Triad Construction Services

Contract Superintendent – Info Needed

1. **Complete W-9**
2. **Complete Drug Test Consent Form**
3. **Complete Safety Handbook Notice**
4. **Complete 2nd Injury Fund Form Signed**
5. **Complete Authorization to Release Driving Records**
6. **Provide a Copy of Driver's License**
7. **Provide a Copy of Social Security Card**
8. **Go take Preemployment Drug Test at Drug Screen Plus (Ask Jeff to call it in before he leaves)**
   Drug Screen Plus
   3431 W Pinhook Rd, #B
   Lafayette, LA 70508
   337-456-1194

Form **W-9**
(Rev. December 2014)
Department of the Treasury
Internal Revenue Service

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:
☐ Individual/sole proprietor or single-member LLC ☐ C Corporation ☐ S Corporation ☐ Partnership ☐ Trust/estate
☐ 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.
☐ 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) _____
(Applies to accounts maintained outside the U.S.)

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:

1. 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
2. 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
3. I am a U.S. citizen or other U.S. person (defined below); and
4. 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 ▶

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): _____

LOUISIANA WORKFORCE COMMISSION

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

SIB FORM D 10/10

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: _____

AUTHORIZATION TO RELEASE DRIVING RECORD

I have Authorized Triad Construction Services LLC and its agents to request any information concerning my driving record. I hereby authorize any persons(s) having knowledge thereof to provide such information to Triad Construction Services LLC or its agents, and I hereby release from liability and agree to Hold Harmless any person that furnishes such information in good faith.

A copy of this form shall have the same effect as the original.

Employee Name Please Print

Employee Social Security Number

Driver's License Number

Date of Birth

Address

Employee Signature

City/State/Zip Code

Marital Status

Number of Years
Commercial Driving Experience

RETURN MVR RESULTS TO:
Triad Construction Services, LLC Triad Construction Services, LLC Triad Construction Services, LLC
P.O. Box 629
Youngsville, LA 70592

☐ **Check the box if you want this driver to be added if the MVR is Clear.**

Form Updated 4-22-2014