Example - Section 1, Completed by Employee

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)
Doe	John	A	

Address (Street Number and Name)	Apt. Number (if any)	City or Town	State	ZIP Code
1234 Main Street		Washington	DC	00000

Date of Birth (mm/dd/yyyy)	U.S. Social Security Number	Employee's Email Address	Employee's Telephone Number
01/01/9999	1 1 1 1 1 1 1 1 1	john.doe@email.com	(555) 555-5555

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

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

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

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

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

Signature of Employee	Today's Date (mm/dd/yyyy)
John Doe *wet handwritten signature required	08/01/2023

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)					

	List A	Additional Information
Document Title 2 (if any)		
Issuing Authority		
Document Number (if any)		
Expiration Date (if any)		
Document Title 3 (if any)		
Issuing Authority		
Document Number (if any)		
Expiration Date (if any)		☐ Check here if you used an alternative procedure authorized by DHS to examine documents.

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

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

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

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**
1. U.S. Passport or U.S. Passport Card		**1.** Driver's license or ID card issued by a State or outlying possession of the United States provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		**1.** A Social Security Account Number card, unless the card includes one of the following restrictions: **(1)** NOT VALID FOR EMPLOYMENT **(2)** VALID FOR WORK ONLY WITH INS AUTHORIZATION **(3)** VALID FOR WORK ONLY WITH DHS AUTHORIZATION
2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551)		**2.** ID card issued by federal, state or local government agencies or entities, provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		**2.** Certification of report of birth issued by the Department of State (Forms DS-1350, FS-545, FS-240)
3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa		**3.** School ID card with a photograph		**3.** 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. Employment Authorization Document that contains a photograph (Form I-766)		**4.** Voter's registration card		**4.** Native American tribal document
5. For an individual temporarily authorized to work for a specific employer because of his or her status or parole: **a.** Foreign passport; and **b.** Form I-94 or Form I-94A that has the following: **(1)** The same name as the passport; and **(2)** An endorsement of the 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.		**5.** U.S. Military card or draft record		**5.** U.S. Citizen ID Card (Form I-197)
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		**6.** Military dependent's ID card		**6.** Identification Card for Use of Resident Citizen in the United States (Form I-179)
		7. U.S. Coast Guard Merchant Mariner Card		**7.** Employment authorization document issued by the Department of Homeland Security For examples, see Section 7 and Section 13 of the M-274 on uscis.gov/i-9-central. The Form I-766, Employment Authorization Document, is a List A, **Item Number 4.** document, not a List C document.
		8. Native American tribal document		
		9. Driver's license issued by a Canadian government authority		
		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		

Acceptable Receipts

May be presented in lieu of a document listed above for a temporary period.

For receipt validity dates, see the M-274.

• 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**	Receipt for a replacement of a lost, stolen, or damaged List B document.	Receipt for a replacement of a lost, stolen, or damaged List C document.

*Refer to the Employment Authorization Extensions page on I-9 Central for more information.

Form **W-4**

Department of the Treasury
Internal Revenue Service

Employee's Withholding Certificate

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

OMB No. 1545-0074

2024

Step 1: Enter Personal Information

(a) First name and middle initial: John
Last name: Doe
(b) Social security number: 111-11-1111

Address: 310 Maple Park Ave SE

City or town, state, and ZIP code: Olympia, WA 98504

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*.

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

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

Step 2: Multiple Jobs or Spouse Works

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

Do **only one** of the following.

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

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

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

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

Step 3: Claim Dependent and Other Credits

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

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

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

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

Step 4 (optional): Other Adjustments

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

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

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

Step 5: Sign Here

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

John Doe *wet handwritten signature required

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

07/18/2024
Date

Employers Only

Employer's name and address	First date of employment	Employer identification number (EIN)

Washington State Department of Transportation

Authorization for Direct Deposit of Wages

Employee: *(1) Complete the upper portion of the form, sign, and date.*
(2) You or your financial institution completes the lower portion.
(3) Deliver the completed form to HQ Payroll Office, MS: 47420 or email PDF to WSDOTHQPAYROLL@wsdot.wa.gov

Employee Legal Name (Last, First, Initial) *	Employee ID Number *	Agency	Agency Code
Doe, John	TBD	WSDOT	405-0

Employee Full Mailing Address *	Telephone *
310 Maple Park Ave SE, Olympia, WA 98504	855-707-8100

*** Required field, form will not be processed without required information.**

In accordance with RCW 43.41.180, I hereby authorize and request the State, until this authorization is revoked as described below, to transfer the full amount of my state salary, after mandatory and authorized deductions, to the designated financial institution for deposit in my account.

In the event that the State may be legally obligated to withhold any additional part of my salary payment for any reason, I understand that the State shall have the authority to immediately terminate any transfer made under this authorization.

If the State discovers that the electronic transmission for this authorization for any reason will result in an overpayment of salary or wages actually due and payable to me, I hereby authorize the State to either process a reversing transaction that will result in sending the net pay amount back to the state, or seek full reimbursement of the overpayment by whatever means is appropriate.

If any action taken by me or my financial institution, without adequate notification to my agency payroll office, results in non-acceptance of the transfer by the designated financial institution, I understand that the State assumes no responsibility for processing supplemental payroll payments until the funds are returned to the agency by the financial institution.

This authority is in force until written notification is received from me regarding its termination, or my death.

If PAY CARD is selected below, the pay card merchant will verify the information provided to identify me. I understand the rules and applicable fees are in the terms and conditions of the pay card merchant. I understand that U.S. Bank Focus Card Visa Payroll Card terms and conditions can be found at http://www.usbankfocus.com. I understand the pay card is intended for deposit of payroll and other state-initiated payments. By signing this authorization and selecting PAY CARD below I agree to abide by the cardholder terms and conditions. I understand and agree that Focus Card is a service provided by U.S. Bank to me and I agree to pay any and all fees incurred through use of the card, and to hold the State of Washington and its agencies and officers harmless for any and all costs, fees, or damages incurred through the use of the card.

Banking information can be provided as follows: ***Note: The completed form is valid only if items a) or b) are completed.***

a) If selecting ACH to your existing financial institution, complete the bottom section. Your financial institution can provide the correct routing number and account number suitable for ACH. You may also attach a voided check.

b) If PAY CARD is selected, information is to be completed by agency Payroll.

Name of Financial Institution *	Check the Type of Account to be Deposited *:
Bank Name Here	☒ Checking Account ☐ Savings Account ☐ Pay Card

COMPLETE ITEM BELOW

Routing Transit Number * (must be 9 digits, see reverse)	Account Number * (as required by financial institution for ACH, see reverse)
1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9

Employee's Signature *	Date *
John Doe *wet handwritten signature required	05/01/2024

DOT Form 670-048
Revised 04-2024

A-1 (Worksheet C): Provided to the employee as notification

Newly hired employee (hourly/salaried)

Employee Name: John Doe Employee ID: TBD

Date notice provided to employee: 07/18/2024

EMPLOYEE ELIGIBILITY NOTIFICATION

1. Stacking Hours Within an Agency *(WAC 182-12-114 (1)(c))*	**Enter a Y or N**
Employee has informed their employer that:	
They are working two or more positions or jobs in the agency (concurrent stacking); or have moved from one position or job to another in the agency (consecutive stacking).	N
2. Requirements for Eligibility *(WAC 182-12-114 (1)(a))*	**Enter a Y or N**
An employee is eligible if they are:	
a. Anticipated to work an average of at least 80 hours per month;	Y
b. Anticipated to work for at least 8 hours in each month; and	Y
c. For more than 6 consecutive months.	Y
Excluded hours: 0	
3. Eligibility Decision	**Decision**
If the answer is "Yes" to all requirements, the employee is benefits-eligible. Go to section #4 of this worksheet.	**Yes**
If an answer was "No" to any of the requirements, the employee is not benefits-eligible at this time. Go to section #8 of this worksheet.	
4. Date of Eligibility *(WAC 182-12-114 (1)(b)(i))*	**Date**
The employee is eligible from the date of employment. This is typically your first day of work.	**07/18/2024**
5. Benefits Begin: *(WAC 182-12-114 (1)(d))*	**Date**
Medical, dental, basic life and accidental death and dismemberment (AD&D) insurance, and employer & employee paid long-term disabilty (LTD) insurance, and if eligible, benefits under the salary reduction plan: begin the first day of the month following the date the employee becomes eligible (see #4 above). • If the employee becomes eligible on the first working day of the month, then benefits begin on that date **Supplemental Life and AD&D insurance** begins on the first day of the month following the date the contracted vendor received the required form or approves the enrollment.	**08/01/2024**

6. New Employee Resources to Enroll in PEBB Benefits	
The following resources are available for newly eligible employees about PEBB benefits: • PEBB website www.hca.wa.gov/public-employee-benefits/employees/how-enroll • The PEBB Employee Enrollment Guide (which includes enrollment forms)	
7. Form Submission Dates: *(WAC 182-08-197 (1)(a))*	**Due Date**
The PEBB *Employee Enrollment/Change* form must be received by the employing agency no later than **31 days** after the employee becomes eligible for PEBB benefits.	08/01/2024
The PEBB MetLife Enrollment/Change form must be received by MetLife or enrollment through the MetLife MyBenefits portal no later than **31 days** after the employee becomes eligible for PEBB benefits. If supplemental life insurance is requested after **31 days**, or the amounts requested are over the guaranteed issue amounts, evidence of insurability (statement of health) will be required. Note: Supplemental accidental death and dismemberment (AD&D) insurance will not require evidence of insurability (statement of health). www.metlife.com/wshca	08/01/2024
Enrollment in employee-paid LTD at the 60% coverage level is automatic (unless declined during the 31 day election period). Declining or reducing to the 50% coverage level is done by submitting The PEBB *Long-Term Disability (LTD) Enrollment/Change* form* to the employing aggency. *Port Commissioners and seasonal employees who work a season of less than 9 months are eligible for basic LTD only.	08/01/2024
If enrolling in the Medical or Limited Purpose FSA and/or DCAP*, the *PEBB Midyear Enrollment* form must be received by the employing agency no later than 31 days after the employee becomes eligible for PEBB benefits. **Available to state and higher education institution employees only.*	08/01/2024
If enrolling dependents, valid Dependent Verification (DV) documents must be received by the employing agency no later than **31 days** after the employee becomes eligible for PEBB benefits. A list of valid DV documents is available on the PEBB website: https://www.hca.wa.gov/public-employee-benefits/employees/dependent-verification	08/01/2024
Auto or home insurance may be applied for at any time with Liberty Mutual. https://www.hca.wa.gov/employee-retiree-benefits/public-employees/auto-and-home-insurance	
* The employee must have no less than ten calendar days after the date of notice to elect coverage. For example, if the employee's date of eligiblity is September 3 and is provided notice of eligibility: • No later than September 24, the employee has until October 4 to make elections. • On September 30, the employee will have until October 10 to make elections.	
Important: Failure by the employee to submit forms timely will result in a default enrollment as follows: Uniform Medical Plan Classic with a monthly premium of $110, Uniform Dental Plan, basic life, basic AD&D insurance, and the employer-paid and employee-paid (60%) LTD insurance, dependents will not be enrolled, and a $25 per account monthly tobacco use premium surcharge will be incurred (WAC 182-08-197 (1)(b)).	
Forms must be submitted even if the employee chooses to waive medical coverage.	

8. Signature and Date: To be reviewed and signed by the employee and employer		
• I (the employee) have reviewed the above information and acknowledge the decision made. I understand I can access PEBB rules and guidance on the above decision through the PEBB website (**www.hca.wa.gov/employee-retiree-benefits/rules- and-policies/pebb-rules-and-policies**), specifically WAC 182-12-114 and 182-12-131. • I understand if I have a change that affects my eligibility for PEBB benefits, my employer will notify me. I also understand I have the right to ask my employer to re-evaluate my eligibility at any time. • I understand it is my responsibility to inform my employer immediately if I am returning from layoff status within 24 months of my original eligible position ending (date of layoff). (For the limited purpose of determining PEBB benefit eligibility, "layoff" is defined in WAC 182-12-109 and there are examples in WAC 182-12-129 and 182-12-133 (1)(b)(v)). • I understand it is my responsibility to immediately inform my employer if I have or obtain multiple jobs or positions within the agency. • I acknowledge I have the right to appeal this and any future eligibility decisions for PEBB benefits made by a PEBB-participating employing agency through the PEBB appeals process (Chapter 182-16 WAC). • I understand the PEBB appeals process begins with requesting a review from my employer. (For a complete explanation of the appeals process and appeal forms, visit the PEBB website) https://www.hca.wa.gov/about-hca/file-appeal-pebb		
Employee Signature		08/01/2024 Date
Agency Representative Signature	405-0 Agency/Sub Agency	07/18/2024 Date

Place a signed copy in the employee's file and provide a copy of the **Employee Eligibility Notification** to the employee.

Washington State Department of Transportation

Plan Choice for New Members of PERS, SERS or TRS

I, John Doe, understand the following:

As a new member in the following retirement system:

- ☒ Public Employees' Retirement System (PERS)
- ☐ School Employees' Retirement System (SERS)
- ☐ Teachers' Retirement System (TRS)

I have the choice between Plan 2 and Plan 3 in the retirement system. If I do not actively choose a plan within 90 days of being hired into a retirement-eligible position, I will be defaulted into Plan 2.

My date of hire is 7/10/2024 and my 90 days expires on 10/08/2024.

I must complete the *Member Information Form* and submit it to my employer as a means of documenting my plan choice decision.

I know that I can find more detailed information on the Washington State Department of Retirement Systems website at *www.drs.wa.gov/choice*.

My plan choice decision for the retirement system indicated above, whether by active choice or by default, is irrevocable. I will not be able to choose another plan in the retirement system in the future. My *Member Information Form* must be submitted by 4:30 pm on the expiration date to the:

- ☒ Human Resources Office at HRHelp@wsdot.wa.gov
- ☐ Payroll Office
- ☐ Other ____________________

John Doe

Signature of Employee

08/18/2024

Date

Retirement Status Verification

Employers can use this form to document the retirement status of all new employees.

DRS Contact Information
Employer Support Services (ESS)
360.664.7200, option 2
800.547.6657, option 6, option 2
drs.employersupport@drs.wa.gov

Employer Instructions

RCW 41.50.139 requires employers to obtain, in writing, the retirement status of all new employees. Your organization can document the status using your own process, or by using this form. If using this form:

- Ask the employee to complete and sign the Employee Information section below.
- Use the Member Management Process in the Employer Reporting Application (ERA) to verify the employee's retirement status.
- Record the results in the Employer Verification section below.
- Use Retiree Return to Work (RRTW) Reporting Charts to review reporting instructions as necessary.
- Sign and date this form. Retain for 60 years.

Employee Information		Employer Verification
Employee Name (Last, First, Middle) Doe, John	Social Security Number 111-11-1111	
Are you a retiree of one of Washington state's retirement systems? If yes, which one(s)? ☐ Yes, ______ ☐ No		☐ Yes ☐ No
Have you retired or will you be eligible to retire from LEOFF Plan 2 in the future? ☐ Yes ☐ No		☐ Yes ☐ No If yes, and filling eligible position (not L2 position), have employee complete LEOFF Plan 2 Re-employment form.
Are you a retiree of a separate retirement plan covered by the city of Seattle, Spokane or Tacoma? If yes, which one(s)? ☐ Yes, ______ ☐ No		If the employee checked yes, stop. Contact ESS before enrolling the employee in a DRS retirement plan.
Are you currently employed by another public employer and contributing to a Washington state retirement system? That is, will you be working at the same time for two public employers? ☐ Yes ☐ No		If the employee checked yes, stop. Contact ESS before enrolling the employee in a DRS retirement plan.
Employee Signature John Doe	Date (mm/dd/yyyy) 07/18/2024	

Employer Comments (optional)

Please enter any additional comments here. If you need more room, use the back of this form and check this box: ☐

Employer Signature

I verified the above information using ERA (or by contacting DRS). I acknowledge that failure to properly report a retiree to DRS can result in a liability to the employer.

Employer Signature	Date (mm/dd/yyyy)

Employee Emergency Contact Information

Washington State Department of Transportation

In order to ensure that the Employee Emergency Contact Information Form is available when an emergency arises, each employee is requested to maintain his or her information at their respective office and/or workplace. The original form will be retained in the Human Resources Office and copies will be provided to the Safety Office and to the employee's timekeeper. It is recommended that the forms be kept in a location that is central and readily available within the immediate workplace. A controlled location and access to the forms is as crucial as the need for this information during an emergency.

Employee Name (please print) John, Doe Employee Number TBD Physical Address 310 Maple Park Ave SE Olympia, WA 98504	Primary Phone (855) 707-8100 ☒ Cell Phone Without Text Capabilities ☐ Cell Phone w/ Text Capabilities ☐ Home (Landline) Phone Alternate Phone ( ) ☐ Cell Phone Without Text Capabilities ☐ Cell Phone w/ Text Capabilities ☐ Home (Landline) Phone
Notify in Case of Emergency	
Name (please print) Physical Address Relationship*:	Primary Phone ( ) ☐ Cell Phone Without Text Capabilities ☐ Cell Phone w/ Text Capabilities ☐ Home (Landline) Phone Alternate Phone ( ) ☐ Cell Phone Without Text Capabilities ☐ Cell Phone w/ Text Capabilities ☐ Home (Landline) Phone
Alternate Contact Person (*Optional*)	
Name (please print) Physical Address Relationship*:	Primary Phone ( ) ☐ Cell Phone Without Text Capabilities ☐ Cell Phone w/ Text Capabilities ☐ Home (Landline) Phone Alternate Phone ( ) ☐ Cell Phone Without Text Capabilities ☐ Cell Phone w/ Text Capabilities ☐ Home (Landline) Phone

* Relationship (for example, spouse/partner/friend/parent/child) section is optional and is only requested to aid the WSDOT staff in the event we must contact this person.)

Signature: John Doe

Date: 07/18/2024

CONFIDENTIAL

WSDOT Employee Affirmative Action and Demographic Data Form

Government agencies provide state and federal periodic reports about the state workforce for equal opportunity and affirmative action efforts. The demographic information from this form also helps us make better decisions about how we increase representation of underrepresented groups and make our workforce more diverse and inclusive.

Important note: Providing any of this information is voluntary, and information will be kept confidential to the extent possible. However, information provided on this form may be subject to disclosure under the Public Records Act (RCW 49.60.040(26)).

Employee Information

1. Name (Last, First, Middle Initial) Doe, John

2. Personnel Number

3. Date 07/18/2024

Please see page 3-5 for definitions

4. Are you 40 years or older?
   - ◯ Yes
   - ◯ No
   - Birthdate

5. Gender Identity
   - ◯ Female
   - ◯ Male
   - ◯ X/Non-binary

6. Gender Designation for Health Insurance Purposes (used by doctors for billing.)
   - ◯ Female
   - ◯ Male

7. Are you a person with a disability? *Veterans with a service-connected disability may also meet the definition of a person with a disability.*
   - ◯ Yes
   - ◯ No

8. Do you identify as LGBTQ+? *Information used to account for workforce representation.*
   - ◯ Yes
   - ◯ No

9. What race and/or ethnicity do you consider yourself? Select all that apply.
   - ☐ American Indian or Alaska Native
   - ☐ Black or African-American
   - ☐ Native Hawaiian or Other Pacific Islander
   - ☐ Asian
   - ☐ Hispanic or Latino
   - ☐ White

Veteran and Military Spouse Information

Employment preference is given to veterans. The state also provides support and assistance to military spouses in accordance with Executive Order 19-01. *Note: To qualify and receive veteran's preference, you may be asked to provide a record of discharge, DD214, NGB Form 22 or alternate verification of military service and a document from the U.S. Department of Veterans Affairs certifying a service-connected disability for disabled veterans.*

10. Veterans Status? Select **all** that apply.

Are you an Eligible Veteran?

◯ Yes ◯ No

If yes, discharge date:

Are you a Vietnam Era Veteran?

◯ Yes ◯ No

Type of discharge:

Are you a Veteran with service-connected disability?

◯ Yes ◯ No

Are you a Special Disabled Veteran?

◯ Yes ◯ No

If you are a Retired Veteran with 20+ years of active service, do you earn $500+ per month retirement pay?

◯ Yes ◯ No

11. Are you currently a member of the reserve component, including the National Guard?

◯ Yes ◯ No

Were you called to active duty from employment with the state?

◯ Yes ◯ No

11a. If yes, dates: From to and

11b. Type of Discharge:

12. Are you a military spouse or military registered domestic partner?

◯ Yes ◯ No

13. Are you the spouse or registered domestic partner of an honorably discharged deceased veteran OR honorably discharged 100% service-connected disabled veteran?

◯ Yes ◯ No

Signature | Date

John Doe | 7/18/2024

Submit the completed form to your agency's Human Resources Office.

For more information on HRMS entry of this form: [Affirmative Action and Demographic Data Guide]

* Required if teleworking within WA State
**Must complete the Out of State Telework Participant Agreement if teleworking outside of WA State

Washington State Department of Transportation

In State Telework Participant Agreement

Employee Name			Employee ID
Position #	Official Duty Station (in position description)	Employee Org Code	Primary Telework City

Estimated Percentage of Time Teleworking

Choose the category that most closely fits, averaged over the next year. Average for employees whose telework varies seasonally. Do not include work from Official Duty Station, field work, travel, Temporary Duty Station, or locations other than Primary Telework City.

91-100% Remote Worker (EP9)	76-90% (EP8)	51-75% (EP7)
40-50% (EP6)	20-39% (EP5)	Less than 20% / ad hoc (EP0)

Terms of Teleworking

☐ Check to verify that you have completed the following:

The supervisor and employee have documented work location requirements for Official Duty Station, work in the field, Temporary Duty Stations, or other locations that are not considered telework.

The supervisor and employee have documented job duty and performance expectations.

The position description denotes telework eligibility. If the position is not telework eligible this form should not be completed.

The supervisor and employee have read, understand and will comply with the Telework Manual and the IT Manual 3017.00 800.00 Telework and Standard IT Equipment.

Terms of Agreement

This Agreement shall become effective on the date signed below and shall remain in effect until changed or canceled by either party. This agreement can be canceled at any time at the discretion of the Manager or Supervisor. The employee and their supervisor will review this Agreement during the annual performance evaluation or within one year of signing. A new form must be completed if the category for the estimated percentage of time teleworking averaged over the next year changes, essential job functions change, job performance, or other reasons.

Secure/Confidential Materials

The employee must receive prior employer approval to (1) remove secure/confidential materials from the official workstation, or (2) access secure/confidential information through computers. The employee will take reasonable precautions to secure confidential materials at all times such materials are in the employee's possession or control.

Liability for Injuries

If approved for telework, the employee understands that the employee remains liable for injuries to third persons and / or members of employee's family on employee's premises. Employee agrees to defend, indemnify, and hold harmless employer, its affiliates, employees, contractors and agents, from and against any and all claims, demands or injury to persons (including death) or damage to property caused, directly or indirectly, by the services provided herein by employee or by employee's willful misconduct, negligent acts or omissions in the performance of the employee's duties and obligation under this Agreement, except where such claims, demands, or liability arise solely from the gross negligence or willful misconduct of the employer.

Additional Information

For more information see WSDOT's Telework Manual at https://wwwi.wsdot.wa.gov/human-resources/telework.

Approval Signatures

Employee's Signature		Date
Supervisor's Name	Supervisor's Signature	Date

Cancellation/Denial Signatures		
☐ Telework Denied		
Supervisor's Name	Supervisor's Signature	
☐ Telework canceled per Employee		
Employee Signature		Effective Date
☐ Telework canceled per Supervisor		
Supervisor Signature		Effective Date
Describe reason for cancellation/denial and attach supporting documentation if applicable		
Email completed form to HRHelp@wsdot.wa.gov **or to your local Human Resource Consultant**		

Washington State Department of Transportation

*Only required if eligible for telework

Telework Safety Assessment

Telework employees should be undisturbed, able to concentrate, and comfortable in their alternative work environment. Recognizing these needs, the Department strives to ensure that employees maintain an alternative work environment that allows them to perform their jobs efficiently and comfortably.

The following check list is completed by the employee and submitted to the manager with the Telework Application. This checklist is meant to provide suggestions to help the employee maintain a safe alternative worksite that allows them to work efficiently. At the time of signature the manager has not verified the condition of the remote location. WSDOT has the right to visit and inspect the remote location, at a mutually agreed upon time to verify a safe location.

- ☐ The workspace is free from excessive noise.
- ☐ There is adequate lighting provided at the worksite.
- ☐ All electrical equipment is free of recognized hazards that could cause physical harm.
- ☐ The electrical system is adequate for office equipment.
- ☐ Aisles, doorways, and corners are free of obstructions permitting visibility and movement.
- ☐ First aid supplies are readily accessible and adequate.
- ☐ Work surfaces and chairs are ergonomically correct
- ☐ If using computer equipment, displaying dark letters on a light computer minimizes glare effects.
- ☐ The office space is neat, clean, and free of hazardous materials.
- ☐ A fire extinguisher is located nearby.

Signatures	
Employee's Name	Supervisor's Name
Date	Date
Employee's Signature	Supervisor's Signature