

**New Hire Triad Construction Services
Contract Superintendent – Info Needed**

- 1. W-9 Completed**
- 2. Copy of Driver's License**
- 3. Copy of Social Security Card**
- 4. Drug Test Consent Form Signed**
- 5. 2nd Injury Fund Form Signed**
- 6. Safety Handbook Notice**
- 7. Preemployment Drug Test at OCC Med of Lafayette (Ask Nicole to call it in before he leaves)
OCC Med of Lafayette
626 Verot School Road
Lafayette, LA 70508**

Request for Taxpayer Identification Number and Certification

Give Form to the requester. Do not send to the IRS.

Print or type See Specific Instructions on page 2.	1 Name (as shown on your income tax return). Name is required on this line; do not leave this line blank.		
	2 Business name/disregarded entity name, if different from above		
	3 Check appropriate box for federal tax classification; check only one of the following seven boxes: <input type="checkbox"/> Individual/sole proprietor or single-member LLC <input type="checkbox"/> Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=partnership) ▶ _____ Note. For a single-member LLC that is disregarded, do not check LLC; check the appropriate box in the line above for the tax classification of the single-member owner. <input type="checkbox"/> Other (see instructions) ▶ _____		4 Exemptions (codes apply only to certain entities, not individuals; see instructions on page 3): Exempt payee code (if any) _____ Exemption from FATCA reporting code (if any) _____ <i>(Applies to accounts maintained outside the U.S.)</i>
	5 Address (number, street, and apt. or suite no.)		Requester's name and address (optional)
	6 City, state, and ZIP code		
	7 List account number(s) here (optional)		

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on line 1 to avoid backup withholding. For individuals, this is generally your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 3. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN* on page 3.

Note. If the account is in more than one name, see the instructions for line 1 and the chart on page 4 for guidelines on whose number to enter.

Social security number	
OR	
Employer identification number	

Part II Certification

Under penalties of perjury, I certify that:

- The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me); and
- I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding; and
- I am a U.S. citizen or other U.S. person (defined below); and
- The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an Individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions on page 3.

Sign Here	Signature of U.S. person ▶	Date ▶
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General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Future developments. Information about developments affecting Form W-9 (such as legislation enacted after we release it) is at www.irs.gov/fw9.

Purpose of Form

An individual or entity (Form W-9 requester) who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) which may be your social security number (SSN), individual taxpayer identification number (ITIN), adoption taxpayer identification number (ATIN), or employer identification number (EIN), to report on an information return the amount paid to you, or other amount reportable on an information return. Examples of information returns include, but are not limited to, the following:

- Form 1099-INT (interest earned or paid)
- Form 1099-DIV (dividends, including those from stocks or mutual funds)
- Form 1099-MISC (various types of income, prizes, awards, or gross proceeds)
- Form 1099-B (stock or mutual fund sales and certain other transactions by brokers)
- Form 1099-S (proceeds from real estate transactions)
- Form 1099-K (merchant card and third party network transactions)

- Form 1098 (home mortgage interest), 1098-E (student loan interest), 1098-T (tuition)
 - Form 1099-C (canceled debt)
 - Form 1099-A (acquisition or abandonment of secured property)
- Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN.

If you do not return Form W-9 to the requester with a TIN, you might be subject to backup withholding. See *What is backup withholding?* on page 2.

By signing the filled-out form, you:

1. Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),
2. Certify that you are not subject to backup withholding, or
3. Claim exemption from backup withholding if you are a U.S. exempt payee. If applicable, you are also certifying that as a U.S. person, your allocable share of any partnership income from a U.S. trade or business is not subject to the withholding tax on foreign partners' share of effectively connected income, and
4. Certify that FATCA code(s) entered on this form (if any) indicating that you are exempt from the FATCA reporting, is correct. See *What is FATCA reporting?* on page 2 for further information.

TRIAD CONSTRUCTION SERVICES
DRUG TESTING AUTHORIZATION & CONSENT FORM

I, the undersigned, hereby knowingly and voluntarily authorize and consent to the collection and testing of specimens of my urine by a collection site and laboratory to be designated by Triad Construction Services or its designated agent, for the purpose of drug testing.

I authorize the collection site, laboratory and medical review officer (MRO) to disclose the results of my drug tests to Drug Screening Plus and I further authorize Drug Screening Plus to disclose the results to Triad Construction Services.

I acknowledge that the drug test results will be utilized by Triad Construction Services to determine my eligibility for employment or continued employment, therewith.

I acknowledge that at the time of collection, a refusal to authorize the collection and testing of my urine by the collection site and laboratory, or a refusal to authorize the above disclosure of the test results will be treated as a positive drug test. I further acknowledge that a positive drug test will result in disciplinary action up to and including denial of employment or termination, if hired.

In addition, I hereby knowingly and voluntarily release Triad Construction Services, Drug Screening Plus - the collection site, the testing laboratory and their respective officers, directors, employees and agents from any and all claims, damages, losses, liabilities, costs and expenses, including attorney fees, arising from or relating to such collection and testing and any disclosure of the results thereof, including without limitation, the disclosure of any inaccurate or incomplete results, to the fullest extent permitted by law.

I further authorize the testing laboratory to disclose the results of my drug screen to Triad Construction Services for a period of time not to exceed two years from the date of my signature below.

I acknowledge that I have the right to receive a copy of this authorization.

I have read and understood the above Authorization & Consent in its entirety, and I agree that a copy of this document is as valid as the original.

Applicant's Signature Date

Applicant's Printed Name

Street Address City State Zip

Social Security Number: _____

Applicant Home Phone Number (may be necessary for sending documents): _____

Applicant Email address (may be necessary for delivering message): _____



1001 North 23rd Street
Post Office Box 44187
Baton Rouge, LA 70804-4187

(O) 225-342-7866
800-201-2493
(F) 225-219-5968

John Bel Edwards, Governor
Ava Dejoie, Executive Director

Office of Workers' Compensation Administration
Second Injury Board

LA OWCA Second Injury Board Knowledge Questionnaire

The following questionnaire should only be completed by individuals that have been hired for employment. Your employer may ask that you complete this questionnaire following your initial hire and periodically thereafter.

The questionnaire may be used in the establishment of prior knowledge for the purpose of obtaining Second Injury Fund relief from the Second Injury Board. The Second Injury Board may reimburse your employer for workers' compensation claims that meet certain criteria should you become injured on the job. This reimbursement in no way affects the benefits owed to you by your employer or their insurance company under the Louisiana Workers' Compensation Act, La. R.S. 23:1021-1361.

WARNING

FAILURE TO ANSWER TRUTHFULLY AND/OR CORRECTLY TO ANY OF THE QUESTIONS ON THIS FORM MAY RESULT IN A FORFEITURE OF YOUR WORKERS COMPENSATION BENEFITS UNDER LA R.S. 23:1208.1.

Employer: _____

Employee Name: _____

Date of Birth (mm/dd/yyyy): _____ Male: Female:

Soc. Sec. # (last 4 digits only): _____

Home Address: _____

Telephone Number: (____) _____

Employee Signature: _____ Date: _____

Employer Witness: _____ Date: _____

Please place a check in the appropriate box next to each medical condition listed below. Each illness or condition requires a Yes (Y) or No (N) answer. For all conditions that you check yes, write a brief explanation on the Explanation Page.

Disease and Other Medical Conditions [Please check the appropriate box. Each illness/injury requires a Yes (Y) or No (N) answer.]

Y N	Y N	Y N	Y N
<input type="checkbox"/> <input type="checkbox"/> Diabetes	<input type="checkbox"/> <input type="checkbox"/> Cerebral Palsy	<input type="checkbox"/> <input type="checkbox"/> Arthritis	<input type="checkbox"/> <input type="checkbox"/> Heart Disease/Heart Attack
<input type="checkbox"/> <input type="checkbox"/> Silicosis	<input type="checkbox"/> <input type="checkbox"/> Tuberculosis	<input type="checkbox"/> <input type="checkbox"/> Parkinson's	<input type="checkbox"/> <input type="checkbox"/> Congestive Heart Failure
<input type="checkbox"/> <input type="checkbox"/> Varicose Veins	<input type="checkbox"/> <input type="checkbox"/> Multiple Sclerosis	<input type="checkbox"/> <input type="checkbox"/> Brain Damage	<input type="checkbox"/> <input type="checkbox"/> Vision Loss, one or both eyes
<input type="checkbox"/> <input type="checkbox"/> Asbestosis	<input type="checkbox"/> <input type="checkbox"/> Post Traumatic Stress	<input type="checkbox"/> <input type="checkbox"/> Asthma	<input type="checkbox"/> <input type="checkbox"/> Disability from Polio
<input type="checkbox"/> <input type="checkbox"/> Hyperinsulinism	<input type="checkbox"/> <input type="checkbox"/> Osteomyelitis	<input type="checkbox"/> <input type="checkbox"/> Dementia	<input type="checkbox"/> <input type="checkbox"/> Psychoneurotic Disability
<input type="checkbox"/> <input type="checkbox"/> Alzheimer's	<input type="checkbox"/> <input type="checkbox"/> Nervous Disorder	<input type="checkbox"/> <input type="checkbox"/> Thrombophlebitis	<input type="checkbox"/> <input type="checkbox"/> Ruptured or Herniated Disc
<input type="checkbox"/> <input type="checkbox"/> Emphysema	<input type="checkbox"/> <input type="checkbox"/> Muscular Dystrophy	<input type="checkbox"/> <input type="checkbox"/> Arteriosclerosis	<input type="checkbox"/> <input type="checkbox"/> Ankylosis or Joint Stiffening
<input type="checkbox"/> <input type="checkbox"/> Hearing Loss	<input type="checkbox"/> <input type="checkbox"/> Migraine Headaches	<input type="checkbox"/> <input type="checkbox"/> Hodgkin's	<input type="checkbox"/> <input type="checkbox"/> High/Low Blood Pressure
<input type="checkbox"/> <input type="checkbox"/> COPD	<input type="checkbox"/> <input type="checkbox"/> Mental Retardation	<input type="checkbox"/> <input type="checkbox"/> Cancer	<input type="checkbox"/> <input type="checkbox"/> Carpal Tunnel Syndrome
<input type="checkbox"/> <input type="checkbox"/> Hypertension	<input type="checkbox"/> <input type="checkbox"/> Kidney Disorder	<input type="checkbox"/> <input type="checkbox"/> Double Vision	<input type="checkbox"/> <input type="checkbox"/> Compressed Air Sequelae
<input type="checkbox"/> <input type="checkbox"/> Head Injury	<input type="checkbox"/> <input type="checkbox"/> Loss of Use of Limb	<input type="checkbox"/> <input type="checkbox"/> Mental Disorders	<input type="checkbox"/> <input type="checkbox"/> Disease of the Lung
<input type="checkbox"/> <input type="checkbox"/> Epilepsy	<input type="checkbox"/> <input type="checkbox"/> Seizure Disorder	<input type="checkbox"/> <input type="checkbox"/> Hemophilia	<input type="checkbox"/> <input type="checkbox"/> Coronary Artery Disease
<input type="checkbox"/> <input type="checkbox"/> Stroke	<input type="checkbox"/> <input type="checkbox"/> Sickle Cell Disease	<input type="checkbox"/> <input type="checkbox"/> Bleeding Disorder	<input type="checkbox"/> <input type="checkbox"/> Heavy Metal Poisoning

Surgical Treatment [Please check the appropriate box. Each illness/injury requires a Yes (Y) or No (N) answer.]

Y N

- Spinal Disc Surgery Year (approximate if unsure) _____
- Spinal Fusion Surgery Year (approximate if unsure) _____
- Amputated Foot Left Right Year (approx. if unsure) _____
- Amputated Leg Left Right Year (approx. if unsure) _____
- Amputated Arm Left Right Year (approx. if unsure) _____
- Amputated Hand Left Right Year (approx. if unsure) _____
- Knee Replacement Left Right Year (approx. if unsure) _____
- Hip Replacement Left Right Year (approx. if unsure) _____
- Other Joint Replacement Joint _____ Year _____
- Other Surgical Procedure Procedure _____ Year _____

Employee Signature: _____ Date: _____

Employer Witness: _____ Date: _____

EXPLANATION PAGE

Please use the space below to explain the illnesses and/or conditions that you checked a Yes (Y) or any other medical conditions that may not be listed on this form. Ask your employer for additional copies of this page if needed.

CONDITION: _____ Year Diagnosed (approx): _____

Are you still treating for this condition? Yes No

Are you taking medication for this condition? Yes No

Do you have any permanent restrictions for this condition? Yes No

Brief Explanation: _____

CONDITION: _____ Year Diagnosed (approx): _____

Are you still treating for this condition? Yes No

Are you taking medication for this condition? Yes No

Do you have any permanent restrictions for this condition? Yes No

Brief Explanation: _____

CONDITION: _____ Year Diagnosed (approx): _____

Are you still treating for this condition? Yes No

Are you taking medication for this condition? Yes No

Do you have any permanent restrictions for this condition? Yes No

Brief Explanation: _____

CONDITION: _____ Year Diagnosed (approx): _____

Are you still treating for this condition? Yes No

Are you taking medication for this condition? Yes No

Do you have any permanent restrictions for this condition? Yes No

Brief Explanation: _____

Employee Signature: _____ Date: _____

Employer Witness: _____ Date: _____

Please answer the following questions.

1. Has any doctor ever restricted your activities? Yes No
If "Yes," please list the restrictions: _____
Were the restrictions: Permanent ____ Temporary ____
Are you currently restricted? Yes No
What is the medical condition for which you are restricted? _____

2. Are you presently treating with a doctor, chiropractor, psychiatrist, psychologist or other health-care provider? Yes No

Please list the medical condition being treated: _____

Doctor's Name: _____ Specialty: _____

Doctor's Address: _____

3. If you are presently taking prescription medication other than those listed on the Explanation Page, please complete the requested information below.

Medication: _____ Prescribing Doctor: _____

Medication: _____ Prescribing Doctor: _____

4. Have you ever had an on the job accident? Yes No
If you answered "YES," please provide the date for each injury and the nature of the injury:

How long were you on compensation? _____

Name of Employer: _____

5. Has a doctor recommended a surgical procedure, which has not been completed prior to this date, including but not limited to knee, hip or shoulder replacement? Yes No
If you answered YES, please provide:

Recommended surgery: _____

Approximate date of recommendation: _____

Doctor's Name: _____ Specialty: _____

Doctor's Address: _____

Employee Signature: _____ Date: _____

Employer Witness: _____ Date: _____

WARNING

FAILURE TO ANSWER TRUTHFULLY AND/OR CORRECTLY TO ANY OF THE QUESTIONS ON THIS FORM MAY RESULT IN A FORFEITURE OF YOUR WORKERS COMPENSATION BENEFITS UNDER LA R.S. 23:1208.1.

I have completed this form honestly and to the best of my knowledge. I understand that providing false information or omitting pertinent information could result in loss of my workers compensation benefits should I become injured on the job.

Employee Signature: _____ Date: _____

Employee Printed: _____

I am an authorized representative of the employer designated to obtain and review the information provided by the employee on this questionnaire. I have confirmed that the employee understands the consequences associated with providing false information or omitting pertinent information. I have confirmed that the employee is able to read and understand the information provided on this questionnaire or I have personally read the questionnaire to the employee. I have provided the employee with as many copies of the Explanation Page as needed. I have confirmed the number of and labeled the pages of this questionnaire.

Employer Witness: _____ Date: _____

Employer Witness Printed: _____

Title: _____

Triad Construction Services Health & Safety Plan

INTRODUCTION

TO: ALL TRIAD CONSTRUCTION SERVICES ("Triad Construction Services")
COMPANY EMPLOYEES

FROM: RICK WARREN, TRIAD CONSTRUCTION SERVICES

SUBJECT: HEALTH & SAFETY PLAN ACKNOWLEDGEMENT

After thoroughly reviewing the Triad Construction Services Health & Safety Plan, please read this statement and sign below.

After receiving a copy of the Triad Construction Services Health & Safety Plan, I have taken the time to review it. Any questions or concerns that I might have, have been brought to the attention of my supervisors and clarified.

I understand that I must abide by the Health & Safety Plan rules and guidelines and my failure to do so may result in discipline including dismissal.

I understand that this manual and its policies shall not be considered a contract of employment and that I am an "at-will" employee of Triad Construction Services.

Employee Name

Signature

Date