Form **W-4** (Rev. December 2020)
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

2021

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 2021 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** $ 0.00

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)
International Inspection Technology, Ltd 7748 Padre Island Hwy Brownsville, TX 78521		74-3011267

Employment Eligibility Verification

Department of Homeland Security

U.S. Citizenship and Immigration Services

USCIS
Form I-9
OMB No. 1615-0047
Expires 10/31/2022

►START HERE: Read instructions carefully before completing this form. The instructions must be available, either in paper or electronically, during completion of this form. Employers are liable for errors in the completion of this form.

ANTI-DISCRIMINATION NOTICE: It is illegal to discriminate against work-authorized individuals. Employers **CANNOT** specify which document(s) an employee may present to establish employment authorization and identity. The refusal to hire or continue to employ an individual because the documentation presented has a future expiration date may also constitute illegal discrimination.

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	Other Last Names Used *(if any)*

Address *(Street Number and Name)*	Apt. Number	City or Town	State	ZIP Code

Date of Birth *(mm/dd/yyyy)*	U.S. Social Security Number	Employee's E-mail Address	Employee's Telephone Number
	☐☐☐ - ☐☐ - ☐☐☐☐		

I am aware that federal law provides for imprisonment and/or fines for false statements or use of false documents in connection with the completion of this form.

I attest, under penalty of perjury, that I am (check one of the following boxes):

☐ 1. A citizen of the United States

☐ 2. A noncitizen national of the United States *(See instructions)*

☐ 3. A lawful permanent resident (Alien Registration Number/USCIS Number): _____

☐ 4. An alien authorized to work until (expiration date, if applicable, mm/dd/yyyy): _____
Some aliens may write "N/A" in the expiration date field. *(See instructions)*

Aliens authorized to work must provide only one of the following document numbers to complete Form I-9: An Alien Registration Number/USCIS Number OR Form I-94 Admission Number OR Foreign Passport Number.

1. Alien Registration Number/USCIS Number: _____

OR

2. Form I-94 Admission Number: _____

OR

3. Foreign Passport Number: _____

Country of Issuance: _____

QR Code - Section 1
Do Not Write In This Space

Signature of Employee	Today's Date *(mm/dd/yyyy)*

Preparer and/or Translator Certification (check one):

☐ I did not use a preparer or translator. ☐ A preparer(s) and/or translator(s) assisted the employee in completing Section 1.

(Fields below must be completed and signed when preparers and/or translators assist an employee in completing Section 1.)

I attest, under penalty of perjury, that I have assisted in the completion of Section 1 of this form and that to the best of my knowledge the information is true and correct.

Signature of Preparer or Translator	Today's Date *(mm/dd/yyyy)*

Last Name *(Family Name)*	First Name *(Given Name)*

Address *(Street Number and Name)*	City or Town	State	ZIP Code

STOP *Employer Completes Next Page* STOP

Authorization for Direct Deposit - Employee Form

This authorizes INTERNATIONAL INSPECTION TECHNOLOGY, LTD (the "Company") to send credit entries (and appropriate debit and adjustment entries), electronically or by any other commercially accepted method, to my (our) account(s) indicated below and to other accounts I (we) identify in the future (the "Account"). This authorizes the financial institution holding the Account to post all such entries.

Note: Enter your company name in the blank space above.

Account #1

Account #1 Type (check one): ☐ Checking ☐ Savings

Employee Bank Name

Bank Routing # (ABA#) Account #

Percentage or Dollar Amount to be Deposited to This Account

Account #2 (remainder to be deposited to this account)

Account #2 Type (check one): ☐ Checking ☐ Savings

Employee Bank Name

Bank Routing # (ABA#) Account #

Please attach a voided check for each account here.

This authorization will be in effect until the Company receives a written termination notice from myself and has a reasonable opportunity to act on it.

Signature

Printed Name

Employee ID # Date

IMPORTANT: This document must be signed by employees requesting automatic deposit of paychecks and retained on file by the employer. Do not send this form to Intuit. Employees must attach a voided check for each of their accounts to help verify their account numbers and bank routing numbers.

Employee: Please fill out and return to your employer. **Employer: Please save for your files only.**

Ver. 041708 DD

WORKWELL, TX

Employee Acknowledgment of Workers' Compensation Network

I have received information that informs me how to get health care under my employer's workers' compensation insurance.

If I am hurt on the job and live in a service area described in this packet, I understand that:

- I must choose a treating doctor from the list of doctors in the network. Or, I may ask my HMO primary care physician to agree to serve as my treating doctor. If I select my HMO primary care physician as my treating doctor, I will call Texas Mutual Insurance Company at (844) 867-2338 to notify them of my choice.
- I must go to my treating doctor for all health care for my injury. If I need a specialist, my treating doctor will refer me to a specialist. If I need emergency care, I may go anywhere.
- Texas Mutual will pay the treating doctor and other network providers for the treatment for my compensable injury.
- I may have to pay the bill if I get health care from someone other than a network doctor without prior network approval.

Knowingly making a false workers' compensation claim may lead to a criminal investigation that could result in criminal penalties such as fines and imprisonment.

_____ _____ _____

Signature Date Printed name

I live at: _____

Street address

_____

City State Zip code

Name of employer: INTERNATIONAL INSPECTION TECHNOLOGY, LTD

Name of network: WorkWell, TX

To the employer:

Each employee must sign this form when you begin the program or within 3 days of being hired, and at the time an injury occurs. Please indicate at which point this acknowledgement was completed.

- ☐ Initiating the network program (companywide)
- ☒ Initial employee notification (new hire)
- ☐ Injury notification (Date of injury: / /)

Keep this completed form in the employee's personnel file. It could be requested by Texas Mutual.

INTERNATIONAL INSPECTION TECHNOLOGY, LTD
EMPLOYEE APPLICATION

The information you provide below will be entered onto the payroll computer. Please PRINT neatly and legibly and provide all information, **OR YOUR PAYCHECK WILL NOT BE CORRECT.**

La información que usted proporcione abajo, sera incorporada sobre el sistema de computadora de la nómina de pago. Por favor escriba legible y proporcione cuidadosamente toda la información correcta, **O SU CHEQUE DE PAGO NO ESTARA CORRECTO.**

Have you ever been employed by I.I.T. before? / Has trabajado antes para I.I.T? ☑ YES/ SI ☐ NO

If Yes, where? / Si dice **Si,** donde? _____Dates / Fechas

Have you plead "Guilty" or "No Contest" to or been convicted of Felony within the last 5 years?
Se ha declarado "Culpable" o "No Culpable" O ha sido convicto a una Felonia en los ultimos 5 anos?
☐ Yes / Si ☐ No
If yes give dates and details / Si dice que si, dar fechas y detalles:

Answering yes to all this questions does not constitute an automatic rejection of employment.
Respondiendo que si a estas preguntas no constituye a unn rechazo automatico de empleo.

Last Name / Apellido Paterno | First Name / Primer Nombre | Middle Name / Segundo Nombre

Address / Direccion | City / Ciudad | State / Estado | Zip Code / Codigo Postal

Home Phone | Cell Phone | Other Phone

S.S. Number | Driver's License / ID Number | State Issue | Exp/ Date

Yes ☐ No ☐

Passport or Alien ID # | Exp/ Date | TWIC Card | Exp/ Date

IN CASE OF AN EMERGENCY WHOM SHOULD WE NOTIFY
EN CASO DE EMERGENCIA A QUIEN PODEMOS NOTIFICAR

Name / Nombre | Relationship / Relacion | Phone / Telefono

Address / Direccion | City / Ciudad | State / Estado | Zip Code / Codigo Postal

Name / Nombre | Relationship / Relacion | Phone / Telefono
Address / Direccion | City / Ciudad | State / Estado | Zip Code / Codigo Postal

INTERNATIONAL INSPECTION TECHNOLOGY, LTD
EMPLOYEE APPLICATION

EMPLOYEE WORK HISTORY EXPERIENCE / HISTORIAL DE EXPERIENCIA DE TRABAJO

1-Employer / Empleador | Date from & to / Fecha desde y hasta | Hourly pay / Pago por hora

Address / Direccion | City / Ciudad | State / Estado | Zip Code / Codigo Postal

Job Title / Titulo de trabajo | Class / Clase | Separation reasons / Razones de separacion

Duties and responsabilities / Labores y responsabilidades:

2-Employer / Empleador | Date from & to / Fecha desde y hasta | Hourly pay / Pago por hora

Address / Direccion | City / Ciudad | State / Estado | Zip Code / Codigo Postal

Job Title / Titulo de trabajo | Class / Clase | Separation reasons / Razones de separacion

Duties and responsabilities / Labores y responsabilidades:

3-Employer / Empleador | Date from & to / Fecha desde y hasta | Hourly pay / Pago por hora

Address / Direccion | City / Ciudad | State / Estado | Zip Code / Codigo Postal

Job Title / Titulo de trabajo | Class / Clase | Separation reasons / Razones de separacion

Duties and responsabilities / Labores y responsabilidades:

Can we contact your previous employer for any work references?
Podemos contactar su previo empleador para cualquier referencia de trabajo?

Yes / Si ☐ No ☐

INTERNATIONAL INSPECTION TECHNOLOGY, LTD
EMPLOYEE APPLICATION

MEDICAL HISTORY QUESTIONNAIRE

I herewith affirm that I.I.T. has made me an offer of employment, condition on satisfactory completion of this questionnaire and, if necessary, with the sole discretion of the employer, a medical examination and drug test. The purpose of this inquiry is to determine whether I currently have the physical or mental qualifications necessary to perform the job that has been offered to me, whether and what accommodations may be necessary, and whether I can performed the job without posing a direct threat to health or safety of myself or others and for the purpose and reasons as stated on the attached questionnaire.

This information will be kept confidential in a separate medical file, apart from my personnel file. I herewith affirm that the questions as in attached medical questionnaire have not been asked by me or anyone with IIT until after I have signed this statement and have been offered a job.

CUESTIONARIO DE HISTORIA MEDICA

Yo (quien firma) confirmo que I.I.T. me ha hecho una oferta de empleo, condicionada a éste cuestionario satisfactoriamente completo y si es necesario con el único criterio del empleador, a un examen medico y prueba de drogas. El propósito de éstas preguntas es determinar si yo actualmente tengo las condiciones físicas y mentales necesarias y si yo puedo desempeñar el trabajo sin ninguna amenaza a la salud o a la seguridad mía o de otros y para el propósito y razones como se puntualizan en el cuestionario adjunto.

Esta información será guardada confidencialmente en un archivo medico separado de mi archivo personal. Yo afirmo que las preguntas de el cuestionario medico adjunto no han sido hechas a mi o alguien mas por IIT hasta después que yo he firmado esta declaración y ha sido ofrecido un trabajo

Applicant's Signature/ Firma de el Aplicante **Date/ Fecha**

- Are you taken any medication at this moment? If so please describe:

Esta usted tomando medicina alguna? Si asi es por favor describa:

- Is there any health related reason you may not be able to perform the job for which you are applying? If yes, Please explain.

Hay alguna razon de salud que impida desempenar su trabajo del cual esta aplicando? Si no, escriba "None"

- Please list any condition or disease for which you have been treated in the past 5 years. If no treatment has been provided, State "None."

Mencione alguna condicion o dolencia por la cual usted ha sido tratado en los ultimos 5 anos, si no ha recibido alguna escriba "None"

- Have you had a mayor illness in the last 5 years? If none, State "none."

Ha usted tenido alguna enfermedad mayor en los ultimos 5 anos? Si no escriba "None"

- How many days were you absent from work because of illness last year? If none, State "none."

Cuantos dias estuvo usted ausente de su trabajo en el ultimo ano por razon de salud? Si no estuvo ausente escriba "None"

- Have you ever been hospitalized? If so, for what condition? If you have not been hospitalized, State "none."

Ha sido usted hospitalizado? Si no ha sido hospitalizado escriba "None"

- Have you ever been treated by a psychologist? If so, for what condition? If no such treatment has been received, State "none."

Ha sido usted tratado por un Psicologo? Si dice que si, por cual razon? Si no escriba "None"

- Have you ever been treated for any mental condition? If no such treatment has been received, State "None."

Ha sido usted tratado por alguna condicion mental? Si no ha recibido ningun tratamiento esriba "None

- Have you ever been exposed to LED in other places? If yes, please write your blood level test results and the date it was taken, If not state "None"

Ha estado usted expuesto a el Plomo en otros lugares? Si asi es escriba los resultados que tuvo al hacerse el examen de sangre, Si no escriba"None"

EMPLOYEE DRUG SCREEN, PHYSICALS & WELDING TEST S/ EMPLEADO EXAMEN DE DROGA EXAMEN FISICO Y TEST DE SOLDADURA

Due to employees quitting on the job, I.I.T has created a new policy regarding Drug Screen, Physicals and Welder Test costs. If an employee quits before 30 working days on the job, the employee will be Payroll deducted from his/her last paycheck the following:
5 Panel Drug Screen cost not to exceed the amount of $60.00
Physical Test cost not to exceed the amount of $250.00
Welding Test cost not to exceed the amount of $250.00

Debido a empleados que han renunciado de su trabajo I.I.T ha creado una nueva póliza nueva respecto a el costo del Examen de Drogas, Examen Fisico y el Examen de Soldadura. Si el empleado renuncia antes de 30 días trabajados, se le cobrará y sera rebajado de su ultimo cheque la cantidad siguiente:
5 Panel Examen de Droga no excediendo la cantidad de $60.00
Examen Fisico no excediendo la cantidad de $250.00
Examen de Soldadura no excediendo la cantidad de $250.00.

Applicant's Signature/ Firma de el Aplicante **Date/ Fecha**

INTERNATIONAL INSPECTION TECHNOLOGY, LTD
EMPLOYEE APPLICATION

TOOL RESPONSIBILITY/ RESPONSABILIDAD DE HERRAMIENTA

I the undersigned agree to be fully responsible for any tool that I use that belong to I.I.T.
I agree that if I check out any tool from the job supervisor/foreman, that I am to return that tool to him when finished or at the end of the work shift, whichever comes first.
I also agree that if do not return the tool/tools as agreed, I may be required to pay for replacement of that tool by deduction of the replacement cost from my next paycheck.

Yo el aplicante acepto ser responsable de cualquier herramienta que yo use que pertenezca a la compañía I.I.T. Y acepto que si recibo cualquier herramienta del supervisor o mayordomo, voy a devolverla cuando termine de usarla o al final de el turno.
Yo también acepto que si no devuelvo la herramienta tal como me comprometi, voy a tener que pagar el costo de lo que esté evaluada y que va a ser deducido de mi próximo cheque de pago.

Applicant's Signature/ Firma de el Aplicante **Date/ Fecha**

EMPLOYEE WORK ATTENDENCE POLICY / ATENDENCIA AL TRABAJO

I understand that I am been hired by International Inspection Technology, Ltd. and that my duties would be to attend my work schedule as assigned to me.

My requirements would be not to be late or absent from work at any time while been employed by IIT I will need to call my supervisor/foreman if any of these problems may occur for any reasons.
I have been informed that three (3) tardiness or absents per month will be in my termination from work automatically.
I agree of my responsibilities with International Inspection Technology to attend work as described above

Yo entiendo que he sido contratado por International Inspection Technology, y que mis responsabilidades seran atender a mi trabajo a como se ha designado el horario. Mis requisitos seran no llegar tarde o estar ausente de mi trabajo mientras permanesca empleado por IIT.Yo tengo que llamar a mi supervisor o mayordomo si uno de estos problemas llegaran a ocurrir.He sido informado que tres (3) llegadas tardes o ausencias por mes seran causa de mi suspencion de trabajo automaticamente.Yo estoy de acuerdo con International Inspection Technology atender a mi trabajo comoesta escrito arriba.

Employee Name: _____

Employee Signature: **Date:** _____

INTERNATIONAL INSPECTION TECHNOLOGY, LTD
EMPLOYEE APPLICATION

EMPLOYEE DIRECT DEPOSIT INFORMATION / INFORMACION PARA DEPOSITO DIRECTO DEL EMPLEADO

IIT company has created a new policy regarding all employee Direct Deposit Information, Beginning November 5, 2018, all employees must provide bank information on the first day of employment and no more than 7 days to provide IIT company all information for direct deposit, if any employee does not provide bank information in the 7 day period, IIT will be forced to remove the employee from work.

IIT ha creado una nueva poliza sobre el deposito directo del empleado empezando la fecha 11/05/2018, todo empleado Nuevo tendra que mostrar prueba y informacion de su deposito directo a no tardar mas de 7 dias para proveer IIT con su deposito directo, si algun empleado no logra proveer su informacion de depsoito directo en el periodo de 7 dias despues de que fue contratado, IIT sera forzado a despedir el empleado inmediatamente de su trabajo.

Employee Name: _____

Employee Signature: **Date:** _____

New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 11-30-2013)

PART A: General Information

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.[1]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution -as well as your employee contribution to employer-offered coverage- is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

Name:_____

Signature:_____

Date:_____

[1] An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer name	4. Employer Identification Number (EIN)
International Inspection Technology, LTD	74-3011267
5. Employer address	**6. Employer phone number**
P.O. Box 23036	361-883-8999

7. City	8. State	9. ZIP code
Corpus Christi	TX	78403

10. Who can we contact at this job?	
Liza Rodriguez	
11. Phone number (if different from above)	**12. Email address**
	liza@gregknoppcpa.com

You are not eligible for health insurance coverage through this employer. You and your family may be able to obtain health coverage through the Marketplace, with a new kind of tax credit that lowers your monthly premiums and with assistance for out-of-pocket costs.

Name:_____

Signature:_____

Date:_____