



NEW EMPLOYEE PERSONAL INFORMATION

Name: _____ SS # _____

Address: _____

Town: _____ State: _____ Zip Code: _____

Home/Cell Phone: _____ Date of Birth: _____

Personal Email: _____

IN CASE OF AN EMERGENCY NOTIFY:

Name: _____ Relationship: _____

Address: _____

Town: _____ State: _____ Zip Code: _____

Home/Cell Phone: _____

RACIAL IDENTIFICATION: (for federally required reporting)

- | | |
|------------------------------------|--|
| <input type="checkbox"/> Caucasian | <input type="checkbox"/> Asian |
| <input type="checkbox"/> Black | <input type="checkbox"/> American Indian |
| <input type="checkbox"/> Hispanic | <input type="checkbox"/> Cape Verdean |

GENDER IDENTITY:

PREFERRED PRONOUN:

MARITAL STATUS:

- Single
- Married

If you would be willing to serve as a translator for the hospital, please indicate the language(s) you are fluent in below.

Language(s): _____

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.

2023

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		
<input type="checkbox"/> Married filing jointly or Qualifying surviving spouse <input type="checkbox"/> 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, other details, and privacy.

Step 2: 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.

Multiple Jobs or Spouse Works

Do **only one** of the following.

(a) Reserved for future use.

(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

TIP: If you have self-employment income, see page 2.

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)

General Instructions

Section references are to the Internal Revenue Code.

Future Developments

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

Purpose of Form

Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay. If too little is withheld, you will generally owe tax when you file your tax return and may owe a penalty. If too much is withheld, you will generally be due a refund. Complete a new Form W-4 when changes to your personal or financial situation would change the entries on the form. For more information on withholding and when you must furnish a new Form W-4, see Pub. 505, Tax Withholding and Estimated Tax.

Exemption from withholding. You may claim exemption from withholding for 2023 if you meet both of the following conditions: you had no federal income tax liability in 2022 **and** you expect to have no federal income tax liability in 2023. You had no federal income tax liability in 2022 if (1) your total tax on line 24 on your 2022 Form 1040 or 1040-SR is zero (or less than the sum of lines 27, 28, and 29), or (2) you were not required to file a return because your income was below the filing threshold for your correct filing status. If you claim exemption, you will have no income tax withheld from your paycheck and may owe taxes and penalties when you file your 2023 tax return. To claim exemption from withholding, certify that you meet both of the conditions above by writing "Exempt" on Form W-4 in the space below Step 4(c). Then, complete Steps 1(a), 1(b), and 5. Do not complete any other steps. You will need to submit a new Form W-4 by February 15, 2024.

Your privacy. If you have concerns with Step 2(c), you may choose Step 2(b); if you have concerns with Step 4(a), you may enter an additional amount you want withheld per pay period in Step 4(c).

Self-employment. Generally, you will owe both income and self-employment taxes on any self-employment income you receive separate from the wages you receive as an employee. If you want to pay income and self-employment taxes through withholding from your wages, you should enter the self-employment income on Step 4(a). Then compute your self-employment tax, divide that tax by the number of pay periods remaining in the year, and include that resulting amount per pay period on Step 4(c). You can also add half of the annual amount of self-employment tax to Step 4(b) as a deduction. To calculate self-employment tax, you generally multiply the self-employment income by 14.13% (this rate is a quick way to figure your self-employment tax and equals the sum of the 12.4% social security tax and the 2.9% Medicare tax multiplied by 0.9235). See Pub. 505 for more information, especially if the sum of self-employment income multiplied by 0.9235 and wages exceeds \$160,200 for a given individual.

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

Specific Instructions

Step 1(c). Check your anticipated filing status. This will determine the standard deduction and tax rates used to compute your withholding.

Step 2. Use this step if you (1) have more than one job at the same time, or (2) are married filing jointly and you and your spouse both work.

If you (and your spouse) have a total of only two jobs, you may check the box in option (c). The box must also be checked on the Form W-4 for the other job. If the box ^{is} checked, the standard deduction and tax brackets will be cut in half for each job to calculate withholding. This option is roughly accurate for jobs with similar pay; otherwise, more tax than necessary may be withheld, and this extra amount will be larger the greater the difference in pay is between ^{the} two jobs.



Multiple jobs. Complete Steps 3 through 4(b) on only one Form W-4. Withholding will be most accurate if you do this on the Form W-4 for the highest paying job.

Step 3. This step provides instructions for determining the amount of the child tax credit and the credit for other dependents that you may be able to claim when you file your tax return. To qualify for the child tax credit, the child must be under age 17 as of December 31, must be your dependent who generally lives with you for more than half the year, and must have the required social security number. You may be able to claim a credit for other dependents for whom a child tax credit can't be claimed, such as an older child or a qualifying relative. For additional eligibility requirements for these credits, see Pub. 501, Dependents, Standard Deduction, and Filing Information. You can also include **other tax credits** for which you are eligible in this step, such as the foreign tax credit and the education tax credits. To do so, add an estimate of the amount for the year to your credits for dependents and enter the total amount in Step 3. Including these credits will increase your paycheck and reduce the amount of any refund you may receive when you file your tax return.

Step 4 (optional).

Step 4(a). Enter in this step the total of your other estimated income for the year, if any. You shouldn't include income from any jobs or self-employment. If you complete Step 4(a), you likely won't have to make estimated tax payments for that income. If you prefer to pay estimated tax rather than having tax on other income withheld from your paycheck, see Form 1040-ES, Estimated Tax for Individuals.

Step 4(b). Enter in this step the amount from the Deductions Worksheet, line 5, if you expect to claim deductions other than the basic standard deduction on your 2023 tax return and want to reduce your withholding to account for these deductions. This includes both itemized deductions and other deductions such as for student loan interest and IRAs.

Step 4(c). Enter in this step any additional tax you want withheld from your pay **each pay period**, including any amounts from the Multiple Jobs Worksheet, line 4. Entering an amount here will reduce your paycheck and will either increase your refund or reduce any amount of tax that you owe.

Step 2(b)—Multiple Jobs Worksheet *(Keep for your records.)*



If you choose the option in Step 2(b) on Form W-4, complete this worksheet (which calculates the total extra tax for all jobs) on **only ONE** Form W-4. Withholding will be most accurate if you complete the worksheet and enter the result on the Form W-4 for the highest paying job. To be accurate, submit a new Form W-4 for all other jobs if you have not updated your withholding since 2019.

Note: If more than one job has annual wages of more than \$120,000 or there are more than three jobs, see Pub. 505 for additional tables.

- 1 Two jobs.** If you have two jobs or you're married filing jointly and you and your spouse each have one job, find the amount from the appropriate table on page 4. Using the "Higher Paying Job" row and the "Lower Paying Job" column, find the value at the intersection of the two household salaries and enter that value on line 1. Then, **skip** to line 3 **1** \$ _____
- 2 Three jobs.** If you and/or your spouse have three jobs at the same time, complete lines 2a, 2b, and 2c below. Otherwise, skip to line 3.
 - a** Find the amount from the appropriate table on page 4 using the annual wages from the highest paying job in the "Higher Paying Job" row and the annual wages for your next highest paying job in the "Lower Paying Job" column. Find the value at the intersection of the two household salaries and enter that value on line 2a **2a** \$ _____
 - b** Add the annual wages of the two highest paying jobs from line 2a together and use the total as the wages in the "Higher Paying Job" row and use the annual wages for your third job in the "Lower Paying Job" column to find the amount from the appropriate table on page 4 and enter this amount on line 2b **2b** \$ _____
 - c** Add the amounts from lines 2a and 2b and enter the result on line 2c **2c** \$ _____
- 3** Enter the number of pay periods per year for the highest paying job. For example, if that job pays weekly, enter 52; if it pays every other week, enter 26; if it pays monthly, enter 12, etc **3** _____
- 4 Divide** the annual amount on line 1 or line 2c by the number of pay periods on line 3. Enter this amount here and in **Step 4(c)** of Form W-4 for the highest paying job (along with any other additional amount you want withheld) **4** \$ _____

Step 4(b)—Deductions Worksheet *(Keep for your records.)*



- 1** Enter an estimate of your 2023 itemized deductions (from Schedule A (Form 1040)). Such deductions may include qualifying home mortgage interest, charitable contributions, state and local taxes (up to \$10,000), and medical expenses in excess of 7.5% of your income **1** \$ _____
 - \$27,700 if you're married filing jointly or a qualifying surviving spouse
- 2** Enter: {
 - \$20,800 if you're head of
 - \$13,850 if you're single or married filing separately
 **2** \$ _____
- 3** If line 1 is greater than line 2, subtract line 2 from line 1 and enter the result here. If line 2 is greater than line 1, enter "-0-" **3** \$ _____
- 4** Enter an estimate of your student loan interest, deductible IRA contributions, and certain other adjustments (from Part II of Schedule 1 (Form 1040)). See Pub. 505 for more information **4** \$ _____
- 5 Add** lines 3 and 4. Enter the result here and in **Step 4(b)** of Form W-4 **5** \$ _____

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 with no other entries on the form; 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 territories 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.

Married Filing Jointly or Qualifying Surviving Spouse

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	\$0-9,999	\$10,000-19,999	\$20,000-29,999	\$30,000-39,999	\$40,000-49,999	\$50,000-59,999	\$60,000-69,999	\$70,000-79,999	\$80,000-89,999	\$90,000-99,999	\$100,000-109,999	\$110,000-120,000
\$0 -9,999	\$0	\$0	\$850	\$850	\$1,000	\$1,020	\$1,020	\$1,020	\$1,020	\$1,020	\$1,020	\$1,870
\$10,000 -19,999	0	930	1,850	2,000	2,200	2,220	2,220	2,220	2,220	2,220	3,200	4,070
\$20,000 -29,999	850	1,850	2,920	3,120	3,320	3,340	3,340	3,340	3,340	4,320	5,320	6,190
\$30,000 -39,999	850	2,000	3,120	3,320	3,520	3,540	3,540	3,540	4,520	5,520	6,520	7,390
\$40,000 -49,999	1,000	2,200	3,320	3,520	3,720	3,740	3,740	4,720	5,720	6,720	7,720	8,590
\$50,000 -59,999	1,020	2,220	3,340	3,540	3,740	3,760	4,750	5,750	6,750	7,750	8,750	9,610
\$60,000 -69,999	1,020	2,220	3,340	3,540	3,740	4,750	5,750	6,750	7,750	8,750	9,750	10,610
\$70,000 -79,999	1,020	2,220	3,340	3,540	4,720	5,750	6,750	7,750	8,750	9,750	10,750	11,610
\$80,000 -99,999	1,020	2,220	4,170	5,370	6,570	7,600	8,600	9,600	10,600	11,600	12,600	13,460
\$100,000 -149,999	1,870	4,070	6,190	7,390	8,590	9,610	10,610	11,660	12,860	14,060	15,260	16,330
\$150,000 -239,999	2,040	4,440	6,760	8,160	9,560	10,780	11,980	13,180	14,380	15,580	16,780	17,850
\$240,000 -259,999	2,040	4,440	6,760	8,160	9,560	10,780	11,980	13,180	14,380	15,580	16,780	17,850
\$260,000 -279,999	2,040	4,440	6,760	8,160	9,560	10,780	11,980	13,180	14,380	15,580	16,780	18,140
\$280,000 -299,999	2,040	4,440	6,760	8,160	9,560	10,780	11,980	13,180	14,380	15,870	17,870	19,740
\$300,000 -319,999	2,040	4,440	6,760	8,160	9,560	10,780	11,980	13,470	15,470	17,470	19,470	21,340
\$320,000 -364,999	2,040	4,440	6,760	8,550	10,750	12,770	14,770	16,770	18,770	20,770	22,770	24,640
\$365,000 -524,999	2,970	6,470	9,890	12,390	14,890	17,220	19,520	21,820	24,120	26,420	28,720	30,880
\$525,000 and over	3,140	6,840	10,460	13,160	15,860	18,390	20,890	23,390	25,890	28,390	30,890	33,250

Single or Married Filing Separately

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	\$0-9,999	\$10,000-19,999	\$20,000-29,999	\$30,000-39,999	\$40,000-49,999	\$50,000-59,999	\$60,000-69,999	\$70,000-79,999	\$80,000-89,999	\$90,000-99,999	\$100,000-109,999	\$110,000-120,000
\$0 -9,999	\$310	\$890	\$1,020	\$1,020	\$1,020	\$1,860	\$1,870	\$1,870	\$1,870	\$1,870	\$2,030	\$2,040
\$10,000 -19,999	890	1,630	1,750	1,750	2,600	3,600	3,600	3,600	3,600	3,760	3,960	3,970
\$20,000 -29,999	1,020	1,750	1,880	2,720	3,720	4,720	4,730	4,730	4,890	5,090	5,290	5,300
\$30,000 -39,999	1,020	1,750	2,720	3,720	4,720	5,720	5,730	5,890	6,090	6,290	6,490	6,500
\$40,000 -59,999	1,710	3,450	4,570	5,570	6,570	7,700	7,910	8,110	8,310	8,510	8,710	8,720
\$60,000 -79,999	1,870	3,600	4,730	5,860	7,060	8,260	8,460	8,660	8,860	9,060	9,260	9,280
\$80,000 - 99,999	1,870	3,730	5,060	6,260	7,460	8,660	8,860	9,060	9,260	9,460	10,430	11,240
\$100,000 -124,999	2,040	3,970	5,300	6,500	7,700	8,900	9,110	9,610	10,610	11,610	12,610	13,430
\$125,000 -149,999	2,040	3,970	5,300	6,500	7,700	9,610	10,610	11,610	12,610	13,610	14,900	16,020
\$150,000 -174,999	2,040	3,970	5,610	7,610	9,610	11,610	12,610	13,750	15,050	16,350	17,650	18,770
\$175,000 -199,999	2,720	5,450	7,580	9,580	11,580	13,870	15,180	16,480	17,780	19,080	20,380	21,490
\$200,000 -249,999	2,900	5,930	8,360	10,660	12,960	15,260	16,570	17,870	19,170	20,470	21,770	22,880
\$250,000 -399,999	2,970	6,010	8,440	10,740	13,040	15,340	16,640	17,940	19,240	20,540	21,840	22,960
\$400,000 -449,999	2,970	6,010	8,440	10,740	13,040	15,340	16,640	17,940	19,240	20,540	21,840	22,960
\$450,000 and over	3,140	6,380	9,010	11,510	14,010	16,510	18,010	19,510	21,010	22,510	24,010	25,330

Head of Household

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	\$0-9,999	\$10,000-19,999	\$20,000-29,999	\$30,000-39,999	\$40,000-49,999	\$50,000-59,999	\$60,000-69,999	\$70,000-79,999	\$80,000-89,999	\$90,000-99,999	\$100,000-109,999	\$110,000-120,000
\$0 -9,999	\$0	\$620	\$860	\$1,020	\$1,020	\$1,020	\$1,020	\$1,650	\$1,870	\$1,870	\$1,890	\$2,040
\$10,000 -19,999	620	1,630	2,060	2,220	2,220	2,220	2,850	3,850	4,070	4,090	4,290	4,440
\$20,000 -29,999	860	2,060	2,490	2,650	2,650	3,280	4,280	5,280	5,520	5,720	5,920	6,070
\$30,000 -39,999	1,020	2,220	2,650	2,810	3,440	4,440	5,440	6,460	6,880	7,080	7,280	7,430
\$40,000 -59,999	1,020	2,220	3,130	4,290	5,290	6,290	7,480	8,680	9,100	9,300	9,500	9,650
\$60,000 -79,999	1,500	3,700	5,130	6,290	7,480	8,680	9,880	11,080	11,500	11,700	11,900	12,050
\$80,000 - 99,999	1,870	4,070	5,690	7,050	8,250	9,450	10,650	11,850	12,260	12,460	12,870	13,820
\$100,000 -124,999	2,040	4,440	6,070	7,430	8,630	9,830	11,030	12,230	13,190	14,190	15,190	16,150
\$125,000 -149,999	2,040	4,440	6,070	7,430	8,630	9,980	11,980	13,980	15,190	16,190	17,270	18,530
\$150,000 -174,999	2,040	4,440	6,070	7,980	9,980	11,980	13,980	15,980	17,420	18,720	20,020	21,280
\$175,000 -199,999	2,190	5,390	7,820	9,980	11,980	14,060	16,360	18,660	20,170	21,470	22,770	24,030
\$200,000 -249,999	2,720	6,190	8,920	11,380	13,680	15,980	18,280	20,580	22,090	23,390	24,690	25,950
\$250,000 -449,999	2,970	6,470	9,200	11,660	13,960	16,260	18,560	20,860	22,380	23,680	24,980	26,230
\$450,000 and over	3,140	6,840	9,770	12,430	14,930	17,430	19,930	22,430	24,150	25,650	27,150	28,600

FORM
M-4

MASSACHUSETTS EMPLOYEE'S WITHHOLDING EXEMPTION CERTIFICATE

Rev. 11/19



Print full name
Print home address.....

Social Security no.
City..... State..... Zip.....

Employee:

File this form with your employer. Otherwise, Massachusetts Income Taxes will be withheld from your wages without exemptions.

Employer:

Keep this certificate with your records. If the employee is believed to have claimed excessive exemptions, the Massachusetts Department of Revenue should be so advised.

HOW TO CLAIM YOUR WITHHOLDING EXEMPTIONS

1. Your personal exemption. Write the figure "1." If you are age 65 or over or will be before next year, write "2"
2. If married and if exemption for spouse is allowed, write the figure "4." If your spouse is age 65 or over or will be before next year and if otherwise qualified, write "5." See Instruction C.....
3. Write the number of your qualified dependents. See Instruction D.....
4. Add the number of exemptions which you have claimed above and write the total.....
5. Additional withholding per pay period under agreement with employer \$.....
 - A. Check if you will file as head of household on your tax return.
 - B. Check if you are blind.
 - C. Check if spouse is blind and not subject to withholding.
 - D. Check if you are a full-time student engaged in seasonal, part-time or temporary employment whose estimated annual income will not exceed \$8,000.

EMPLOYER: DO NOT withhold if Box D is checked.

I certify that the number of withholding exemptions claimed on this certificate does not exceed the number to which I am entitled.

Date..... Signed.....

THIS FORM MAY BE REPRODUCED

THE COMMONWEALTH OF MASSACHUSETTS, DEPARTMENT OF REVENUE

A. Number. The more exemptions you claim on this certificate, the less tax withheld from your employer. If you claim more exemptions than you are entitled to, civil and criminal penalties may be imposed. However, you may claim a smaller number of exemptions without penalty. If you do not file a certificate, your employer must withhold on the basis of no exemptions.

If you expect to owe more income tax than will be withheld, you may either claim a smaller number of exemptions or enter into an agreement with your employer to have additional amounts withheld.

You should claim the total number of exemptions to which you are entitled to prevent excessive overwithholding, unless you have a significant amount of other income. Underwithholding may result in owing additional taxes to the Commonwealth at the end of the year.

If you work for more than one employer at the same time, you must not claim any exemptions with employers other than your principal employer.

If you are married and if your spouse is subject to withholding, each may claim a personal exemption.

B. Changes. You may file a new certificate at any time if the number of exemptions increases. You must file a new certificate within 10 days if the number of exemptions previously claimed by you decreases. For example, if during the year your dependent son's income indicates that you will not

provide over half of his support for the year, you must file a new certificate.

C. Spouse. If your spouse is not working or if she or he is working but not claiming the personal exemption or the age 65 or over exemption, generally you may claim those exemptions in line 2. However, if you are planning to file separate annual tax returns, you should not claim withholdingg exemptions for your spouse or for any dependents that will not be claimed on your annual tax return.

If claiming a spouse, write "4" in line 2. Entering "4" makes a withholding system adjustment for the \$4,400 exemption for a spouse.

D. Dependent(s). You may claim an exemption in line 3 for each individual who qualifies as a dependent under the Federal Income Tax Law. In addition, if one or more of your dependents will be under age 12 at year end, add "1" to your dependents total for line 3.

You are not allowed to claim "federal withholding deductions and adjustments" under the Massachusetts withholding system.

If you have income not subject to withholding, you are urged to have additional amounts withheld to cover your tax liability on such income. See line 5.



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	
<p>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.</p>		Check one of the following boxes to attest to your citizenship or immigration status (See page 2 and 3 of the instructions.):				
		<input type="checkbox"/> 1. A citizen of the United States				
		<input type="checkbox"/> 2. A noncitizen national of the United States (See Instructions.)				
		<input type="checkbox"/> 3. A lawful permanent resident (Enter USCIS or A-Number.)				
<input type="checkbox"/> 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)	<p>Additional Information</p> <p>Check here if you used an alternative procedure authorized by DHS to examine documents.</p>				
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)					

<p>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.</p>		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)
Employer's Business or Organization Name		Employer's Business or Organization Address, City or Town, State, ZIP Code

For reverification or rehire, complete [Supplement B, Reverification and Rehire](#) on Page 4.

LISTS OF ACCEPTABLE DOCUMENTS

All documents containing an expiration date must be unexpired.

* Documents extended by the issuing authority are considered unexpired.

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

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

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
<ol style="list-style-type: none"> 1. U.S. Passport or U.S. Passport Card 2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551) 3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa 4. Employment Authorization Document that contains a photograph (Form I-766) 5. For an individual temporarily authorized to work for a specific employer because of his or her status or parole: <ol style="list-style-type: none"> a. Foreign passport; and b. Form I-94 or Form I-94A that has the following: <ol style="list-style-type: none"> (1) The same name as the passport; and (2) An endorsement of the individual's status or parole 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. 6. Passport from the Federated States of Micronesia (FSM) or the Republic of the Marshall Islands (RMI) with Form I-94 or Form I-94A indicating nonimmigrant admission under the Compact of Free Association Between the United States and the FSM or RMI 	OR	<ol style="list-style-type: none"> 1. Driver's license or ID card issued by a State or outlying possession of the United States provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address 2. ID card issued by federal, state or local government agencies or entities, provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address 3. School ID card with a photograph 4. Voter's registration card 5. U.S. Military card or draft record 6. Military dependent's ID card 7. U.S. Coast Guard Merchant Mariner Card 8. Native American tribal document 9. Driver's license issued by a Canadian government authority <li style="text-align: center;">For persons under age 18 who are unable to present a document listed above: 10. School record or report card 11. Clinic, doctor, or hospital record 12. Day-care or nursery school record 	AND	<ol style="list-style-type: none"> 1. A Social Security Account Number card, unless the card includes one of the following restrictions: <ol style="list-style-type: none"> (1) NOT VALID FOR EMPLOYMENT (2) VALID FOR WORK ONLY WITH INS AUTHORIZATION (3) VALID FOR WORK ONLY WITH DHS AUTHORIZATION 2. Certification of report of birth issued by the Department of State (Forms DS-1350, FS-545, FS-240) 3. Original or certified copy of birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal 4. Native American tribal document 5. U.S. Citizen ID Card (Form I-197) 6. Identification Card for Use of Resident Citizen in the United States (Form I-179) 7. Employment authorization document issued by the Department of Homeland Security <p style="margin-left: 20px;">For examples, see Section 7 and Section 13 of the M-274 on uscis.gov/i-9-central.</p> <p style="margin-left: 20px;">The Form I-766, Employment Authorization Document, is a List A, Item Number 4, document, not a List C document.</p>
<p>Acceptable Receipts</p> <p>May be presented in lieu of a document listed above for a temporary period.</p> <p>For receipt validity dates, see the M-274.</p>				
<ul style="list-style-type: none"> • Receipt for a replacement of a lost, stolen, or damaged List A document. • Form I-94 issued to a lawful permanent resident that contains an I-551 stamp and a photograph of the individual. • Form I-94 with "RE" notation or refugee stamp issued to a refugee. 	OR	<p>Receipt for a replacement of a lost, stolen, or damaged List B document.</p>	AND	<p>Receipt for a replacement of a lost, stolen, or damaged List C document.</p>

*Refer to the Employment Authorization Extensions page on [I-9 Central](#) for more information.



Supplement A, Preparer and/or Translator Certification for Section 1

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

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

Last Name (<i>Family Name</i>) from Section 1 .	First Name (<i>Given Name</i>) from Section 1 .	Middle initial (if any) from Section 1 .
--	--	---

Instructions: This supplement must be completed by any preparer and/or translator who assists an employee in completing Section 1 of Form I-9. The preparer and/or translator must enter the employee's name in the spaces provided above. Each preparer or translator must complete, sign, and date a separate certification area. Employers must retain completed supplement sheets with the employee's completed Form I-9.

I attest, under penalty of perjury, that I have assisted in the completion of Section 1 of this form and that to the best of my knowledge the information is true and correct.

Signature of Preparer or Translator		Date (<i>mm/dd/yyyy</i>)	
Last Name (<i>Family Name</i>)	First Name (<i>Given Name</i>)		Middle Initial (<i>if any</i>)
Address (<i>Street Number and Name</i>)	City or Town	State	ZIP Code

I attest, under penalty of perjury, that I have assisted in the completion of Section 1 of this form and that to the best of my knowledge the information is true and correct.

Signature of Preparer or Translator		Date (<i>mm/dd/yyyy</i>)	
Last Name (<i>Family Name</i>)	First Name (<i>Given Name</i>)		Middle Initial (<i>if any</i>)
Address (<i>Street Number and Name</i>)	City or Town	State	ZIP Code

I attest, under penalty of perjury, that I have assisted in the completion of Section 1 of this form and that to the best of my knowledge the information is true and correct.

Signature of Preparer or Translator		Date (<i>mm/dd/yyyy</i>)	
Last Name (<i>Family Name</i>)	First Name (<i>Given Name</i>)		Middle Initial (<i>if any</i>)
Address (<i>Street Number and Name</i>)	City or Town	State	ZIP Code

I attest, under penalty of perjury, that I have assisted in the completion of Section 1 of this form and that to the best of my knowledge the information is true and correct.

Signature of Preparer or Translator		Date (<i>mm/dd/yyyy</i>)	
Last Name (<i>Family Name</i>)	First Name (<i>Given Name</i>)		Middle Initial (<i>if any</i>)
Address (<i>Street Number and Name</i>)	City or Town	State	ZIP Code



Supplement B, Reverification and Rehire (formerly Section 3)

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

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

Last Name (<i>Family Name</i>) from Section 1.	First Name (<i>Given Name</i>) from Section 1.	Middle initial (if any) from Section 1.
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Instructions: This supplement replaces Section 3 on the previous version of Form I-9. Only use this page if your employee requires reverification, is rehired within three years of the date the original Form I-9 was completed, or provides proof of a legal name change. Enter the employee's name in the fields above. Use a new section for each reverification or rehire. Review the Form I-9 instructions before completing this page. Keep this page as part of the employee's Form I-9 record. Additional guidance can be found in the [Handbook for Employers: Guidance for Completing Form I-9 \(M-274\)](#)

Date of Rehire (<i>if applicable</i>)	New Name (<i>if applicable</i>)		
Date (<i>mm/dd/yyyy</i>)	Last Name (Family Name)	First Name (Given Name)	Middle Initial

Reverification: If the employee requires reverification, your employee can choose to present any acceptable List A or List C documentation to show continued employment authorization. Enter the document information in the spaces below.

Document Title	Document Number (if any)	Expiration Date (if any) (<i>mm/dd/yyyy</i>)
----------------	--------------------------	--

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 documentation, the documentation I examined appears to be genuine and to relate to the individual who presented it.

Name of Employer or Authorized Representative	Signature of Employer or Authorized Representative	Today's Date (<i>mm/dd/yyyy</i>)
---	--	------------------------------------

Additional Information (Initial and date each notation.)	Check here if you used an alternative procedure authorized by DHS to examine documents.
--	---

Date of Rehire (<i>if applicable</i>)	New Name (<i>if applicable</i>)		
Date (<i>mm/dd/yyyy</i>)	Last Name (Family Name)	First Name (Given Name)	Middle Initial

Reverification: If the employee requires reverification, your employee can choose to present any acceptable List A or List C documentation to show continued employment authorization. Enter the document information in the spaces below.

Document Title	Document Number (if any)	Expiration Date (if any) (<i>mm/dd/yyyy</i>)
----------------	--------------------------	--

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 documentation, the documentation I examined appears to be genuine and to relate to the individual who presented it.

Name of Employer or Authorized Representative	Signature of Employer or Authorized Representative	Today's Date (<i>mm/dd/yyyy</i>)
---	--	------------------------------------

Additional Information (Initial and date each notation.)	Check here if you used an alternative procedure authorized by DHS to examine documents.
--	---

Date of Rehire (<i>if applicable</i>)	New Name (<i>if applicable</i>)		
Date (<i>mm/dd/yyyy</i>)	Last Name (Family Name)	First Name (Given Name)	Middle Initial

Reverification: If the employee requires reverification, your employee can choose to present any acceptable List A or List C documentation to show continued employment authorization. Enter the document information in the spaces below.

Document Title	Document Number (if any)	Expiration Date (if any) (<i>mm/dd/yyyy</i>)
----------------	--------------------------	--

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 documentation, the documentation I examined appears to be genuine and to relate to the individual who presented it.

Name of Employer or Authorized Representative	Signature of Employer or Authorized Representative	Today's Date (<i>mm/dd/yyyy</i>)
---	--	------------------------------------

Additional Information (Initial and date each notation.)	Check here if you used an alternative procedure authorized by DHS to examine documents.
--	---

CONFIDENTIALITY AGREEMENT

All individuals must read and sign this Confidentiality Agreement prior to beginning their Emerson Hospital work assignment and issuance of passwords. **It is the responsibility of each individual (including employees, affiliates, partners, or contractors) with access to Emerson systems to preserve and protect confidential information and systems (e.g. patient, employee and business information and systems) whether in hard copy, file/paper, oral or electronic form.** This responsibility applies to the data types below in accordance with the laws, regulations standards, and policies that apply. I acknowledge, and agree to follow the rules set forth in this agreement, understanding that non-compliance can result in disciplinary action or termination of employment and/or access.

Protected Health Information (PHI) is any individually identifiable information associated with the provision of health care, and is governed by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the subsequent HIPAA Privacy Rule and Security Rule. Personally Identifiable Information (PII) is any individually identifiable information including a social security number or credit card number, and is governed by state regulation, including the Massachusetts Data Protection Act. Card Holder Data (CHD) is credit card information that is protected by the Payment Card Industry (PCI) Data Security Standards (DSS). PHI, PII and CHD will collectively be referred as confidential information through this agreement.

1. It is my legal and ethical responsibility to protect the privacy, confidentiality, integrity, and availability of all confidential information. I understand that unauthorized access, use or disclosure of data is strictly prohibited whether working at Emerson Hospital facilities, IPA practices, or any remote work location.
2. All of Emerson Hospital's information technology (IT) resources (including but not limited to: computers, mobile devices, telephones, copiers, e-mail, Internet access, and other electronic devices and systems) are the property of Emerson Hospital and should be used for business purposes. I will comply with Emerson Hospital's Acceptable Use Policy. Usage of Emerson's data and systems is monitored and periodically audited for compliance with policies.
3. I will only access, use, create, store, or transmit confidential information for treatment, payment, and healthcare operations in the performance of my assigned duties, only where required by or permitted by law, and only in a manner which is consistent with Emerson Hospital policies. I will always utilize the minimum necessary amount of information to accomplish the attended purpose.
4. I will discuss confidential information only as appropriate, and only for job related purposes. I will refrain from discussing confidential information within the hearing of unauthorized persons. I will only use Emerson-approved devices and methods to communicate with patients. Unencrypted texting of PHI and/or CHD is prohibited by federal law, regulations and Emerson Hospital policies.
5. I understand that confidential information must be sent securely whether by fax, email, paper, or upload I can either send an email from my emersonhosp.org email account to another emersonhosp.org email address OR if I need to send an email with PHI outside of Emerson, I will type ENCRYPT in the subject line. Sending unencrypted PHI is prohibited by hospital policy. I will confirm the fax number and include a standard cover page. I will double check all paper PHI being mailed or handed to patients. I will upload data only if the site is secure and authorized. I will never upload PHI to public cloud sites, such as GoogleDocs, DropBox, etc.
6. I will dispose of confidential information using approved methods. I will store confidential paper records in locked cabinets and locked recycle bins. If locked bins are unavailable I will shred the information. All computer hard drives no longer needed must be brought to information systems for proper destruction.
7. I will utilize strong passphrases. My Emerson password will be unique, i.e. I will not re-use my Emerson ID or Password to access non-Emerson systems (e.g. email; social networking sites; online shopping sites). I will secure my access credentials (log-in User ID & Password) and I will not share them with anyone.
8. If connecting remotely I will connect using a secure application that is approved by the Emerson Hospital Information Security Officer and the network that I am connecting from must meet the Emerson Information Security minimum standards. I understand that remote work must be approved by my department manager. If I am a vendor or contractor I understand my organization must have a security risk assessment on file and a signed business associate agreement (BAA) prior to being granted access.
9. I understand my personal mobile device is authorized to connect to the Emerson "BYOD" network only. I understand that if Emerson email is configured on my personal mobile device it requires installation of Emerson's mobile device management software. I am required to keep my phone up-to-date and understand connectivity can be blocked if suspicious or malicious activity is detected.
10. I understand that I am prohibited from posting any information or images to social media that are about patients or patient care.
11. I will report any actual or suspected loss, theft, improper use of, or access to confidential information/systems - e.g. attempts to collect login credentials (phishing) or suspicious attachments (malware) via email to HELPDESK@emersonhosp.org or call extension 3447. I will email the Healthcare Information Protection (HiP) team - HiP@emersonhosp.org with specific HIPAA privacy, security or compliance issues or concerns.

Acknowledgment: I have read and understand the Confidentiality Agreement and I will comply with it. I understand that a violation of any part of the Confidentiality Agreement may result in disciplinary action up to and including termination of my employment. For individuals who are not employed by the Hospital, non-compliance with this agreement may result in termination of access to the Hospital's information systems and/or facilities.

Print Name

Mother's Maiden Name (for security verification purposes)

Date of Hire /Transfer

Position Title

Department

Physician Practice

Signature

Date



133 Old Road to Nine Acre Corner
Concord, MA 01742
(978) 369-1400
www.emersonhospital.org

Dear New Employee:

The attached policies reflect information that we are responsible for providing to new employees. The information is important for you to read and, as your employment with us proceeds, you will be asked to learn other policies and procedures that relate to your employment with Emerson Hospital.

As mandated by the Massachusetts Board of Registration in Medicine, health care facilities are required to give written instructions on their incident reporting system and their Patient's Rights Policy to all new employees involved in patient care.

We are providing you these written instructions, as they must be received within five days of employment. You will then receive an education and training session during your orientation program that will assist you in understanding these policies and your responsibilities.

Please note: All policies are available and accessible to all employees, which are located on the hospital intranet. Please sign below that you have received the policies and information listed and that you agree to fully comply with the Hospital policies. This acknowledgment will be placed in your personnel file.

I have received copies of the following policies/informational posters:

1. Code of Conduct
2. Harassment/Sexual Harassment
3. Drug and Alcohol Free
4. Substance Abuse Prevention
5. Social Media
6. Inclement Weather
7. Dress and Appearance
0. Organ & Tissue Donation
8. Pain Management
9. Abuse Identification and Reporting
1. Everify

Employee Signature

Date

Employee Printed Name

Witness Signature

Date

Witness Printed Name



LICENSURE VERIFICATION UPON TIME OF HIRE

Full Name:	Other Names Used:
Social Security #:	Position Title:

License Name	ID Number	Expiration Date

Certification Name	ID Number	Expiration Date

Other	Expiration Date
BLS/CPR	
ACLS	
PALS	
NRP	

Per my respective job description, I am aware that I must obtain the following *(if applicable)*:

Name of Licensure	Within	Due Date
	_____ months/year from my hire date	
	_____ months/year from my hire date	
	_____ months/year from my hire date	

My licensure information has been accurately transferred to this document, and my licensure is not currently under investigation.

Employee Signature

Date

To be completed by Human Resources:

I have viewed the original licensure of the above individual and verify that this information is accurate.

Print Name

Date

Signature

H.R. Assistant
Title

AUTHORIZATION FOR DIRECT DEPOSIT OF PAY

NAME: _____ EMPLOYEE ID# _____

FUNDS MAY BE DIRECTLY DEPOSITED INTO MORE THAN ONE ACCOUNT
ONLY FILL OUT THE SECTION(S) THAT APPLY

ONCE DIRECT DEPOSIT IS SET UP, EMPLOYEES WILL RECEIVE PAYSTUBS ELECTRONICALLY VIA EMERSON EMAIL ACCOUNT

******YOU MUST ATTACH A VOIDED CHECK IN ORDER TO PROCESS THIS FORM******

NEW DIRECT DEPOSIT:				
BANK NAME	TRANSIT NUMBER	ACCOUNT NUMBER	ACCOUNT TYPE <small>(CHECKING OR SAVINGS)</small>	DEPOSIT AMOUNT <small>(FIXED AMT OR NET PAY)</small>

CHANGE EXISTING DIRECT DEPOSIT TO THE FOLLOWING:				
BANK NAME	TRANSIT NUMBER	ACCOUNT NUMBER	ACCOUNT TYPE <small>(CHECKING OR SAVINGS)</small>	DEPOSIT AMOUNT <small>(FIXED AMT OR NET PAY)</small>

CANCEL THE FOLLOWING DIRECT DEPOSIT:				
BANK NAME	TRANSIT NUMBER	ACCOUNT NUMBER	ACCOUNT TYPE <small>(CHECKING OR SAVINGS)</small>	DEPOSIT AMOUNT <small>(FIXED AMT OR NET PAY)</small>

ALL CHANGES, EXCEPT FOR DOLLAR AMOUNTS WILL GENERATE A LIVE CHECK (RED) FOR TWO WEEKS.

Direct deposits are processed through the New England Automated Clearing House (NEACH) System. The deposits are normally processed by the NEACH system on Wednesdays. Credits to your accounts will appear 24 to 48 hours after the deposit is processed

DURING HOLIDAY WEEKS, DEPOSITS MAY BE DELAYED.

If your direct deposit rejects due to inaccurate information on this form, it will automatically be cancelled and you will continue to receive live checks until the correct information is received.

I hereby authorize my employer to have my pay directly deposited according to the above information.

EMPLOYEE SIGNATURE: _____ DATE: _____



Parking Registration

Full Name:	Email Address:
Title:	Department:
Badge Number:	Date of Hire:
Work Schedule:	

Vehicle #1 Information

Year:	Make:
Model:	Color:
License Plate Number:	Registration State:

Vehicle #2 Information

Year:	Make:
Model:	Color:
License Plate Number:	Registration State:

By signing below, I understand and authorize payroll to process the transactions for all fees associated with parking assignments and violations. I certify that the statements made on this application are true and I will notify the parking department whenever a change occurs. Falsification of information could result in the loss of all parking privileges. I understand Emerson Hospital will not be responsible for theft or damage to my vehicle or its contents while in any Emerson Hospital parking facility.

Signature: _____ Date: _____

Department of Family and Medical Leave (DFML) Contact Information

The Massachusetts Department of Family and Medical Leave

Charles F. Hurley Building
19 Staniford Street, 1st Floor
Boston, MA 02114
(617) 626-6565
www.mass.gov/DFML

Payment for Concurrent Leave

Any paid leave provided under a collective bargaining agreement or employer policy and paid at the same or higher rate than paid leave available under this law shall count against the allotment of leave benefits available under this law.

More Information is Available

For more detailed information, please consult the Department's website: www.mass.gov/DFML.

ACKNOWLEDGMENT

Your signature below acknowledges your receipt of the information above within 30 days from the start date of your employment or prior to September 20th, 2019, whichever is later.

Signature

Date

Name (Print)

Your signed acknowledgement will be retained by your employer. Please retain a copy for your own reference. In the event that you refuse to sign this acknowledgement, your employer must permit you to sign a statement indicating your refusal to sign this acknowledgement, and that will be retained by your employer.



Code of Organizational Behavior and Ethics

Employee Acknowledgement of Training

I hereby acknowledge that I have read and understand the information set forth in the Emerson Hospital Code of Organizational Behavior and Ethics (the “Code”). I certify that I will comply with these standards in my daily work activities and that I have a responsibility to report any suspected violations of the Code. I also understand that adhering to these standards is a condition of my employment or business relationship with Emerson Hospital and that if I have any questions about the Code I should ask my manager and/or call the Compliance Officer.

PRINT NAME: _____

SIGNATURE: _____

DATE: _____

Employer Notice to Employee

Rights and Obligations under the Massachusetts Family and Medical Leave Law, M.G.L. c. 175M

Emerson Hospital
(Employer Name)
133 Old Road to Nine Acre Corner
(Employer Street Address)
Concord MA, 01742
(Employer City, State, Zip)
04-2770977
(Employer's ID Number)

Explanation of Benefits

- **Beginning January 1, 2021,**
 - employees may be entitled to up to 12 weeks of paid family leave in a benefit year for the birth, adoption, or foster care placement of a child, or because of a qualifying exigency arising out of the fact that a family member is on active duty or has been notified of an impending call to active duty in the Armed Forces;
 - employees may be entitled to up to 20 weeks of paid medical leave in a benefit year if they have a serious health condition that incapacitates them from work
 - employees may be entitled to up to 26 weeks of paid family leave in a benefit year to care for a family member who is a covered service member undergoing medical treatment or otherwise addressing consequences of a serious health condition relating to the family member's military service.
- **Beginning July 1, 2021,**
 - employees may be entitled to up to 12 weeks of paid family leave in a benefit year to care for a family member with a serious health condition.
- Employees may be eligible for up to 26 total weeks, in the aggregate, of paid family and medical leave in a single benefit year.
- An employee's weekly benefit amount will be based on the employee's earnings, with a maximum benefit of \$850 per week.

Job Protection, Continuation of Health Insurance, No Retaliation

- Job Protection:** Generally, an employee who has taken family or medical leave under the law must be restored to the employee's previous position or to an equivalent position, with the same status, pay, employment benefits, length-of-service credit and seniority as of the date of leave.
- Continuation of Health Insurance:** The employer must continue to provide for and contribute to the employee's employment-related health insurance benefits, if any, at the level and under the conditions coverage would have been provided if the employee had continued working continuously for the duration of such leave.
- No Retaliation:** It is unlawful for any employer to discriminate or retaliate against an employee for exercising any right to which such employee is entitled under the paid family and medical leave law. An employee or former employee who is discriminated or retaliated against for exercising rights under the law may, not more than three years after the violation occurs, institute a civil action in the superior court.

Employer/Employee Contributions to the DFML Family and Employment Security Trust Fund

On October 1st 2019, contributions to the Department of Family and Medical Leave (DFML) Employment Security Trust Fund will begin. An employer will be responsible for sending contributions to the DFML for all employees.

Currently, the **total** contribution amount is **00.75%** of wages. Of that 00.75% total contribution amount, there is a split: **17.3% is a family leave contribution** and **82.7% is a medical leave contribution**.

Under the law, employers are responsible for a minimum of 60% of the medical leave contribution (.372% of wages), but are permitted to deduct from employees' wages up to 40% of the medical leave contribution (.248% of wages) and up to 100% of the family leave contribution (.13% of wages).

Medical Leave	<u>Emerson Hospital</u> (Employer Name)	will contribute	<u>60</u> %	of the medical leave contribution
		and the remaining	<u>40</u> %	will be deducted from your earnings

Family Leave	Emerson Hospital _____ (Employer Name)	will contribute	<u>0</u> %	of the family leave contribution
		and the remaining	<u>100</u> %	will be deducted from your earnings

How to File a Claim

Employees must file claims for paid family and medical leave benefits with the DFML using the Department's forms. Forms and claim instructions will be available on the Department's website www.mass.gov/DFML before January 2021.

Employees are required to provide at least 30 days' notice to their employer of the anticipated starting date of any leave, the anticipated length of the leave and the expected date of return. An employee who is unable to provide 30 days' notice due to circumstances beyond his or her control is required to provide notice as soon as practicable.

Private Plan Exemption

An employer that offers paid leave with benefits that are at least as generous as those provided under the law may apply for an exemption from paying the Department of Family and Medical Leave Family and Employment Security Trust Fund contribution. An employer may apply for an exemption from the medical leave contribution, family leave contribution, or both.

The details of any private plan must be provided to employees by an employer at the same time as this Notice.

Employees enjoy rights to job-protected leave and from discrimination and retaliation under the law even if their employer is approved to provide leave benefits through a private plan.

Emerson Hospital _____ (Employer Name)	<input checked="" type="checkbox"/> Does not have an approved private plan; <input type="checkbox"/> Has an approved private plan for both family and medical leave; <input type="checkbox"/> Has an approved private plan for family leave only; <input type="checkbox"/> Has an approved private plan for medical leave only.
--	--

Parking FAQ

How do I contact Parking?

Parking can be reached at 978-287-3009 or parking@emersonhosp.org. Parking can assist you with parking assignments, schedule changes and any questions you may have.

What are the Shuttle hours?

The Shuttle operates Monday-Friday 4:45am-10:00pm. Shuttle telephone # 978-505-8434.

Shuttle runs every 15 minutes from 4:45am to 10:00am and from 2:00pm-8:30pm. All other times call the shuttle telephone for pickup or drop off.

What is a Shuttle Rider?

New Employees who work the first shift are assigned to the shuttle lot across the street and utilize the shuttle for transportation to and from the Hospital. Shuttle riders have campus access to Lot D and Garage Monday-Friday starting at 1pm and all day access on Saturdays and Sundays.

How do I get campus parking?

Shuttle riders are automatically moved to campus lot parking when campus parking becomes available and is free to employees. Access to on campus parking is based on hire date, employment status and availability. Per Diem staff are not eligible for Lot D or Garage access Monday thru Friday 1st shift.

What if I am Per Diem or work the Second or Third shift?

Per Diem parking location depends upon the shifts worked. First shift employees working the weekday will be assigned to ride the shuttle. If an employee is working the second or third shift, they have access to Lot D and Garage Monday-Friday starting at 1pm and all day access on Saturday and Sundays.

How do I request parking in the garage?

If you are interested in parking in the Garage, please email parking@emersonhosp.org and your name will be added to the waitlist. Employees assigned to park in the garage are charged a fee.

What is the Garage Fee? How are Fee's deducted?

The Garage fee is \$6.94 per pay period and the fee is deducted through payroll.

Garage Parking:

Employee parking is on the upper levels, please do not park in a spot identified as Patient/Visitor parking.

Parking FAQ

Parking Violations:

The Garage and Lots are monitored daily. Employees found to be in violation of the parking program will be subject to disciplinary action and/or fees.

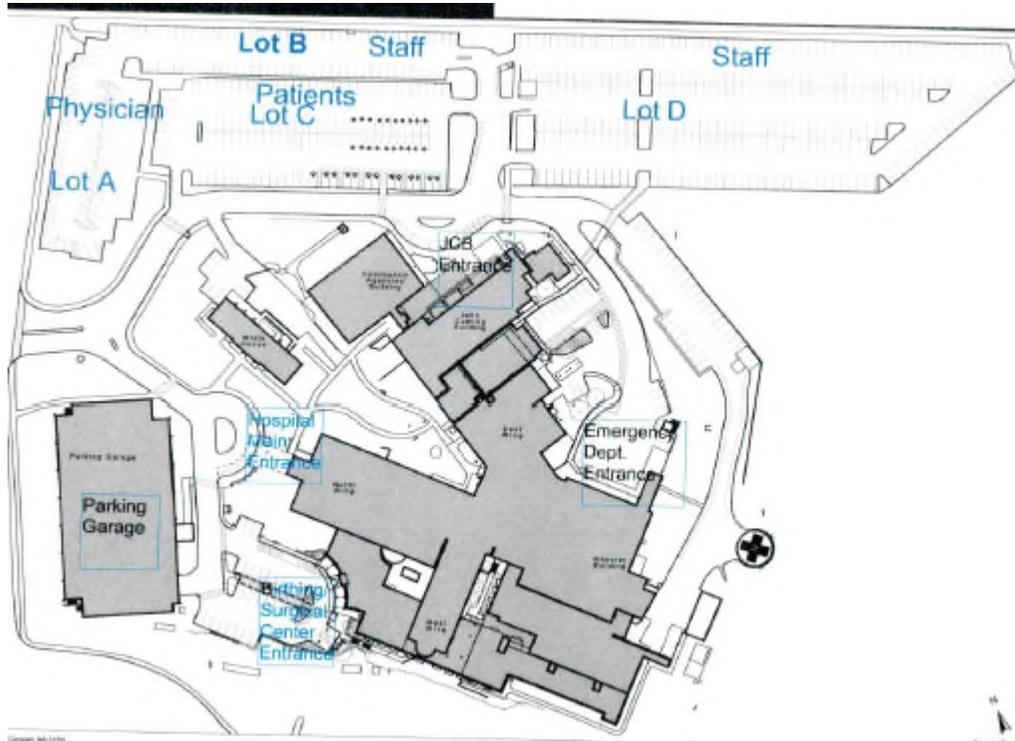
Badging at the Kiosks:

Employee badges are used to open the gates. Swiping or Waving the badge at the proxy card location circled in red below will activate the gate arm. An error message will occur if a Shuttle rider tries to enter Lot D or the Garage before the assigned time of 1PM Monday thru Friday.

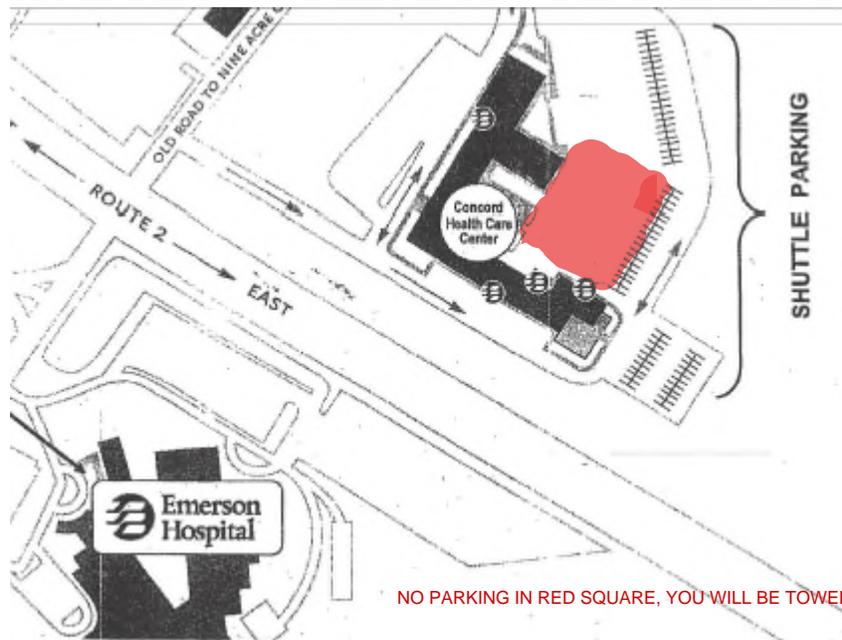


Parking FAQ

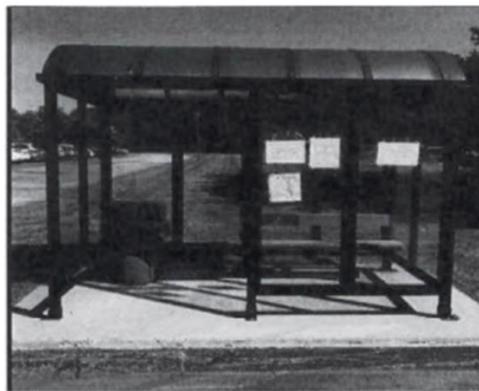
Campus Parking Map



Shuttle Lot Map



The Employee Shuttle Lot is across the street from the Hospital behind the Care One at Concord Facility. If you are coming off Rt. 2 West make a right at the traffic light. If coming Rt. 2 East enter the turning lane at the traffic light and turn left. If coming Old Road to Nine Acre Corner proceed through the traffic light. Make the first right turn into the Care One facility. There is a large sign at the turn (picture below). The lot is beside the shuttle shelter (picture below) and marked (see pictures). Refer to map for additional spaces if first lot is full.



This Organization Participates in E-Verify

Esta Organización Participa en E-Verify



This employer participates in E-Verify and will provide the federal government with your Form I-9 information to confirm that you are authorized to work in the U.S.

If E-Verify cannot confirm that you are authorized to work, this employer is required to give you written instructions and an opportunity to contact Department of Homeland Security (DHS) or Social Security Administration (SSA) so you can begin to resolve the issue before the employer can take any action against you, including terminating your employment.

Employers can only use E-Verify once you have accepted a job offer and completed the Form I-9.

E-Verify Works for Everyone

For more information on E-Verify, or if you believe that your employer has violated its E-Verify responsibilities, please contact DHS.

Este empleador participa en E-Verify y proporcionará al gobierno federal la información de su Formulario I-9 para confirmar que usted está autorizado para trabajar en los EE.UU..

Si E-Verify no puede confirmar que usted está autorizado para trabajar, este empleador está requerido a darle instrucciones por escrito y una oportunidad de contactar al Departamento de Seguridad Nacional (DHS) o a la Administración del Seguro Social (SSA) para que pueda empezar a resolver el problema antes de que el empleador pueda tomar cualquier acción en su contra, incluyendo la terminación de su empleo.

Los empleadores sólo pueden utilizar E-Verify una vez que usted haya aceptado una oferta de trabajo y completado el Formulario I-9.

E-Verify Funciona Para Todos

Para más información sobre E-Verify, o si usted cree que su empleador ha violado sus responsabilidades de E-Verify, por favor contacte a DHS.

888-897-7781

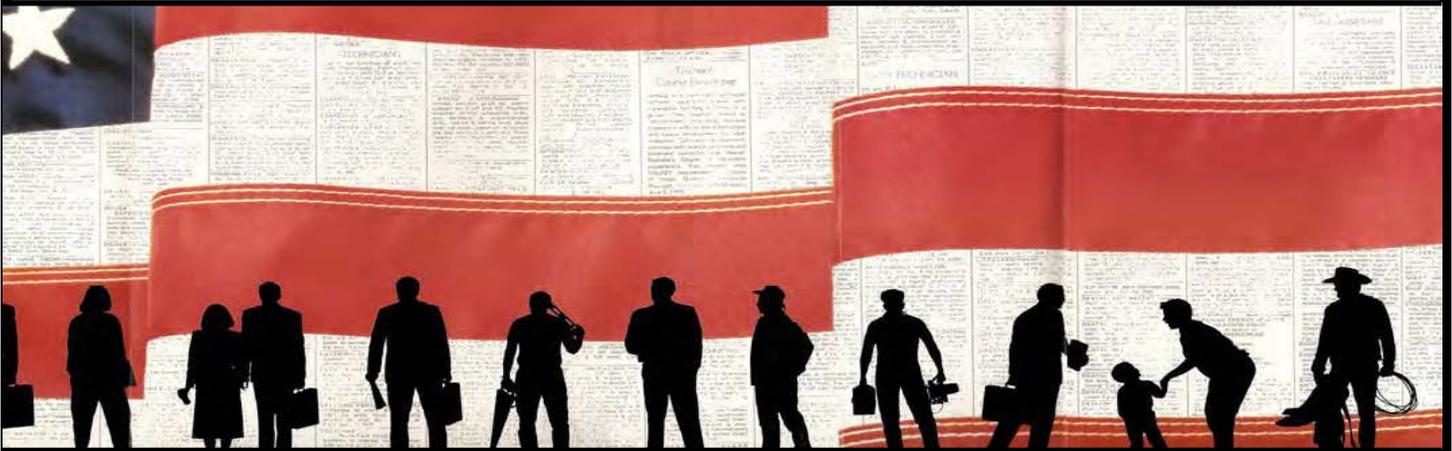
dhs.gov/e-verify



E-VERIFY IS A SERVICE OF DHS AND SSA

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IF YOU HAVE THE RIGHT TO WORK



Don't let anyone take it away.

There are laws to protect you from discrimination in the workplace.

You should know that...

In most cases, employers cannot deny you a job or fire you because of your national origin or citizenship status or refuse to accept your legally acceptable documents.

Employers cannot reject documents because they have a future expiration date.

Employers cannot terminate you because of E-Verify without giving you an opportunity to resolve the problem.

In most cases, employers cannot require you to be a U.S. citizen or a lawful permanent resident.

Contact IER

For assistance in your own language
Phone: 1-800-255-7688
TTY: 1-800-237-2515

Email us
IER@usdoj.gov

Or write to
U.S. Department of Justice – CRT
Immigrant and Employee Rights – NYA
950 Pennsylvania Ave., NW
Washington, DC 20530

If any of these things happen to you, contact the Immigrant and Employee Rights Section (IER).



— DEPARTMENT OF JUSTICE —
IMMIGRANT & EMPLOYEE RIGHTS SECTION
— CIVIL RIGHTS DIVISION —

Immigrant and Employee Rights Section

U.S. Department of Justice, Civil Rights Division

www.justice.gov/ier

SI USTED TIENE DERECHO A TRABAJAR



No deje que nadie se lo quite.

Existen leyes que lo protegen contra la discriminación en el trabajo.

Usted debe saber que...

En la mayoría de los casos, los empleadores no pueden negarle un empleo o despedirlo debido a su nacionalidad de origen o estatus de ciudadanía, ni tampoco negarse a aceptar sus documentos válidos y legales.

Los empleadores no pueden rechazar documentos porque tengan una fecha de vencimiento futura.

Los empleadores no pueden despedirlo debido a E-Verify sin darle una oportunidad de resolver el problema

En la mayoría de los casos, los empleadores no pueden exigir que usted sea ciudadano estadounidense o residente legal permanente.

Comuníquese con la IER

Para ayuda en su propio idioma:
Teléfono: 1-800-255-7688
TTY: 1-800-237-2515

Mándenos un correo:
IER@usdoj.gov

O escribanos a:
U.S. Department of Justice – CRT
Immigrant and Employee Rights – NYA
950 Pennsylvania Ave., NW
Washington, DC 20530

Si alguna de estas cosas le ha sucedido, comuníquese con la Sección de Derechos de Inmigrantes y Empleados (IER, por sus siglas en inglés)



DEPARTAMENTO DE JUSTICIA DE LOS EE. UU.
SECCIÓN DE DERECHOS DE INMIGRANTES Y EMPLEADOS
DIVISIÓN DE DERECHOS CIVILES

Sección de Derechos de Inmigrantes y Empleados
Departamento de Justicia de los EE. UU., División de Derechos Civiles

www.justice.gov/ier
www.justice.gov/crt-about/espanol/ier

Para información en español, visite www.consumerfinance.gov/learnmore o escribe a la Consumer Financial Protection Bureau, 1700 G Street N.W., Washington, DC 20552.

A Summary of Your Rights Under the Fair Credit Reporting Act

The federal Fair Credit Reporting Act (FCRA) promotes the accuracy, fairness, and privacy of information in the files of consumer reporting agencies. There are many types of consumer reporting agencies, including credit bureaus and specialty agencies (such as agencies that sell information about check writing histories, medical records, and rental history records). Here is a summary of your major rights under FCRA. **For more information, including information about additional rights, go to www.consumerfinance.gov/learnmore or write to: Consumer Financial Protection Bureau, 1700 G Street N.W., Washington, DC 20552.**

- **You must be told if information in your file has been used against you.** Anyone who uses a credit report or another type of consumer report to deny your application for credit, insurance, or employment – or to take another adverse action against you – must tell you, and must give you the name, address, and phone number of the agency that provided the information.
- **You have the right to know what is in your file.** You may request and obtain all the information about you in the files of a consumer reporting agency (your “file disclosure”). You will be required to provide proper identification, which may include your Social Security number. In many cases, the disclosure will be free. You are entitled to a free file disclosure if:
 - a person has taken adverse action against you because of information in your credit report;
 - you are the victim of identity theft and place a fraud alert in your file;
 - your file contains inaccurate information as a result of fraud;
 - you are on public assistance;
 - you are unemployed but expect to apply for employment within 60 days.

In addition, all consumers are entitled to one free disclosure every 12 months upon request from each nationwide credit bureau and from nationwide specialty consumer reporting agencies. See www.consumerfinance.gov/learnmore for additional information.

- **You have the right to ask for a credit score.** Credit scores are numerical summaries of your credit-worthiness based on information from credit bureaus. You may request a credit score from consumer reporting agencies that create scores or distribute scores used in residential real property loans, but you will have to pay for it. In some mortgage transactions, you will receive credit score information for free from the mortgage lender.
- **You have the right to dispute incomplete or inaccurate information.** If you identify information in your file that is incomplete or inaccurate, and report it to the consumer reporting agency, the agency must investigate unless your dispute is frivolous. See www.consumerfinance.gov/learnmore for an explanation of dispute procedures.
- **Consumer reporting agencies must correct or delete inaccurate, incomplete, or unverifiable information.** Inaccurate, incomplete, or unverifiable information must be removed or corrected, usually within 30 days. However, a consumer reporting agency may continue to report information it has verified as accurate.
- **Consumer reporting agencies may not report outdated negative information.** In most cases, a consumer reporting agency may not report negative information that is more than seven years old, or bankruptcies that are more than 10 years old.

- **Access to your file is limited.** A consumer reporting agency may provide information about you only to people with a valid need – usually to consider an application with a creditor, insurer, employer, landlord, or other business. The FCRA specifies those with a valid need for access.
- **You must give your consent for reports to be provided to employers.** A consumer reporting agency may not give out information about you to your employer, or a potential employer, without your written consent given to the employer. Written consent generally is not required in the trucking industry. For more information, go to www.consumerfinance.gov/learnmore.
- **You may limit “prescreened” offers of credit and insurance you get based on information in your credit report.** Unsolicited “prescreened” offers for credit and insurance must include a toll-free phone number you can call if you choose to remove your name and address from the lists these offers are based on. You may opt out with the nationwide credit bureaus at 1-888-5-OPTOUT (1-888-567-8688).
- The following FCRA right applies with respect to nationwide consumer reporting agencies:

CONSUMERS HAVE THE RIGHT TO OBTAIN A SECURITY FREEZE

You have a right to place a “security freeze” on your credit report, which will prohibit a consumer reporting agency from releasing information in your credit report without your express authorization.

The security freeze is designed to prevent credit, loans, and services from being approved in your name without your consent. However, you should be aware that using a security freeze to take control over who gets access to the personal and financial information in your credit report may delay, interfere with, or prohibit the timely approval of any subsequent request or application you make regarding a new loan, credit, mortgage, or any other account involving the extension of credit.

As an alternative to a security freeze, you have the right to place an initial or extended fraud alert on your credit file at no cost. An initial fraud alert is a 1-year alert that is placed on a consumer’s credit file. Upon seeing a fraud alert display on a consumer’s credit file, a business is required to take steps to verify the consumer’s identity before extending new credit. If you are a victim of identity theft, you are entitled to an extended fraud alert, which is a fraud alert lasting 7 years.

A security freeze does not apply to a person or entity, or its affiliates, or collection agencies acting on behalf of the person or entity, with which you have an existing account that requests information in your credit report for the purposes of reviewing or collecting the account. Reviewing the account includes activities related to account maintenance, monitoring, credit line increases, and account upgrades and enhancements.

- **You may seek damages from violators.** If a consumer reporting agency, or, in some cases, a user of consumer reports or a furnisher of information to a consumer reporting agency violates the FCRA, you may be able to sue in state or federal court.
- **Identity theft victims and active duty military personnel have additional rights.** For more information, visit www.consumerfinance.gov/learnmore.

States may enforce the FCRA, and many states have their own consumer reporting laws. In some cases, you may have more rights under state law. For more information, contact your state or local consumer protection agency or your state Attorney General. For information about your federal rights, contact:

TYPE OF BUSINESS:	CONTACT:
<p>1.a. Banks, savings associations, and credit unions with total assets of over \$10 billion and their affiliates</p> <p>b. Such affiliates that are not banks, savings associations, or credit unions also should list, in addition to the CFPB:</p>	<p>a. Consumer Financial Protection Bureau 1700 G Street, N.W. Washington, DC 20552</p> <p>b. Federal Trade Commission Consumer Response Center 600 Pennsylvania Avenue, N.W. Washington, DC 20580 (877) 382-4357</p>
<p>2. To the extent not included in item 1 above:</p> <p>a. National banks, federal savings associations, and federal branches and federal agencies of foreign banks</p> <p>b. State member banks, branches and agencies of foreign banks (other than federal branches, federal agencies, and Insured State Branches of Foreign Banks), commercial lending companies owned or controlled by foreign banks, and organizations operating under section 25 or 25A of the Federal Reserve Act.</p> <p>c. Nonmember Insured Banks, Insured State Branches of Foreign Banks, and insured state savings associations</p> <p>d. Federal Credit Unions</p>	<p>a. Office of the Comptroller of the Currency Customer Assistance Group 1301 McKinney Street, Suite 3450 Houston, TX 77010-9050</p> <p>b. Federal Reserve Consumer Help Center P.O. Box 1200 Minneapolis, MN 55480</p> <p>c. FDIC Consumer Response Center 1100 Walnut Street, Box #11 Kansas City, MO 64106</p> <p>d. National Credit Union Administration Office of Consumer Financial Protection (OCFP) Division of Consumer Compliance Policy and Outreach 1775 Duke Street Alexandria, VA 22314</p>
<p>3. Air carriers</p>	<p>Asst. General Counsel for Aviation Enforcement & Proceedings Aviation Consumer Protection Division Department of Transportation 1200 New Jersey Avenue, S.E. Washington, DC 20590</p>
<p>4. Creditors Subject to the Surface Transportation Board</p>	<p>Office of Proceedings, Surface Transportation Board Department of Transportation 395 E Street, S.W. Washington, DC 20423</p>
<p>5. Creditors Subject to the Packers and Stockyards Act, 1921</p>	<p>Nearest Packers and Stockyards Administration area supervisor</p>
<p>6. Small Business Investment Companies</p>	<p>Associate Deputy Administrator for Capital Access United States Small Business Administration 409 Third Street, S.W., Suite 8200 Washington, DC 20416</p>
<p>7. Brokers and Dealers</p>	<p>Securities and Exchange Commission 100 F Street, N.E. Washington, DC 20549</p>
<p>8. Federal Land Banks, Federal Land Bank Associations, Federal Intermediate Credit Banks, and Production Credit Associations</p>	<p>Farm Credit Administration 1501 Farm Credit Drive McLean, VA 22102-5090</p>
<p>9. Retailers, Finance Companies, and All Other Creditors Not Listed Above</p>	<p>Federal Trade Commission Consumer Response Center 600 Pennsylvania Avenue, N.W. Washington, DC 20580 (877) 382-4357</p>



**Adult Occupational Immunizations
Massachusetts Recommendations and Requirements for 2020/2021**

Vaccine	Recommendations in Brief
Influenza	1 dose of flu vaccine every flu season
Tdap/Td (Tetanus, diphtheria, pertussis)	1 dose of Tdap as soon as possible, then Td boosters every 10 years
MMR (Measles, mumps, rubella)	2 doses of MMR, > 28 days apart or documented laboratory-confirmed immunity to measles and mumps and rubella
Varicella	2 doses of varicella vaccine, or serologic proof of immunity, or history of varicella disease
Hepatitis B	3-dose series (see footnote)
Meningococcal	1 dose of quadrivalent meningococcal vaccine for microbiologists who are routinely exposed to <i>N. meningitidis</i> isolates. Booster every 5 years

Health care personnel (HCP) include full- and part-time staff with or without direct patient contact, including physicians, students, and volunteers who work in inpatient, outpatient and home-care settings. See Immunization of Health-Care Personnel - Recommendations of the ACIP. <https://www.cdc.gov/mmwr/preview/mmwrhtml/rr6007a1.htm>

Influenza: All HCP should receive annual flu vaccine. Give live, attenuated influenza vaccine (LAIV) to non-pregnant healthy HCP < 49 years of age. TIV is preferred over LAIV for HCP in close contact with severely immunosuppressed persons when patients require a protective environment.

Tetanus/Diphtheria/Pertussis (Td/Tdap): All HCP, regardless of age, should receive a single dose of Tdap as soon as feasible if they have not previously received Tdap, and regardless of the interval since last Td dose.

Measles, Mumps, Rubella (MMR): All HCP should be have presumptive evidence of immunity to measles, mumps, and rubella. Documentation of immunity: a) 2 doses of MMR at least 28 days apart; or b) laboratory evidence of immunity to measles **and** mumps **and** rubella or laboratory confirmation of each disease.

Varicella: All HCP should be immune to Varicella. Evidence of immunity to varicella for HCP includes: documentation of 2 doses of vaccine, > 4 weeks apart; laboratory evidence of immunity or laboratory confirmation of disease; diagnosis of history of varicella disease or herpes zoster by a health-care provider.

Hepatitis B: HCP should receive 3 doses hepatitis B vaccine on a 0, 1, and 6 month schedule. Test for hepatitis B surface antibody (anti-HBs) 1–2 months after 3rd dose to document immunity. HCP and trainees in certain populations at high risk for chronic hepatitis B (e.g., those born in countries with high and intermediate endemicity) should be tested for HBsAg and anti-HBc/anti-HBs to determine infection status.

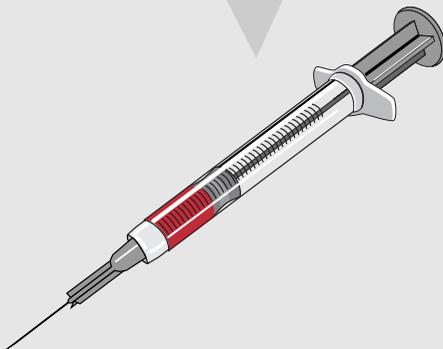
Meningococcal: A single dose of MCV4 is recommended for microbiologists 55 years and younger who may routinely be exposed to isolates of *N. meningitidis*. A booster dose should be given every 5 years while exposed. Health-care personnel over the age of 55 who have any of the above risk factors for meningococcal disease should be vaccinated with MPSV4.

These guidelines are based on the recommendations of the [Advisory Committee on Immunization Practices \(ACIP\)](#). For specific ACIP recommendations, refer to the full statements at <https://www.cdc.gov/mmwr/preview/mmwrhtml/rr6007a1.htm> visit the MDPH website at www.mass.gov/dph/imm; or call MDPH 617-983-6800.



What Every Worker Should Know

How to Protect Yourself From Needlestick Injuries



U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Public Health Service
Centers for Disease Control and Prevention
National Institute for Occupational Safety and Health



U.S. Department of Health and Human Services

Public Health Service

Centers for Disease Control and Prevention

National Institute for Occupational Safety and Health

Robert A. Taft Laboratories

4676 Columbia Parkway

Cincinnati, OH 45226-1998

Official Business

Penalty for Private Use \$300

What infections can be caused by needlestick injuries?

Needlestick injuries can expose workers to a number of blood-borne pathogens that can cause serious or fatal infections. The pathogens that pose the most serious health risks are

- Hepatitis B virus (HBV)
- Hepatitis C virus (HCV)
- Human immunodeficiency virus (HIV)—the virus that causes AIDS

HBV vaccination is recommended for all health care workers (unless they are immune because of previous exposure). HBV vaccine has proved highly effective in preventing infection in workers exposed to HBV. However, no vaccine exists to prevent HCV or HIV infection.

Preventing needlestick injuries is the best way to protect yourself from these infections.

Who is at risk of needlestick injury?

Any worker who may come in contact with needles is at risk, including *nursing staff, lab workers, doctors, and housekeepers.*

How common are needlestick injuries among health care workers?

Estimates indicate that 600,000 to 800,000 needlestick injuries occur each year. Unfortunately, about half of these injuries are not reported. *Always report needlestick injuries to your employer to ensure that you receive appropriate followup care.*

What kinds of needles usually cause needlestick injuries?

- Hypodermic needles
- Blood collection needles
- Suture needles
- Needles used in IV delivery systems

Do certain work practices increase the risk of needlestick injury?

Yes. Past studies have shown that needlestick injuries are often associated with these activities:

- Recapping needles
- Transferring a body fluid between containers
- Failing to dispose of used needles properly in puncture-resistant sharps containers

How can I protect myself from needlestick injuries?

- Avoid the use of needles where safe and effective alternatives are available.
- Help your employer select and evaluate devices with safety features that reduce the risk of needlestick injury.
- Use devices with safety features provided by your employer.
- Avoid recapping needles.
- Plan for safe handling and disposal of needles before using them.
- Promptly dispose of used needles in appropriate sharps disposal containers.
- Report all needlestick and sharps-related injuries promptly to ensure that you receive appropriate followup care.
- Tell your employer about any needlestick hazards you observe.
- Participate in training related to infection prevention.
- Get a hepatitis B vaccination.

For additional information, see ***NIOSH Alert: Preventing Needlestick Injuries in Health Care Settings*** [DHHS (NIOSH) Publication No. 2000-108]. Single copies of the Alert are available from the following:

NIOSH-Publications Dissemination
4676 Columbia Parkway
Cincinnati, OH 45226-1998

1-800-35-NIOSH (1-800-356-4674)

Fax: 513-533-8573

E-mail: pubstaff@cdc.gov

Web site: www.cdc.gov/niosh

Needlestick injuries can lead to serious or fatal infections. Health care workers who use or may be exposed to needles are at increased risk of needlestick injury. All workers who are at risk should take steps to protect themselves from this significant health hazard.