Emerson Health

NEW EMPLOYEE PERSONAL INFORMATION

Name: _____ SS #_____

Address: _____

Town: _____ State: _____ Zip Code: _____

Home/Cell Phone: _____ Date of Birth: _____

Email: _____

IN CASE OF AN EMERGENCY NOTIFY:

Name: _____ Relationship: _____

Address: _____

Town: _____ State: _____ Zip Code: _____

Home/Cell Phone: _____

RACIAL IDENTIFICATION: (for federally required reporting)

☐ Caucasian ☐ Asian

☐ Black ☐ American Indian

☐ Hispanic ☐ Cape Verdean

GENDER IDENTITY:

_____

PREFERRED PRONOUN:

_____

MARITAL STATUS:

☐ Single

☐ Married

If you would be willing to serve as a translator for the hospital, please indicate the language(s) you are fluent in below.

Language(s): _____

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

2025

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 surviving spouse**
☐ **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.)

TIP: Consider using the estimator at *www.irs.gov/W4App* to determine the most accurate withholding for the rest of the year if: you are completing this form after the beginning of the year; expect to work only part of the year; or have changes during the year in your marital status, number of jobs for you (and/or your spouse if married filing jointly), dependents, other income (not from jobs), deductions, or credits. Have your most recent pay stub(s) from this year available when using the estimator. At the beginning of next year, use the estimator again to recheck your withholding.

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, and when to use the estimator at *www.irs.gov/W4App*.

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 the most accurate withholding for this step (and Steps 3–4). If you or your spouse have self-employment income, use this option; **or**

(b) Use the Multiple Jobs Worksheet on page 3 and enter the result in Step 4(c) below; **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 generally more accurate than (b) if pay at the lower paying job is more than half of the pay at the higher paying job. Otherwise, (b) is more accurate . . . . . ☐

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 Dependent and Other Credits

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 for qualifying children and other dependents. You may add to this the amount of any other credits. 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)

General Instructions

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

Future Developments

For the latest information about developments related to Form W-4, such as legislation enacted after it was published, go to *www.irs.gov/FormW4*.

Purpose of Form

Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay. If too little is withheld, you will generally owe tax when you file your tax return and may owe a penalty. If too much is withheld, you will generally be due a refund. Complete a new Form W-4 when changes to your personal or financial situation would change the entries on the form. For more information on withholding and when you must furnish a new Form W-4, see Pub. 505, Tax Withholding and Estimated Tax.

Exemption from withholding. You may claim exemption from withholding for 2025 if you meet both of the following conditions: you had no federal income tax liability in 2024 **and** you expect to have no federal income tax liability in 2025. You had no federal income tax liability in 2024 if (1) your total tax on line 24 on your 2024 Form 1040 or 1040-SR is zero (or less than the sum of lines 27, 28, and 29), or (2) you were not required to file a return because your income was below the filing threshold for your correct filing status. If you claim exemption, you will have no income tax withheld from your paycheck and may owe taxes and penalties when you file your 2025 tax return. To claim exemption from withholding, certify that you meet both of the conditions above by writing "Exempt" on Form W-4 in the space below Step 4(c). Then, complete Steps 1(a), 1(b), and 5. Do not complete any other steps. You will need to submit a new Form W-4 by February 17, 2026.

Your privacy. Steps 2(c) and 4(a) ask for information regarding income you received from sources other than the job associated with this Form W-4. If you have concerns with providing the information asked for in Step 2(c), you may choose Step 2(b) as an alternative; if you have concerns with providing the information asked for in Step 4(a), you may enter an additional amount you want withheld per pay period in Step 4(c) as an alternative.

When to use the estimator. Consider using the estimator at *www.irs.gov/W4App* if you:

1. Are submitting this form after the beginning of the year;

2. Expect to work only part of the year;

3. Have changes during the year in your marital status, number of jobs for you (and/or your spouse if married filing jointly), or number of dependents, or changes in your deductions or credits;

4. Receive dividends, capital gains, social security, bonuses, or business income, or are subject to the Additional Medicare Tax or Net Investment Income Tax; or

5. Prefer the most accurate withholding for multiple job situations.

TIP: Have your most recent pay stub(s) from this year available when using the estimator to account for federal income tax that has already been withheld this year. At the beginning of next year, use the estimator again to recheck your withholding.

Self-employment. Generally, you will owe both income and self-employment taxes on any self-employment income you receive separate from the wages you receive as an employee. If you want to pay these taxes through withholding from your wages, use the estimator at *www.irs.gov/W4App* to figure the amount to have withheld.

Nonresident alien. If you're a nonresident alien, see Notice 1392, Supplemental Form W-4 Instructions for Nonresident Aliens, before completing this form.

Specific Instructions

Step 1(c). Check your anticipated filing status. This will determine the standard deduction and tax rates used to compute your withholding.

Step 2. Use this step if you (1) have more than one job at the same time, or (2) are married filing jointly and you and your spouse both work. Submit a separate Form W-4 for each job.

Option **(a)** most accurately calculates the additional tax you need to have withheld, while option **(b)** does so with a little less accuracy.

Instead, if you (and your spouse) have a total of only two jobs, you may check the box in option **(c)**. The box must also be checked on the Form W-4 for the other job. If the box is checked, the standard deduction and tax brackets will be cut in half for each job to calculate withholding. This option is accurate for jobs with similar pay; otherwise, more tax than necessary may be withheld, and this extra amount will be larger the greater the difference in pay is between the two jobs.

Multiple jobs. *Complete Steps 3 through 4(b) on only one Form W-4. Withholding will be most accurate if you do this on the Form W-4 for the highest paying job.*

Step 3. This step provides instructions for determining the amount of the child tax credit and the credit for other dependents that you may be able to claim when you file your tax return. To qualify for the child tax credit, the child must be under age 17 as of December 31, must be your dependent who generally lives with you for more than half the year, and must have the required social security number. You may be able to claim a credit for other dependents for whom a child tax credit can't be claimed, such as an older child or a qualifying relative. For additional eligibility requirements for these credits, see Pub. 501, Dependents, Standard Deduction, and Filing Information. You can also include **other tax credits** for which you are eligible in this step, such as the foreign tax credit and the education tax credits. To do so, add an estimate of the amount for the year to your credits for dependents and enter the total amount in Step 3. Including these credits will increase your paycheck and reduce the amount of any refund you may receive when you file your tax return.

Step 4 (optional).

Step 4(a). Enter in this step the total of your other estimated income for the year, if any. You shouldn't include income from any jobs or self-employment. If you complete Step 4(a), you likely won't have to make estimated tax payments for that income. If you prefer to pay estimated tax rather than having tax on other income withheld from your paycheck, see Form 1040-ES, Estimated Tax for Individuals.

Step 4(b). Enter in this step the amount from the Deductions Worksheet, line 5, if you expect to claim deductions other than the basic standard deduction on your 2025 tax return and want to reduce your withholding to account for these deductions. This includes both itemized deductions and other deductions such as for student loan interest and IRAs.

Step 4(c). Enter in this step any additional tax you want withheld from your pay **each pay period**, including any amounts from the Multiple Jobs Worksheet, line 4. Entering an amount here will reduce your paycheck and will either increase your refund or reduce any amount of tax that you owe.

Step 2(b)—Multiple Jobs Worksheet *(Keep for your records.)*

If you choose the option in Step 2(b) on Form W-4, complete this worksheet (which calculates the total extra tax for all jobs) on **only ONE** Form W-4. Withholding will be most accurate if you complete the worksheet and enter the result on the Form W-4 for the highest paying job. To be accurate, submit a new Form W-4 for all other jobs if you have not updated your withholding since 2019.

Note: If more than one job has annual wages of more than $120,000 or there are more than three jobs, see Pub. 505 for additional tables; or, you can use the online withholding estimator at *www.irs.gov/W4App*.

1 **Two jobs.** If you have two jobs or you're married filing jointly and you and your spouse each have one job, find the amount from the appropriate table on page 4. Using the "Higher Paying Job" row and the "Lower Paying Job" column, find the value at the intersection of the two household salaries and enter that value on line 1. Then, **skip** to line 3 . . . . . 1 $

2 **Three jobs.** If you and/or your spouse have three jobs at the same time, complete lines 2a, 2b, and 2c below. Otherwise, skip to line 3.

a Find the amount from the appropriate table on page 4 using the annual wages from the highest paying job in the "Higher Paying Job" row and the annual wages for your next highest paying job in the "Lower Paying Job" column. Find the value at the intersection of the two household salaries and enter that value on line 2a . . . . . 2a $

b Add the annual wages of the two highest paying jobs from line 2a together and use the total as the wages in the "Higher Paying Job" row and use the annual wages for your third job in the "Lower Paying Job" column to find the amount from the appropriate table on page 4 and enter this amount on line 2b . . . . . 2b $

c Add the amounts from lines 2a and 2b and enter the result on line 2c . . . . . 2c $

3 Enter the number of pay periods per year for the highest paying job. For example, if that job pays weekly, enter 52; if it pays every other week, enter 26; if it pays monthly, enter 12, etc. 3

4 **Divide** the annual amount on line 1 or line 2c by the number of pay periods on line 3. Enter this amount here and in **Step 4(c)** of Form W-4 for the highest paying job (along with any other additional amount you want withheld) . . . . . 4 $

Step 4(b)—Deductions Worksheet *(Keep for your records.)*

1 Enter an estimate of your 2025 itemized deductions (from Schedule A (Form 1040)). Such deductions may include qualifying home mortgage interest, charitable contributions, state and local taxes (up to $10,000), and medical expenses in excess of 7.5% of your income . . . . . 1 $

2 Enter:
- $30,000 if you're married filing jointly or a qualifying surviving spouse
- $22,500 if you're head of household
- $15,000 if you're single or married filing separately

. . . . . 2 $

3 If line 1 is greater than line 2, subtract line 2 from line 1 and enter the result here. If line 2 is greater than line 1, enter "-0-" . . . . . 3 $

4 Enter an estimate of your student loan interest, deductible IRA contributions, and certain other adjustments (from Part II of Schedule 1 (Form 1040)). See Pub. 505 for more information . . . . 4 $

5 **Add** lines 3 and 4. Enter the result here and in **Step 4(b)** of Form W-4 . . . . . 5 $

Privacy Act and Paperwork Reduction Act Notice. We ask for the information on this form to carry out the Internal Revenue laws of the United States. Internal Revenue Code sections 3402(f)(2) and 6109 and their regulations require you to provide this information; your employer uses it to determine your federal income tax withholding. Failure to provide a properly completed form will result in your being treated as a single person with no other entries on the form; providing fraudulent information may subject you to penalties. Routine uses of this information include giving it to the Department of Justice for civil and criminal litigation; to cities, states, the District of Columbia, and U.S. commonwealths and territories for use in administering their tax laws; and to the Department of Health and Human Services for use in the National Directory of New Hires. We may also disclose this information to other countries under a tax treaty, to federal and state agencies to enforce federal nontax criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism.

You are not required to provide the information requested on a form that is subject to the Paperwork Reduction Act unless the form displays a valid OMB control number. Books or records relating to a form or its instructions must be retained as long as their contents may become material in the administration of any Internal Revenue law. Generally, tax returns and return information are confidential, as required by Code section 6103.

The average time and expenses required to complete and file this form will vary depending on individual circumstances. For estimated averages, see the instructions for your income tax return.

If you have suggestions for making this form simpler, we would be happy to hear from you. See the instructions for your income tax return.

Married Filing Jointly or Qualifying Surviving Spouse

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	$0 - 9,999	$10,000 - 19,999	$20,000 - 29,999	$30,000 - 39,999	$40,000 - 49,999	$50,000 - 59,999	$60,000 - 69,999	$70,000 - 79,999	$80,000 - 89,999	$90,000 - 99,999	$100,000 - 109,999	$110,000 - 120,000
$0 - 9,999	$0	$0	$700	$850	$910	$1,020	$1,020	$1,020	$1,020	$1,020	$1,020	$1,020
$10,000 - 19,999	0	700	1,700	1,910	2,110	2,220	2,220	2,220	2,220	2,220	2,220	3,220
$20,000 - 29,999	700	1,700	2,760	3,110	3,310	3,420	3,420	3,420	3,420	3,420	4,420	5,420
$30,000 - 39,999	850	1,910	3,110	3,460	3,660	3,770	3,770	3,770	3,770	4,770	5,770	6,770
$40,000 - 49,999	910	2,110	3,310	3,660	3,860	3,970	3,970	3,970	4,970	5,970	6,970	7,970
$50,000 - 59,999	1,020	2,220	3,420	3,770	3,970	4,080	4,080	5,080	6,080	7,080	8,080	9,080
$60,000 - 69,999	1,020	2,220	3,420	3,770	3,970	4,080	5,080	6,080	7,080	8,080	9,080	10,080
$70,000 - 79,999	1,020	2,220	3,420	3,770	3,970	5,080	6,080	7,080	8,080	9,080	10,080	11,080
$80,000 - 99,999	1,020	2,220	3,420	4,620	5,820	6,930	7,930	8,930	9,930	10,930	11,930	12,930
$100,000 - 149,999	1,870	4,070	6,270	7,620	8,820	9,930	10,930	11,930	12,930	14,010	15,210	16,410
$150,000 - 239,999	1,870	4,240	6,640	8,190	9,590	10,890	12,090	13,290	14,490	15,690	16,890	18,090
$240,000 - 259,999	2,040	4,440	6,840	8,390	9,790	11,100	12,300	13,500	14,700	15,900	17,100	18,300
$260,000 - 279,999	2,040	4,440	6,840	8,390	9,790	11,100	12,300	13,500	14,700	15,900	17,100	18,300
$280,000 - 299,999	2,040	4,440	6,840	8,390	9,790	11,100	12,300	13,500	14,700	15,900	17,100	18,300
$300,000 - 319,999	2,040	4,440	6,840	8,390	9,790	11,100	12,300	13,500	14,700	15,900	17,170	19,170
$320,000 - 364,999	2,040	4,440	6,840	8,390	9,790	11,100	12,470	14,470	16,470	18,470	20,470	22,470
$365,000 - 524,999	2,790	6,290	9,790	12,440	14,940	17,350	19,650	21,950	24,250	26,550	28,850	31,150
$525,000 and over	3,140	6,840	10,540	13,390	16,090	18,700	21,200	23,700	26,200	28,700	31,200	33,700

Single or Married Filing Separately

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	$0 - 9,999	$10,000 - 19,999	$20,000 - 29,999	$30,000 - 39,999	$40,000 - 49,999	$50,000 - 59,999	$60,000 - 69,999	$70,000 - 79,999	$80,000 - 89,999	$90,000 - 99,999	$100,000 - 109,999	$110,000 - 120,000
$0 - 9,999	$200	$850	$1,020	$1,020	$1,020	$1,370	$1,870	$1,870	$1,870	$1,870	$1,870	$2,040
$10,000 - 19,999	850	1,700	1,870	1,870	2,220	3,220	3,720	3,720	3,720	3,720	3,890	4,090
$20,000 - 29,999	1,020	1,870	2,040	2,390	3,390	4,390	4,890	4,890	4,890	5,060	5,260	5,460
$30,000 - 39,999	1,020	1,870	2,390	3,390	4,390	5,390	5,890	5,890	6,060	6,260	6,460	6,660
$40,000 - 59,999	1,220	3,070	4,240	5,240	6,240	7,240	7,880	8,080	8,280	8,480	8,680	8,880
$60,000 - 79,999	1,870	3,720	4,890	5,890	7,030	8,230	8,930	9,130	9,330	9,530	9,730	9,930
$80,000 - 99,999	1,870	3,720	5,030	6,230	7,430	8,630	9,330	9,530	9,730	9,930	10,130	10,580
$100,000 - 124,999	2,040	4,090	5,460	6,660	7,860	9,060	9,760	9,960	10,160	10,950	11,950	12,950
$125,000 - 149,999	2,040	4,090	5,460	6,660	7,860	9,060	9,950	10,950	11,950	12,950	13,950	14,950
$150,000 - 174,999	2,040	4,090	5,460	6,660	8,450	10,450	11,950	12,950	13,950	15,080	16,380	17,680
$175,000 - 199,999	2,040	4,290	6,450	8,450	10,450	12,450	13,950	15,230	16,530	17,830	19,130	20,430
$200,000 - 249,999	2,720	5,570	7,900	10,200	12,500	14,800	16,600	17,900	19,200	20,500	21,800	23,100
$250,000 - 399,999	2,970	6,120	8,590	10,890	13,190	15,490	17,290	18,590	19,890	21,190	22,490	23,790
$400,000 - 449,999	2,970	6,120	8,590	10,890	13,190	15,490	17,290	18,590	19,890	21,190	22,490	23,790
$450,000 and over	3,140	6,490	9,160	11,660	14,160	16,660	18,660	20,160	21,660	23,160	24,660	26,160

Head of Household

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	$0 - 9,999	$10,000 - 19,999	$20,000 - 29,999	$30,000 - 39,999	$40,000 - 49,999	$50,000 - 59,999	$60,000 - 69,999	$70,000 - 79,999	$80,000 - 89,999	$90,000 - 99,999	$100,000 - 109,999	$110,000 - 120,000
$0 - 9,999	$0	$450	$850	$1,000	$1,020	$1,020	$1,020	$1,020	$1,870	$1,870	$1,870	$1,890
$10,000 - 19,999	450	1,450	2,000	2,200	2,220	2,220	2,220	3,180	4,070	4,070	4,090	4,290
$20,000 - 29,999	850	2,000	2,600	2,800	2,820	2,820	3,780	4,780	5,670	5,690	5,890	6,090
$30,000 - 39,999	1,000	2,200	2,800	3,000	3,020	3,980	4,980	5,980	6,890	7,090	7,290	7,490
$40,000 - 59,999	1,020	2,220	2,820	3,830	4,850	5,850	6,850	8,050	9,130	9,330	9,530	9,730
$60,000 - 79,999	1,020	3,030	4,630	5,830	6,850	8,050	9,250	10,450	11,530	11,730	11,930	12,130
$80,000 - 99,999	1,870	4,070	5,670	7,060	8,280	9,480	10,680	11,880	12,970	13,170	13,370	13,570
$100,000 - 124,999	1,950	4,350	6,150	7,550	8,770	9,970	11,170	12,370	13,450	13,650	14,650	15,650
$125,000 - 149,999	2,040	4,440	6,240	7,640	8,860	10,060	11,260	12,860	14,740	15,740	16,740	17,740
$150,000 - 174,999	2,040	4,440	6,240	7,640	8,860	10,860	12,860	14,860	16,740	17,740	18,940	20,240
$175,000 - 199,999	2,040	4,440	6,640	8,840	10,860	12,860	14,860	16,910	19,090	20,390	21,690	22,990
$200,000 - 249,999	2,720	5,920	8,520	10,960	13,280	15,580	17,880	20,180	22,360	23,660	24,960	26,260
$250,000 - 449,999	2,970	6,470	9,370	11,870	14,190	16,490	18,790	21,090	23,280	24,580	25,880	27,180
$450,000 and over	3,140	6,840	9,940	12,640	15,160	17,660	20,160	22,660	25,050	26,550	28,050	29,550

FORM M-4

MASSACHUSETTS EMPLOYEE'S WITHHOLDING EXEMPTION CERTIFICATE

Rev. 11/19

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

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

Employee:

File this form 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. The more exemptions you claim on this certificate, the less tax withheld from your employer. If you claim more exemptions than you are entitled to, civil and criminal penalties may be imposed. However, you may claim a smaller number of exemptions without penalty. 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. Underwithholding may result in owing additional taxes to the Commonwealth at the end of the year.

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

If claiming a spouse, write "4" in line 2. Entering "4" makes a 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.

Employment Eligibility Verification

Department of Homeland Security

U.S. Citizenship and Immigration Services

USCIS Form I-9

OMB No.1615-0047

Expires 07/31/2026

START HERE: Employers must ensure the form instructions are available to employees when completing this form. Employers are liable for failing to comply with the requirements for completing this form. See below and the Instructions.

ANTI-DISCRIMINATION NOTICE: All employees can choose which acceptable documentation to present for Form I-9. Employers cannot ask employees for documentation to verify information in **Section 1**, or specify which acceptable documentation employees must present for **Section 2** or Supplement B, Reverification and Rehire. Treating employees differently based on their citizenship, immigration status, or national origin may be illegal.

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 (if any)	Other Last Names Used (if any)

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

Date of Birth (mm/dd/yyyy)	U.S. Social Security Number	Employee's Email Address	Employee's Telephone Number

I am aware that federal law provides for imprisonment and/or fines for false statements, or the use of false documents, in connection with the completion of this form. I attest, under penalty of perjury, that this information, including my selection of the box attesting to my citizenship or immigration status, is true and correct.

Check one of the following boxes to attest to your citizenship or immigration status (See page 2 and 3 of the instructions.):

- ☐ 1. A citizen of the United States
- ☐ 2. A noncitizen national of the United States (See Instructions.)
- ☐ 3. A lawful permanent resident (Enter USCIS or A-Number.)
- ☐ 4. A noncitizen (other than **Item Numbers 2.** and **3.** above) authorized to work until (exp. date, if any)

If you check **Item Number 4.**, enter one of these:

USCIS A-Number	OR	Form I-94 Admission Number	OR	Foreign Passport Number and Country of Issuance

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

If a preparer and/or translator assisted you in completing Section 1, that person MUST complete the Preparer and/or Translator Certification on Page 3.

Section 2. Employer Review and Verification: Employers or their authorized representative must complete and sign Section 2 within three business days after the employee's first day of employment, and must physically examine, or examine consistent with an alternative procedure authorized by the Secretary of DHS, documentation from List A OR a combination of documentation from List B and List C. Enter any additional documentation in the Additional Information box; see Instructions.

	List A	OR	List B	AND	List C
Document Title 1					
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					
Document Title 2 (if any)					
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					
Document Title 3 (if any)					
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					

Additional Information

☐ Check here if you used an alternative procedure authorized by DHS to examine documents.

Certification: I attest, under penalty of perjury, that (1) I have examined the documentation presented by the above-named employee, (2) the above-listed documentation appears to be genuine and to relate to the employee named, and (3) to the best of my knowledge, the employee is authorized to work in the United States.

First Day of Employment (mm/dd/yyyy):

Last Name, First Name and Title of Employer or Authorized Representative	Signature of Employer or Authorized Representative	Today's Date (mm/dd/yyyy)

Employer's Business or Organization Name	Employer's Business or Organization Address, City or Town, State, ZIP Code

For reverification or rehire, complete Supplement B, Reverification and Rehire on Page 4.

LISTS OF ACCEPTABLE DOCUMENTS

All documents containing an expiration date must be unexpired.
* Documents extended by the issuing authority are considered unexpired.
Employees may present one selection from List A or a
combination of one selection from List B and one selection from List C.
Examples of many of these documents appear in the Handbook for Employers (M-274).

LIST A Documents that Establish Both Identity and Employment Authorization	OR	LIST B Documents that Establish Identity	AND	LIST C Documents that Establish Employment Authorization
1. U.S. Passport or U.S. Passport Card		**1.** Driver's license or ID card issued by a State or outlying possession of the United States provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		**1.** A Social Security Account Number card, unless the card includes one of the following restrictions: **(1)** NOT VALID FOR EMPLOYMENT **(2)** VALID FOR WORK ONLY WITH INS AUTHORIZATION **(3)** VALID FOR WORK ONLY WITH DHS AUTHORIZATION
2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551)		**2.** ID card issued by federal, state or local government agencies or entities, provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		**2.** Certification of report of birth issued by the Department of State (Forms DS-1350, FS-545, FS-240)
3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa		**3.** School ID card with a photograph		**3.** Original or certified copy of birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal
4. Employment Authorization Document that contains a photograph (Form I-766)		**4.** Voter's registration card		**4.** Native American tribal document
5. For an individual temporarily authorized to work for a specific employer because of his or her status or parole: **a.** Foreign passport; and **b.** Form I-94 or Form I-94A that has the following: **(1)** The same name as the passport; and **(2)** An endorsement of the individual's status or parole as long as that period of endorsement has not yet expired and the proposed employment is not in conflict with any restrictions or limitations identified on the form.		**5.** U.S. Military card or draft record		**5.** U.S. Citizen ID Card (Form I-197)
		6. Military dependent's ID card		**6.** Identification Card for Use of Resident Citizen in the United States (Form I-179)
		7. U.S. Coast Guard Merchant Mariner Card		**7.** Employment authorization document issued by the Department of Homeland Security For examples, see **Section 7** and **Section 13** of the M-274 on **uscis.gov/i-9-central**. The Form I-766, Employment Authorization Document, is a List A, **Item Number 4.** document, not a List C document.
		8. Native American tribal document		
		9. Driver's license issued by a Canadian government authority		
		For persons under age 18 who are unable to present a document listed above:		
		10. School record or report card		
		11. Clinic, doctor, or hospital record		
		12. Day-care or nursery school record		
6. Passport from the Federated States of Micronesia (FSM) or the Republic of the Marshall Islands (RMI) with Form I-94 or Form I-94A indicating nonimmigrant admission under the Compact of Free Association Between the United States and the FSM or RMI				

Acceptable Receipts

May be presented in lieu of a document listed above for a temporary period.
For receipt validity dates, see the M-274.

• Receipt for a replacement of a lost, stolen, or damaged List A document. • Form I-94 issued to a lawful permanent resident that contains an I-551 stamp and a photograph of the individual. • Form I-94 with "RE" notation or refugee stamp issued to a refugee.	**OR**	Receipt for a replacement of a lost, stolen, or damaged List B document.	Receipt for a replacement of a lost, stolen, or damaged List C document.

*Refer to the Employment Authorization Extensions page on **I-9 Central** for more information.

Supplement A,
Preparer and/or Translator Certification for Section 1

Department of Homeland Security
U.S. Citizenship and Immigration Services

USCIS
Form I-9
Supplement A
OMB No. 1615-0047
Expires 07/31/2026

Last Name *(Family Name)* from **Section 1.**	First Name *(Given Name)* from **Section 1.**	Middle initial (if any) from **Section 1.**

Instructions: This supplement must be completed by any preparer and/or translator who assists an employee in completing Section 1 of Form I-9. The preparer and/or translator must enter the employee's name in the spaces provided above. Each preparer or translator must complete, sign, and date a separate certification area. Employers must retain completed supplement sheets with the employee's completed Form I-9.

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			Date *(mm/dd/yyyy)*
Last Name *(Family Name)*	First Name *(Given Name)*		Middle Initial *(if any)*
Address *(Street Number and Name)*	City or Town	State	ZIP Code

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			Date *(mm/dd/yyyy)*
Last Name *(Family Name)*	First Name *(Given Name)*		Middle Initial *(if any)*
Address *(Street Number and Name)*	City or Town	State	ZIP Code

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			Date *(mm/dd/yyyy)*
Last Name *(Family Name)*	First Name *(Given Name)*		Middle Initial *(if any)*
Address *(Street Number and Name)*	City or Town	State	ZIP Code

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			Date *(mm/dd/yyyy)*
Last Name *(Family Name)*	First Name *(Given Name)*		Middle Initial *(if any)*
Address *(Street Number and Name)*	City or Town	State	ZIP Code

Supplement B,
Reverification and Rehire (formerly Section 3)

Department of Homeland Security
U.S. Citizenship and Immigration Services

USCIS
Form I-9
Supplement B
OMB No. 1615-0047
Expires 07/31/2026

Last Name *(Family Name)* from **Section 1.**	First Name *(Given Name)* from **Section 1.**	Middle initial (if any) from **Section 1.**

Instructions: This supplement replaces Section 3 on the previous version of Form I-9. Only use this page if your employee requires reverification, is rehired within three years of the date the original Form I-9 was completed, or provides proof of a legal name change. Enter the employee's name in the fields above. Use a new section for each reverification or rehire. Review the Form I-9 instructions before completing this page. Keep this page as part of the employee's Form I-9 record. Additional guidance can be found in the Handbook for Employers: Guidance for Completing Form I-9 (M-274)

Date of Rehire *(if applicable)*	New Name *(if applicable)*		
Date *(mm/dd/yyyy)*	Last Name (Family Name)	First Name (Given Name)	Middle Initial

Reverification: If the employee requires reverification, your employee can choose to present any acceptable List A or List C documentation to show continued employment authorization. Enter the document information in the spaces below.

Document Title	Document Number (if any)	Expiration Date (if any) (mm/dd/yyyy)

I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented documentation, the documentation I examined appears to be genuine and to relate to the individual who presented it.

Name of Employer or Authorized Representative	Signature of Employer or Authorized Representative	Today's Date *(mm/dd/yyyy)*

Additional Information (Initial and date each notation.)

☐ Check here if you used an alternative procedure authorized by DHS to examine documents.

Date of Rehire *(if applicable)*	New Name *(if applicable)*		
Date *(mm/dd/yyyy)*	Last Name (Family Name)	First Name (Given Name)	Middle Initial

Reverification: If the employee requires reverification, your employee can choose to present any acceptable List A or List C documentation to show continued employment authorization. Enter the document information in the spaces below.

Document Title	Document Number (if any)	Expiration Date (if any) (mm/dd/yyyy)

I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented documentation, the documentation I examined appears to be genuine and to relate to the individual who presented it.

Name of Employer or Authorized Representative	Signature of Employer or Authorized Representative	Today's Date *(mm/dd/yyyy)*

Additional Information (Initial and date each notation.)

☐ Check here if you used an alternative procedure authorized by DHS to examine documents.

Date of Rehire *(if applicable)*	New Name *(if applicable)*		
Date *(mm/dd/yyyy)*	Last Name (Family Name)	First Name (Given Name)	Middle Initial

Reverification: If the employee requires reverification, your employee can choose to present any acceptable List A or List C documentation to show continued employment authorization. Enter the document information in the spaces below.

Document Title	Document Number (if any)	Expiration Date (if any) (mm/dd/yyyy)

I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented documentation, the documentation I examined appears to be genuine and to relate to the individual who presented it.

Name of Employer or Authorized Representative	Signature of Employer or Authorized Representative	Today's Date *(mm/dd/yyyy)*

Additional Information (Initial and date each notation.)

☐ Check here if you used an alternative procedure authorized by DHS to examine documents.

Emerson Health

Version Approved: September 2020

CONFIDENTIALITY AGREEMENT

All individuals must read and sign this Confidentiality Agreement prior to beginning their Emerson Hospital work assignment and issuance of passwords. **It is the responsibility of each individual (including employees, affiliates, partners, or contractors) with access to Emerson systems to preserve and protect confidential information and systems (e.g. patient, employee and business information and systems) whether in hard copy, file/paper, oral or electronic form.** This responsibility applies to the data types below in accordance with the laws, regulations standards, and policies that apply. I acknowledge, and agree to follow the rules set forth in this agreement, understanding that non-compliance can result in disciplinary action or termination of employment and/or access.

Protected Health Information (PHI) is any individually identifiable information associated with the provision of health care, and is governed by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the subsequent HIPAA Privacy Rule and Security Rule. Personally Identifiable Information (PII) is any individually identifiable information including a social security number or credit card number, and is governed by state regulation, including the Massachusetts Data Protection Act. Card Holder Data (CHD) is credit card information that is protected by the Payment Card Industry (PCI) Data Security Standards (DSS). PHI, PII and CHD will collectively be referred as confidential information through this agreement.

1. It is my legal and ethical responsibility to protect the privacy, confidentiality, integrity, and availability of all confidential information. I understand that unauthorized access, use or disclosure of data is strictly prohibited whether working at Emerson Hospital facilities, IPA practices, or any remote work location.

2. All of Emerson Hospital's information technology (IT) resources (including but not limited to: computers, mobile devices, telephones, copiers, e-mail, Internet access, and other electronic devices and systems) are the property of Emerson Hospital and should be used for business purposes. I will comply with Emerson Hospital's Acceptable Use Policy. Usage of Emerson's data and systems is monitored and periodically audited for compliance with policies.

3. I will only access, use, create, store, or transmit confidential information for treatment, payment, and healthcare operations in the performance of my assigned duties, only where required by or permitted by law, and only in a manner which is consistent with Emerson Hospital policies. I will always utilize the minimum necessary amount of information to accomplish the attended purpose.

4. I will discuss confidential information only as appropriate, and only for job related purposes. I will refrain from discussing confidential information within the hearing of unauthorized persons. I will only use Emerson-approved devices and methods to communicate with patients. Unencrypted texting of PHI and/or CHD is prohibited by federal law, regulations and Emerson Hospital policies.

5. I understand that confidential information must be sent securely whether by fax, email, paper, or upload I can either send an email from my emersonhosp.org email account to another emersonhosp.org email address OR if I need to send an email with PHI outside of Emerson, I will type ENCRYPT in the subject line. Sending unencrypted PHI is prohibited by hospital policy. I will confirm the fax number and include a standard cover page. I will double check all paper PHI being mailed or handed to patients. I will upload data only if the site is secure and authorized. I will never upload PHI to public cloud sites, such as GoogleDocs, DropBox, etc.

6. I will dispose of confidential information using approved methods. I will store confidential paper records in locked cabinets and locked recycle bins. If locked bins are unavailable I will shred the information. All computer hard drives no longer needed must be brought to information systems for proper destruction.

7. I will utilize strong passphrases. My Emerson password will be unique, i.e. I will not re-use my Emerson ID or Password to access non-Emerson systems (e.g. email; social networking sites; online shopping sites). I will secure my access credentials (log-in User ID & Password) and I will not share them with anyone.

8.. If connecting remotely I will connect using a secure application that is approved by the Emerson Hospital Information Security Officer and the network that I am connecting from must meet the Emerson Information Security minimum standards. I understand that remote work must be approved by my department manager. If I am a vendor or contractor I understand my organization must have a security risk assessment on file and a signed business associate agreement (BAA) prior to being granted access.

9. I understand my personal mobile device is authorized to connect to the Emerson "BYOD" network only. I understand that if Emerson email is configured on my personal mobile device it requires installation of Emerson's mobile device management software. I am required to keep my phone up-to-date and understand connectivity can be blocked if suspicious or malicious activity is detected.

10. I understand that I am prohibited from posting any information or images to social media that are about patients or patient care.

11.I will report any actual or suspected loss, theft, improper use of, or access to confidential information/systems - e.g. attempts to collect login credentials (phishing) or suspicious attachments (malware) via email to HELPDESK@emersonhosp.org or call extension 3447. I will email the Healthcare Information Protection (HiP) team - **HiP@emersonhosp.org** with specific HIPAA privacy, security or compliance issues or concerns.

Acknowledgment: I have read and understand the Confidentiality Agreement and I will comply with it. I understand that a violation of any part of the Confidentiality Agreement may result in disciplinary action up to and including termination of my employment. For individuals who are not employed by the Hospital, non-compliance with this agreement may result in termination of access to the Hospital's information systems and/or facilities.

_____ _____

Print Name Mother's Maiden Name (for security verification purposes)

_____ _____ _____ _____

Date of Hire /Transfer Position Title Department Physician Practice

_____ _____

Signature Date

Emerson Health

133 Old Road to Nine Acre Corner
Concord, MA 01742
(978) 369-1400
www.emersonhospital.org

Dear New Employee:
The attached policies reflect information that we are responsible for providing to new employees. The information is important for you to read and, as your employment with us proceeds, you will be asked to learn other policies and procedures that relate to your employment with Emerson Hospital.

As mandated by the Massachusetts Board of Registration in Medicine, health care facilities are required to give written instructions on their incident reporting system and their Patient's Rights Policy to all new employees involved in patient care.

We are providing you these written instructions, as they must be received within five days of employment. You will then receive an education and training session during your orientation program that will assist you in understanding these policies and your responsibilities.

Please note: All policies are available and accessible to all employees, which are located on the hospital intranet. Please sign below that you have received the policies and information listed and that you agree to fully comply with the Hospital policies. This acknowledgment will be placed in your personnel file.

I have received copies of the following policies/informational posters:

1. Code of Conduct
2. Harassment/Sexual Harassment
3. Drug and Alcohol Free
4. Substance Abuse Prevention
5. Social Media
6. Inclement Weather
7. Dress and Appearance
0. Organ & Tissue Donation
8. Pain Management
9. Abuse Identification and Reporting
1. Everify

_____ _____

Employee Signature Date

_____

Employee Printed Name

_____ _____

Witness Signature Date

_____

Witness Printed Name

LICENSURE VERIFICATION UPON TIME OF HIRE

Full Name:	Other Names Used:
Social Security #:	Position Title:

License Name	ID Number	Expiration Date

Other	Expiration Date
BLS/CPR	
ACLS	
PALS	
NRP	

Certification Name	ID Number	Expiration Date

Per my respective job description, I am aware that I must obtain the following *(If applicable)*:

Name of Licensure	Within	Due Date
	_____ months/year from my hire date	
	_____ months/year from my hire date	
	_____ months/year from my hire date	

My licensure information has been accurately transferred to this document, and my licensure is not currently under investigation.

_____ _____

Employee Signature Date

To be completed by Human Resources:

I have viewed the original licensure of the above individual and verify that this information is accurate.

_____ _____

Print Name Date

_____ *H.R. Assistant*

Signature Title

AUTHORIZATION FOR DIRECT DEPOSIT OF PAY

NAME:_____ EMPLOYEE ID# _____

FUNDS MAY BE DIRECTLY DEPOSITED INTO MORE THAN ONE ACCOUNT
ONLY FILL OUT THE SECTION(S) THAT APPLY

ONCE DIRECT DEPOSIT IS SET UP, EMPLOYEES WILL RECEIVE PAYSTUBS ELECTRONICALLY VIA EMERSON EMAIL ACCOUNT

******YOU MUST ATTACH A VOIDED CHECK IN ORDER TO PROCESS THIS FORM******

NEW DIRECT DEPOSIT:				
BANK NAME	**TRANSIT NUMBER**	**ACCOUNT NUMBER**	**ACCOUNT TYPE** (CHECKING OR SAVINGS)	**DEPOSIT AMOUNT** (FIXED AMT OR NET PAY)

CHANGE EXISTING DIRECT DEPOSIT TO THE FOLLOWING:				
BANK NAME	**TRANSIT NUMBER**	**ACCOUNT NUMBER**	**ACCOUNT TYPE** (CHECKING OR SAVINGS)	**DEPOSIT AMOUNT** (FIXED AMT OR NET PAY)

CANCEL THE FOLLOWING DIRECT DEPOSIT:				
BANK NAME	**TRANSIT NUMBER**	**ACCOUNT NUMBER**	**ACCOUNT TYPE** (CHECKING OR SAVINGS)	**DEPOSIT AMOUNT** (FIXED AMT OR NET PAY)

ALL CHANGES, EXCEPT FOR DOLLAR AMOUNTS WILL GENERATE A LIVE CHECK (RED) FOR TWO WEEKS.

Direct deposits are processed through the New England Automated Clearing House (NEACH) System. The deposits are normally processed by the NEACH system on Wednesdays. Credits to your accounts will appear 24 to 48 hours after the deposit is processed

DURING HOLIDAY WEEKS, DEPOSITS MAY BE DELAYED.

If your direct deposit rejects due to inaccurate information on this form, it will automatically be cancelled and you will continue to receive live checks until the correct information is received.

I hereby authorize my employer to have my pay directly deposited according to the above information.

EMPLOYEE SIGNATURE:_____ DATE:_____

Emerson Health

Parking Registration

Full Name:	**Email Address:**
Title:	**Department:**
Badge Number:	**Date of Hire:**
Work Schedule:	

Vehicle #1 Information

Year:	**Make:**
Model:	**Color:**
License Plate Number:	**Registration State:**

Vehicle #2 Information

Year:	**Make:**
Model:	**Color:**
License Plate Number:	**Registration State:**

☐ By signing below, I understand and authorize payroll to process the transactions for all fees associated with parking assignments and violations. I certify that the statements made on this application are true and I will notify the parking department whenever a change occurs. Falsification of information could result in the loss of all parking privileges. I understand Emerson Hospital will not be responsible for theft or damage to my vehicle or its contents while in any Emerson Hospital parking facility.

Signature: _____ Date: _____

Department of Family and Medical Leave (DFML) Contact Information

The Massachusetts Department of Family and Medical Leave
Charles F. Hurley Building
19 Staniford Street, 1st Floor
Boston, MA 02114
(617) 626-6565
www.mass.gov/DFML

Payment for Concurrent Leave

Any paid leave provided under a collective bargaining agreement or employer policy and paid at the same or higher rate than paid leave available under this law shall count against the allotment of leave benefits available under this law.

More Information is Available

For more detailed information, please consult the Department's website: **www.mass.gov/DFML**.

ACKNOWLEDGMENT

Your signature below acknowledges your receipt of the information above within 30 days from the start date of your employment or prior to September 20th, 2019, whichever is later.

_____ _____

Signature **Date**

_____

Name (Print)

Your signed acknowledgement will be retained by your employer. Please retain a copy for your own reference. In the event that you refuse to sign this acknowledgement, your employer must permit you to sign a statement indicating your refusal to sign this acknowledgement, and that will be retained by your employer.

Code of Organizational Behavior and Ethics

Employee Acknowledgement of Training

I hereby acknowledge that I have read and understand the information set forth in the Emerson Hospital Code of Organizational Behavior and Ethics (the "Code"). I certify that I will comply with these standards in my daily work activities and that I have a responsibility to report any suspected violations of the Code. I also understand that adhering to these standards is a condition of my employment or business relationship with Emerson Hospital and that if I have any questions about the Code I should ask my manager and/or call the Compliance Officer.

PRINT NAME: _____

SIGNATURE: _____

DATE: _____

Notice of Benefits Available Under M.G.L. Chapter 175M

Paid Family and Medical Leave (PFML)

Available Leave

Covered individuals may be entitled to family and medical leave for the following reasons:

- up to 20 weeks of paid medical leave in a benefit year if they have a serious health condition that incapacitates them from work.
- up to 12 weeks of paid family leave in a benefit year related to the birth, adoption, or foster care placement of a child, to care for a family member with a serious health condition, or because of a qualifying exigency arising out of the fact that a family member is on active duty or has been notified of an impending call to active duty in the Armed Forces.
- up to 26 weeks of paid family leave in a benefit year to care for a family member who is a covered service member with a serious health condition.

Covered individuals are eligible for no more than 26 total weeks, in the aggregate, of paid family and medical leave in a single benefit year.

Benefits

To fund PFML benefits, employers may deduct payroll contributions of up to 0.46% (adjusted annually) from a covered individual's wages or other earnings. A covered individual's average weekly earnings will determine his or her benefit amount, for a maximum weekly benefit of up to $1,170.64 (adjusted annually).

Who is a Covered Individual Under the Law?

Generally, a worker qualifies as a covered individual eligible for PFML benefits if they are:

- covered by unemployment insurance in Massachusetts and paid wages by a Massachusetts employer; or
- a self-employed individual who resides and works in Massachusetts and chooses to opt-in to the program; and
- has earned at least 30 times the expected benefit and at least $6,300 (adjusted annually) in the last four completed quarters preceding the application for benefits.

Job Protection

Generally, an employee who has taken paid family or medical leave must be restored to the employee's previous position or to an equal position, with the same status, pay, employment benefits, length-of-service credit, and seniority as of the date of leave.

These job protections do not apply to former employees, independent contractors, or self-employed individuals.

Health Insurance

Employers must provide for, contribute to, or otherwise maintain the employee's employment-related health insurance benefits, if any, at the level and under the conditions coverage would have been provided if the employee had continued working continuously for the duration of such leave.

Private Plans

If an employer offers employees paid family leave, medical leave, or both, with benefits that are at least as generous as those provided under the law, the employer may apply for an exemption from paying the contributions. Employees continue to be protected from discrimination and retaliation under the law even when an employer opts to provide paid leave benefits through a private plan.

Name of Private Insurer: _____ Private plan is for: ☐ Medical ☐ Family ☐ Both

Address: _____ Phone: _____

City, State & Zip Code: _____ Website: _____

No Retaliation or Discrimination

- It is unlawful for an employer to discriminate or retaliate against an employee for exercising any right to which s/he is entitled under the law.
- An employee or former employee who is discriminated or retaliated against for exercising rights under the law may, not more than three years after the violation occurs, institute a civil action in the superior court, and may be entitled to damages of as much as three times his or her lost wages.

If you have questions or concerns about your PFML rights, call:

(833) 344-7365 or visit: https://www.mass.gov/DFML

Paid Family & Medical Leave MASSACHUSETTS

2025 Poster
Revised 10/2024

MPML and MPFL – Mass Paid Family Medical Leave and Mass Paid Medical Leave 2025

25 or More Employees Notice- Instructions for Use

As a Massachusetts employer, you are required to inform your Massachusetts employees and covered contract workers about their rights and obligations under the Massachusetts Paid Family and Medical Leave (PFML) law. To do so, you may provide this form to your employees and covered contract workers. You may also create or use a different notice of your choosing as long as the notice you use provides the same information as required by law.

This form is for employers who have 25 or more Massachusetts employees and covered contract workers. If you have less than 25 Massachusetts employees and covered contract workers, please use the Employer notice for a workforce with fewer than 25 covered individuals form. Likewise, if you engage with self-employed individuals who are *not* covered contract workers, you may provide them the Employer notice to self-employed individuals for a workforce with fewer than 25 covered individuals form to notify them of their option to elect coverage for themselves. These forms can be downloaded at mass.gov/dfml.

To use this form, first complete:

1. The chart on page 2 indicating whether you have an approved private plan;
2. The chart on page 5 indicating what percentage of the employee contribution will be deducted from your employees' wages, and what percentage (if any) you will pay;
3. The employer information chart on page 6;
4. The check boxes on page 2 indicating where employees can find information on your private plan, if any. (Check N/A if you are participating in the state Trust Fund.)

Once you have filled out these sections, provide pages 2-6 of this form to your employees and covered contract workers for them to review and sign.

PAID FAMILY AND MEDICAL LEAVE NOTICE TO EMPLOYEES (25 or more Workers)

Please read this notice carefully. It contains important information about your rights, obligations, and eligibility under the Massachusetts Paid Family and Medical Leave (PFML) law. Please keep this notice for your records.

The Massachusetts PFML law provides most Massachusetts employees the right to paid family and medical leave. These rights are described further below and include both (1) job protection when the employee returns to work and (2) partial wage-replacement benefits while the employee is out of work. Employers can provide these benefits either by (1) participating in the PFML Trust Fund operated by the Massachusetts Department of Family and Medical Leave (the Department), or (2) providing an exempt private plan that offers benefits at least as generous as those available through the Department.

Regardless of whether your employer participates in the state Trust Fund or has a private plan, you will be entitled to certain benefits and protections. You may be required to make contributions to the Trust Fund or to fund your employer's private plan, but only up to a certain amount. You will also need to tell your employer when you need leave, and you will need to file an application for benefits with the Department or through your employer's private plan.

An employer may apply for an exemption from the medical leave contribution, family leave contribution, or both. Your employer must provide you information about the private plan and the application process. Your employer has made that information available:

- ☑ In the box below
- ☐ As an attachment to this Notice
- ☑ Other: Orientation and Employee Intranet
- ☐ N/A (Employer contributes to Trust Fund)

Emerson Health
(Employer Name)

(Private Plan Name)

(Private Plan Phone Number)

(Private Plan Address)

(Private Plan Website)

- ☑ Does not have an approved private plan and is providing all leave benefits through the Department;
- ☐ Has an approved private plan for both family and medical leave benefits;
- ☐ Has an approved private plan for family leave benefits only, and is providing medical leave benefits through the Department;
- ☐ Has an approved private plan for medical leave benefits only and is providing family leave benefits through the Department.

I. Explanation of Benefits

Leave Allotments. Under the PFML Law, you may be entitled to up to:

- 12 weeks of paid family leave in a benefit year for the birth, adoption, or foster care placement of a child; to care for a family member with a serious health condition; or because of a qualifying exigency arising out of the fact that a family member is on active duty or has been notified of an impending call to active duty in the Armed Forces;
- 20 weeks of paid medical leave in a benefit year if they have a serious health condition that incapacitates them from work;
- 26 weeks of paid family leave in a benefit year to care for a family member who is a covered service member undergoing medical treatment or otherwise addressing consequences of a serious health condition relating to the family member's military service;
- 26 total weeks, in the aggregate, of paid family and medical leave in a single benefit year.

A "benefit year" is the 12 months preceding the Sunday immediately before your leave begins.

Other Leaves. Any leave you take – paid or unpaid – for the same qualifying reasons listed above will count towards your amount of leave for that benefit year.

Eligibility. You will be eligible for leave and wage-replacement benefits if you meet the earnings test. You must have earned at least 30 times the expected benefit amount and met the minimum earnings requirement established annually by the Department of Unemployment Assistance (DUA), which is $6,300 for 2025, during the last 4 completed calendar quarters. (This is the amount calculated in the "Wage Replacement Payments" section below.)

Wage Replacement Payments. When you take leave for any of the reasons described above, you will be eligible to apply to the Department or to your employer's private plan for wage replacement benefits. These benefits will be a proportion of your average weekly earnings. Your maximum potential benefit amount will be as follows:

- 80% of earnings up to 50% of the State Average Weekly Wage
- 50% of earnings above the State Average Weekly Wage
- In no event more than a maximum amount. For 2025, this maximum benefit amount is $1,170.64. This amount will be adjusted annually based on increases in the State Average Weekly Wage.

Private plans may choose to provide higher benefits but may not provide lower amounts than what the Department would pay.

Concurrent Benefits Payments. If you receive benefits from other sources while you are also receiving benefits from the Department, the benefits you receive from the Department may be reduced. Certain types of other benefits will cause a one-for-one reduction in benefits you receive from the Department. This means that for each dollar you receive from these benefits, your benefit from the Department will decrease by a dollar. Benefits that will have this effect include:

- Workers' Compensation
- Unemployment Insurance
- Permanent Disability Policies or Programs
- Extended Illness Leave Bank Leave

Other forms of benefits will not reduce the benefits you receive from the Department unless you are receiving more than your average weekly wage in total benefits. Benefits that will have this effect include:

- Temporary Disability Policies or Programs (including both Short-Term Disability and Long-Term Disability)
- Employer-run Family and/or Medical Leave Policies or Programs

Topping off PFML benefit payments In general, employees may use their paid leave (sick time, vacation, or other PTO) to top off their PFML benefits up to a certain amount, but you will need to follow your employer's policies regarding earning and using time off. Your employer's PTO policy may not discriminate against you for exercising a right to which you are entitled under the PFML program (M.G.L. c 175M). For employees who choose to supplement their PFML benefits in this way, the combined weekly sum of PFML benefits and employer-provided paid leave benefits cannot exceed the employee's Individual Average Weekly Wage (IAWW). Employers will be responsible for monitoring and ensuring that the combined weekly sum of employer-provided paid leave benefits and PFML benefits does not exceed an employee's IAWW. Employers are also responsible for managing any payments made to an employee that exceed the employee's IAWW. The Department is not involved in the repayment process for top off overages. This process is solely the responsibility of the employer and the employee.

II. Employee Rights and Protections

Job Protection. Generally, if you take family or medical leave, once you return to work, your employer must restore you to your previous position or to an equivalent position, with the same status, pay, employment benefits, length-of-service credit, and seniority as of the date you started your leave. This may not apply if your position was eliminated due to economic reasons unrelated to your use of leave.

Continuation of Health Insurance. Your employer must continue to provide for and contribute to your employment-related health insurance benefits, if any, at the level and under the conditions coverage would have been provided if you had continued working for the duration of such leave. Your employer may require you to continue to pay your portion of your health insurance premium on the same terms and conditions as before your leave.

No Retaliation. It is unlawful for any employer to discriminate or retaliate against you for exercising any right to which you are entitled under the paid family and medical leave law. An employee or former employee who is retaliated against for exercising rights under the law may, not more than three years after the violation occurs, institute a civil action in the superior court.

III. Contribution Amounts

To help fund paid leave benefits available under the PFML law, your employer may make a contribution, funded in part by a deduction from your wages, which will either be remitted to the Trust Fund or to the operator of your employer's private plan. An employer who contributes to the Trust Fund will be required to contribute the following amounts:

Family Leave Contribution	Medical Leave Contribution	Total Contribution Amount
0.18% of earnings*	0.70% of earnings*	0.88% of earnings*

Because your employer has 25 or more covered workers, the total contribution amount is 0.88% of wages.

Under the law, employers are responsible for a minimum of 60% of the medical leave contribution (.42% of wages) but are permitted to deduct from employees' wages up to 40% of the medical leave contribution (.28% of wages) and up to 100% of the family leave contribution (.18% of wages) for a total of .46% of wages. Whether your employer has a private plan or participates in the state Trust Fund, your employer cannot deduct more than these percentages from your wages.

Your employer has elected to allocate the contribution amount as follows:

Medical Leave				
Total Required Contribution: .70%*				
Emerson Health _____ (Employer Name)	will contribute		**.42%**	of the medical leave contribution
	and the remaining		**.28%**	will be deducted from your earnings

Family Leave				
Total Required Contribution: .18%*				
Emerson Health _____ (Employer Name)	will contribute		**0%**	of the family leave contribution
	and the remaining		**.18%**	will be deducted from your earnings

******Please initial here to indicate that you understand that this percentage of your wages earned in a pay period will be deducted from your pay each pay period: _____

* The numbers provided are through 2025. These rates may be adjusted on an annual basis, effective January 1 of each calendar year.

IV. Notifying your Employer

BEFORE you take leave or apply for benefits, you MUST notify your employer that you need to take leave. You are required to provide at least 30 days' notice of your need for leave. If 30 days' notice is not possible due to circumstances beyond your control, you must provide notice as soon as practicable, and in any event, before you file any application for benefits.

When you notify your employer of your need for leave, you must provide the following information:

1. The anticipated start date of leave;
2. The anticipated length of the leave;
3. The expected date of return from leave;
4. Whether you will need intermittent leave (leave taken in separate blocks of two or more) or reduced leave (leave that involves a reduced schedule of fewer hours or days per week), and;

5. If you need intermittent or reduced leave schedule, the expected frequency of leave and expected duration of each instance of leave.

If any of this information changes, you must tell your employer as soon as you are aware of the change.

V. Submitting an application

To apply for PFML benefits, you will need the following information about your employer:

Emerson Health
(Employer Name)
133 Old Road to Nine Acre Corner
(Employer Street Address)
Concord, MA 01742
(Employer City, State, Zip)
04-210-3565 or for EPA 80-0482067
(Federal Employer ID Number) (FEIN)

If your employer contributes to the Trust Fund, you must submit an application for benefits with the Department. You may submit this application in one of two ways:

1. You can create an account to apply online through the Department's Application Website at paidleave.mass.gov/login/
2. You can call the Department's Contact Center at (833) 344-7365 to complete an application over the phone.

Forms and application instructions are available on the Department's website at www.mass.gov/info-details/get-ready-to-apply-for-paid-family-and-medical-leave-pfml-benefits.

VI. For More Information

For more detailed information, please consult the Department's website: www.mass.gov/DFML. You may contact the Department of Family and Medical Leave at:

The Massachusetts Department of Family and Medical Leave
PO Box 838
Lawrence, MA 01842
Contact Center: (833) 344-7365

Parking FAQ

How do I contact Parking?

Parking can be reached at 978-287-3009 or parking@emersonhosp.org. Parking can assist you with parking assignments, schedule changes and any questions you may have.

What are the Shuttle hours?

The Shuttle operates Monday-Friday 4:45am-10:00pm. Shuttle telephone # 978-505-8434.

Shuttle runs every 15 minutes from 4:45am to 10:00am and from 2:00pm-8:30pm. All other times call the shuttle telephone for pickup or drop off.

What is a Shuttle Rider?

New Employees who work the first shift are assigned to the shuttle lot across the street and utilize the shuttle for transportation to and from the Hospital. Shuttle riders have campus access to Lot D and Garage Monday-Friday starting at 1pm and all day access on Saturdays and Sundays.

How do I get campus parking?

Shuttle riders are automatically moved to campus lot parking when campus parking becomes available and is free to employees. Access to on campus parking is based on hire date, employment status and availability. Per Diem staff are not eligible for Lot D or Garage access Monday thru Friday 1st shift.

What if I am Per Diem or work the Second or Third shift?

Per Diem parking location depends upon the shifts worked. First shift employees working the weekday will be assigned to ride the shuttle. If an employee is working the second or third shift, they have access to Lot D and Garage Monday-Friday starting at 1pm and all day access on Saturday and Sundays.

How do I request parking in the garage?

If you are interested in parking in the Garage, please email parking@emersonhosp.org and your name will be added to the waitlist. Employees assigned to park in the garage are charged a fee.

What is the Garage Fee? How are Fee's deducted?

The Garage fee is $6.94 per pay period and the fee is deducted through payroll.

Garage Parking:

Employee parking is on the upper levels, please do not park in a spot identified as Patient/Visitor parking.

Parking FAQ

Parking Violations:

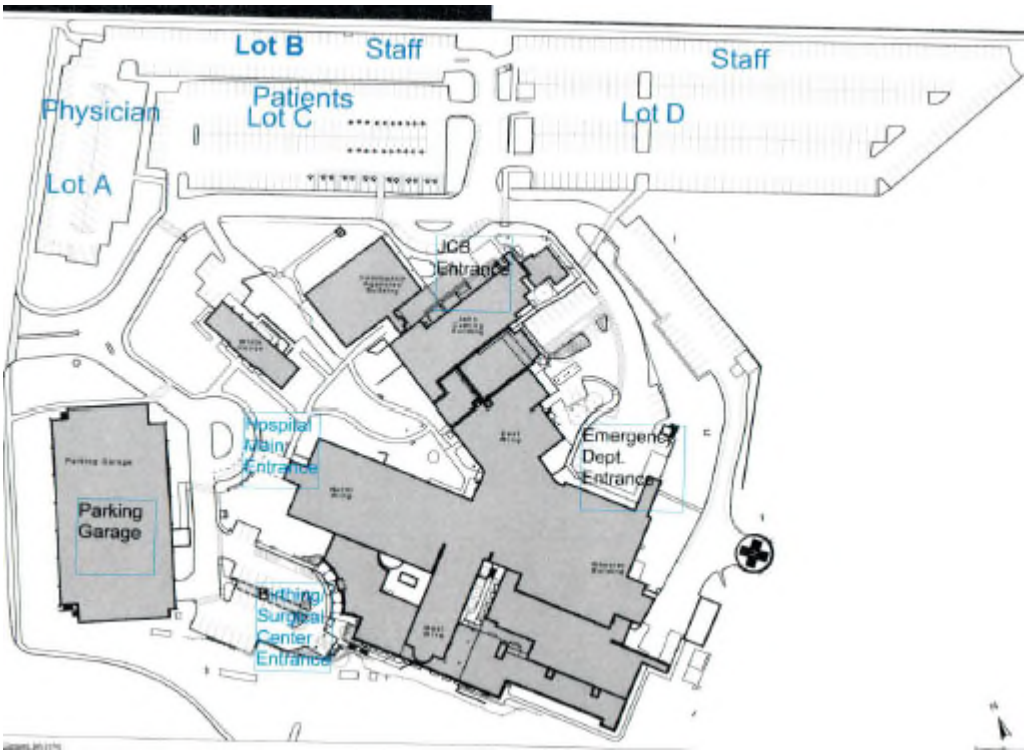
The Garage and Lots are monitored daily. Employees found to be in violation of the parking program will be subject to disciplinary action and/or fees.

Badging at the Kiosks:

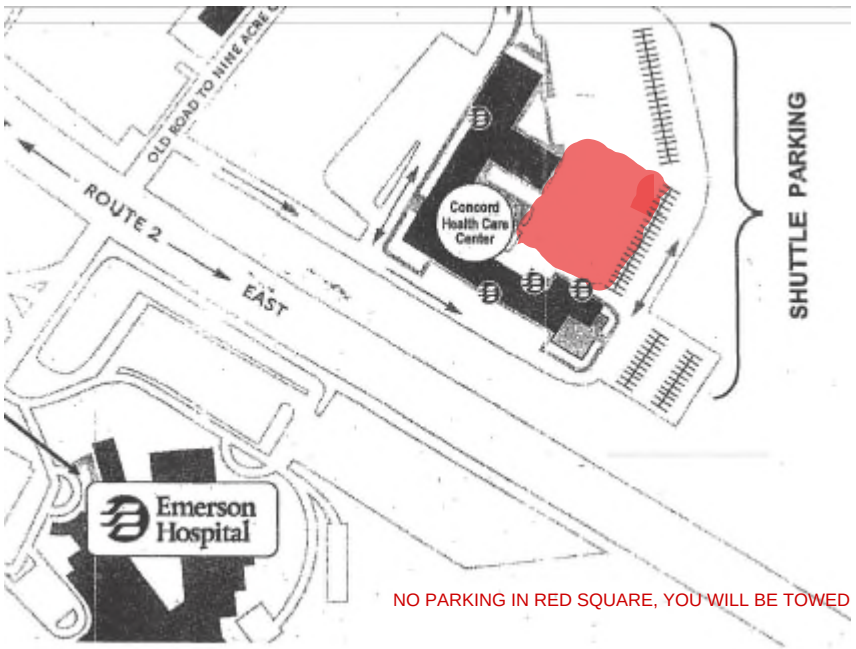
Employee badges are used to open the gates. Swiping or Waving the badge at the proxy card location circled in red below will activate the gate arm. An error message will occur if a Shuttle rider tries to enter Lot D or the Garage before the assigned time of 1PM Monday thru Friday.

Parking FAQ

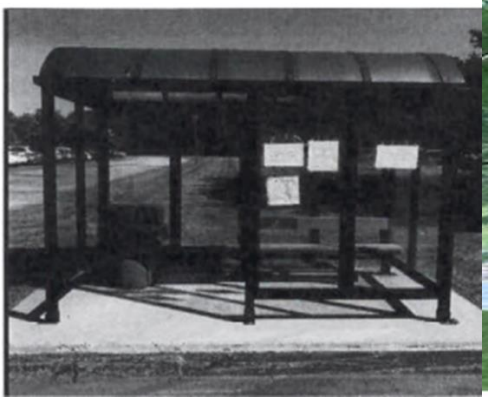
Campus Parking Map



Shuttle Lot Map



The Employee Shuttle Lot is across the street from the Hospital behind the Care One at Concord Facility. If you are coming off Rt. 2 West make a right at the traffic light. If coming Rt. 2 East enter the turning lane at the traffic light and turn left. If coming Old Road to Nine Acre Corner proceed through the traffic light. Make the first right turn into the Care One facility. There is a large sign at the turn (picture below). The lot is beside the shuttle shelter (picture below) and marked (see pictures). Refer to map for additional spaces if first lot is full.



This Organization Participates in E-Verify

Esta Organización Participa en E-Verify

This employer participates in E-Verify and will provide the federal government with your Form I-9 information to confirm that you are authorized to work in the U.S.

If E-Verify cannot confirm that you are authorized to work, this employer is required to give you written instructions and an opportunity to contact Department of Homeland Security (DHS) or Social Security Administration (SSA) so you can begin to resolve the issue before the employer can take any action against you, including terminating your employment.

Employers can only use E-Verify once you have accepted a job offer and completed the Form I-9.

Este empleador participa en E-Verify y proporcionará al gobierno federal la información de su Formulario I-9 para confirmar que usted está autorizado para trabajar en los EE.UU..

Si E-Verify no puede confirmar que usted está autorizado para trabajar, este empleador está requerido a darle instrucciones por escrito y una oportunidad de contactar al Departamento de Seguridad Nacional (DHS) o a la Administración del Seguro Social (SSA) para que pueda empezar a resolver el problema antes de que el empleador pueda tomar cualquier acción en su contra, incluyendo la terminación de su empleo.

Los empleadores sólo pueden utilizar E-Verify una vez que usted haya aceptado una oferta de trabajo y completado el Formulario I-9.

E-Verify Works for Everyone

For more information on E-Verify, or if you believe that your employer has violated its E-Verify responsibilities, please contact DHS.

E-Verify Funciona Para Todos

Para más información sobre E-Verify, o si usted cree que su empleador ha violado sus responsabilidades de E-Verify, por favor contacte a DHS.

888-897-7781

dhs.gov/e-verify

E-VERIFY IS A SERVICE OF DHS AND SSA

English / Spanish Poster

IF YOU HAVE THE RIGHT TO WORK

Don't let anyone take it away.

There are laws to protect you from discrimination in the workplace.

You should know that…

In most cases, employers cannot deny you a job or fire you because of your national origin or citizenship status or refuse to accept your legally acceptable documents.

Employers cannot reject documents because they have a future expiration date.

Employers cannot terminate you because of E-Verify without giving you an opportunity to resolve the problem.

In most cases, employers cannot require you to be a U.S. citizen or a lawful permanent resident.

Contact IER

For assistance in your own language
Phone: 1-800-255-7688
TTY: 1-800-237-2515

Email us
IER@usdoj.gov

Or write to
U.S. Department of Justice – CRT
Immigrant and Employee Rights – NYA
950 Pennsylvania Ave., NW
Washington, DC 20530

If any of these things happen to you, contact the Immigrant and Employee Rights Section (IER).

DEPARTMENT OF JUSTICE
IMMIGRANT & EMPLOYEE RIGHTS SECTION
CIVIL RIGHTS DIVISION

Immigrant and Employee Rights Section

U.S. Department of Justice, Civil Rights Division

www.justice.gov/ier

SI USTED TIENE DERECHO A TRABAJAR

No deje que nadie se lo quite.

Existen leyes que lo protegen contra la discriminación en el trabajo.

Usted debe saber que…

En la mayoría de los casos, los empleadores no pueden negarle un empleo o despedirlo debido a su nacionalidad de origen o estatus de ciudadanía, ni tampoco negarse a aceptar sus documentos válidos y legales.

Los empleadores no pueden rechazar documentos porque tengan una fecha de vencimiento futura.

Los empleadores no pueden despedirlo debido a E-Verify sin darle una oportunidad de resolver el problema

En la mayoría de los casos, los empleadores no pueden exigir que usted sea ciudadano estadounidense o residente legal permanente.

Comuníquese con la IER

Para ayuda en su propio idioma:
Teléfono: 1-800-255-7688
TTY: 1-800-237-2515

Mándenos un correo:
IER@usdoj.gov

O escríbanos a:
U.S. Department of Justice – CRT
Immigrant and Employee Rights – NYA
950 Pennsylvania Ave., NW
Washington, DC 20530

Si alguna de estas cosas le ha sucedido, comuníquese con la Sección de Derechos de Inmigrantes y Empleados (IER, por sus siglas en inglés)

DEPARTAMENTO DE JUSTICIA DE LOS EE. UU.
SECCIÓN DE DERECHOS DE INMIGRANTES Y EMPLEADOS
DIVISIÓN DE DERECHOS CIVILES

Para información en español, visite www.consumerfinance.gov/learnmore o escribe a la Consumer Financial Protection Bureau, 1700 G Street N.W., Washington, DC 20552.

A Summary of Your Rights Under the Fair Credit Reporting Act

The federal Fair Credit Reporting Act (FCRA) promotes the accuracy, fairness, and privacy of information in the files of consumer reporting agencies. There are many types of consumer reporting agencies, including credit bureaus and specialty agencies (such as agencies that sell information about check writing histories, medical records, and rental history records). Here is a summary of your major rights under FCRA. For more information, including information about additional rights, go to www.consumerfinance.gov/learnmore or write to: Consumer Financial Protection Bureau, 1700 G Street N.W., Washington, DC 20552.

- You must be told if information in your file has been used against you. Anyone who uses a credit report or another type of consumer report to deny your application for credit, insurance, or employment – or to take another adverse action against you – must tell you, and must give you the name, address, and phone number of the agency that provided the information.

- You have the right to know what is in your file. You may request and obtain all the information about you in the files of a consumer reporting agency (your "file disclosure"). You will be required to provide proper identification, which may include your Social Security number. In many cases, the disclosure will be free. You are entitled to a free file disclosure if:

    - a person has taken adverse action against you because of information in your credit report;
    - you are the victim of identity theft and place a fraud alert in your file;
    - your file contains inaccurate information as a result of fraud;
    - you are on public assistance;
    - you are unemployed but expect to apply for employment within 60 days.

    In addition, all consumers are entitled to one free disclosure every 12 months upon request from each nationwide credit bureau and from nationwide specialty consumer reporting agencies. See www.consumerfinance.gov/learnmore for additional information.

- You have the right to ask for a credit score. Credit scores are numerical summaries of your credit-worthiness based on information from credit bureaus. You may request a credit score from consumer reporting agencies that create scores or distribute scores used in residential real property loans, but you will have to pay for it. In some mortgage transactions, you will receive credit score information for free from the mortgage lender.

- You have the right to dispute incomplete or inaccurate information. If you identify information in your file that is incomplete or inaccurate, and report it to the consumer reporting agency, the agency must investigate unless your dispute is frivolous. See www.consumerfinance.gov/learnmore for an explanation of dispute procedures.

- Consumer reporting agencies must correct or delete inaccurate, incomplete, or unverifiable information. Inaccurate, incomplete, or unverifiable information must be removed or corrected, usually within 30 days. However, a consumer reporting agency may continue to report information it has verified as accurate.

- Consumer reporting agencies may not report outdated negative information. In most cases, a consumer reporting agency may not report negative information that is more than seven years old, or bankruptcies that are more than 10 years old.

- Access to your file is limited. A consumer reporting agency may provide information about you only to people with a valid need – usually to consider an application with a creditor, insurer, employer, landlord, or other business. The FCRA specifies those with a valid need for access.

- You must give your consent for reports to be provided to employers. A consumer reporting agency may not give out information about you to your employer, or a potential employer, without your written consent given to the employer. Written consent generally is not required in the trucking industry. For more information, go to www.consumerfinance.gov/learnmore.

- You may limit "prescreened" offers of credit and insurance you get based on information in your credit report. Unsolicited "prescreened" offers for credit and insurance must include a toll-free phone number you can call if you choose to remove your name and address form the lists these offers are based on. You may opt out with the nationwide credit bureaus at 1-888-5-OPTOUT (1-888-567-8688).

- The following FCRA right applies with respect to nationwide consumer reporting agencies:

  CONSUMERS HAVE THE RIGHT TO OBTAIN A SECURITY FREEZE

  You have a right to place a "security freeze" on your credit report, which will prohibit a consumer reporting agency from releasing information in your credit report without your express authorization. The security freeze is designed to prevent credit, loans, and services from being approved in your name without your consent. However, you should be aware that using a security freeze to take control over who gets access to the personal and financial information in your credit report may delay, interfere with, or prohibit the timely approval of any subsequent request or application you make regarding a new loan, credit, mortgage, or any other account involving the extension of credit.

  As an alternative to a security freeze, you have the right to place an initial or extended fraud alert on your credit file at no cost. An initial fraud alert is a 1-year alert that is placed on a consumer's credit file. Upon seeing a fraud alert display on a consumer's credit file, a business is required to take steps to verify the consumer's identity before extending new credit. If you are a victim of identity theft, you are entitled to an extended fraud alert, which is a fraud alert lasting 7 years.

  A security freeze does not apply to a person or entity, or its affiliates, or collection agencies acting on behalf of the person or entity, with which you have an existing account that requests information in your credit report for the purposes of reviewing or collecting the account. Reviewing the account includes activities related to account maintenance, monitoring, credit line increases, and account upgrades and enhancements.

- You may seek damages from violators. If a consumer reporting agency, or, in some cases, a user of consumer reports or a furnisher of information to a consumer reporting agency violates the FCRA, you may be able to sue in state or federal court.

- Identity theft victims and active duty military personnel have additional rights. For more information, visit www.consumerfinance.gov/learnmore.

States may enforce the FCRA, and many states have their own consumer reporting laws. In some cases, you may have more rights under state law. For more information, contact your state or local consumer protection agency or your state Attorney General. For information about your federal rights, contact:

TYPE OF BUSINESS:	CONTACT:
1.a. Banks, savings associations, and credit unions with total assets of over $10 billion and their affiliates b. Such affiliates that are not banks, savings associations, or credit unions also should list, in addition to the CFPB:	a. Consumer Financial Protection Bureau 1700 G Street, N.W. Washington, DC 20552 b. Federal Trade Commission Consumer Response Center 600 Pennsylvania Avenue, N.W. Washington, DC 20580 (877) 382-4357
2. To the extent not included in item 1 above: a. National banks, federal savings associations, and federal branches and federal agencies of foreign banks b. State member banks, branches and agencies of foreign banks (other than federal branches, federal agencies, and Insured State Branches of Foreign Banks), commercial lending companies owned or controlled by foreign banks, and organizations operating under section 25 or 25A of the Federal Reserve Act. c. Nonmember Insured Banks, Insured State Branches of Foreign Banks, and insured state savings associations d. Federal Credit Unions	a. Office of the Comptroller of the Currency Customer Assistance Group 1301 McKinney Street, Suite 3450 Houston, TX 77010-9050 b. Federal Reserve Consumer Help Center P.O. Box 1200 Minneapolis, MN 55480 c. FDIC Consumer Response Center 1100 Walnut Street, Box #11 Kansas City, MO 64106 d. National Credit Union Administration Office of Consumer Financial Protection (OCFP) Division of Consumer Compliance Policy and Outreach 1775 Duke Street Alexandria, VA 22314
3. Air carriers	Asst. General Counsel for Aviation Enforcement & Proceedings Aviation Consumer Protection Division Department of Transportation 1200 New Jersey Avenue, S.E. Washington, DC 20590
4. Creditors Subject to the Surface Transportation Board	Office of Proceedings, Surface Transportation Board Department of Transportation 395 E Street, S.W. Washington, DC 20423
5. Creditors Subject to the Packers and Stockyards Act, 1921	Nearest Packers and Stockyards Administration area supervisor
6. Small Business Investment Companies	Associate Deputy Administrator for Capital Access United States Small Business Administration 409 Third Street, S.W., Suite 8200 Washington, DC 20416
7. Brokers and Dealers	Securities and Exchange Commission 100 F Street, N.E. Washington, DC 20549
8. Federal Land Banks, Federal Land Bank Associations, Federal Intermediate Credit Banks, and Production Credit Associations	Farm Credit Administration 1501 Farm Credit Drive McLean, VA 22102-5090
9. Retailers, Finance Companies, and All Other Creditors Not Listed Above	Federal Trade Commission Consumer Response Center 600 Pennsylvania Avenue, N.W. Washington, DC 20580 (877) 382-4357

Emerson Hospital

Adult Occupational Immunizations
Massachusetts Recommendations and Requirements for 2020/2021

Vaccine	Recommendations in Brief
Influenza	1 dose of flu vaccine every flu season
Tdap/Td (Tetanus, diphtheria, pertussis)	1 dose of Tdap as soon as possible, then Td boosters every 10 years
MMR (Measles, mumps, rubella)	2 doses of MMR, > 28 days apart or documented laboratory-confirmed immunity to measles **and** mumps **and** rubella
Varicella	2 doses of varicella vaccine, or serologic proof of immunity, or history of varicella disease
Hepatitis B	3-dose series (see footnote)
Meningococcal	1 dose of quadrivalent meningococcal vaccine for microbiologists who are routinely exposed to *N. meningitidis* isolates. Booster every 5 years

Health care personnel (HCP) include full- and part-time staff with or without direct patient contact, including physicians, students, and volunteers who work in inpatient, outpatient and home-care settings. See Immunization of Health-Care Personnel - Recommendations of the ACIP. https://www.cdc.gov/mmwr/preview/mmwrhtml/rr6007a1.htm

Influenza: All HCP should receive annual flu vaccine. Give live, attenuated influenza vaccine (LAIV) to non-pregnant healthy HCP < 49 years of age. TIV is preferred over LAIV for HCP in close contact with severely immunosuppressed persons when patients require a protective environment.

Tetanus/Diphtheria/Pertussis (Td/Tdap): All HCP, regardless of age, should receive a single dose of Tdap as soon as feasible if they have not previously received Tdap, and regardless of the interval since last Td dose.

Measles, Mumps, Rubella (MMR): All HCP should be have presumptive evidence of immunity to measles, mumps, and rubella. Documentation of immunity: a) 2 doses of MMR at least 28 days apart; or b) laboratory evidence of immunity to measles **and** mumps **and** rubella or laboratory confirmation of each disease.

Varicella: All HCP should be immune to Varicella. Evidence of immunity to varicella for HCP includes: documentation of 2 doses of vaccine, > 4 weeks apart; laboratory evidence of immunity or laboratory confirmation of disease; diagnosis of history of varicella disease or herpes zoster by a health-care provider.

Hepatitis B: HCP should receive 3 doses hepatitis B vaccine on a 0, 1, and 6 month schedule. Test for hepatitis B surface antibody (anti-HBs) 1–2 months after 3rd dose to document immunity. HCP and trainees in certain populations at high risk for chronic hepatitis B (e.g., those born in countries with high and intermediate endemicity) should be tested for HBsAg and anti-HBc/anti-HBs to determine infection status.

Meningococcal: A single dose of MCV4 is recommended for microbiologists 55 years and younger who may routinely be exposed to isolates of N. meningitides. A booster dose should be given every 5 years while exposed. Health-care personnel over the age of 55 who have any of the above risk factors for meningococcal disease should be vaccinated with MPSV4.

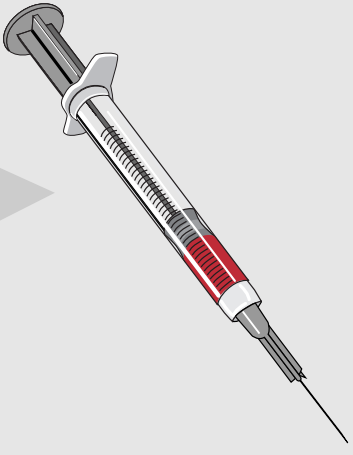
These guidelines are based on the recommendations of the Advisory Committee on Immunization Practices (ACIP). For specific ACIP recommendations, refer to the full statements at https://www.cdc.gov/mmwr/preview/mmwrhtml/rr6007a1.htm visit the MDPH website at www.mass.gov/dph/imm; or call MDPH 617-983-6800.

National Institute for Occupational Safety and Health

NIOSH

What *Every Worker Should Know*

How to Protect Yourself From Needlestick Injuries



U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Public Health Service
Centers for Disease Control and Prevention
National Institute for Occupational Safety and Health

CDC
CENTERS FOR DISEASE CONTROL AND PREVENTION

DEPARTMENT OF HEALTH

U.S. Department of Health and Human Services
Public Health Service
Centers for Disease Control and Prevention
National Institute for Occupational Safety and Health
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What infections can be caused by needlestick injuries?

Needlestick injuries can expose workers to a number of blood-borne pathogens that can cause serious or fatal infections. The pathogens that pose the most serious health risks are

- Hepatitis B virus (HBV)
- Hepatitis C virus (HCV)
- Human immunodeficiency virus (HIV)—the virus that causes AIDS

HBV vaccination is recommended for all health care workers (unless they are immune because of previous exposure). HBV vaccine has proved highly effective in preventing infection in workers exposed to HBV. However, no vaccine exists to prevent HCV or HIV infection.

Preventing needlestick injuries is the best way to protect yourself from these infections.

Who is at risk of needlestick injury?

Any worker who may come in contact with needles is at risk, including ***nursing staff, lab workers, doctors, and housekeepers.***

How common are needlestick injuries among health care workers?

Estimates indicate that 600,000 to 800,000 needlestick injures occur each year. Unfortunately, about half of these injuries are not reported. ***Always report needlestick injuries to your employer to ensure that you receive appropriate followup care***.

What kinds of needles usually cause needlestick injuries?

- Hypodermic needles
- Blood collection needles
- Suture needles
- Needles used in IV delivery systems

Do certain work practices increase the risk of needlestick injury?

Yes. Past studies have shown that needlestick injuries are often associated with these activities:

- Recapping needles
- Transferring a body fluid between containers
- Failing to dispose of used needles properly in puncture-resistant sharps containers

How can I protect myself from needlestick injuries?

- Avoid the use of needles where safe and effective alternatives are available.
- Help your employer select and evaluate devices with safety features that reduce the risk of needlestick injury.
- Use devices with safety features provided by your employer.
- Avoid recapping needles.
- Plan for safe handling and disposal of needles before using them.
- Promptly dispose of used needles in appropriate sharps disposal containers.
- Report all needlestick and sharps-related injuries promptly to ensure that you receive appropriate followup care.
- Tell your employer about any needlestick hazards you observe.
- Participate in training related to infection prevention.
- Get a hepatitis B vaccination.

For additional information, see ***NIOSH Alert: Preventing Needlestick Injuries in Health Care Settings*** [DHHS (NIOSH) Publication No. 2000-108]. Single copies of the Alert are available from the following:

NIOSH-Publications Dissemination
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Needlestick injuries can lead to serious or fatal infections. Health care workers who use or may be exposed to needles are at increased risk of needlestick injury. All workers who are at risk should take steps to protect themselves from this significant health hazard.