

PH: 772-466-0440  
FAX: 772-264-0775  
WWW.IPSPEO.COM

TWO LOCATIONS  
3802 CROSSROADS PKWY  
FORT PIERCE, FL 34945

207 AVE K S.E.  
WINTER HAVEN, FL 33880



**New Hire Packet**

**PLEASE SUBMIT PACKET TO:**

[PAYROLL@IPSPEO.COM](mailto:PAYROLL@IPSPEO.COM) OR FAX 772-264-0775

**Notice to CLIENT COMPANY:** NO Person shall be considered an employee of Intercoastal Payroll Solutions, LLC until the "NEW HIRE PACKET" forms have been completed in full, signed, and submitted to Intercoastal Payroll Solutions. If the CLIENT COMPANY does place such person into service prior to submitting the completed "NEW HIRE PACKET", the person is NOT working under Intercoastal Payroll Solutions' workers' compensation policy and the CLIENT COMPANY is completely responsible for all liabilities and or penalties should any occur (Refer to Client Service Agreement for details).

**\*\*\*\*Supervisor/manager MUST complete "Section 5" on the last page of this packet.\*\*\*\***

CLIENT COMPANY : _____
NEW HIRE NAME: _____
Rate of Pay: \$ _____ per _____
W/C CLASS CODE: _____

**SECTION 1 - EMPLOYEE INFORMATION**

**Intercoastal Payroll Solutions, LLC (IPS)** is a professional employer organization, which means that IPS is a co-employer of the employees working for its worksite employers/client companies. As a co-employer, IPS is the employer of record for payroll, tax reporting, workers compensation insurance, claims management, and other possible administrative functions. The client company or worksite employer is responsible for the day to day work of the employees and otherwise running the client company.

**EQUAL OPPORTUNITY EMPLOYER**

We adhere to a policy of making employment decisions without regard to race, color, age, sex, religion, nationality, disability, handicap or marital status. If you require reasonable accommodation in completing the form, please inform us.

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle initial: \_\_\_\_\_

Social Security #: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Marital Status: \_\_\_\_\_

Address: \_\_\_\_\_ Apt/unit #: \_\_\_\_\_ City: \_\_\_\_\_ ST: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Do you have any limitations which may affect your ability to safely or effectively perform the position you are offered? If YES, please explain: \_\_\_\_\_

**SECTION 2 – EMPLOYEE AGREEMENT –**

***I, the undersigned employee, in consideration of my hiring by Intercoastal Payroll Solutions, LLC (IPS) as an at-will leased employee of IPS, acknowledge and agree to the following:***

1. I have been hired as an at-will employee of IPS, which is an Employee Leasing Company, and there is no contract of employment which exists between me and the CLIENT COMPANY to which I have been assigned, nor between IPS and me. I understand and agree that either IPS or I can terminate our employment relationship at any time, as I am an at-will employee.
2. I also agree that while I am a leased employee of IPS, if IPS does not receive payment from CLIENT COMPANY for services which I perform as a leased employee, IPS will still pay me the applicable minimum wage (or the legally required minimum salary or overtime pay) for any such period, and I agree to this method of compensation. I understand that the CLIENT COMPANY to which I am assigned at all times remains obligated to pay me my regular hourly rate of pay if I am a non-exempt employee and to pay me my full salary if I am an exempt employee even if IPS is not paid by CLIENT COMPANY to which I am assigned.
3. In recognition of the fact that any work related injuries which might be sustained by me are covered by state workers' compensation statutes, and to avoid circumvention of such state statutes which may result from suits against customers or clients of IPS or against IPS based on the same injury or injuries, and the extent permitted by law, I hereby waive and forever release any rights I may have to make claims or bring suit against CLIENT COMPANY or customer of IPS or against IPS for damages based upon injuries which are covered under such workers' compensation statutes. I also agree to comply with any drug testing policy, which IPS may adopt, and I specifically agree to post-accident drug testing in any situation where it is allowed by law. I also agree that if I am injured, unless any other leave program is applicable, I will accept any modified/light duty assignment provided to be within the scope of my physical capabilities as determined by the workers' compensation treating physician.
4. I also agree that if at any time during my employment I am subjected to any type of discrimination, including discrimination because of race, sex, age, religion, color, retaliation, veteran status, national origin, handicap, disability or marital status, or if I am subjected to any type of harassment including sexual harassment, I will immediately contact an appropriate person of the CLIENT COMPANY to which I am assigned. In most instances, this appropriate person will be the president of the CLIENT COMPANY. Should I choose not to contact the CLIENT COMPANY for any reason, I may contact IPS Human Resource Director at 772-466-0440 in order to obtain assistance in the resolution of such matters. I understand and agree that IPS does not have actual control over my workplace, and as such, is not in a position to end or remediate any discrimination, harassment, or retaliation which may be occurring. The responsibility to end such inappropriate conduct rests solely with the CLIENT COMPANY; however IPS will attempt to facilitate a resolution.
5. I understand that I will receive my daily instructions from the co-employer to whom I have been assigned. There will be a 90-day probationary period at which time any party can terminate employment without further obligation.
6. As a drug and alcohol free workplace, IPS prohibits , among other things, the unlawful possession , consumption, distribution, or unauthorized use by all employees of alcohol or any illegal drugs or illegally obtained drugs in the workplace or when conducting work. Nor is any employee permitted to work after having ingested illegal or illegally obtained drugs or while impaired or under the influence of alcohol or drugs. Employees can be required to submit to drug and or alcohol testing under certain circumstances in accordance with IPS's drug and alcohol free workplace testing program, including post accident and reasonable suspicion testing. Any employee who violates IPS's policies may be subject to immediate discharge. Questions concerning IPS's drug and alcohol free policies/ testing should be directed to IPS Human Resources Director at 772-466-0440.
7. I further agree that at the end of my assignment with the CLIENT COMPANY, ***I will report back to IPS for possible reassignment to another client. If I fail to report within 48 hours, I may be denied unemployment benefits.***
8. I hereby authorize any party or agency contacted by the CLIENT COMPANY, IPS, or their respective agent(s) to furnish information requested. I understand that I may be required to complete additional releases authorizing the CLIENT COMPANY or its agents to investigate all statements contained in this or any other employment related documents. I hereby release, discharge, and hold harmless, to the extent permitted by federal, state, or local law, the CLIENT COMPANY, IPS, their respective agents(s) and any party delivering information to them pursuant to this authorization from any liabilities, claims, charges, or cause of action that I may have as a result of gathering, delivery or disclosure of any requested information.
9. I hereby certify that all information contained in this New Employee Packet or in any other application, resume, or document provided to the CLIENT COMPANY or IPS is true, accurate and complete, and is provided knowingly and voluntarily. I understand that providing any false, inaccurate, or incomplete information may result in disciplinary action, up to and including termination of my employment.

***By signing below, I acknowledge that I understand all of the items above. I further understand that I am an employee of Intercoastal Payroll Solutions LLC and that of Intercoastal Payroll Solutions LLC is my employer of record.***

EMPLOYEE SIGNATURE: \_\_\_\_\_ Date: \_\_\_\_\_

SECTION 3 – W4

PLEASE PRINT NAME AS IT APPEARS ON YOUR SOCIAL SECURITY CARD

Form <b>W-4</b> Department of the Treasury Internal Revenue Service	<b>Employee's Withholding Allowance Certificate</b> Whether you are entitled to claim a certain number of allowances or exemption from withholding is Subject to review by IRS. Your Employer may be required to send a copy of the form to the IRS.	OMB No. 1545-0074 <b>2015</b>
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<b>1</b> Type or print your first name and middle initial.	Last name	<b>2</b> Your social security number
Home address (number and street or rural route)		<b>3</b> Single Married Married, but withhold at higher Single rate. <b>Note.</b> If married, but legally separated, or spouse is a nonresident alien, check the "Single" box.
City or town, state, and ZIP code		<b>4</b> If your last name differs from that shown on your social security card, check here. You must call 1-800-772-1213 for a replacement card. ▶
<b>5</b> Total number of allowances you are claiming (from line H above or from the applicable worksheet on page 2)	<b>5</b>	
<b>6</b> Additional amount, if any, you want withheld from each paycheck	<b>6</b> \$	
<b>7</b> I claim exemption from withholding for 2015, and I certify that I meet <b>both</b> of the following conditions for exemption. <ul style="list-style-type: none"> <li>• Last year I had a right to a refund of <b>all</b> federal income tax withheld because I had <b>no</b> tax liability <b>and</b></li> <li>• This year I expect a refund of <b>all</b> federal income tax withheld because I expect to have <b>no</b> tax liability.</li> </ul> If you meet both conditions, write "Exempt" here . . . . . ▶ <b>7</b>		

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

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

<b>8</b> Employer's name and address (Employer: Complete lines 8 and 10 only if sending to the IRS.)	<b>9</b> Office code (optional)	<b>10</b> Employer identification number (EIN)
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**For Privacy Act and Paperwork Reduction Act Notice, see page 2.** Cat. No. 10220Q **Form W-4**  
**Instructions and worksheets for completing the W-4 furnished upon request.**

**SECTION 4 – EQUAL OPPORTUNITY EMPLOYER**

We are an Equal Opportunity employer and do not discriminate on the basis of race, ancestry, color, religion, sex, age, marital status, sexual orientation, national origin, medical condition, disability, veteran status, or any other basis protected by law. The Information provided will be used for research, reporting, statistical purposes and to monitor legal compliance. To help us comply with these government requirements, please complete the following information. Completion of this form is voluntary and will not affect your opportunity for employment or terms or conditions of employment. We appreciate your cooperation.

Gender (Choose One):  Male  Female  I Choose Not to Respond

<b>Race/Ethnicity (Choose One):</b>		
<input type="checkbox"/> American Indian or Alaska Native (Not Hispanic or Latino)	<input type="checkbox"/> Black or African American (Not Hispanic or Latino)	<input type="checkbox"/> Hispanic or Latino
<input type="checkbox"/> Asian (Not Hispanic or Latino)	<input type="checkbox"/> White (Not Hispanic or Latino)	<input type="checkbox"/> Two or More Races
<input type="checkbox"/> Some Other Race	<input type="checkbox"/> I Choose Not to Respond	
<input type="checkbox"/> Native Hawaiian/Other Pacific Islander (Not Hispanic or Latino)		

**SECTION 5 – TO BE COMPLETED BY EMPLOYEE'S SUPERVISOR OR MANAGER**

Client Company: \_\_\_\_\_

Location/Dept. Name: \_\_\_\_\_

Date of Hire: \_\_\_\_\_

Job Title: \_\_\_\_\_

Workers Comp Class Code: \_\_\_\_\_

Pay Cycle: <input type="checkbox"/> Weekly <input type="checkbox"/> Bi-Weekly <input type="checkbox"/> Semi-Monthly <input type="checkbox"/> Monthly
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<input type="checkbox"/> Hourly <input type="checkbox"/> Salary <b>Accurate Time Records Must Be Maintained</b> Rate of Pay: \$ _____ per _____ Tipped Employees: <input type="checkbox"/> NO <input type="checkbox"/> YES Shift Pay: <input type="checkbox"/> NO <input type="checkbox"/> YES Rate: \$ _____ per _____ Piecework: <input type="checkbox"/> NO <input type="checkbox"/> YES Rate: \$ _____ per _____ Commissions: <input type="checkbox"/> NO <input type="checkbox"/> YES Rate: \$ _____ per _____
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**\*Client Company is responsible for completing, verifying, and maintaining I-9 Form for every employee**

Supervisor, Manger or Authorized Signature: \_\_\_\_\_

Title: \_\_\_\_\_ Date: \_\_\_\_\_