TOWN OF HOLLISTON

SEASONAL EMPLOYEE CHECKLIST

Welcome to your seasonal position with the Town of Holliston!

Please bring the following forms and documentation to the Recreation Department, 1750 Washington Street, or to the Human Resources Office on the Lower Level of Town Hall, 703 Washington Street.

Seasonal Employment Forms can be found on the Town website on the Human Resources page at https://www.townofholliston.us/human-resources/pages/new-employee-information.

If you have any questions, or would like to review the forms with us, please call Human Resources at 508-474-3335.

REQUIRED FORMS CHECKLIST:

_____ New Employee Form

_____ I-9 Employment Eligibility Verification Form & documentation (not required if returning within 2 years)

_____ Work Permit Required if under 18

_____ W4- Federal Income Tax Withholding Form

_____ M4- State Income Tax Withholding Form

_____ Social Security Acknowledgement Form

_____ Mandatory Massachusetts Deferred Compensation OBRA Form (in lieu of social security)

_____ Direct Deposit Form and Authorized Bank Account Information (Voided Check or Printout)

_____ W2 Consent for Email Delivery Form

_____ Policy Acknowledgement Form

_____ Certification of Seasonal Employment

_____ Medical Form

HUMAN RESOURCES DEPARTMENT
TOWN HALL, 703 WASHINGTON STREET, HOLLISTON, MASSACHUSETTS 01746-2168
TEL: 508-474-3335 FAX: 508-474-5923
Website: www.townofholliston.us

NEW EMPLOYEE FORM

DATE: _____ JOB DESCRIPTION: _____

NAME: _____
PLEASE PRINT

SOCIAL SECURITY #:_____ BIRTH DATE_____

ADDRESS: _____GENDER: _____

CITY: _____ STATE: _____ZIP:_____

TELEPHONE #: _____MARITAL STATUS: _____
CIRCLE ONE: HOME, CELL, OTHER

EMAIL ADDRESS: _____

IN CASE OF EMERGERENCY NOTIFY: _____

RELATIONSHIP_____TELEPHONE #_____
HOME, WORK, CELL, OTHER

ETHNICITY: _____ (CAUCASIAN, ASIAN, BLACK, HISPANIC, AMERICAN INDIAN)

SUPERVISOR'S SECTION

DATE OF EMPLOYMENT: _____

DEPARTMENT NAME: _____ DEPARTMENT #:_____

SCHEDULED HOURS PER PAY PERIOD: _____

POSITION TITLE: _____ PAY TYPE _____

ACCOUNT NUMBER TO BE PAID FROM: _____

STATUS: _____FULL TIME PERMANENT - 35 TO 40 HOURS WEEKLY
_____ TEMPORARY – WORKING LESS THAN 1 YEAR, # MONTHS_____
_____PART TIME
_____ SEASONAL _____ELECTED OFFICAL
_____FIREFIGHTER/EMT _____ LONG TERM SUB

PAY FREQUENCY: _____ GRADE _____ STEP_____
(PLEASE PROVIDE AUTHORIZATION IF EMPLOYEE HIRED AT OTHER THAN STEP 1)

SALARY: _____ HOURLY /WEEKLY RATE_____

ACCRUALS:
VACATION_____SICK_____PERSONAL_____

SUPERVISOR'S SIGNATURE _____

DATE_____
8/2020

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

2022

Step 1: Enter Personal Information

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

(c) ☐ **Single** or **Married filing separately**
☐ **Married filing jointly** or **Qualifying widow(er)**
☐ **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, when to use the estimator at *www.irs.gov/W4App*, and privacy.

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); **or**

(b) Use the Multiple Jobs Worksheet on page 3 and enter the result in Step 4(c) below for roughly accurate withholding; **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 accurate for jobs with similar pay; otherwise, more tax than necessary may be withheld . . ▶ ☐

TIP: To be accurate, submit a 2022 Form W-4 for all other jobs. If you (or your spouse) have self-employment income, including as an independent contractor, use the estimator.

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 Dependents

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 and 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)

FORM M-4

MASSACHUSETTS EMPLOYEE'S WITHHOLDING EXEMPTION CERTIFICATE

Rev. 1/12

Print full name ..... Social Security no. .....

Print home address ..... City..... State ..... Zip .....

Employee:
File this form or Form W-4 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. If you claim **more** than the correct number of exemptions, civil and criminal penalties may be imposed. You may claim a smaller number of exemptions. 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.

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 withholding exemptions for your spouse or for any dependents that will not be claimed on your annual tax return.

If claiming a wife or husband, write "4" in line 2. Using "4" is the 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.

IF THE ALLOWABLE MASSACHUSETTS WITHHOLDING EXEMPTIONS ARE THE SAME AS YOU ARE CLAIMING FOR U.S. INCOME TAXES, COMPLETE U.S. FORM W-4 ONLY.

Social Security Administration

Statement Concerning Your Employment in a Job Not Covered by Social Security

Employee Name _____ **Employee ID#** _____

Employer Name _____ **Employer ID#** _____

Your earnings from this job are not covered under Social Security. When you retire, or if you become disabled, you may receive a pension based on earnings from this job. If you do, and you are also entitled to a benefit from Social Security based on either your own work or the work of your husband or wife, or former husband or wife, your pension may affect the amount of the Social Security benefit you receive. Your Medicare benefits, however, will not be affected. Under the Social Security law, there are two ways your Social Security benefit amount may be affected.

Windfall Elimination Provision

Under the Windfall Elimination Provision, your Social Security retirement or disability benefit is figured using a modified formula when you are also entitled to a pension from a job where you did not pay Social Security tax. As a result, you will receive a lower Social Security benefit than if you were not entitled to a pension from this job. For example, if you are age 62 in 2013, the maximum monthly reduction in your Social Security benefit as a result of this provision is $395.50. This amount is updated annually. This provision reduces, but does not totally eliminate, your Social Security benefit. For additional information, please refer to Social Security Publication, "Windfall Elimination Provision."

Government Pension Offset Provision

Under the Government Pension Offset Provision, any Social Security spouse or widow(er) benefit to which you become entitled will be offset if you also receive a Federal, State or local government pension based on work where you did not pay Social Security tax. The offset reduces the amount of your Social Security spouse or widow(er) benefit by two-thirds of the amount of your pension.

For example, if you get a monthly pension of $600 based on earnings that are not covered under Social Security, two-thirds of that amount, $400, is used to offset your Social Security spouse or widow(er) benefit. If you are eligible for a $500 widow(er) benefit, you will receive $100 per month from Social Security ($500 - $400=$100). Even if your pension is high enough to totally offset your spouse or widow(er) Social Security benefit, you are still eligible for Medicare at age 65. For additional information, please refer to Social Security Publication, "Government Pension Offset."

For More Information

Social Security publications and additional information, including information about exceptions to each provision, are available at www.socialsecurity.gov. You may also call toll free 1-800-772-1213, or for the deaf or hard of hearing call the TTY number 1-800-325-0778, or contact your local Social Security office.

I certify that I have received Form SSA-1945 that contains information about the possible effects of the Windfall Elimination Provision and the Government Pension Offset Provision on my potential future Social Security Benefits.

Signature of Employee _____ **Date** _____

Information about Social Security Form SSA-1945 Statement Concerning Your Employment in a Job Not Covered by Social Security

New legislation [Section 419(c) of Public Law 108-203, the Social Security Protection Act of 2004] requires State and local government employers to provide a statement to employees hired January 1, 2005 or later in a job not covered under Social Security. The statement explains how a pension from that job could affect future Social Security benefits to which they may become entitled.

Form SSA-1945, **Statement Concerning Your Employment in a Job Not Covered by Social Security,** is the document that employers should use to meet the requirements of the law. The SSA-1945 explains the potential effects of two provisions in the Social Security law for workers who also receive a pension based on their work in a job not covered by Social Security. The Windfall Elimination Provision can affect the amount of a worker's Social Security retirement or disability benefit. The Government Pension Offset Provision can affect a Social Security benefit received as a spouse, surviving spouse, or an ex-spouse.

Employers must:

- Give the statement to the employee prior to the start of employment;
- Get the employee's signature on the form; and
- Submit a copy of the signed form to the pension paying agency.

Social Security will not be setting any additional guidelines for the use of this form.

Copies of the SSA-1945 are available online at the Social Security website, www.socialsecurity.gov/online/ssa-1945.pdf. Paper copies can be requested by email at ofsm.oswm.rqct.orders@ssa.gov or by fax at 410-965-2037. The request must include the name, complete address and telephone number of the employer. Forms will not be sent to a post office box. Also, if appropriate, include the name of the person to whom the forms are to be delivered. The forms are available in packages of 25. Please refer to Inventory Control Number (ICN) 276950 when ordering.

Participant Enrollment
Governmental 457(b) Plan

Massachusetts Deferred Compensation SMART Plan - Mandatory OBRA 98966-02

Participant Information

Last Name | First Name | MI

Social Security Number

Address - Number & Street

E-Mail Address

City | State | Zip Code

❑ Married ❑ Unmarried ❑ Female ❑ Male

( ) Home Phone ( ) Work Phone

Mo Day Year — Date of Birth

Mo Day Year — Date of Hire

Do you have a retirement savings account with a previous employer or an IRA? ❑ Yes or ❑ No

Important Notice: Employees participating in the Massachusetts Deferred Compensation SMART Plan - OBRA Mandatory Plan (the Plan) must complete Social Security Form SSA-1945. The Plan has been designated as an alternative retirement system for part time employees not covered by their employers retirement system. The SSA-1945 explains the potential effects of the Windfall Elimination Provision and Government Pension Offset Provision under the Social Security law which may reduce the amount of your Social Security retirement or disability benefits, and/or benefits received by you as a spouse or an ex-spouse. If you have any questions regarding SSA-1945 or if you have not completed SSA-1945, please contact your employer.

Statement Delivery - Participant quarterly statements are sent regular mail via the U.S. Postal Service. If you prefer an environmentally friendly alternative, please visit www.mass-smart.com for fast and easy enrollment in our Online File Cabinet service.

Payroll Information

Town of Holliston
Division Name

To be completed by Representative: 6921
Division Number

Investment Option Information (applies to all contributions) - Please refer to your communication materials for information regarding each investment option.

I understand that funds may impose redemption fees on certain transfers, redemptions or exchanges if assets are held less than the period stated in the fund's prospectus or other disclosure documents. I will refer to the fund's prospectus and/or disclosure documents for more information.

INVESTMENT OPTION NAME	INVESTMENT OPTION CODE (Internal Use Only)	
The Income Fund	MELINC	100%

Last Name	First Name	MI	Social Security Number

Plan Beneficiary Designation

This designation is effective upon execution and delivery to Service Provider at the address below. I have the right to change the beneficiary. If any information is missing, additional information may be required prior to recording my beneficiary designation. If my primary and contingent beneficiaries predecease me or I fail to designate beneficiaries, amounts will be paid pursuant to the terms of the Plan Document or applicable state law.

You may only designate one primary and one contingent beneficiary on this form. However, the number of primary or contingent beneficiaries you name is not limited. If you wish to designate more than one primary and/or contingent beneficiary, do not complete the section below. Instead, complete and forward the Beneficiary Designation form.

Primary Beneficiary

% of Account Balance	Social Security Number	Primary Beneficiary Name	Relationship	Date of Birth
100.00%				

Contingent Beneficiary

% of Account Balance	Social Security Number	Contingent Beneficiary Name	Relationship	Date of Birth
100.00%				

Participation Agreement

Withdrawal Restrictions - I understand that the Internal Revenue Code (the "Code") and/or my employer's Plan Document may impose restrictions on transfers and/or distributions. I understand that I must contact the Plan Administrator/Trustee to determine when and/or under what circumstances I am eligible to receive distributions or make transfers.

Compliance With Plan Document and/or the Code - Participation in this Plan is mandatory. A deduction will be taken from your wages and invested on your behalf based on your employer's Plan Document. I agree that my employer or Plan Administrator/Trustee may take any action that may be necessary to ensure that my participation in the Plan is in compliance with any applicable requirement of the Plan Document and/or the Code. I understand that the maximum annual limit on contributions is determined under the Plan Document and/or the Code. I understand that it is my responsibility to monitor my total annual contributions to ensure that I do not exceed the amount permitted. If I exceed the contribution limit, I assume sole liability for any tax, penalty, or costs that may be incurred.

Incomplete Forms - I understand that in the event my Participant Enrollment form is incomplete or is not received by Service Provider at the address below prior to the receipt of any deposits, I specifically consent to Service Provider retaining all monies received and allocating them to the default investment option.

Account Corrections - I understand that it is my obligation to review all confirmations and quarterly statements for discrepancies or errors. Corrections will be made only for errors which I communicate within 90 calendar days of the last calendar quarter. After this 90 days, account information shall be deemed accurate and acceptable to me. If I notify Service Provider of an error after this 90 days, the correction will only be processed from the date of notification forward and not on a retroactive basis.

Signature(s) and Consent

Participant Consent

I have completed, understand and agree to all pages of this Participant Enrollment form. I understand that Service Provider is required to comply with the regulations and requirements of the Office of Foreign Assets Control, Department of the Treasury ("OFAC"). As a result, Service Provider cannot conduct business with persons in a blocked country or any person designated by OFAC as a specially designated national or blocked person. For more information, please access the OFAC Web site at:
http://www.treasury.gov/about/organizational-structure/offices/Pages/Office-of-Foreign-Assets-Control.aspx.
Deferral agreements must be entered into prior to the first day of the month that the deferral will be made. I verify that this enrollment was unsolicited. I did not meet with a representative on a one-on-one basis regarding investment options.

Participant Signature **Date**

Participant forward to Service Provider at:
Great-West Retirement Services®
P.O. Box 173764
Denver, CO 80217-3764
Phone #: 1-877-457-1900
Fax #: 1-866-745-5766
Web site: www.mass-smart.com

TOWN OF HOLLISTON

DIRECT DEPOSIT AUTHORIZATION FORM

Employee Name (Print) _____

Bank Name _____

Bank Address _____

Account Type: (Please Check) Checking ____ Savings _____

Routing Number: _____

Account Number: _____

Primary Deposit: _____ Secondary Deposit (Amount) _____

EMAIL ADDRESS: _____

I hereby authorize the Town of Holliston to deposit my net pay, or my secondary deposit, at the financial institution named above. I understand that the Town of Holliston may cause my account to be adjusted to the extent necessary to correct any over-deposits, and I agree to hold the above named financial institution harmless for any erroneous deposits or adjustments not caused by the financial institution.

It is understood that this agreement may be terminated by me at any time with written notification to the Town of Holliston. Any such notification to the Town shall be effective only with respect to entries initiated by the Town after receipt of such notification and reasonable opportunity to act on it. Any notification to the Bank by the employee is unacceptable. The Bank may terminate this agreement by written notice to the employee for just cause.

Employee Signature: _____ Date: _____

PLEASE PROVIDE AUTHORIZED ACCOUNT DOCUMENTATION FROM THE BANK OR A VOIDED CHECK WHEN YOU SUBMIT THIS FORM.

Revised: 3/2022

HUMAN RESOURCES DEPARTMENT
TOWN HALL, 703 WASHINGTON STREET, HOLLISTON, MASSACHUSETTS 01746-2168
TEL: 508-474-3335 FAX: 508-474-5923
Website: www.townofholliston.us

W-2 Consent for E-Mail Delivery

☐ Consent to receive Form W-2 as an attachment to an e-mail

☐ Change of Consent – I no longer wish to receive my W-2 via e-mail

PLEASE PRINT CLEARLY

Employee Name: _____ Last four digits of SSN: _____

Your W-2 will be sent to your Primary E-Mail Address as listed in your Employee Master record. If you have your check direct deposited, your Payroll Advice uses this same address for e-mail delivery. You can change this on the Employee Self Service website at any time.

The W-2 document is password protected. To open the attachment you will need to enter the last four digits of your SSN.

Note: The W-2 form will be a Portable Document Format (PDF) that requires Adobe Acrobat Reader. If you do not already have it installed, you may download a copy free from the following address, http://www.adobe.com/products/acrobat/readstep2.html.

IMPORTANT DISCLOSURE INFORMATION

- If this form is not signed and returned to the payroll department for consent to receive a W-2 via e-mail, the employee will receive a paper Form W-2.
- The only requirement to open the PDF attachment will be a copy of Adobe Acrobat Reader. Your e-mail service provider must accept password protected attachments.
- This consent will remain in effect until the employee signs another form and checks the "Change of Consent" box that will release the Town of Holliston to return to sending the employee their Form W-2 as a printed copy. This change of consent will only apply to future Form W-2 forms and does not apply to the previously issued Forms W-2.
- At any time, an employee may request an official printed Form W-2 from the Town of Holliston. That request will not change the consent to receive future Form W2 forms electronically by e-mail.
- This consent remains in effect after a person is no longer an employee of the Town of Holliston. All former employees of the Town of Holliston have the ability to update their e-mail information using the Employee Self Service (ESS) web site. All former employees remain active on the ESS website to be able to view pay history, W-2s and leave history. .

Return completed form to:

Town Treasurer – W2
Town of Holliston
PO Box 6737
Holliston, MA 01746
Email: treasurer@holliston.k12.ma.us
Interoffice Mail: Treasurer-W2

Signature: _____ Date: _____
(By typing your name you are agreeing to the information on this form.)

For office use only:

Received by: _____ Date Updated in MUNIS _____

TOWN OF HOLLISTON

POLICY ACKNOWLEDGMENT FORM
SEASONAL EMPLOYEES

Information regarding the following acknowledgments can be found on the Town of Holliston's website at www.townofholliston.us/human-resources.

IT IS YOUR RESPONSIBILITY TO READ, DOWNLOAD AND/OR PRINT THE FOLLOWING FOR YOUR RECORDS.

I acknowledge the receipt of the following policies:

____ Direct Deposit Policy

____ Drug and Alcohol Policy

____ Pregnancy Fair Act

____ Sexual Harassment Policy

____ Conflict of Interest Law

HUMAN RESOURCES DEPARTMENT
TOWN HALL, 703 WASHINGTON STREET, HOLLISTON, MASSACHUSETTS 01746-2168
TEL: 508-474-3335 FAX: 508-474-5923
Website: www.townofholliston.us

MEDICAL FORM

Name:_____ Date of Birth:_____
Last First Middle

Home Address:_____ Age:_____ Sex: M F

Telephone:_____ School:_____

Mothers Name:_____ Work Telephone:_____

Fathers Name:_____ Work Telephone:_____

Health Plan/HMO:_____ Policy or Group #_____

In an Emergency Notify (other than parents):

Name:_____

Address:_____

Phone (___)_____ Relationship:_____

Allergies and Other Medical Conditions

Medications_____ Foods_____

Bee/Insect Stings_____ Other_____ Has EpiPen Y N

Medical Problems_____

Medications Taken On A Regular or As Needed Basis:

Medication:_____ Dosage:_____

Route of Administration:_____ Frequency:_____

Side Effects/Special Precautions:_____

Please complete both sides of this form

MEDICAL FORM

MEDICATION ADMINISTRATION (Does not apply to Epi-pens or inhalers)

Parents who want their minor child to self-administer a prescription must submit a written request specifying the following:

*The medication is necessary to the employee's health and must be taken during working hours;
*Neither parent is available during working hours to administer the medication;
*The employee is physically and mentally capable of assuming the responsibility; and
*The employee has been adequately instructed in self-administration of the medication at home.

The Program Director will determine whether or not the Department will comply with the parent's request. Self-administered medication will be kept in a specified location, in accordance with the requirements of 105 CMR 430.000. The Director has sole discretion in determining whether employees are permitted to carry medication on their person, if parents provide a release relieving the Department of all responsibility.

WAIVER
This is a release of liability – Read Before Signing

This Agreement is intended to be as broad and inclusive as is permitted by law. If any provision or any part of any provision of this Agreement is held to be invalid or legally unenforceable for any reason, the remainder of this Agreement shall not be affected thereby and shall remain valid and fully enforceable.

To the fullest extent allowed by law, I agree **to WAIVE, DISCHARGE CLAIMS, AND RELEASE FROM LIABILITY** the Town of Holliston, its officers, directors, employees, agents, and leaders from any and all liability on account of, or in any way resulting from injuries and Damages, even if caused by negligence of the sponsoring Department, its officers, directors, employees, agents, and leaders, in any way connected with the self-administration of medication by my minor child. I further agree to **HOLD HARMLESS** the Town of Holliston, its officers, directors, employees, agents, and leaders from any claims, damages, injuries or losses caused by my request that my child be allowed to self-administer his/her own medication while an employee of the Town of Holliston. I understand and intend that this assumption of risk and release is binding upon my heirs, executors, administrators, and assigns.

I have read this document in its entirety and I freely and voluntarily assume all risks of such injuries and Damages and notwithstanding such risks, I request that my minor child _____, be allowed to self-administer medication (which has been prescribed by a physician) while employed by the Town of Holliston.

Name (Please print)_____

Parent/Guardian_____Date:_____

In Case of a Medical Emergency for Staff under 18 years of age:

I understand every effort will be made to contact parents/guardians of staff less than 18 years of age. In the event that I can not be reached, I hereby grant permission to the attending physician and staff to administer anesthesia, medical, x-ray and surgical procedures as may be deemed necessary or advisable.

Parent/Guardian_____Date:_____

This form must be returned to the Program Director before your child's first day of work.

THE COMMONWEALTH OF MASSACHUSETTS
EXECUTIVE OFFICE OF LABOR AND WORKFORCE DEVELOPMENT
DEPARTMENT OF UNEMPLOYMENT ASSISTANCE

NOTICE TO EMPLOYEES
Certification as a Seasonal Employer

Employer: Town of Holliston_____

EAN: _78-301390_____

Plan#: _2022-83_____

The above-named employer has been approved by the Massachusetts Department of Unemployment Assistance for certification as a seasonal employer. This applies only to the category of employees listed on the Notice of Seasonal Determination dated **_2/2/22**_____

If you are a seasonal employee, seasonal wages cannot be used to establish an Unemployment Insurance benefit claim, except under certain conditions. A seasonal employee is one who is hired to work for a specific time period totaling less than 20 weeks in a calendar year. If you were hired as a seasonal employee, you must be notified in writing by your employer before beginning your seasonal employment.

Employee Signature

_____provided me with a copy of the Seasonal Determination from the Department of Unemployment Assistance dated_____. I understand that I am a seasonal employee and that wages from this occupation cannot be used to establish an Unemployment Insurance benefit claim, except under certain conditions.

Employee Name (Print): _____

Employee Signature: _____ _____Date: _____

Employer Signature

I have provided the above-referenced employee with a copy of the Seasonal Determination from the Department or Unemployment Assistance dated 2/2/22. The employee understands that he/she is a seasonal employee and that wages from this occupation cannot be used to establish an Unemployment Insurance benefit claim. except under certain conditions.

Name of Employer Representative (Print): __Kathleen Buckley_____

Employer Rep. Signature: Kathleen Buckley Date: 3/14/22

Seasonal Certification Unit
Email: EmployerCharge@detma.org
Phone: (617) 626-5075

THE COMMONWEALTH OF MASSACHUSETTS
EXECUTIVE OFFICE OF PUBLIC SAFETY AND SECURITY
Department of Criminal Justice Information Services 200
Arlington Street, Suite 2200, Chelsea, MA 02150
TEL: 617-660-4640 | TTY: 617-660-4606 | FAX: 617-660-5973
MASS.GOV/CJIS

This form is not to be faxed. Please return form to organization .

Criminal Offender Record Information (CORI) Acknowledgement Form

To be used by organizations conducting CORI checks for employment or licensing purposes.

_____ is registered under the
(Organization)
provisions of M.G.L. c.6, § 172 to receive CORI for the purpose of screening current and otherwise qualified prospective employees, subcontractors, volunteers, license applicants, or current licensees.

As a prospective or current employee, subcontractor, volunteer, license applicant or current licensee, I understand that a CORI check will be submitted for my personal information to the DCJIS. I hereby acknowledge and provide permission to
_____
(Organization)
to submit a CORI check for my information to the DCJIS. This authorization is valid for one year from the date of my signature. I may withdraw this authorization at any time by providing _____
(Organization)

with written notice of my intent to withdraw consent to a CORI check.

I also understand, that _____may conduct
(Organization)
subsequent CORI checks within one year of the date this Form was signed by me.

By signing below, I provide my consent to a CORI check and affirm that the information provided on Page 2 of this Acknowledgement Form is true and accurate.

_____ _____
Signature of CORI Subject *Date*

THE COMMONWEALTH OF MASSACHUSETTS
EXECUTIVE OFFICE OF PUBLIC SAFETY AND SECURITY
Department of Criminal Justice Information Services
200 Arlington Street, Suite 2200, Chelsea, MA 02150
TEL: 617-660-4640 | TTY: 617-660-4606 | FAX: 617-660-5973
MASS.GOV/CJIS

SUBJECT INFORMATION

Please complete this section using the information of the person whose CORI you are requesting.
The fields marked with an asterisk (*) are required fields.

* First Name: _____ Middle Initial: _____

* Last Name: _____ Suffix (Jr., Sr., etc.): _____

Former Last Name 1: _____

Former Last Name 2: _____

Former Last Name 3: _____

Former Last Name 4: _____

* Date of Birth (MM/DD/YYYY): _____ Place of Birth: _____

* Last **SIX** digits of Social Security Number: ___ ___ -- ___ ___ ___ ___ ☐ No Social Security Number

Sex: _____ Height: _____ ft. _____ in. Eye Color: _____ Race: _____

Driver's License or ID Number: _____ State of Issue: _____

Father's Full Name: _____

Mother's Full Name: _____

Current Address

* Street Address: _____

Apt. # or Suite: _____ *City: _____ *State: _____ *Zip: _____

SUBJECT VERIFICATION

The above information was verified by reviewing the following form(s) of government-issued identification:

_____

_____

_____

Verified by:

_____
Print Name of Verifying Employee

_____ _____
Signature of Verifying Employee *Date*