

VIKING DIVING SERVICES, Inc

Application for employment

IRS W-4

Form <b style="font-size: 2em;">W-4 Department of the Treasury Internal Revenue Service	<b style="font-size: 1.2em;">Employee's Withholding Allowance Certificate ▶ Whether you are entitled to claim a certain number of allowances or exemption from withholding is subject to review by the IRS. Your employer may be required to send a copy of this form to the IRS.	OMB No. 1545-0074 2011
1 Type or print your first name and middle initial. Last name		2 Your social security number
Home address (number and street or rural route)		3 <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Married, but withhold at higher Single rate. <small>Note. If married, but legally separated, or spouse is a nonresident alien, check the "Single" box.</small>
City or town, state, and ZIP code		4 If your last name differs from that shown on your social security card, check here. You must call 1-800-772-1213 for a replacement card. ▶ <input type="checkbox"/>
5 Total number of allowances you are claiming (from line H above or from the applicable worksheet on page 2)	<input style="width: 50px;" type="text"/>	5
6 Additional amount, if any, you want withheld from each paycheck	<input style="width: 50px;" type="text"/>	6 \$
7 I claim exemption from withholding for 2011, and I certify that I meet both of the following conditions for exemption. <ul style="list-style-type: none"> • Last year I had a right to a refund of all federal income tax withheld because I had no tax liability and • This year I expect a refund of all federal income tax withheld because I expect to have no tax liability. If you meet both conditions, write "Exempt" here ▶		7
Under penalties of perjury, I declare that I have examined this certificate and to the best of my knowledge and belief, it is true, correct, and complete.		
Employee's signature (This form is not valid unless you sign it.) ▶		Date ▶
8 Employer's name and address (Employer: Complete lines 8 and 10 only if sending to the IRS.)		9 Office code (optional) 10 Employer identification number (EIN)

Personal Information

Nickname		
Present address		
City	State	Zip code
Phone	Cell	
Refereed by		
Place of Birth	Date of Birth	
Email address		

Emergency contact

Name	
Phone	Cell
Relationship	

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

Form I-9, Employment Eligibility Verification

Please read instructions carefully before completing this form. The instructions must be available during completion of this form.

ANTI-DISCRIMINATION NOTICE: It is illegal to discriminate against work eligible individuals. Employers CANNOT specify which document(s) they will accept from an employee. The refusal to hire an individual because the documents have a future expiration date may also constitute illegal discrimination.

Section 1. Employee Information and Verification. To be completed and signed by employee at the time employment begins.

Print Name: Last	First	Middle Initial	Maiden Name
Address (Street Name and Number)		Apt. #	Date of Birth (month/day/year)
City	State	Zip Code	Social Security #

<p>I am aware that federal law provides for imprisonment and/or fines for false statements or use of false documents in connection with the completion of this form.</p>	<p>I attest, under penalty of perjury, that I am (check one of the following):</p> <input type="checkbox"/> A citizen or national of the United States <input type="checkbox"/> A lawful permanent resident (Alien #) A _____ <input type="checkbox"/> An alien authorized to work until _____ (Alien # or Admission #) _____
	<p>Employee's Signature</p> <p>Date (month/day/year)</p>

Preparer and/or Translator Certification. (To be completed and signed if Section 1 is prepared by a person other than the employee.) I attest, under penalty of perjury, that I have assisted in the completion of this form and that to the best of my knowledge the information is true and correct.

Preparer's/Translator's Signature	Print Name
Address (Street Name and Number, City, State, Zip Code)	
Date (month/day/year)	

Section 2. Employer Review and Verification. To be completed and signed by employer. Examine one document from List A OR examine one document from List B and one from List C, as listed on the reverse of this form, and record the title, number and expiration date, if any, of the document(s).

List A	OR	List B	AND	List C
Document title: _____		_____		_____
Issuing authority: _____		_____		_____
Document #: _____		_____		_____
Expiration Date (if any): _____		_____		_____
Document #: _____		_____		_____
Expiration Date (if any): _____		_____		_____

CERTIFICATION - I attest, under penalty of perjury, that I have examined the document(s) presented by the above-named employee, that the above-listed document(s) appear to be genuine and to relate to the employee named, that the employee began employment on (month/day/year) _____ and that to the best of my knowledge the employee is eligible to work in the United States. (State employment agencies may omit the date the employee began employment.)

Signature of Employer or Authorized Representative	Print Name	Title
Business or Organization Name and Address (Street Name and Number, City, State, Zip Code)		Date (month/day/year)

Section 3. Updating and Reverification. To be completed and signed by employer.

A. New Name (if applicable)	B. Date of Rehire (month/day/year) (if applicable)
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C. If employee's previous grant of work authorization has expired, provide the information below for the document that establishes current employment eligibility.

Document Title: _____	Document #: _____	Expiration Date (if any): _____
I attest, under penalty of perjury, that to the best of my knowledge, this employee is eligible to work in the United States, and if the employee presented document(s), the document(s) I have examined appear to be genuine and to relate to the individual.		
Signature of Employer or Authorized Representative		Date (month/day/year)

Former Employers (last 4 employers)

Date: Month/Year	Business name	Position	Reason for leaving

References (3 persons not related to you)

Name	Phone number	Business	Years known

The information contained in these forms is vital to your employment with Viking Diving Services. All documents must be filled Out completely and signed by you. You will be considered for employment without regard to race, color, religion, sex, national origin or age.

Authorization

I authorize investigation of all information contained herein and the references and employers listed above to give you any and all information concerning my previous employment and any pertinent information they may have, personal or otherwise, and release the company from all liability from any damage that may result from utilization of such information.”

Signature _____

Date _____

Print name _____

VIKING DIVING SERVICES, Inc Medical History Form

Last name	First name	MI
S.S.N.		
Address		
City	State	Zip code
Phone number		
Sex M () F ()	Height	Weight
Single () Married ()	Spouse name	Phone number

My present state of health is:

GOOD
 FAIR
 POOR

List ALL Surgeries, Serious Illness or injuries:

year

My personal physician is

Name
Address
Phone number

Answer the following questions: Explain all items checked YES

	YES	NO
Do you have any physical defects or any partial disabilities?		
Do you have any conditions that may require special work assignments?		
Have you ever be rejected for insurance/employment/armed forces for health reasons?		
Have you ever had ill affects from any work that you have done?		

Are you taking any type of medication including Patent medicines?		
Have you ever been advised to have a surgical operation or medical treatment and declined?		
Have you ever resigned, been terminated or changed jobs for medical reasons?		
Have you ever been dismissed because of excess use of alcohol /drugs?		
Do you presently use marijuana, LSD, narcotics or controlled substances?		
Do you have any allergies/reactions to food, chemicals, drugs, or insect stings?		

Have you ever had or been treated for

YES	NO		YES	NO	
		Abnormal heart rhythm			Heart trouble
		Airway obstruction			High blood pressure
		Anemia			Irregular menses
		Appendicitis			Jaundice
		Arthritis			Kidney trouble
		Asthma			Knee injury
		Back strain			Liver disease
		Blood disease			Lung trouble
		Blood in urine			Nervous breakdown
		Broken bones			Nose bleed
		Chest pain			Painful menses
		Chronic cough			Paralysis
		Color vision defect			Perforated Eardrum
		Convulsion			Rectal bleeding
		Coughing of blood			Rectal pains
		Diabetes			Rheumatic fever
		Disabling headaches			Rheumatism
		Disc problems			Shortness of breath
		Dislocations			Shoulder injury
		Ear trouble			Skin rash
		Elbow injury			Stomach trouble
		Epilepsy			Swollen ankles
		Eye trouble (not glasses)			Thyroid trouble
		Food trouble			Tuberculosis
		Head injury			Tumor or cancer
		Heart attack			Urinary trouble
		Heart murmur			Varicose veins

PLEASE EXPLAIN THE DETAILS OF ALL CHECKED YES

Diving history

How long have you been diving?		Max depth Air	
		Max depth Gas	
Longest bottom Time Air			
Longest bottom Time Gas			
Have you made any saturation Dives?	Yes ()	No ()	Where
Have you passed an oxygen tolerance test?	Yes ()	No ()	where
Number of decompression incidents		Any residuals?	Yes () No ()
Explain:			
Have you ever been involved in a diving accident?	Yes ()		No ()
Explain:			
While diving, have you had a history of:			
Gas Embolism		Lung Squeeze	Oxygen Toxicity
Near drowning		CO2 toxicity	Asphyxiation
CO Toxicity		Vertigo (dizziness)	Ear squeeze
Deafness		Ear Drum Rupture	Nitrogen narcosis
Loss of consciousness		Strums squeeze	

Date of last physical examination _____

For what company or organization were you examined last? _____

Medical Authorization

By signing below, I authorize full access to copies of medical records, radiology reports, drug/alcohol screenings, and documents of any kind relating to my past or present injury/illness to Viking Diving Services. I hereby agree to release this information and hold all such medical providers harmless from the release of this information as set forth in thin authorization.

Signature _____

Date _____

Print name _____

Direct Deposit

First name	MI	Last name	SSN
Bank name		Branch	
Bank address, City, State and zip code			
:		:	
Routing Number		Account Number	

Checking Account

Savings Account

I hereby authorize Viking Diving Services and its affiliates, hereinafter called the Company, to initiate credits entries and to initiate, debit entries and adjustments for any credit entries in error to my checking and or savings account indicated below and the depository named below, hereinafter called Depository, to credit and or debit the same to such account.

This authority is to remain in full force and effect until Company has received written notification from me of its termination in such time and in such manner as to afford Company and Depository a reasonable opportunity to act on it.

By signing below, I authorize deductions when applicable to be made out of my paycheck for cash advances, tools, uniforms, health insurance, and errors in payroll, overpayments and any other work related deductions.

Employee Signature _____

Date _____

