school district policies conflict, the more restrictive law (the one most protective of the minor) prevails. (FLSA)**
- Employers of minors required to attend school must complete a "Statement of Intent to Employ a Minor and Request for Work Permit" (CDE B1-1) for the school attendance for each such minor. (*EC* 49162)
- Employers must retain a "Permit to Employ and Work" (CDE B1-4) for each such minor. *(EC* 49161)
- Work permits (CDE B1-4) must be retained for three years and be available for inspection by sanctioned authorities at all times. (*EC* 49164)
- A work permit (CDE B1-4) must be revoked whenever the issuing authority determines the employment is illegal or is impairing the health or education of the minor. (*EC* 49164)
- A day of rest from work is required in every seven days, and shall not exceed six days in seven. (*LC* 551, 552)

Minors under the age of 18 may not work in environments declared hazardous or dangerous for young workers, examples listed below: (*LC* 1294.1 and 1294.5, 29 *CFR* 570 Subpart E)

1. Explosive exposure
2. Motor vehicle driving/outside helper
3. Roofing
4. Logging and sawmilling
5. Power-driven woodworking machines
6. Radiation exposure
7. Power-driven hoists/forklifts
8. Power-driven metal forming, punching, and shearing machines
9. Power saws and shears
10. Power-driving meat slicing/processing machines

HOURS OF WORK

16 & 17 Year Olds	14 & 15 Year Olds	12 & 13 Year Olds
Must have completed 7th grade to work while school is in session. (*EC* 49112)	Must have completed 7th grade to work while school is in session (*EC* 49112)	Labor laws generally prohibit non-farm employment of children younger than 14. Special rules apply to agricultural work, domestic work, and the entertainment industry. (*LC* 1285–1312)
School In Session		
4 hours per day on any schoolday (*EC* 49112; 49116; *LC* 1391) 8 hours on any non-schoolday or on any day preceding a non-schoolday. (*EC* 49112; *LC* 1391) 48 hours per week (*LC* 1391) WEE students & personal attendants may work more than 4 hours on a schoolday, but never more than 8. (*EC* 49116; *LC* 1391, 1392)	3 hours per schoolday outside of school hours (*EC* 49112, 49116; *LC* 1391) 8 hours on any non-schoolday No more than 18 hours per week (*EC* 49116; *LC* 1391) WEE students may work during school hours & up to 23 hours per week. (*EC* 49116; *LC* 1391)	2 hours per schoolday and a maximum of 4 hours per week. (*EC* 49112)
School Not In Session		
8 hours per day (*LC* 1391, 1392) 48 hours per week (*LC* 1391)	8 hours per day (*LC* 1391, 1392) 40 hours per week (*LC* 1391)	8 hours per day (*LC* 1391, 1392) 40 hours per week (*LC* 1391)
Spread of Hours		
5 a.m.–10 p.m. However, until 12:30 a.m. on any evening preceding a non-schoolday (*LC* 1391) WEE students, with permission, until 12:30 a.m. on any day (*LC* 1391.1) Messengers: 6 a.m.–9 p.m.	7 a.m.–7 p.m., except that from June 1 through Labor Day, until 9 p.m. (*LC* 1391)	7 a.m.–7 p.m., except that from June 1 through Labor Day, until 9 p.m. (*LC* 1391)

For more information about child labor laws, contact the U.S. Department of Labor at http://www.dol.gov/, and the State of California Department of Industrial Relations, Division of Labor Standards Enforcement at http://www.dir.ca.gov/DLSE/dlse.html.

Do Not Staple 6969

Form **1096**

Department of the Treasury
Internal Revenue Service

Annual Summary and Transmittal of U.S. Information Returns

OMB No. 1545-0108

2013

FILER'S name

SAMPLE - Seventh-day Adventist Church

Street address (including room or suite number)

12345 Hope Street
Anytown, CA 92641

City or town, province or state, country, and ZIP or foreign postal code

For Official Use Only

Name of person to contact	Telephone number
Joe Treasurer	(951) 509-2345
Email address	Fax number

1 Employer identification number	2 Social security number	3 Total number of forms	4 Federal income tax withheld	5 Total amount reported with this Form 1096
91-2165741		2	$ 0	$ 2,100.00

6 Enter an "X" in only one box below to indicate the type of form being filed.

7 If this is your **final return**, enter an "X" here . . . . . . ▶ ☐

W-2G 32	1097-BTC 50	1098 81	1098-C 78	1098-E 84	1098-T 83	1099-A 80	1099-B 79	1099-C 85	1099-CAP 73	1099-DIV 91	1099-G 86	1099-H 71	1099-INT 92	1099-K 10	1099-LTC 93	1099-MISC 95	1099-OID 96
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

1099-PATR 97	1099-Q 31	1099-R 98	1099-S 75	1099-SA 94	3921 25	3922 26	5498 28	5498-ESA 72	5498-SA 27
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Return this entire page to the Internal Revenue Service. Photocopies are not acceptable.

Under penalties of perjury, I declare that I have examined this return and accompanying documents, and, to the best of my knowledge and belief, they are true, correct, and complete.

Signature ▶ **Title ▶** **Date ▶**

Instructions

Future developments. For the latest information about developments related to Form 1096, such as legislation enacted after they were published, go to *www.irs.gov/form1096.*

Reminder. The only acceptable method of filing information returns with Internal Revenue Service/Information Returns Branch is electronically through the FIRE system. See Pub. 1220, Specifications for Filing Forms 1097, 1098, 1099, 3921, 3922, 5498, 8935, and W-2G Electronically.

Purpose of form. Use this form to transmit paper Forms 1097, 1098, 1099, 3921, 3922, 5498, and W-2G to the Internal Revenue Service. Do not use Form 1096 to transmit electronically. For electronic submissions, see Pub. 1220.

Caution. If you are required to file 250 or more information returns of any one type, you must file electronically. If you are required to file electronically but fail to do so, and you do not have an approved waiver, you may be subject to a penalty. For more information, see part F in the 2013 General Instructions for Certain Information Returns.

Who must file. The name, address, and TIN of the filer on this form must be the same as those you enter in the upper left area of Forms 1097, 1098, 1099, 3921, 3922, 5498, or W-2G. A filer is any person or entity who files any of the forms shown in line 6 above.

Enter the filer's name, address (including room, suite, or other unit number), and TIN in the spaces provided on the form.

When to file. File Form 1096 as follows.

- With Forms 1097, 1098, 1099, 3921, 3922, or W-2G, file by February 28, 2014.
- With Forms 5498, file by June 2, 2014.

Where To File

Send all information returns filed on paper with Form 1096 to the following:

If your principal business, office or agency, or legal residence in the case of an individual, is located in	Use the following three-line address
Alabama, Arizona, Arkansas, Connecticut, Delaware, Florida, Georgia, Kentucky, Louisiana, Maine, Massachusetts, Mississippi, New Hampshire, New Jersey, New Mexico, New York, North Carolina, Ohio, Pennsylvania, Rhode Island, Texas, Vermont, Virginia, West Virginia	Department of the Treasury Internal Revenue Service Center Austin, TX 73301

For more information and the Privacy Act and Paperwork Reduction Act Notice, see the 2013 General Instructions for Certain Information Returns.

Cat. No. 14400O

Alaska, California, Colorado, District of Columbia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Maryland, Michigan, Minnesota, Missouri, Montana, Nebraska, Nevada, North Dakota, Oklahoma, Oregon, South Carolina, South Dakota, Tennessee, Utah, Washington, Wisconsin, Wyoming	Department of the Treasury Internal Revenue Service Center Kansas City, MO 64999

If your legal residence or principal place of business is outside the United States, file with the Department of the Treasury, Internal Revenue Service Center, Austin, TX 73301.

Transmitting to the IRS. Group the forms by form number and transmit each group with a separate Form 1096. For example, if you must file both Forms 1098 and 1099-A, complete one Form 1096 to transmit your Forms 1098 and another Form 1096 to transmit your Forms 1099-A. You need not submit original and corrected returns separately. Do not send a form (1099, 5498, etc.) containing summary (subtotal) information with Form 1096. Summary information for the group of forms being sent is entered only in boxes 3, 4, and 5 of Form 1096.

Box 1 or 2. Complete only if you are not using a preaddressed Form 1096. Make an entry in either box 1 or 2; not both. Individuals not in a trade or business must enter their social security number (SSN) in box 2; sole proprietors and all others must enter their employer identification number (EIN) in box 1. However, sole proprietors who do not have an EIN must enter their SSN in box 2. Use the same EIN or SSN on Form 1096 that you use on Forms 1097, 1098, 1099, 3921, 3922, 5498, or W-2G.

Box 3. Enter the number of forms you are transmitting with this Form 1096. Do not include blank or voided forms or the Form 1096 in your total. Enter the number of correctly completed forms, not the number of pages, being transmitted. For example, if you send one page of three-to-a-page Forms 1098 with a Form 1096 and you have correctly completed two Forms 1098 on that page, enter "2" in box 3 of Form 1096.

Box 4. Enter the total federal income tax withheld shown on the forms being transmitted with this Form 1096.

Box 5. No entry is required if you are filing Form 1098-T, 1099-A, or 1099-G. For all other forms, enter the total of the amounts from the specific boxes of the forms listed below.

Form W-2G	Box 1
Form 1097-BTC	Box 1
Form 1098	Boxes 1 and 2
Form 1098-C	Box 4c
Form 1098-E	Box 1
Form 1099-B	Boxes 1d and 14
Form 1099-C	Box 2
Form 1099-CAP	Box 2
Form 1099-DIV	Boxes 1a, 2a, 3, 8, 9, and 10
Form 1099-H	Box 1
Form 1099-INT	Boxes 1, 3, and 8
Form 1099-K	Box 1
Form 1099-LTC	Boxes 1 and 2
Form 1099-MISC	Boxes 1, 2, 3, 5, 6, 7, 8, 10, 13, and 14
Form 1099-OID	Boxes 1, 2, and 8
Form 1099-PATR	Boxes 1, 2, 3, and 5
Form 1099-Q	Box 1
Form 1099-R	Box 1
Form 1099-S	Box 2
Form 1099-SA	Box 1
Form 3921	Boxes 3 and 4
Form 3922	Boxes 3, 4, and 5
Form 5498	Boxes 1, 2, 3, 4, 5, 8, 9, 10, 12b, 13a, and 14a
Form 5498-ESA	Boxes 1 and 2
Form 5498-SA	Box 1

Final return. If you will not be required to file Forms 1097, 1098, 1099, 3921, 3922, 5498, or W-2G in the future, either on paper or electronically, enter an "X" in the "final return" box.

Corrected returns. For information about filing corrections, see the 2013 General Instructions for Certain Information Returns. Originals and corrections of the same type of return can be submitted using one Form 1096.

9595 ☐ VOID ☐ CORRECTED

PAYER'S name, street address, city or town, province or state, country, ZIP or foreign postal code, and telephone no.		1 Rents	OMB No. 1545-0115	Miscellaneous Income
SAMPLE - Seventh-day Adventist Church 12345 Hope Street Anytown, CA 92641		$	2013	
		2 Royalties $	Form 1099-MISC	
		3 Other income $	4 Federal income tax withheld $	Copy A For Internal Revenue Service Center
PAYER'S federal identification number 91-2165741	RECIPIENT'S identification number 123-45-6789	5 Fishing boat proceeds $	6 Medical and health care payments $	File with Form 1096.
RECIPIENT'S name Joseph Smith		7 Nonemployee compensation $ 1,500.00	8 Substitute payments in lieu of dividends or interest $	For Privacy Act and Paperwork Reduction Act Notice, see the **2013 General Instructions for Certain Information Returns.**
Street address (including apt. no.) 13356 Third Street		9 Payer made direct sales of $5,000 or more of consumer products to a buyer (recipient) for resale ▶ ☐	10 Crop insurance proceeds $	
City or town, province or state, country, and ZIP or foreign postal code Loma Linda, CA 92354		11 Foreign tax paid $	12 Foreign country or U.S. possession	
Account number (see instructions)	2nd TIN not. ☐	13 Excess golden parachute payments $	14 Gross proceeds paid to an attorney $	
15a Section 409A deferrals $	15b Section 409A income $	16 State tax withheld $ $	17 State/Payer's state no.	18 State income $ $

Form **1099-MISC** Cat. No. 14425J www.irs.gov/form1099misc Department of the Treasury - Internal Revenue Service

Do Not Cut or Separate Forms on This Page — Do Not Cut or Separate Forms on This Page

Independent Contractor Reporting Requirements

Background

California State Senate Bill 542 was passed during the 1999-2000 legislative session and signed into law. This law requires businesses and government entities to report specified information to the Employment Development Department (EDD) on independent contractors.

Who Must Report

Any business or government entity (defined as a "service-recipient") that is required to file a federal Form 1099-MISC for services performed by an independent contractor (defined as a "service-provider") must report. A service-recipient means any individual, person, corporation, association, or partnership, or agent thereof, doing business in this State, deriving trade or business income from sources within this State, or in any manner in the course of trade or business subject to the laws of this State.

An independent contractor is defined as an individual who is not an employee of the business or government entity for California purposes and who receives compensation or executes a contract for services performed for that business or government entity either in or outside of California.

Benefits of the Program

The information you provide to EDD will increase child support collection by helping to locate parents who are delinquent in their child support obligations.

Effective Date

January 1, 2001.

When the Information Must Be Reported

You must report to EDD within twenty (20) days of EITHER making payments totaling $600 or more OR entering into a contract for $600 or more with an independent contractor in any calendar year, whichever is earlier.

What Information Must Be Reported

You are required to provide the following information that applies.

Business or government entity's (service-recipient):

- Federal employer identification number
- California employer account number
- Social security number
- Business name, address, and telephone number

Independent contractor's (service-provider):

- First name, middle initial and last name
- Social security number
- Address
- Start date of contract (if no contract, date payments equal $600 or more)
- Amount of contract, including cents (if applicable)
- Contract expiration date (if applicable)
- Ongoing contract (check box if applicable)

General Information

Report independent contractor information on the *Report of Independent Contractor(s)* (DE 542) form or online with EDD's expanded e-Services for Business. To obtain forms and/or information, call our hotline number (916) 657-0529. You may also call our toll-free number (888) 745-3886, visit your local Employment Tax Office listed in your local telephone directory in the State Government section under "Employment Development Department," or online.

Where to Send Reports

Employment Development Department
P.O. Box 997350, Document Management Group, MIC 96
Sacramento, CA 95899-7350

Información en Español

Self-Service Options

- e-Services for Business
- Register as an Employer
- File and Pay Taxes
- Rates and Withholding
- Forms and Publications

Top Links This Month

- e-Services for Business Enrollment Process
- e-Services for Business Information
- File and Pay Taxes
- Forms and Publications
- Rates and Withholding

FAQs

- Payroll Taxes FAQs

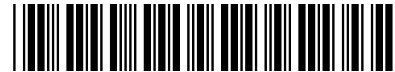
Contact Us

- About Payroll Taxes

EDD Employment Development Department State of California

REPORT OF INDEPENDENT CONTRACTOR(S)

See detailed instructions on reverse side. Please type or print.


05420101

SERVICE-RECIPIENT (BUSINESS OR GOVERNMENT ENTITY):

DATE

FEDERAL ID NUMBER

CA EMPLOYER ACCOUNT NUMBER

SOCIAL SECURITY NUMBER

SERVICE-RECIPIENT NAME / BUSINESS NAME

CONTACT PERSON

ADDRESS

PHONE NUMBER

CITY

STATE

ZIP CODE

SERVICE-PROVIDER (INDEPENDENT CONTRACTOR):

FIRST NAME

MI

LAST NAME

SOCIAL SECURITY NUMBER

STREET NUMBER

STREET NAME

UNIT/APT

CITY

STATE

ZIP CODE

START DATE OF CONTRACT

M M D D Y Y

AMOUNT OF CONTRACT

, , .

CONTRACT EXPIRATION DATE

M M D D Y Y

CHECK HERE IF CONTRACT IS ONGOING

FIRST NAME

MI

LAST NAME

SOCIAL SECURITY NUMBER

STREET NUMBER

STREET NAME

UNIT/APT

CITY

STATE

ZIP CODE

START DATE OF CONTRACT

M M D D Y Y

AMOUNT OF CONTRACT

, , .

CONTRACT EXPIRATION DATE

M M D D Y Y

CHECK HERE IF CONTRACT IS ONGOING

FIRST NAME

MI

LAST NAME

SOCIAL SECURITY NUMBER

STREET NUMBER

STREET NAME

UNIT/APT

CITY

STATE

ZIP CODE

START DATE OF CONTRACT

M M D D Y Y

AMOUNT OF CONTRACT

, , .

CONTRACT EXPIRATION DATE

M M D D Y Y

CHECK HERE IF CONTRACT IS ONGOING

Fast, Easy, and Convenient!
Visit the EDD's website at www.edd.ca.gov

MAIL TO: Employment Development Department • P.O. Box 997350, MIC 96 • Sacramento, CA 95899-7350
or Fax to 916-319-4410

INSTRUCTIONS FOR COMPLETING THE REPORT OF INDEPENDENT CONTRACTOR(S)

WHO MUST REPORT:

Any business or government entity (defined as a "Service-Recipient") that is required to file a federal Form 1099-MISC for service performed by an independent contractor (defined as a "Service-Provider") must report. You must report to the Employment Development Department (EDD) within twenty (20) days of EITHER making payments of $600 or more OR entering into a contract for $600 or more with an independent contractor in any calendar year, whichever is earlier. This information is used to assist state and county agencies in locating parents who are delinquent in their child support obligations.

An independent contractor is further defined as an individual who is not an employee of the business or government entity for California purposes and who receives compensation or executes a contract for services performed for that business or government entity either in or outside of California. For further clarification, request *Information Sheet: Employment Work Status Determination* (DE 231ES). See below for information on how to obtain additional forms.

YOU ARE REQUIRED TO PROVIDE THE FOLLOWING INFORMATION THAT APPLIES:

Service-Recipient (Business or Government Entity)

- Federal Employer Identification Number
- California employer account number
- Social Security Number
- Service-recipient name/business name, address, and phone number

Service-Provider (Independent Contractor)

- First name, middle initial, and last name
- Social Security Number
- Address
- Start date of contract (if no contract, date payments equal $600 or more)
- Amount of contract including cents (if applicable)
- Contract expiration date (if applicable)
- Ongoing contract (check box if applicable)

HOW TO COMPLETE THIS FORM:

If you use a typewriter or printer, ignore the boxes and type in UPPER CASE as shown. Do not use commas or periods.

FIRST NAME	MI	LAST NAME	
IMOGENE	A	SAMPLE	
SOCIAL SECURITY NUMBER	**STREET NUMBER**	**STREET NAME**	**UNIT / APT.**
xxxxxxxxx	12345	MAIN STREET	301

If you **handwrite this form**, print each letter or number in a separate box as shown. Do not use commas or periods.

FIRST NAME	MI	LAST NAME	
I M O G E N E	A	S A M P L E	
SOCIAL SECURITY NUMBER	**STREET NUMBER**	**STREET NAME**	**UNIT / APT.**
X X X X X X X X X	1 2 3 4 5	M A I N S T R E E T	3 0 1

ADDITIONAL INFORMATION:

If you have questions concerning the independent contractor reporting requirement, you may visit the EDD's website at **www.edd.ca.gov/Payroll_Taxes/Independent_Contractor_Reporting.htm**, call the New Employee Registry and Independent Contractor Reporting phone line at 916-657-0529, call the Taxpayer Assistance Center at 888-745-3886, or visit your local Employment Tax Office listed in the *California Employer's Guide* (DE 44).

To obtain additional DE 542 forms:

- Visit the website at **www.edd.ca.gov/Forms/default.asp**
- For 25 or more forms, call 916-322-2835
- For less than 25 forms, call 916-657-0529 or call 888-745-3886

HOW TO REPORT:

For a faster, easier, and more convenient method of reporting your DE 542 information, you are encouraged to report online using the EDD's e-Services for Business. Visit the website at **https://eddservices.edd.ca.gov** to choose the option that is best for you.

To file a DE 542 form, complete the information in the boxes provided on the form and fax to 916-319-4410 or mail to the following address:

EMPLOYMENT DEVELOPMENT DEPARTMENT
P.O. Box 997350, MIC 96
Sacramento, CA 95899-7350

HONORARIUM AND OTHER PAYMENTS TO NON-SECC-EMPLOYEE SERVICE PROVIDERS

INFORMATION FORM

For Year 20_____

(Please read reverse side for complete instructions)

For ***non-SECC employees:***

a. Obtain required information in items #2-7from person receiving payment
b. Churches and schools: Please use this form or a Form W-9 for your records and file a Form 1099 Misc. directly with the IRS.

(1) Payment Made By: ________________________________ ________________________________
Name of Church/School/Dept. etc. *Name of person filling out form*

(2) Unincorporated service provider: ____
Name of person or business receiving payment

(3) DBA(Doing Business As), if applicable: ____

(4) Type of Entity (Check One):

___ Individual/Sole Proprietor __ Corporation
___ Partnership __ Other (please describe) ________________________________

(5) Address: ____
P.O. Box/Street *City* *State* *Zip*

(6) Phone Number: ____

(7) Taxpayer Identification Number:
Social Security # ________ - _____ - ________ **or** Employer Identification #________________

(8) Payment Amount $ ________ (9) Payment Date: _________ (10) Check #________________

(1 l)If cash is paid, signature of person receiving cash: ____
Signature of person receiving cash

(12)Brief description of service: ____

(13)1 certify that my tax payer identification number as listed above is correct and that I am not subject to

backup withholding ____ Date:________________________
Signature of person receiving payment

Revised 10/2013

HONORARIUM AND OTHER PAYMENTS TO NON-EMPLOYEE SERVICE PROVIDERS

INSTRUCTIONS

(For persons and entities who receive payments for services (e.g. honorariums, fees, etc.). Payments to SECC employees **must** be processed through conference payroll.

Law Under Internal Revenue Code Section [6041A(a)], all payments aggregating $600 or more during a calendar year, paid to a non-employee, unincorporated service provider in the course of a trade or business (except doctors and lawyers), must be reported to the IRS on a Form 1099 Misc. All payments to doctors and lawyers must be reported on a Form 1099 Misc. Payments for merchandise, telephone, freight, storage, etc., are excluded. The church's status as a non-profit organization does not exempt it from these requirements.

Definition of a Service Provider

A service provider is a person or business who receives honorariums, fees, commissions, or other forms of compensation for services rendered. Examples of service providers are:

Attorneys	*Repair persons*	*Commercially contracted Janitor/Custodian*
Architects	*Guest lecturers and speakers*	*Clergy (SDA or not, given as Honorariums)*
Accountants	*Musicians and entertainers*	*Sub-contractor (painter, carpenter etc.)*

Note: Most Janitors/Custodians, etc. in SECC churches/schools are considered employees with wages being paid through conference payroll. If you want to know if your custodian, etc. can be paid as an independent contractor, contact Human Resources. Also, you do not have to report payments to any corporations (except corporations providing medical care and incorporated law firms).

Note to Church/School Treasurers: Please ask your non-SECC-employee service provider to complete items 2-7 (over) or complete IRS Form W-9. Issue checks only when the required information is **complete.**

Conference Policy

Each church and school is required to obtain an Employer Identification Number (EIN). Using the EIN, churches and schools are required to issue 1099-Misc. Forms at the end of each calendar year to each non-employee service provider for payments totaling $600 or more in one calendar year. Churches and schools who fail to report may be responsible for IRS penalties.

IRS Penalties

Penalties will be assessed for failure to file correct information. There are additional penalties for failure to file by the due date (January 31 of the year following the payments), for failure to include all the required information, or for including incorrect TIN, payee surname, or payment amount. Penalties are $15 to $50 per reporting form, with maximum penalties $25,000 to $250,000 per year.

HONORARIUM FOR SECC EMPLOYEES

<u>REQUEST FORM</u>

PAY TO: ____

____

____

____

AMOUNT: **$** ____________________

❑ Add to payroll ❑ Add to wages for tax reporting purposes only. Already paid.

DESCRIPTION: ____

____

____

____

REQUESTING ORGANIZATION: ______________________________

ADDRESS: ______________________________

____

PHONE #: ______________________________

E-MAIL: ______________________________

AFFIRMATION: We understand that by submitting this request, the above honorarium will be added to the SECC employee's bi-weekly payroll, and will be subject to all tax and other reporting requirements, and our organization will be billed for the resulting charges.

REQUESTED BY: ________________________ DATE: ______________

AUTHORIZED BY: ________________________ DATE: ______________

(Business Manager, Treasurer or Pastor)

Email to payroll@seccsda.org or FAX to 951-509-2393

CLAIM REPORTING

24/7 Hotline: (888) 951-4276 (press 2)

CLAIMS@ADVENTISTRISK.ORG

Claim FORMS are available at www.adventistrisk.org > Forms > Claims

DO NOT WAIT TO FILE YOUR CLAIM – Provide as much information as you can but do not delay filing your claim because you are waiting on additional information.

DUTY TO PROTECT – You have a duty to protect your property. If you have a situation where the damage from a loss may cause additional risk or damage it is important to mitigate the loss. For example, this may mean turning off the water if you have broken pipes and calling a clean-up company. Do not hesitate to take care of your property. It will need to be done whether you have insurance coverage or not. Waiting will only make the problem worse.

HOW THE CLAIMS PROCESS WORKS

Your claims examiner will help you understand the process in greater detail; however, the process follows this model:

1 **FILE CLAIM** - A claim is filed with ARM, you have provided as much information as possible and the claim examiner helps you know what additional information is necessary. You work to provide all required information as quickly as possible. **VERIFY THAT THE CONTACT INFORMATION YOU PROVIDE IS CURRENT.**

2 **INVESTIGATION** - The claims examiner, often with the help of an on-site adjuster, conducts the investigation.

3 **RESULT** - When the investigation is complete the claims examiner will relate the result to you (if you are the designated contact person). The result may be that the claim is accepted, partially paid or denied. This is determined by the terms of the insurance policy, the deductible or perhaps a sublimit that applies to that type of loss.

4 **PAYMENT** - Adventist Risk Management will issue a payment for the loss.

- For property losses the payment goes to the insured (Conference).
- For automobile losses the payment will go to the body shop or claimant.
- For personal injury losses the payment will go either to the claimant or to the provider, according to the policy.

DEDUCTIBLES

Claims are paid based on the insurance policy. Most insurance policies include a deductible, which is the amount you are responsible for before your coverage begins. Various types of losses may have different deductible amounts.

GLOSSARY:

ADJUSTER - An independent representative of the insurer who seeks to determine the extent of the insurer's liability for loss when a claim is submitted.
DAMAGE – Harm or injury resulting in loss of value or usefulness.
DEDUCTIBLE - Amount of loss that the insured incurs before the insurance can pay.
EXAMINER - The representative of an insurance company assigned to review claims made against insurance companies.
MITIGATE - To make less severe or serious, often with professional help.
POLICY - The written insurance contract including all clauses, riders, endorsements, and attached papers.
SUBLIMIT - The limit of how much can be paid on a specific type of loss.
WEAR & TEAR - The normal, expected deterioration of an insured object (wear and tear is excluded from insurance policy coverage because it is inevitable).

FOR MORE INFORMATION, SUBSCRIBE TO OUR SOLUTIONS NEWSLETTER AT: www.adventistrisk.org

Adventist Risk Management® Inc. ©2013

NORTH AMERICAN DIVISION GENERAL LIABILITY (ed. 05/2013)
STATEMENT OF LOSS

12501 Old Columbia Pike
Silver Spring, MD 20904
OFFICE: (301) 680-6870 **FAX:** (301) 680-6878 **EMAIL:** claims@adventistrisk.org

CONFERENCE ____________________

	ABOUT THE INSURED			
CHURCH/SCHOOL/OTHER NAME				
CHURCH/SCHOOL/OTHER ADDRESS				
CONTACT PERSON NAME			TITLE	
TELEPHONE NUMBER	BUSINESS		HOME	
EMAIL ADDRESS				
	ABOUT THE LOSS			
DATE & TIME OF LOSS			AM	PM
DESCRIPTION OF ACCIDENT/NATURE OF ACTIVITY (USE ADDITIONAL SHEETS IF NECESSARY)				
	ABOUT THE LOCATION OF INCIDENT			
NAME OF OWNER OF PREMISES				
ADDRESS				
TELEPHONE	BUSINESS		HOME	
RELATIONSHIP TO INSURED				
LOCATION OF ACCIDENT (+ CITY & STATE)				
	ABOUT THE INJURED PERSON OR DAMAGED PROPERTY			
NAME			☐ MALE	☐ FEMALE
	DATE OF BIRTH		SOCIAL SECURITY #	
ADDRESS				
TELEPHONE	BUSINESS		HOME	
EMAIL ADDRESS				
DESCRIBE INJURY OR DAMAGE (EXAMPLE: FRACTURED ARM, SPRAINED BACK, BROKEN WINDOW, ETC.)				
DESCRIBE PROPERTY (TYPE, MODEL, ETC.)				
ESTIMATED AMOUNT OF REPAIR				
EMPLOYER'S NAME			RELATIONSHIP TO INSURED/ENTITY	
ADDRESS				
TELEPHONE	BUSINESS		HOME	
	ABOUT WITNESSES (USE REVERSE SIDE IF NECESSARY)			
NAME				
ADDRESS				
TELEPHONE	BUSINESS		HOME	
NAME				
ADDRESS				
TELEPHONE	BUSINESS		HOME	
	COMMENTS (USE ADDITIONAL SHEETS IF NECESSARY)			

REPORTED BY:	TITLE:	PHONE#:
REPORTED TO:	TITLE:	DATE:
SIGNATURE OF INSURED:		DATE:

GENERAL LIABILITY

CLAIM INFORMATION
IMMEDIATE AND TIMELY REPORTING IS CRITICAL

DOCUMENTATION NEEDED: (TO ACCOMPANY COMPLETED CLAIM FORM)

- If an attorney is involved, provide name and address.
- Have papers been served? If so, when? Attach a copy.
- Copies of medical bills, if any.

ADDITIONAL DOCUMENTATION NEEDED FOR MEDICAL PROFESSIONAL LIABILITY SITUATIONS:

- Medical Records
- Incident Report
- Any statements by medical personnel.

PROCEDURE:

Please send above information to Adventist Risk Management, Inc. ARM may assign an adjuster in complex situations, it is important for you to cooperate with them. **If there are any problems, let us know immediately.**

ANY ADDITIONAL INFORMATION MUST BE FORWARDED UPON RECEIPT

Adventist Risk Management, Inc.
12501 Old Columbia Pike
Silver Spring, MD 20904
OFFICE: (301) 680-6870 **FAX:** (301) 680-6878 **EMAIL:** claims@adventistrisk.org

Robert H. Burrow | *JD*
Managing Claims Counsel
OFFICE: (301) 680-6875
CELL: (301) 346-9642
EMAIL: rburrow@adventistrisk.org

J. Victor Elliott | *AIC*
Claims Counsel
OFFICE: (301) 680-6808
CELL: (301) 332-2017
EMAIL: jvelliott@adventistrisk.org

Donna L. Diaz | *JD*
Claims Counsel
OFFICE: (951) 353-6803
CELL: (951) 754-3574
EMAIL: ddiaz@adventistrisk.org

Geoffrey Hayton | *JD*
Claims Counsel
OFFICE: (951) 353-6822
CELL: (909) 894-8235
EMAIL: ghayton@adventistrisk.org

ADVENTIST RISK MANAGEMENT, INC.
ATTN: CLAIMS & LEGAL SERVICES
12501 Old Columbia Pike Silver Spring MD 20904
301-680-6870 * Fax 301-680-6878
Email: claims@adventistrisk.org

PROPERTY LOSS NOTICE

FOR YOUR PROTECTION SOME STATE LAWS REQUIRE THAT THE FOLLOWING STATEMENT APPEAR ON THIS FORM: "It is unlawful to: (a) Present or cause to be presented any false or fraudulent claim for the payment of a loss under a contract of insurance and/or (b) Prepare, make, or subscribe any writing with intent to present or use the same, or to allow it to be presented or used in support of any such claim. Every person who violates any provision of this section is punishable by imprisonment in the State Prison not exceeding three years, or by fine not exceeding one thousand dollars, or by both."

POLICY	Conference		Name of Entity	
	Address of Damaged Property			
	Contact Person (please print)		Telephone	
LOSS	DESCRIPTION OF WHEN AND HOW LOSS OCCURRED **Give details--be specific (attach additional sheet if necessary)**			
	MONTH	DAY	YEAR	
	DESCRIPTION OF PROPERTY DAMAGED OR STOLEN		**Support with written vendor estimates**	
	MAKE, MODEL, SERIAL NO.		APPROX. AGE	REPLACEMENT COST
Attached Additional Sheet If Necessary				
ESTIMATE OF LOSS	Building $_______________	Stolen Goods $_______________	Total Estimates $_______________	
	Contents $_______________	Stolen Money $_______________	Less Deductible $_______________	
	Temp. Repairs $_______________	Glass $_______________	Net Estimate $_______________	
ALL CRIME LOSSES MUST BE REPORTED TO POLICE	Date Reported to Police:	Police Report No.:	**Phone**:	
	Investigating Organization:			
	Address:			
DATE	SIGNATURE Of Authorized Entity Representative		TITLE/CAPACITY	
DATE	SIGNATURE Of Authorized Insured Representative		TITLE/CAPACITY	

Failure to promptly report loss or damage is a contract violation and may void coverage. Supply as much information as possible to avoid delay.

Ed. 5/10

DENOMINATIONAL PROPERTIES

If reporting a catastrophic loss, (hurricane, fire, floods, earthquake, volcano, etc.) PLEASE report immediately to the ARM CLAIMS DEPARTMENT by phone (301) 680-6870; or fax (301) 680-6878 or E-mail: claims@adventistrisk.org for further instructions before completing the following steps

CLAIMS INFORMATION

Send loss notice immediately. The following documentation is needed to complete claim process as soon as it is available.

Building: **(ITEMIZED REPLACEMENT COST)**
- Itemized written estimates or invoices for material and labor by a contractor.
- If labor is done by members, number of man-hours times the amount that would be paid per hour.

Contents: (REPLACEMENT COST)
- Must have written replacement estimates or bills for items of like kind and quality, or repair estimates if items are repairable.

Money and Securities:
- Furnish accounting records to substantiate loss. If unavailable, give explanation of how amount was determined.

Inland Marine(Scheduled Declared Value)
- Give name of entity under which the item is scheduled and the serial number as listed on your statement of values.

Burglary and Theft:
- Police report. If you cannot get report, give name of Police Station reported to and the report number.

Storm and Fire Losses:
- Pictures and newspaper clippings.
- Fire Marshall's Report of Fire

CHECKLIST

- Date of loss
- Exact location and complete street address
- Exactly what is being claimed (material, labor, cash, contents, etc.)
- Signature of authorized representative of entity

Failure to promptly report loss or damage is a contract violation and may void coverage. Supply as much information as possible to avoid delay.

Ed. 5/10

ADVENTIST RISK MANAGEMENT, INC. (CLAIMS SERVICES)
12501 Old Columbia Pike * Silver Spring MD 20904 *
(301) 680-6870 * FAX (301) 680-6878 * Email: claims@adventistrisk.org

AUTOMOBILE LOSS NOTICE (ED. 2010)

INSURED

Insured Entity Name & Address	Contact Person	Contact's Phone
Church, School or other:	Name:	Home:
Conference:	Email:	Work:

LOSS INFORMATION

Date of Loss:		Time of Loss:
Location of Accident (including City & State)	Police Report & Number	Violations /Citations
Description of Accident/Nature of Activity (Use additional sheet if necessary)		

INSURED VEHICLE

Year, Make, Model			V.I.N. (Last 5 digits of ID#)
Owner's Name & Address			Owner's Phone
Driver's Name & Address		Driver's Residence Phone	Driver's Business Phone
Driver's Relationship to Insured	Driver's Date of Birth (Age)	Purpose of Vehicle Use	Was Driver Injured? Yes ☐ No ☐
Describe Damage	Estimate Amount	Where can vehicle be seen?	Used with Permission Yes ☐ No ☐

DAMAGED PROPERTY (*For vehicle information other than above*)

Describe Property (If Auto: Year, Make, Model, Plate No.)	Insurance Company or Agency Name & Policy # (if any)		
Owner's Name & Address	Owner's Residence Phone	Owner's Business Phone	
Driver's Name & Address (Check if same as owner) ☐	Driver's Residence Phone	Driver's Business Phone	
Describe Damage	Estimate Amount	Where can vehicle be seen?	Was Driver Injured? Yes ☐ No ☐

PASSENGERS (Use additional sheets if necessary)

Name & Address	Phone	Injured
		YES NO
		YES NO

WITNESSES (Use additional sheets if necessary)

Name & Address	Phone

Incident Reported by ______________________ Date: __________

Loss Notice Completed by ______________________ Date: __________

Signature of Insured's authorized representative ______________________ Date: __________

NORTH AMERICAN DIVISION MEDICAL PAYMENTS (ed. 09/2013)
CLAIM FORM

12501 Old Columbia Pike
Silver Spring, MD 20904
OFFICE: (301) 680-6870 **FAX:** (301) 680-6878 **EMAIL:** claims@adventistrisk.org

TO BE COMPLETED BY CHURCH ORGANIZATION			
CONFERENCE			
CHURCH NAME			
CHURCH ADDRESS			
CHURCH CONTACT PERSON		TELEPHONE	
	EMAIL ADDRESS		

ABOUT THE INJURED PERSON

PLEASE COMPLETE ALL FIELDS BELOW. THOSE MARKED WITH AN (*) ARE REQUIRED.

FIRST NAME*		LAST NAME*	
DATE OF BIRTH*		GENDER*	
SOCIAL SECURITY NUMBER*			
ADDRESS			
	TELEPHONE	EMAIL ADDRESS	
NAME OF PARENT/GUARDIAN			
DATE OF ACCIDENT*		TIME OF ACCIDENT	
DESCRIBE THE INJURY*			
HOW DID ACCIDENT HAPPEN?*			
LOCATION OF ACCIDENT		DATE ACCIDENT REPORTED*	
TYPE OF ACTIVITY			
TIME ACTIVITY	COMMENCED	DISMISSED	

DID ACCIDENT OCCUR DURING: (CIRCLE YES OR NO)			ACTIVITY LEADER		TITLE	
CHURCH FUNCTION	Y	N	NAME AND ADDRESS OF WITNESS		TELEPHONE	
VACATION BIBLE SCHOOL	Y	N				
PATHFINDER	Y	N				
CAMP	Y	N				
OTHER	Y	N	NAME AND ADDRESS OF WITNESS		TELEPHONE	
WHILE SUPERVISED	Y	N				
DURING SPONSORED ACTIVITY	Y	N				
DURING PROGRAMMED HOURS	Y	N				
ON ACTIVITY PREMISES	Y	N	NAME AND ADDRESS OF WITNESS		TELEPHONE	
WHILE TRAVELING TO OR FROM AN ACTIVITY IN AN AUTHORIZED AUTOMOBILE	Y	N				
IN THE COURSE OF YOUR EMPLOYMENT	Y	N				
DOES THE INJURED PERSON HAVE OTHER INSURANCE?	Y	N	NAME AND ADDRESS OF OTHER INSURANCE:			

I hereby certify that the statements made above are correct to the best of my knowledge and believe that the above claimant was covered hereunder at the time of the accident/sickness.

Signature of Supervisory Official________________________________Date______________

ATTACH PHYSICIAN'S STATEMENT AND/OR ITEMIZED BILLING TO THIS FORM

VOLUNTEER LABOR

Most Seventh-day Adventist conferences and institutions carry Volunteer Labor Accident insurance for their members. This limited **excess policy** will pay for covered medical costs that occur as a result of an accident "while performing all voluntary labor and services for an insured institution." The insurance is for one year **from the date of accidental injury**, subject to a maximum benefit. This insurance is payable only in **excess of any expenses payable by other valid and collectible group insurance**, which means it pays only for covered medical expenses not paid by your own group insurance, or a plan through your employer, or government. The policy provides "a weekly accident indemnity when as the result of injury the insured person is totally and continuously disabled and prevented from performing each and every duty pertaining to his occupation and volunteer work." A death benefit is also provided should life be lost due to the volunteer-related accident.

A volunteer is described as a person "participating in any scheduled, sponsored and supervised activity." If you were being paid for any work done for the church, you should submit this accident claim to the Worker's compensation department for your State.

In order to properly and completely process a volunteer labor claim, the following checked items should be provided:

__________ Letter from church pastor, head elder or conference employee verifying **accident occurred while you were participating in a scheduled, sponsored and supervised volunteer activity, or traveling to or from such activity.**

__________ "**Accident and Sickness Claim Form**" completed on both sides signed by you and your attending physician.

__________ Itemized medical bills

__________ Statement from your insurance company showing how much they paid (or denial of benefits). This includes Medicare Explanation of Benefits.

If you lost wages due to this accident:

__________ Fully completed and signed "**Supplementary Statement for Continuing Disability Under Accident Policy**" claim form with **Attending Physician Supplementary Statement.**

__________ Statement of wages from employer for two months preceding accident.

Send this information to the above address. The claim will be filed by ARM Claims with American International Companies to be processed under the terms of the policy. Should you have any questions, call (301) 680-6870.

AMERICAN INTERNATIONAL COMPANIES ®

INSURANCE COMPANY OF THE STATE OF PENNSYLVANIA

MAIL TO:

Adventist Risk Management, Inc.
12501 Old Columbia Pike
Silver Spring, MD 20904
Phone: (301) 680-6870 Fax: (301) 680-6878
Email: claims@adventistrisk.org

PROOF OF LOSS

VOLUNTEER LABOR

NAME OF GROUP:

POLICY NUMBER:

SPECIAL RISK ACCIDENT AND SICKNESS CLAIM FORM

INSTRUCTIONS:

1) You must have SECTION A fully completed by a designated official of the Policyholder.
2) SECTION B is to be completed, signed and dated by the claimant or parent/guardian of claimant, if claimant is a minor.
3) If claimant is treated in the hospital, please attach an itemized hospital bill.
4) If claimant is treated by a doctor, have the doctor complete the Physician's Statement or attach an itemized bill.
5) Attach itemized bills for all medical expenses being claimed including the claimant's name, condition being treated (diagnosis), description of services, date of service(s) and the charge made for each service.
6) Please mail completed form and bills to above address.

The furnishing of this form, or its acceptance by the Company, must not be construed as an admission of any liability on the Company, nor a waiver of any of the conditions of the insurance contract.
Any person who knowingly and/or with intent to injure, defraud, or deceive an insurance company or other person files a statement of claim containing false, incomplete or misleading information, may be guilty of insurance fraud and subject to criminal and substantial civil penalties.

SECTION A

LOCATION OF GROUP POLICYHOLDER
Maryland

CLAIMANT'S FULL NAME	SOCIAL SECURITY NO. (IF AVAILABLE)	DATE OF BIRTH	NAME OF SUPERVISOR
DATE COVERAGE BEGAN		DATE COVERAGE WILL EN/HAS ENDED	
NATURE OF INJURY OR ILLNESS (DESCRIBE FULLY , INCLUDING WHICH PART OF BODY WAS INJURED)		DESCRIBE HOW, WHEN AND WHERE ACCIDENT OCCURRED (DATE AND TIME)	
NAME OF ACTIVITY INDICATE THE SPORT (IF APPLICABLE)	DID ACCIDENT OCCUR: A. WHILE CLAIMANT WAS SUPERVISED B DURING SPONSORED ACTIVITY C DURING PROGRAMMED HOURS D WHILE TRAVELING TO OR FROM REGULARLY SCHEDULED ACTIVITY IN A SUPERVISED GROUP	■ YES ■ YES ■ YES ■ YES	■ NO ■ NO ■ NO ■ NO
DATE LAST WORKED	DATE RETURNED TO WORK	WEEKLY EARNINGS	
POLICYHOLDER REPRESENTATIVE TITLE (PLEASE PRINT OR TYPE)		DAYTIME TELEPHONE NUMBER ( )	
SIGNATURE OF POLICYHOLDER REPRESENTATIVE		DATE	

SECTION B

NAME OF CLAIMANT (PARENT OR GUARDIAN IF A MINOR)	DAYTIME TELEPHONE NO. ( )
ADDRESS OF CLAIMANT (PARENT OR GUARDIAN IF A MINOR)	
OTHER THEALTH INSURANCE COVERAGE (ENTER NAME OF INSURED, NAME AND ADDRESS OF INSURANCE COMPANY NAME OF EMPLOYER AND POLICY NUMBER) ■ YES ■ NO	
I HEREBY CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF.	
SIGNATURE (CLAIMANT OR PARENT, IF CLAIMANT IS A MINOR)	

AUTHORIZATION

I, the undersigned authorize any hospital or other medical-care institution, physician or other medical professional, pharmacy, insurance support organization, governmental agency, group policyholder, insurance company, association, employer or benefit plan administrator to furnish to the Insurance Company named above or its representative, any and all information with respect to any injury or sickness suffered by, the medical history of, or any consultation, prescription or treatment provided to, the person whose death, injury, sickness or loss is the basis of claim and copies of all of that person's hospital or medical records, including information relating to mental illness and use of drugs and alcohol, to determine eligibility for benefit payments under the Policy Number identified above. I authorize the group policyholder, employer or benefit plan administrator to provide the Insurance Company named above with financial and employment-related information. I understand that this authorization is valid for the term of coverage of the Policy identified above and that a copy of this authorization shall be considered as valid as the original. I understand that I or my authorized representative may request a copy of this authorization.

I HEREBY CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF.

SIGNATURE **DATE**

I hereby certify that the above information is true and correct to the best of my knowledge and belief.

SIGNATURE DATE

CLAIMANT INFORMATION

1. MEDICARE 0 (Medicare *) MEDICAID 0 (Medicaid) CHAMPUS 0 (Sponsor's SSN) CHAMPVA 0 (VA File *) GROUP HEALTH PLAN 0 (SSN or ID) FECA BLKLUNG 0 (SSN) OTHER 0 (ID)

1A. INSURED'S I.D. NUMBER

2. PATIENT'S NAME (First Name, Middle Initial, Last Name

3. PATIENT'S DATE OF BIRTH MM DD YY / / / SEX M 0 F 0

4. INSURED'S NAME (First Name, Middle Initial, Last Name)

5. PATIENT'S ADDRESS (No. Street)

CITY STATE

ZIP CODE TELEPHONE NO. ( )

6. PATIENT'S RELATIONSHIP TO INSURED SELF 0 SPOUSE 0 CHILD 0 OTHER 0 (Specify)

8. PATIENT STATUS Single 0 Married 0 Other 0 Employed 0 Full Time Student 0 part-time Student 0

7. INSURED'S ADDRESS (No. Street)

CITY STATE

ZIP CODE TELEPHONE NO. ( )

9. OTHER INSURED'S NAME

A. OTHER INSURED'S POLICY OR GROUP NUMBER

B. OTHER INSURED'S DATE OF MM DD YY / / / SEX M 0 F 0

C. EMPLOYER'S NAME OR SCHOOL NAME

D. INSURANCE PLAN NAME OR PROGRAM NAME

10. IS PATIENT'S CONDITION RELATED TO:

A. PATIENT'S EMPLOYMENT? YES 0 NO 0

B. AN AUTO ACCIDENT? YES 0 NO 0

C. OTHER ACCIDENT? YES 0 NO 0

D. RESERVED FOR LOCAL USE

11. INSURED'S POLICY GROUP OR FECA NUMBER

3. PATIENT'S DATE OF BIRTH MM DD YY / / / SEX M 0 F 0

EMPLOYER'S NAME OR SCHOOL NAME

C. INSURANCE PLAN NAME OR PROGRAM NAME

D. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES 0 NO 0

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE
I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below

Signatures Date

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE
I authorize payment of medical benefits to undersigned physician or supplier for service described below

Signature Date

14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) MM DD YY / /

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS GIVE FIRST DATE: MM DD YR / /

16. Dates Patient Unable To Work in Current Occupation FROM MM / DD / YY TO MM / DD / YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. Hospitalization Dates Related to Current Services FROM MM / DD / YY TO MM / DD / YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES 0 NO 0 $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (RELATE ITEMS 1, 2, 3 OR 4 TO ITEM 24E BY LINE)

1 ________________ __________ 3 ________________ ____________

2 ________________ __________ 4 _________________ ____________

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24 A	B	C	D	E	F	G	H	I	J	K
DATE(S) OFERVICE FROM TO MM/DD/YY MM/DD/YY	PLACE OF SERVICE	TYPE OF SERVICE	PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CP/HCPCS MODIFIER	DIAGNOSIS CODE	$ CHARGES	DAYS OR UNITS	DPSDT Family Plan	EMG	COB	RESERVED FOR LOCAL USE

25. FEDERAL TAX NUMBER SSN 0 EIN 0

26. PATIENT'S ACCOUNT .NO

27. ACCEPT ASSIGNMENT 0 YES 0 NO

28. TOTAL CHARGES $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREE OR CREDENTIALS (I certify that the statements apply to this bill and are made a part thereof)

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S OR SUPPLIER'S NAME, ADDRESS, ZIP CODE & TELEPHONE #

PIN # GRP #

PLACE OF SERVICE CODES

1-(H) – INPATIENT HOSPITAL
2- (OH) – OUTPATIENT HOSPITAL
3-(O) – DOCTOR'S OFFICE
4-(H) PATIENT'S HOME
5 – DAYCARE FACILITY (PSY)
6- NIGHT CARE FACILITY(PSY)
7-(NH) NURSING HOME
8- (SNF)-SKILLED NURSING FACILITY
9- - AMBULANCE
O-(OL)-OTHER LOCATIONS
A-(IL)-INDEPENDENT LABORATORY
B- OTHER

ADVENTIST RISK MANAGEMENT, INC.
Request for Certificate of Insurance

Insured: Southeastern California Conference

Policy #: **GL201880**

Property Value:

Limit: **1,000,000**

☒ General Liability
☐ Property
☐ Hospital Property
☐ Automobile
☐ Excess Liability
☐ Workers Compensation

Name of Certificate Holder:
Address :

Location of Property Included:

Activity Requiring Certificate:

Beginning Date: Ending Date:

Additional Endorsement Required: ☐ Yes ☐ No

Specific Wording Required:

Sponsored by :

PLEASE EMAIL TO:

Comments:

Requested by:

CSR**:** **FABIANA ABREU**

Date**:**

COI (08-03)