Employment Eligibility Verification

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

USCIS Form I-9
OMB No.1615-0047
Expires 07/31/2026

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

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

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

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

Address (Street Number and Name)	Apt. Number (if any)	City or Town	State	ZIP Code

Date of Birth (mm/dd/yyyy)	U.S. Social Security Number	Employee's Email Address	Employee's Telephone Number

I am aware that federal law provides for imprisonment and/or fines for false statements, or the use of false documents, in connection with the completion of this form. I attest, under penalty of perjury, that this information, including my selection of the box attesting to my citizenship or immigration status, is true and correct.

Check one of the following boxes to attest to your citizenship or immigration status (See page 2 and 3 of the instructions.):

- ☐ 1. A citizen of the United States
- ☐ 2. A noncitizen national of the United States (See Instructions.)
- ☐ 3. A lawful permanent resident (Enter USCIS or A-Number.)
- ☐ 4. A noncitizen (other than **Item Numbers 2.** and **3.** above) authorized to work until (exp. date, if any)

If you check **Item Number 4.**, enter one of these:

USCIS A-Number	OR	Form I-94 Admission Number	OR	Foreign Passport Number and Country of Issuance

Signature of Employee	Today's Date (mm/dd/yyyy)

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

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

	List A	OR	List B	AND	List C
Document Title 1					
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					
Document Title 2 (if any)					
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					
Document Title 3 (if any)					
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					

Additional Information

☐ Check here if you used an alternative procedure authorized by DHS to examine documents.

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

First Day of Employment (mm/dd/yyyy):

Last Name, First Name and Title of Employer or Authorized Representative	Signature of Employer or Authorized Representative	Today's Date (mm/dd/yyyy)
HR Representative		

Employer's Business or Organization Name	Employer's Business or Organization Address, City or Town, State, ZIP Code
Allegheny College	520 North Main St Meadville, PA 16335

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

Form **W-4**

Department of the Treasury
Internal Revenue Service

Employee's Withholding Certificate

Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay.
Give Form W-4 to your employer.
Your withholding is subject to review by the IRS.

OMB No. 1545-0074

2024

Step 1: Enter Personal Information

(a) First name and middle initial	Last name	(b) Social security number
Address		**Does your name match the name on your social security card?** If not, to ensure you get credit for your earnings, contact SSA at 800-772-1213 or go to *www.ssa.gov*.
City or town, state, and ZIP code		

(c) ☐ **Single** or **Married filing separately**
☐ **Married filing jointly** or **Qualifying surviving spouse**
☐ **Head of household** (Check only if you're unmarried and pay more than half the costs of keeping up a home for yourself and a qualifying individual.)

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

Step 2: Multiple Jobs or Spouse Works

Complete this step if you (1) hold more than one job at a time, or (2) are married filing jointly and your spouse also works. The correct amount of withholding depends on income earned from all of these jobs.

Do **only one** of the following.

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

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

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

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

Step 3: Claim Dependent and Other Credits

If your total income will be $200,000 or less ($400,000 or less if married filing jointly):

Multiply the number of qualifying children under age 17 by $2,000 $ _____

Multiply the number of other dependents by $500 . . . . . $ _____

Add the amounts above for qualifying children and other dependents. You may add to this the amount of any other credits. Enter the total here . . . . . **3** $

Step 4 (optional): Other Adjustments

(a) Other income (not from jobs). If you want tax withheld for other income you expect this year that won't have withholding, enter the amount of other income here. This may include interest, dividends, and retirement income . . . . . **4(a)** $

(b) Deductions. If you expect to claim deductions other than the standard deduction and want to reduce your withholding, use the Deductions Worksheet on page 3 and enter the result here . . . . . **4(b)** $

(c) Extra withholding. Enter any additional tax you want withheld each **pay period** . . **4(c)** $

Step 5: Sign Here

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

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

Employers Only

Employer's name and address	First date of employment	Employer identification number (EIN)
Allegheny College 520 North Main Street Meadville, PA 16335		25-0965212

DCED-CLGS-06 (1-11)

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF COMMUNITY & ECONOMIC DEVELOPMENT
GOVERNOR'S CENTER FOR LOCAL GOVERMENT SERVICES

LOCAL EARNED INCOME TAX RESIDENCY CERTIFICATION FORM

TO EMPLOYERS/TAXPAYERS:

This form is to be used by employers and/or taxpayers to report essential information for the collection and distribution of Local Earned Income Taxes. This form must be utilized by employers when a new employee is hired or when a current employee notifies employer of a name and/or address change.

EMPLOYEE INFORMATION - RESIDENCE LOCATION

NAME (Last, FIrst, Middle Initial)			SOCIAL SECURITY NUMBER
FIRST LINE OF ADDRESS (If PO Box, please include actual street address)			
SECOND LINE OF ADDRESS			
CITY	STATE	ZIP CODE	DAYTIME PHONE NUMBER
MUNICIPALITY (City, Borough, Township)			
COUNTY	PSD CODE		TOTAL RESIDENT EIT RATE

EMPLOYER INFORMATION - EMPLOYMENT LOCATION

EMPLOYER NAME (Use Federal ID Name)			EMPLOYER FEIN
Allegheny College			25-0965212
FIRST LINE OF ADDRESS (If PO Box, please include actual street address)			
520 N. Main Street			
SECOND LINE OF ADDRESS			
CITY	STATE	ZIP CODE	PHONE NUMBER
Meadville	PA	16335	(814)-332-3100
MUNICIPALITY (City, Borough, Township)			
Meadville City			
COUNTY	PSD CODE		MUNICIPAL NON-RESIDENT EIT RATE
Crawford County	2 0 0 2 0 4		

CERTIFICATION

SIGNATURE OF EMPLOYEE	DATE
PHONE NUMBER	EMAIL ADDRESS

For information on obtaining the appropriate MUNICIPALITY (City, Borough, Township), PSD CODES and EIT (Earned Income Tax) RATES, please refer to the Pennsylvania Department of Community & Economic Development website:

www.newPA.com

Select Get Local Gov Support, >Municipal Statistics

NOTICE: MEDICAL TREATMENT FOR YOUR WORK INJURY OR OCCUPATIONAL ILLNESS

Your employer has selected a list of 6 or more physician and other health care providers who are available to treat your work related injuries and illnesses during the first 90 days of treatment. This list is posted at Allegheny College and a copy is attached to this form. If you are injured at work or suffer an occupational illness, you have certain legal RIGHTS and DUTIES under Section 306 (f.1)(1)(i) of the Workers' Compensation Act regarding your medical treatment. These rights and duties are summarized below:

MEDICAL TREATMENT: DURING THE FIRST 90 DAYS

- You have the RIGHT to receive reasonable and necessary medical treatment for your work injury or occupational illness. Your employer must pay for the treatment, as long as the treatment is by one of the listed providers

- You have the RIGHT to choose which of the listed providers will treat you for your work injury or illness.

- You have the RIGHT to switch among any of the listed providers when you receive treatment; and if a listed provider refers you to a provider not on your employer's list, you have the RIGHT to receive treatment from the referral provider

- You have the RIGHT to receive emergency medical treatment from any provider. However, non-emergency treatment must be given by a listed provider.

- If a listed provider prescribes surgery for you, you have the RIGHT to receive a second opinion from any provider of your choice. If that opinion is different from the opinion of the listed provider, you have the RIGHT to choose which course of treatment to follow. If you choose the treatment prescribed in the second opinion, you must receive the treatment from a listed provider for a period of 90 days after the date of your visit to the provider of the second opinion.

- You have the DUTY to visit one or more of the listed providers for the first 90 days of treatment for your work injury or illness if you expect your employer to pay for the medical treatment you receive.

- If you seek treatment for your work injury or illness from a provider who is not on the list, your employer may not have to pay for this medical treatment during the 90-day period. Therefore, you should talk to your employer before seeking treatment from a provider who is not on the list.

Important: The requirements your employer must meet to have a valid list of at least 6 providers are shown on page 2 of this document. If the list does not meet the requirements, it is not a valid list and you have the right to seek medical treatment for your work injury or occupational illness from any health care provider of your choice.

MEDICAL TREATMENT AFTER THE FIRST 90 DAYS

- You have the RIGHT to receive treatment from any physician or other health care provider of your choice, whether or not they are listed by your employer. Your employer must pay for this treatment, as long as it is reasonable and necessary for your work injury or occupational illness and has been properly documented by the physician or other health care provider.

- You have the DUTY to notify your employer if you receive treatment from a physician or other health care provider who is not listed by your employer. You must notify your employer within five days of the first visit to any provider who is not on your employer's list. The employer may not be required to pay for treatment received until you have given this notice.

Your signature on this form indicates that you have been informed of and you understand theses rights and duties. If you have questions, be sure you have your rights and duties explained to you before you sign.

I HAVE BEEN INFORMED OF MY MEDICAL TREATMENT RIGHTS AND DUTIES WTH REGARD TO WORK-RELATED INJURIES AND OCCUPATIONAL ILLNESSES. THIS NOTICE WAS PRESENTED TO ME AT (check one)

☑ Time of hire ☐ When I was injured ☐ Other:_____

_____ _____
Employee Signature Date

_____ _____
Employer Representative Date

WORKERS' COMPENSATION INFORMATION

To all employees:

The workers' compensation law provides wage loss and medical benefits to employees who cannot work, or who need medical care, because of a work-related injury.

Benefits are required to be paid by your employer when self-insured, or through insurance provided by your employer. Your employer is required to post the name of the company responsible for paying workers' compensation benefits at its primary place of business and at its sites of employment in a prominent and easily accessible place, including, without limitation, areas used for the treatment of injured employees or for the administration of first aid.

You should report immediately any injury or work-related illness to your employer.

Your benefits could be delayed or denied if you do not notify your employer immediately.

If your claim is denied by your employer, you have the right to request a hearing before a Workers' Compensation Judge.

The Bureau of Workers' Compensation cannot provide legal advice. However, you may contact the Bureau of Workers' Compensation for additional general information at:

Bureau of Workers' Compensation
1171 South Cameron Street, Room 103
Harrisburg, Pennsylvania 17104-2501
Telephone No. within Pennsylvania: 800-482-2383
Telephone No. outside of this Commonwealth: 717-772-4447
TTY-800-362-4228 (for hearing and speech impaired only);
www.state.pa.us, Pa keyword; workers' comp.

Also attached to this sheet is a complete list of panel physicians and medical providers for your reference.

I,_____, employee of Allegheny College, certify that I have been provided with and understand the information set forth above consistent with the requirements of the Pennsylvania Workers' Compensation Act.

_____ _____

Employee Signature Date

City of Meadville

LOCAL SERVICES TAX – EXEMPTION CERTIFICATE

2024
Tax Year

APPLICATION FOR EXEMPTION FROM LOCAL SERVICES TAX

- A copy of this application for exemption from the Local Services Tax (LST), and all necessary supporting documents, must be completed and presented to your employer AND to the political subdivision levying the Local Services Tax where you are principally employed.
- This application for exemption from the Local Services Tax must be signed and dated.
- **No exemption will be approved until proper documentation has been received.**

Name:_____ Soc Sec #: _____
Address:_____ Phone #: _____
City/State: _____ Zip: _____

REASON FOR EXEMPTION

1. _____ MULTIPLE EMPLOYERS: Attach a copy of a current pay statement from your principal employer that shows the name of the employer, the length of the payroll period and the amount of Local Services Tax withheld. List all employers on the reverse side of this form. **You must notify your other employers of a change in principal place of employment within two weeks of the change.**

2. __X__ EXPECTED TOTAL EARNED INCOME AND NET PROFITS FROM ALL SOURCES WITHIN **Meadville** (municipality or school district) WILL BE LESS THAN $ **12,000** : Attach copies of your last pay statements or your W-2 for the year prior.

   If you are self-employed, please attach a copy of your PA Schedule C, F, or RK-1 for the prior year.

3. _____ ACTIVE DUTY MILITARY EXEMPTION: Please attach a copy of your orders directing you to active duty status. Annual training is not eligible for exemption. You are required to advise the tax office when you are discharged from active duty status.

4. _____ MILITARY DISABILITY EXEMPTION: Please attach copy of your discharge orders and a statement from the United States Veterans Administrator documenting your disability. Only 100% permanent disabilities are recognized for this exemption.

EMPLOYER: Once you receive this Exemption Certificate, you shall not withhold the Local Services Tax for the portion of the calendar year for which this certificate applies, unless you are otherwise notified or instructed by the tax collector to withhold the tax.

Tax Office: Receiver of Taxes
Address: 894 Diamond Park Phone #: 814-724-6000
City/State: Meadville, PA Zip: 16335

IMPORTANT NOTE TO EMPLOYERS

1. The municipality is required by law to exempt from the LST employees whose earned income from all sources (employers and self-employment) in their municipality is less than $12,000 when the combined rate exceeds $10.00.
2. The school district for the municipality in which your worksite(s) is located may or may not levy an LST. If it does, the income exemption provided may differ from the municipality and can be anywhere from $0 to $11,999.
3. Contact the tax office where your business worksites are located to obtain this information.

LST Exemption 10-07

Employment Information: List all places of employment for the applicable tax year. Please list your PRIMARY EMPLOYER under #1 below and your secondary employers under the other columns. If self employed, write SELF under Employer Name column.

	1. PRIMARY EMPLOYER	2.	3.
Employer Name	Allegheny College		
Address	520 North Main Street		
Address 2			
City, State Zip	Meadville, PA 16335		
Municipality	City of Meadville		
Phone	814-332-2312		
Start Date	01/01/2024		
End Date	12/31/2024		
Status (FT or PT)	PT		
Gross Earnings	$2,500		

	4.	5.	6.
Employer Name			
Address			
Address 2			
City, State Zip			
Municipality			
Phone			
Start Date			
End Date			
Status (FT or PT)			
Gross Earnings			

PLEASE NOTE:

All information received by the Tax Collector is considered to be CONFIDENTIAL and is only used for official purposes relating to the collection, administration and enforcement of the LOCAL SERVICES TAX.

I DECLARE UNDER PENALTY OF LAW THAT THE INFORMATION STATED ON AND ATTACHED TO THIS FORM IS TRUE AND CORRECT:

SIGNATURE:_____ **DATE:** _____

ALLEGHENY COLLEGE

Authorization for Payroll Direct Deposit

Please remember that initial requests, account changes or cancellations must be received by the Payroll Office at least 10 days before a pay date in order to be processed.

Employee Name: _____

Direct Deposit #1	**Circle One:**	**Checking**	**Savings**	**Dollar Amount**
Bank Name _____				$ _____
Routing # _____				
Account #				

Direct Deposit #2	**Circle One:**	**Checking**	**Savings**	**Dollar Amount**
Bank Name _____				$ _____
Routing # _____				
Account #				

Direct Deposit #3	**Circle One:**	**Checking**	**Savings**	**Dollar Amount**
Bank Name _____				$ _____
Routing # _____				
Account #				

Direct Deposit #4	**Circle One:**	**Checking**	**Savings**	**Dollar Amount**
Bank Name _____				$ _____
Routing # _____				
Account #				

If you want all of your check deposited to a single bank account, put ALL in the dollar amount for Direct Deposit #1. If you wish to specify a fixed dollar amount for additional account(s), enter those amounts in the remaining direct deposit boxes with your desired dollar amounts.

NOTE: First time set up or if you make changes, the verification process may take one payroll cycle to verify the account number and bank routing information. This means that your direct deposit to your account(s) may not occur until the following pay date.

_____Discontinue Direct Deposit

Signature: _____ Date: _____