2018 Paperwork Checklist
Returning Employee

(Rev 1-8-18)

Attention Employees: DO NOT FILL OUT - For office use only – Please keep with packet

_____	_____	_____
Name	Department	Final Date Completed
_____	_____	_____/_____
Reviewing Supervisor	Date turned into Payroll	Payroll initial/Date

Forms

____Letter of Understanding

____ Returning Employee Affidavit

____ Maryland New Hire Registry Reporting Form*

____Emergency Medical Form

____ E-Verify submitted*

____ Direct Deposit Authorization Form* (If New/Different Bank Account)

* These forms go to Payroll

Action Items

____ Attended ALL training

____ Skills Checklist

____ Passed Exam

Notes:_____

_____

_____

CBWP – Returning Employee Affidavit

(This Form is being used in lieu of the Employee Paperwork Packet that has been collected in previous years and will be locked with the Personnel Files for Security Purposes.)

Revised 1-8-18

It is crucial that you write neatly and legibly. (Office use only. Employee Pay for this coming season $_____________)

Employee's Name ____ Today's Date _________________

Birthday _________________ Social Security # __________________________ Employee #_____________

Email address ____

Current Address____

Circle one of the following: My address is the same/ different from last season.

Phone number(s) cell # ___________________________ home # _________________________________

_ _

1) Circle the one position below to best describe the department and specific position that you have been hired to work for this upcoming season:

<u>Aquatics</u>	<u>Sales</u>	<u>Food & Beverage</u>
Lead/Lifeguard	Lead/Cashier/CSS	Lead/Runner/Griller

2) Including this upcoming season I have been employed by the CBWP for ________ # of Seasons.

The positions that I was employed for in previous seasons, listed in chronological order are:

YR 1 ______________________ YR 2 _______________________ YR 3 _______________________

YR 4 ______________________ YR 5 ______________________ YR 6 _______________________

3) I understand that I am a Seasonal Employee and that I am rehired each Season and each Season I have a new probationary period which begins the first day we open in May. (please initial) _____________
4) I understand that this form is being completed in lieu of the paperwork packet that I completed in previous seasons. (please initial) _____________
5) I hereby agree, my previously signed copy of the Drug/Alcohol Testing Policy for the Town of Chesapeake Beach is still valid and that I am still at the liberty of any request made for drug and alcohol testing of my urine, breath, and or blood for analysis. (please initial) _____________

Please (✓) check and sign A <u>OR</u> B below:

A) _____ I certify that my bank account information is still the same from last season and that it is okay for the Town of Chesapeake Beach to deposit my paycheck into this account. ___________

B) _____ My bank account has changed since last season. Therefore I have completed and attached a new Direct Deposit Form to include all the necessary information so that my paycheck will be directed into the proper bank account.

_______________________________________ ____

Employee Signature Parent/Guardian Signature (if Employee is Under 18 Yrs of age)

Maryland New Hire Registry Reporting Form

Send completed forms to:
Maryland New Hire Registry
PO Box 1316
Baltimore, MD 21203-1316
Fax: (410) 281-6004 or toll-free fax 1 (888) 657-3534

To ensure the highest level of accuracy, please print neatly in capital letters and avoid contact with the edges of the boxes. The following will serve as an example:

A	B	C		1	2	3

EMPLOYER INFORMATION

Federal Employer Id Number (FEIN):

5	2		6		0	2	0	7	4

Please use the same FEIN that appears on quarterly wage reports.

State Unemployment Insurance Number (MD Only SUIN):

If SUIN not issued yet, please write "APPLIEDFOR" in the above box. If Exempt, write "EXEMPT".

Employer Name:

T	O	W	N		O	F		C	H	E	S	A	P	E	A	K	E		B	E	A	C	H	

Employer Address *(Please indicate the address where the Income Withholding Orders should be sent):*

P	O		B	O	X		4	0	0															

Employer City:

C	H	E	S		B	E	A	C	H															

Employer State: Zip Code (5 digit):

M	D		2	0	7	3	2

Employer Phone (optional):

Employer Fax (optional):

Contact Name (optional):

Email (optional):

EMPLOYEE INFORMATION

Employee Social Security Number (SSN):

Date of Hire (mm/dd/yyyy):

Employee First Name:

Middle Initial (optional):

Employee Last Name:

Employee Address:

Employee City:

Employee State:

Zip Code (5 digit):

Date of Birth mm/dd/yyyy (optional):

Employee Salary (Dollars and Cents):

Hourly

Monthly

Yearly

Are health care benefits available to employee? (Y/N):

Employee Gender (M)ale/(F)emale:

Reports must be submitted within 20 days of the date of hire or rehire

Rev (09/02)

Questions? Call us at (410) 281-6000 or toll-free 1 (888) MDHIRES (634-4737). Report online at www.mdnewhire.com

CBWP Emergency Medical Information Sheet

(Rev 1-15-15)

Last name_____ First Name_____

Employee Cell_____ Home#_____

Email address _____ Date of Birth_____

Address: Official for W-2/ Taxes:

_____

_____

Parents/ Guardian(s) Name(s) _____

Parent email _____

Parent cell _____

Other Parent Name _____

Other cell _____

In Case of Emergency:

1) Contact: _____ Relationship_____

Phone_____

2) Contact: _____Relationship_____

Phone_____

Medical Conditions/Allergies/Concerns:

_____

_____

_____

Employee Signature_____

Parent Signature (if under 18) _____

DIRECT DEPOSIT AUTHORIZATION FORM

Fill in the boxes below and sign the form.

Last Name

First Name

MI

Social Security Number

Work Phone

Action

New ☐ Change ☐ Cancel ☐

Effective Date

Month ☐☐ Day ☐☐ Year ☐☐

Name of Financial Institution

Account Number

(Include hyphens but omit spaces and special symbols.)

Type of Account

Checking ☐ Savings ☐

Routing Transit Number

(All 9 boxes must be filled. The first two numbers must be 01 through 12 or 21 through 32.)

Ownership of Account

Self ☐ Joint ☐ Other ☐

By signing this agreement, I authorize _____ to initiate credit entries to the account indicated above for the purpose of expense and/or payroll. I also authorize _____ to initiate, if necessary, debit entries and adjustments for any credit entries made in error.

Signature _____ Date _____

If the account is a joint account or in someone else's name, that individual must also agree to the terms stated above by signing below.

Signature _____ Date _____

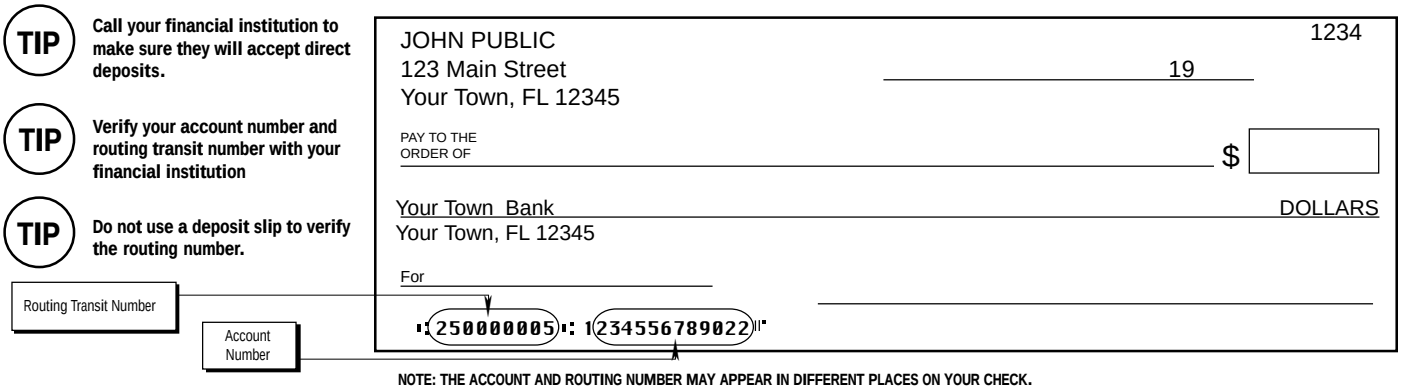
HOW TO COMPLETE THIS FORM

1. Fill in all boxes above.
2. Sign and date the form.

TIP **Call your financial institution to make sure they will accept direct deposits.**

TIP **Verify your account number and routing transit number with your financial institution**

TIP **Do not use a deposit slip to verify the routing number.**



NOTE: THE ACCOUNT AND ROUTING NUMBER MAY APPEAR IN DIFFERENT PLACES ON YOUR CHECK.