

Barrow Regional Medical Center
NEW HIRE CHECKLIST

Please print the documents listed below, review, sign and bring with you on the day of your scheduled pre-employment screening. All documents must be completed in their entirety. You will also need to bring a copy of your driver license, social security card, and any license or certifications that you have pertaining to your job.

Documents required for pre-employment screening:

- Application (completed online at www.barrowregional.com)
- Driver license (current)
- Social Security Card
- License/Certifications (current for job you have applied for if applicable)
- I-9 Form
- Employee Nondisclosure Agreement Form
- Benefits Summary Signature Form
- COBRA: Initial Notice Signature Form
- Acknowledgement of Drug-Free Workplace Policy & Procedure
- Post-Offer Pre-Employment Drug Testing Consent Form
- W-4 Form
- State of Georgia Tax Form
- Retirement Automatic Enrollment (401k) Notice Form
- Cafeteria Charge Form (if applicable)
- Investigative Consumer Report Form
- 8850 Form
- Self Identification Form
- Direct Deposit Form (please include a copy of a cancelled check)
- Emergency Contact Form
- Beneficiary Form

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

Form I-9, Employment Eligibility Verification

Read instructions carefully before completing this form. The instructions must be available during completion of this form.

ANTI-DISCRIMINATION NOTICE: It is illegal to discriminate against work-authorized individuals. Employers CANNOT specify which document(s) they will accept from an employee. The refusal to hire an individual because the documents have a future expiration date may also constitute illegal discrimination.

Section 1. Employee Information and Verification *(To be completed and signed by employee at the time employment begins.)*

Print Name: Last	First	Middle Initial	Maiden Name
Address <i>(Street Name and Number)</i>		Apt. #	Date of Birth <i>(month/day/year)</i>
City	State	Zip Code	Social Security #

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

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

- A citizen of the United States
- A noncitizen national of the United States (see instructions)
- A lawful permanent resident (Alien #) _____
- An alien authorized to work (Alien # or Admission #) _____ until (expiration date, if applicable - month/day/year)

Employee's Signature	Date <i>(month/day/year)</i>
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Preparer and/or Translator Certification *(To be completed and signed if Section 1 is prepared by a person other than the employee.) I attest, under penalty of perjury, that I have assisted in the completion of this form and that to the best of my knowledge the information is true and correct.*

Preparer's/Translator's Signature	Print Name
Address <i>(Street Name and Number, City, State, Zip Code)</i>	
Date <i>(month/day/year)</i>	

Section 2. Employer Review and Verification *(To be completed and signed by employer. Examine one document from List A OR examine one document from List B and one from List C, as listed on the reverse of this form, and record the title, number, and expiration date, if any, of the document(s).)*

List A	OR	List B	AND	List C
Document title: _____	:	_____	:	_____
Issuing authority: _____	:	_____	:	_____
Document #: _____	:	_____	:	_____
Expiration Date <i>(if any)</i> : _____	:	_____	:	_____
Document #: _____	:	_____	:	_____
Expiration Date <i>(if any)</i> : _____	:	_____	:	_____

CERTIFICATION: I attest, under penalty of perjury, that I have examined the document(s) presented by the above-named employee, that the above-listed document(s) appear to be genuine and to relate to the employee named, that the employee began employment on *(month/day/year)* _____ and that to the best of my knowledge the employee is authorized to work in the United States. (State employment agencies may omit the date the employee began employment.)

Signature of Employer or Authorized Representative	Print Name	Title
Business or Organization Name and Address <i>(Street Name and Number, City, State, Zip Code)</i>		Date <i>(month/day/year)</i>

Section 3. Updating and Reverification *(To be completed and signed by employer.)*

A. New Name <i>(if applicable)</i>	B. Date of Rehire <i>(month/day/year) (if applicable)</i>
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C. If employee's previous grant of work authorization has expired, provide the information below for the document that establishes current employment authorization.

Document Title: _____	Document #: _____	Expiration Date <i>(if any)</i> : _____
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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 document(s), the document(s) I have examined appear to be genuine and to relate to the individual.

Signature of Employer or Authorized Representative	Date <i>(month/day/year)</i>
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LISTS OF ACCEPTABLE DOCUMENTS

All documents must be unexpired

LIST A

**Documents that Establish Both
Identity and Employment
Authorization**

LIST B

**Documents that Establish
Identity**

LIST C

**Documents that Establish
Employment Authorization**

OR

AND

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. Social Security Account Number card other than one that specifies on the face that the issuance of the card does not authorize employment in the United States
2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551)		2. Certification of Birth Abroad issued by the Department of State (Form FS-545)
3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa	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	3. Certification of Report of Birth issued by the Department of State (Form DS-1350)
4. Employment Authorization Document that contains a photograph (Form I-766)	3. School ID card with a photograph	4. 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. Voter's registration card	
5. In the case of a nonimmigrant alien authorized to work for a specific employer incident to status, a foreign passport with Form I-94 or Form I-94A bearing the same name as the passport and containing an endorsement of the alien's nonimmigrant status, as long as the 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. Native American tribal document
	6. Military dependent's ID card	
	7. U.S. Coast Guard Merchant Mariner Card	
	8. Native American tribal document	
	9. Driver's license issued by a Canadian government authority	
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	For persons under age 18 who are unable to present a document listed above:	6. U.S. Citizen ID Card (Form I-197)
	10. School record or report card	7. Identification Card for Use of Resident Citizen in the United States (Form I-179)
	11. Clinic, doctor, or hospital record	
	12. Day-care or nursery school record	

Illustrations of many of these documents appear in Part 8 of the Handbook for Employers (M-274)

Health Management Associates, Inc.

EMPLOYEE NONDISCLOSURE AGREEMENT

The undersigned employee recognizes and acknowledges:

That the services the hospital performs for its patients are confidential and that to enable the hospital to perform those services, its patients furnish to the hospital confidential information concerning their affairs; that the good will of the hospital depends, among other things, upon its keeping such services and information confidential; and that by reason of the employee's duties, the employee may come into possession of patient information or information concerning the services performed by the hospital for its patients, even though the employee does not take any direct part in or furnish the services performed for those patients.

The employee accordingly agrees that, except as directed by the hospital, the employee will not at any time during or after his/her employment by the hospital disclose any of such services or information to any person whatsoever, or permit any person whatsoever to examine or make copies of any reports or other documents prepared by the employee, or coming into his/her possession under his/her control, that have in any way to do with the patients of the hospital. The employee recognizes that the disclosure of information by the employee may give rise to irreparable injury to the hospital or to the owner of such information, and that, accordingly, the hospital or the owner of such information may seek any legal remedies against the employee which may be available. Disclosure of information by the employee will result in cause for immediate termination.

The employee further agrees that he/she will at all times comply with all hospital and Health Management Associates, Inc. policies and security regulations in effect from time to time for all materials belonging or relating to the hospital or Health Management Associates, Inc.

I have read all of this Agreement, I understand it, and agree to abide by its terms.

AGREED TO AND ACCEPTED ON _____, 20 ____

BY: _____
Employee

WITNESSES: _____

**Barrow Regional Medical Center
BENEFIT SUMMARY
2009 BENEFITS**

MEDICAL INSURANCE

- Eligible Employees: Full time employees (minimum of 64 hours ppp)
- Premiums are on a pre-tax basis, which effectively reduces the cost to the employee.

Major Medical Plan: Plan A and Plan B. Exactly the same except for deductible, co-insurance, and out-of-pocket maximum.

Plan A

\$250 deductible (\$500 family deductible)
80%/20% co-insurance
Out-of-pocket maximums:
- \$2000 individual
- \$4000 family
\$250 per admission co-pay to HMA facility

Plan B

\$500 deductible (\$1000 family deductible)
70%/30% co-insurance
Out-of-pocket maximums:
- \$2400 individual
- \$4800 family
\$250 per admission co-pay to HMA facility

- **Must use HMA facility for non-emergency admission if services are available or plan pays \$0. If emergency, may use any hospital.**
- **Exclusions to coverage do apply, consult Blue Cross/Blue Shield member services to ensure coverage.**
- For services not available at BRMC, you must use the Blue Cross/Blue Shield Network or you are penalized to 60%/40% coverage, 50%/50% for Plan B and out of pocket maximums are doubled.
- You may use any other HMA hospital to receive in-network benefits.
- Must use HMA for outpatient procedures over \$500 if service is available or plan pays \$0 (excluding surgery in physician's office)
- Most hospital services (Ex. X-Ray, lab, etc) provided by BRMC paid at 100% with no deductible. Exclusions do apply, please consult your member booklet.
- ER services provided at HMA facility 100%, with no deductible.
- Pre-existing conditions do apply. Under most circumstances pre-existing rule can be waived if a certificate of creditable coverage from your former insurance company is provided to BCBS. Please consult your plan booklet.
- Pre-certification required, details on ID card.
- For details on plan, READ PLAN BOOKLET and the enclosed amendments.
- **MUST HAVE REFERRAL AND APPROVAL FOR SERVICES NOT PROVIDED AT AN HMA FACILITY.**

Employee Premium (per pay period)	Plan A	Plan B
Employee Only:	\$37.00	\$32.00
Employee and Children:	\$91.50	\$70.50
Family:	\$111.00	\$90.00

CAREMARK:

- Caremark provides a separate prescription drug card program for all eligible employees with health insurance coverage. Payment for prescription drugs occurs at the time the prescription is filled at a participating pharmacy, subject to a:
 - \$50 annual deductible (\$100 family deductible), and the following co-payments:
 - Generic Prescription (must use if available) \$8.00
 - Preferred Brand Prescription
 - (if generic not available): \$20.00
 - Non-Preferred Brand Prescription
 - (if generic not available): \$35.00
- A mail order pharmacy program is available for those who wish to receive a 90-day supply of covered medications. Once the deductible is met, you pay the following co-payment per mail order prescription:
 - Generic Prescription (must use if available) \$16.00
 - Preferred Brand Prescription
 - (if generic not available): \$40.00
 - Non-Preferred Brand Prescription
 - (if generic not available): \$70.00
- The prescription drug card program is tailored around the use of generic drugs. You will still be able to receive brand name drugs, but, when a generic is available, you must use it or it will cost you more.

DENTAL INSURANCE

- Eligible employees: Full time employees (64 hours per pay period).
- Preventative dental covered 100% in or out-of-network
- \$50 deductible per individual up to three per family.
- Waiting period required.
- Premiums paid on a pre-tax basis, which effectively reduces cost to employee.
- The self insured dental plan is a Dental PPO administered by CIGNA. Participants can visit any dentist in or out of the CIGNA Preferred Provider Network. Participants that visit a network provider will have a lower co-payment responsibility than if they visit a non-network provider. There is no referral required to see a specialist.
- **Dental Premiums:**
 - **Employee Only:** \$10.50 per pay period.
 - **Employee and Child(ren):** \$17.25 per pay period.
 - **Family:** \$24.25 per pay period.

LIFE INSURANCE

(Basic Term Insurance and AD&D)

- Eligible Employees: Full time employees (minimum of 64 hours per pay period)
- Benefit provided at no cost to employees
- One times base salary (non-exempt employees)
- Two times base salary (exempt employees)

OPTIONAL LIFE

- Eligible Employees: Full-time employees (minimum of 64 hours per pay period)
- Two Times annual salary
- Employee pays cost of \$.21 per \$1000 coverage per month.
 - (example: salary of \$20,000 provides \$40,000 of coverage per year at \$3.88 per pay period)
- Dependent life for full-time employees: spouse \$25,000, children \$10,000 each. Cost is \$4.52 per pay period.

LONG-TERM DISABILITY

- UNUM plan
- After 6 months
- Step rates age based

SHORT-TERM DISABILITY

- UNUM plan
- After 30 days
- \$1.44 per hundred of monthly covered payroll

VISION INSURANCE

- Coverage by Vision Service Plan (VPS)
- Premiums:
 - Employee Only: \$3.63
 - Employee and Spouse: \$5.91
 - Employee and Child(ren): \$6.06
 - Employee and family: \$9.39

Barrow Regional Medical Center
BENEFIT SUMMARY

I have received and understand the Benefits Summary for Barrow Regional Medical Center. I understand that my benefits begin 30 days after full time employment and that it is my responsibility to provide the Human Resource department with my benefit elections on or before my 30 days of full time employment. If I fail do so, I understand that my next option to enroll in benefits is during annual enrollment with an effective date of January 20_____.

Employee Signature

Date

Print Name

COBRA - INITIAL Notice
*** VERY IMPORTANT NOTICE ***

A federal law, called COBRA, requires that most employers sponsoring group health plans (e.g., medical, dental, vision) offer employees and their families the opportunity for a temporary extension of health coverage (called "continuation coverage") at group rates in certain instances where plan coverage would otherwise end. This notice is intended to inform you, in a summary fashion, of your rights and obligations under the continuation of coverage provisions of COBRA. (Both you and your spouse should take the time to read this notice carefully.)

When You Are Eligible for COBRA

If you are an employee of Health Management Associates and are covered under the group medical or dental plan (the "Plan"), you have the right to choose this continuation coverage if you lose your group health coverage because of a reduction in your hours of employment, or the termination of employment (for reasons other than gross misconduct on your part), or at the end of a leave under the Family and Medical Leave Act. If you are a covered retiree, you have a right to continuation coverage if your Employer has filed for reorganization under Chapter 11 of the Bankruptcy Code.

If you are the covered spouse of an employee (or a retiree for number 5 below) covered by the Plan, you have the right to choose continuation of coverage for yourself if you lose group health coverage under the Plan for any of the following five reasons:

1. The death of your spouse;
2. The termination of your spouse's employment (for reasons other than gross misconduct) or reduction in your spouse's hours of employment;
3. Divorce or legal separation from your spouse;
4. Your spouse becomes entitled (that is, covered) under Medicare; or
5. Your spouse's employer filed for reorganization under Chapter 11 of the Bankruptcy Code and your spouse was covered by the Plan on the day before the commencement of bankruptcy proceedings and was retired from the employer.

In the case of a covered dependent child of an employee (or a retiree for number 6 below) covered by the Plan, he or she has the right to continuation coverage if group health coverage under the Plan is lost for any of the following six reasons:

1. The death of the covered parent;
2. The termination of the covered parent's employment (for reasons other than gross misconduct) or reduction in the covered parent's hours of employment with Health Management Associates;
3. Covered parents' divorce or legal separation;
4. The covered parent becomes entitled (that is, covered) under Medicare;
5. The dependent ceases to be a "dependent child" under the Plan; or
6. The covered parent's employer files for reorganization under Chapter 11 of the Bankruptcy Code.

Notice Requirements

Under COBRA, the employee or family member has the responsibility to inform [Plan Administrator] of a divorce, legal separation, or a child losing dependent status under the Plan. Such notice must be sent within 60 days after the later of: (a) the date of any such qualifying event, or (b) the date the qualified beneficiary would lose coverage on account of the qualifying event. If notice is not received within that 60-day period, the dependent will not be entitled to choose continuation coverage.

Health Management Associates has the responsibility to notify the Plan Administrator of the employee's death, termination of employment or reduction in hours, or Medicare entitlement.

When the Plan Administrator is notified that one of these events has happened, the Plan Administrator will in turn have 14 days to notify the affected family members of their rights to choose continuation coverage. Under COBRA, you have 60 days from the date coverage would be lost because of one of the events described above, or the date of receipt of notice, if later, to inform the Plan Administrator of your election of continuation coverage.

If you do not choose continuation coverage within the 60-day election period, your group health coverage will end as of the date of the qualifying event.

If you choose continuation coverage, Health Management Associates is required to provide coverage which, as of the time coverage is being provided, is identical to the coverage provided under the Plan to similarly situated employees or family members. This means that if the coverage for similarly situated employees or family members is modified, your coverage will be modified.

How Long COBRA Coverage Will Continue

Duration of COBRA Coverage: COBRA requires that you be offered the opportunity to maintain continuation coverage for 18 months if you lose coverage under the Plan due to the employee's termination (for a reason other than gross misconduct) or a reduction in work hours. An employee's covered spouse and/or dependents are required to be offered the opportunity to maintain continuation coverage for 36 months if coverage is lost under the Plan because of an event other than the employee's termination or a reduction in work hours.

Multiple Qualifying Events: If, during an 18-month period of coverage continuation, another event takes place that would also entitle a qualified beneficiary (other than the employee) to their own continuation coverage (for example, the former employee dies, is divorced or legally separated or becomes entitled to Medicare, or a dependent ceases to be a "dependent child" under the Plan), the continuation coverage may be extended for the affected qualified beneficiary. However, in no case will any period of continuation coverage be more than 36 months.

Adding a New Dependent: If you are a former *employee* and you have a newborn or adopted child while you are on COBRA continuation and you enroll the new child for coverage, the new child will be considered a "qualified beneficiary" rather than merely an after-acquired dependent. This gives the child additional rights, such as the right to continue COBRA benefits even if you die during the COBRA period, and the right to an additional 18 months of coverage if a second qualifying event occurs during the initial 18-month COBRA period following your termination or retirement.

COBRA Extension for Disability: If you are entitled to 18 months of continuation coverage, and if the Social Security Administration determines that you were disabled *within 60 days after the date of the qualifying event*, you are eligible for an additional 11 months of continuation coverage after the expiration of the 18 month period. To qualify for this additional period of coverage, you must notify the Plan Administrator within 60 days after receiving a disability determination from the Social Security Administration, and such notice must be given before the end of the initial 18 months of continuation coverage. If the individual entitled to the disability extension has non-disabled family members who are qualified beneficiaries and have COBRA coverage, those non-disabled qualified beneficiaries will also be entitled to this 11-month disability extension. During the additional 11 months of continuation coverage, the premium for that coverage will be 150% of the applicable premium for all covered family members if the disabled individual is part of the COBRA unit. However, if the disabled individual is not part of the COBRA unit, the rate for other covered family members will continue to be only 102% of the applicable premium.

Early Termination of COBRA: The law also provides that your continuation coverage may be cut short for any of the following four reasons:

1. The Employer no longer provides group health coverage to any of its employees;
2. The premium for your continuation coverage is not paid in a timely fashion;
3. After electing COBRA, you become covered under another group health plan (unless that other plan contains an exclusion or limitation with respect to any pre-existing condition affecting you or a covered dependent); or
4. After electing COBRA, you become entitled (that is, covered) under Medicare.

However, if, prior to electing COBRA, you become covered under Medicare or under another group health plan, you will still be eligible to elect COBRA under this plan.

Additional Information

If there is a choice among types of coverage under the plan, each qualified beneficiary who is eligible for continuation of coverage is entitled to make a separate election among the types of coverage. Thus, a spouse or dependent child who is a qualified beneficiary is entitled to elect continuation of coverage even if the covered employee does not make that election. Similarly, at a subsequent open enrollment, a spouse or dependent child may elect a different coverage from the coverage the employee elects.

You do not have to provide proof of insurability to obtain continuation coverage. However, under COBRA, you will have to pay all of the premium (both employer and employee portion) for your continuation coverage, plus a 2% administrative fee. You will have an initial grace period of 45 days (starting with the date you choose continuation coverage) to pay any premiums then due; after that initial 45-day grace period, you will have a grace period of 30 days to pay any subsequent premiums. (COBRA also says that during the last 180 days of your continuation coverage period, you must be allowed to enroll in an individual conversion health plan if one is provided by the Plan. However, conversion coverage is not available if the group contract terminates or the employer goes out of business, and it may be available if the plan is self-insured. Call the Plan Administrator during your last 180 days of COBRA for information on conversion.)

**Barrow Regional Medical Center
COBRA NOTIFICATION**

I have received and understand the COBRA notification of benefits for Barrow Regional Medical Center.

Employee Signature

Date

Print Name

BARROW REGIONAL MEDICAL CENTER
POLICY AND PROCEDURE

DRUG- FREE WORKPLACE	DEPARTMENT HR	Policy # HR-010	Page No. 1 of 5
	REVIEWED 09/06, 09/08, 07/09	DATE EFFECTIVE 09/06, 09/08, 07/09	DATE REVISED 09/06, 09/08, 07/09
	APPROVED BY:		APPROVED BY:

PURPOSE:

To deter the use of drugs and alcohol in the workplace by establishing a drug-free workplace program in accordance with the State of Georgia requirements.

POLICY:

It is a condition of employment to refrain from taking drugs on or off the job. All Barrow Regional Medical Center employees are expected to report to work and perform their duties without any effects due to the use or abuse of any drug, medication or alcohol. Possession and/or use by an employee of an illegal, un-prescribed, controlled drug or usage of an unauthorized alcoholic beverages is prohibited on BRMC premises.

It shall be the policy of BRMC to provide each prospective employee and employee a written copy of this Drug-Free Workplace program (hereinafter "Program").

BRMC will not discriminate against any prospective employees because of past abuse of drugs or alcohol. It is the current abuse of drugs and alcohol that will not be tolerated.

BRMC's drug testing program and procedures shall be conducted in compliance with Georgia's Drug-Free Workplace program statutes, Ga. Code Ann.34-9-410 et seq.

A. Drugs

Employees are absolutely prohibited from using, possessing, distributing, manufacturing, selling, attempting to sell or purchase or being under the influence of illegal drugs or inhalants while on or off duty or while on BRMC property. Employees who violate this Program will be subject to disciplinary action, up to and including termination. As used in this Program, an "illegal drug" is any drug: (1) which is not legally obtainable; (2) which may be legally obtainable but has not been legally obtained or (3) which is being used in a manner or for a purpose other than as prescribed. The term drug shall include all forms of alcohol, amphetamines, cannabinoids, cocaine, phencyclidine (PCP), methaqualone, methaqualene, opiates, barbiturates, benzodiazepines, propoxyphene, or a metabolite of any of the substances listed herein.

B. Alcohol

All employees are absolutely prohibited from using, possessing, distributing, manufacturing, selling, attempting to sell or purchase or be under the influence of alcohol while on duty or while on BRMC property. Any employee who violates this Program will be subject to disciplinary action, up to and including, termination. For the purposes of this program, alcohol includes ethyl alcohol, hydrated oxide of ethyl, distilled spirits, wine, malt beverages and intoxicating liquors.

C. Prescription Drugs

Employees must notify their supervisor when under any medication that may limit their ability to perform their job duties. Verification of any and all medication may be required. Where prescription medication is involved, verification may include the employee submitting a prescription copy and/or physician's statement showing the medication is required and dates of use. Failure to do so may result in disciplinary action, up to and including, termination.

BARROW REGIONAL MEDICAL CENTER
POLICY AND PROCEDURE

DRUG- FREE WORKPLACE	DEPARTMENT HR	Policy # HR-010	Page No. 2 of 5
	REVIEWED 09/06, 09/08, 07/09	DATE EFFECTIVE 09/06, 09/08, 07/09	DATE REVISED 09/06, 09/08, 07/09
	APPROVED BY:		APPROVED BY:

D. Employee Assistance Program

An employee who has a drug or alcohol dependency problem should seek employee assistance information through the Human Resources Department. Because chemical dependencies are treatable, employees seeking help for a drug or alcohol problem, voluntarily or through disciplinary action, may be eligible for health benefits and/or sick time. The employee may also request a leave of absence in writing, for the purpose of rehabilitation.

E. Drug and Alcohol Testing

Pursuant to the requirement of the Drug-Free Workplace Program, BRMC shall conduct tests for any and all of the drugs and alcohol listed in paragraphs 2a and 2b of the policy.

BRMC will conduct the following types of tests:

(1) Post-Offer/Pre-Employment Prospective Employees

All prospective employees must submit to a drug test and execute the “Post-Offer/Pre-Employment Drug Testing Consent and Release” Form, HR 0041. The refusal to submit to a substance abuse test or a positive confirmed test will terminate the hiring process.

(2) Reasonable Suspicion

BRMC will conduct a “reasonable suspicion” drug and/or alcohol test whenever BRMC’s Human Resources Department has determined there is “reasonable suspicion” to believe an employee may be using drugs and/or alcohol in violation of BRMC’s policy, based on an employee’s appearance, behavior, conduct, speech or body odors. All decisions to require an employee to submit to a “reasonable suspicion” test will be made in accordance with the Company’s “Guidelines for Making Reasonable Suspicion Determinations.”

When at least one supervisor or manager believes there is “reasonable suspicion” to test an employee, the following procedures should be *immediately* followed:

- Step 1: Immediately complete the “Reasonable Suspicion Drug and/or Alcohol Test Report” form, which documents the Company’s basis for its determination to test.
- Step 2: Discuss your observations with Human Resources in order to determine if Human Resources agrees with your observations.
- Step 3: If Human Resources disagrees with your observations (or is not available), **immediately contact the Hospital Administrator-On-Call to discuss your determination. Remember, no testing is to be conducted without the prior approval of the Human Resources Department or the Administrator-On-Call.**
- Step 4: If the Human Resources Department agrees with your determination and authorizes the test to be conducted, have the employee come to your office and, in the presence of Human Resources or another supervisor if Human Resources is not available (a second witness is recommended), read the following statement to the employee:

“[I] [We] have been observing your [appearance], [behavior], [conduct], [speech] and/or [body odor] and it appears that you have been using drugs and/or alcohol. In accordance with BRMC’s Drug-Free Workplace Policy, BRMC has the right to test you. As a condition of your employment, you have agreed to submit to such tests immediately. **You will be suspended while awaiting your drug and/or alcohol test result.** Although you have a right to refuse to submit to the test, if you do, you are subject to disciplinary action, including immediate termination of employment. Do you understand? Do you have anything to say?”

BARROW REGIONAL MEDICAL CENTER
POLICY AND PROCEDURE

DRUG- FREE WORKPLACE	DEPARTMENT HR	Policy # HR-010	Page No. 3 of 5
	REVIEWED 09/06, 09/08, 07/09	DATE EFFECTIVE 09/06, 09/08, 07/09	DATE REVISED 09/06, 09/08, 07/09
	APPROVED BY:		APPROVED BY:

- Step 5: If the employee consents to be tested:
 - (i) Receipt: Provide the employee with a copy of the Drug-Free Workplace Policy to review and an “Acknowledgment of Drug-Free Workplace Policy” to sign.
 - (ii) Escort: Advise the employee that he/she will be escorted to the collection site and also escorted home following the drug and/or alcohol test. Also advise the employee that if he/she refuses to be escorted, either to or from the site, he/she is subject to disciplinary action, up to and including termination of employment.
 - (iii) Contact with MRO and Company: Remind employees who are being drug tested of the need to be available for contact from BRMC’s medical review officer (MRO) and/or Human Resources to discuss a test result, if necessary. If an employee will be away from his/her home, advise the employee that he/she is responsible for calling the MRO’s office periodically after the test is conducted to obtain the test result and also responsible for calling Human Resources to advise where the employee can be reached in the event the MRO or Company needs to contact the employee to discuss the test result.

- Step 6: If the employee refuses to be escorted:
 - (i) Have the employee wait in your office with another supervisor and go to Step 7.
 - (ii) Complete the section of the “Reasonable Suspicion Drug and/or Alcohol Test Report” form which documents that the employee refused to submit to the test and/or refused to be escorted. If the refusal was witnessed by another supervisor, that supervisor should document the refusal as well.

- Step 7: Regardless of whether the employee consents or refuses to be escorted to the test site, immediately contact the employee’s spouse or another family member, domestic partner, or emergency contact person, or make other arrangements for transporting the employee home from the collection site or worksite. In the event you are unable to contact the employee’s spouse, another family member, domestic partner or other emergency contact, you must make other arrangements for transporting the employee home. In the event the employee refuses this assistance, advise the employee that the Company will take the measures it deems appropriate to transport the employee home. **REMEMBER**: When conducting a “reasonable suspicion” alcohol test, a negative alcohol test result would only rule out that alcohol use was not the underlying cause for the employee’s conduct. Therefore, if an alcohol test is the only test taken, unless there is sound evidence upon which to conclude that there is no longer any reason to continue questioning the employee’s fitness, the Company will still have need to escort the employee home following an alcohol test even if the employee’s test result is negative.
 - (3) Follow-up
If an employee, in the course of his/her employment, enters an employee assistance program as a result of a positive test, BRMC will require the employee to submit to a substance abuse testing without notice as a follow-up to such program. Testing shall be at least once a year for up to two (2) years after completion of the program with no advance notice to the testing date to the employee. The employee must execute the “Consent for Follow-Up Drug Screening, “ Form HR 0043.
 - (4) Post-Accident Testing
An employee who is involved in an accident while at work, which results in bodily injury to himself/herself or another person, or which results in property damage, or which results in loss of work time, will be required to submit to testing. He/she will be asked to execute the “Consent for Reasonable Suspicion and/or Workers’ Compensation Drug Screening,” Form HR 0042. Post- Accident Testing must be completed by the end of the employees scheduled shift or disciplinary action, up to and including termination, may occur.

BARROW REGIONAL MEDICAL CENTER
POLICY AND PROCEDURE

DRUG- FREE WORKPLACE	DEPARTMENT HR	Policy # HR-010	Page No. 4 of 5
	REVIEWED 09/06, 09/08, 07/09	DATE EFFECTIVE 09/06, 09/08, 07/09	DATE REVISED 09/06, 09/08, 07/09
	APPROVED BY:		APPROVED BY:

F. Refusal To Test

An employee who refuses to submit to a test for drugs or alcohol may be discharged from employment or otherwise disciplined.

G. Use of Prescription Drugs

Prior to testing, employees and prospective employees will be given the opportunity to record any information he/she considers relevant to the test, including identification of prescription or non-prescription medications or other relevant medical information which might be taken into account in interpreting a positive confirmed result.

H. Confidentiality

All information, interviews, reports, statement memoranda and substance abuse test results, written or otherwise, received by BRMC through this substance abuse testing program are confidential communications and will be maintained as part of each employee’s medical record file.

BRMC shall keep all information concerning substance abuse test results confidential. The release of such information shall be pursuant to a voluntary written consent form signed by the person tested, unless such release or use is compelled or authorized by state or federal law.

I. Collection Procedures and Laboratories

BRMC has been designated the drug screening collection site. BRMC shall maintain all necessary personnel, materials, equipment, facilities, and supervision to provide for the collection, security, chain of custody procedures, temporary storage and shipping or transportation of urine and blood specimens.

J. Challenges to Test Results

Within five (5) working days after receiving written notice of a positive confirmed test result, an employee or prospective employee will be allowed to submit information to BRMC explaining or contesting the test results.

K. Reporting of Abuse

Any employee who, in good faith based on reasonable suspicion, reports any alleged violation of this Program, or any supervisory or managerial employee who investigates or takes action in good faith based on reasonable suspicion, shall not be harassed, retaliated against, or discriminated against in any way for making reports or participating in any investigation or action based thereon.

L. Criminal Drug Convictions

Employees who are convicted of illegal drug activity, including plead of no contest, will be considered in violation of this program and subject to disciplinary action, up to and including, termination. Employees must immediately report such conviction to BRMC no later than five (5) days after the conviction.

M. Search Policy

Employees and physicians, and facility based equipment and containers under their control, are subject to search and

BARROW REGIONAL MEDICAL CENTER
POLICY AND PROCEDURE

DRUG- FREE WORKPLACE	DEPARTMENT HR	Policy # HR-010	Page No. 5 of 5
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	APPROVED BY:		APPROVED BY:

surveillance at all times while on the BRMC premises or while conducting BRMC business.

PROCEDURES:

A. Prospective Employees

A Drug Free Workplace Notice will be posted. BRMC shall include a notice of substance abuse testing on all announcements for open positions and employment advertisements for those positions where substance abuse testing is required.

The Post-Offer/Pre-Employment Drug Testing Consent and release Form (HR0041), Over-The-Counter and Prescriptions Drugs Which Could Alter or Affect the Outcome of a Drug Test (HR0038), the Employee handbook and its acknowledgement form will be part of each new hire packet and must be signed by the prospective employee after offer of employment has been accepted.

A post-offer, pre-employment drug screen will be performed on each prospective employees prior to his/her physical examination.

Any prospective employee who tests positive on the drug or alcohol screen will not be considered for employment with BRMC. If the prospective employee wishes to be considered for employment in the future, he/she may submit a new application after a minimum of one (1) year has passed from the date of the positive drug screen.

Refusal to be drug or alcohol screened at the designated time or tampering or attempting to tamper with a specimen will terminate the hiring process.

Following negative test results, the prospective employee will be noticed by the Human Resources Department to schedule the post-offer physical examination and completion of the medical history questionnaire.

B. Employees

A sample will be collected at BRMC and the testing administered. The “chain of custody” of the specimen will be maintained. Employees who are directed to submit to such a test and who refuse or fail to do so or who tamper or attempt to tamper with the specimen are guilty of misconduct and will be subject to disciplinary action, up to and including termination.

C. Contract Employees

All contractors doing work for BRMC will be informed and given a copy of this Program and will be requested to acknowledge receipt of same. Violation of the Program or refusal to cooperate can result in BRMC barring contract personnel from BRMC or participating in BRMC operations.

ACKNOWLEDGEMENT OF DRUG-FREE WORKPLACE POLICY

I hereby agree, upon a request made under the Drug-Free Workplace Policy of Health Management Associates (the "Company"), to submit to a drug and/or alcohol test and to furnish a sample of my urine for analysis. I understand and agree that if I refuse to submit to a drug and/or alcohol test under the policy, or if I otherwise fail to cooperate with the testing procedures, I will be subject to disciplinary action, including immediate termination. I further authorize and give full permission to have the Company and/or its MRO send the specimen to a laboratory for a screening test for the presence of any prohibited substances under the policy, and for the laboratory or other testing facility to release any and all documentation relating to such test to the Company and/or to any governmental entity involved in a legal proceeding or investigation connected with the test. Finally, I authorize the Company to disclose any documentation relating to such test to its agents and attorneys, and any governmental entity involved in a legal proceeding or investigation connected with the test.

I understand that only duly-authorized Company officers, employees, agents, and attorneys will have access to information furnished or obtained in connection with the test; that they will maintain and protect the confidentiality of such information to the greatest extent possible; and that they will share such information only to the extent necessary to make employment decisions and to respond to inquiries or notices from government entities.

I will hold harmless the Company, its MRO, and any testing laboratory the Company might use, meaning that I will not sue or hold responsible such parties for any alleged harm to me that might result from such testing, including loss of employment or any other kind of adverse job action that might arise as a result of the drug and/or alcohol test, unless such harm results from the grossly negligent or willful act of a Company or Laboratory representative during the administration or analysis of the test or the reporting of the results. I will further hold harmless the Company, its MRO, and any testing laboratory the Company might use for any alleged harm to me that might result from the release or use of information or documentation relating to the drug and/or alcohol test, as long as the release or use of the information is within the scope of this policy and the procedures as explained in the paragraph above.

This policy and authorization have been explained to me in a language I understand, and I have been given an opportunity to ask any questions about the test and the policy prior to signing this authorization.

Signature of Employee: _____ Date: _____

(print name)

**POST-OFFER PRE-EMPLOYMENT DRUG TESTING
CONSENT & RELEASE FORM**

I have received, read, and understand the Facility Drug-Free Workplace Program and I freely and voluntarily agree to submit to a urinalysis (drug screen) as apart of my application for employment or subcontracting on site services. I further understand that a refusal to submit to urinalysis screen, tampering with or attempting to tamper with a specimen, or a confirmed positive test result will disqualify me from further consideration for employment for one year.

Your facility has selected a laboratory vendor for the drug screening and collection process. I agree that this Facility may collect the urine specimens for the urine drug screen. I further agree to hereby authorize the release of the results of said testing to the Facility in confidence.

I further understand that upon commencement of employment with the Facility I may again, on the basis of reasonable suspicion and/or following a work injury, be required to submit to a urine drug screen and/or blood alcohol test for continued employment.

I agree to hold harmless the Facility and its officers, agents, and employees from and against any harm, claim, suit or cause of action which may occur as a direct or indirect result of the test or release of the test results to the facility.

I have carefully read the foregoing and fully understand its contents. I acknowledge that my signing of this consent and release form is a voluntary act on my part and that I have not been coerced into signing this document by anyone.

Prospective Employee's Name (Print)

Witness' Name (Print)

Prospective Employee's Signature

Witness' Signature

Date

Date

This consent from becomes part of the employee's personnel file

R041 (Rev. 3/1/01)

Provide to the employee upon offer and acceptance. Drug test will be performed within 24 hours of the acceptance.)

OVER-THE-COUNTER AND PRESCRIPTION DRUGS WHICH COULD ALTER OR AFFECT THE OUTCOME OF A DRUG TEST

Alcohol

All liquid medications containing ethyl alcohol (ethanol). Please read the label for alcohol content. As an example, Vick's Nyquil is 25% (50 proof) ethyl alcohol, Comtrex is 20% (40 proof), Contact Severe Cold Formula Night Strength is 25% (50 proof) and Listerine is 26% (54 proof).

Amphetamines

Obetrol, Biphphetamine, Desoxyn, Dexedrine, Didrex.

Cannabinoids

Marinol (Dronabinol, THC).

Cocaine

Cocaine HCl topical solution (Roxanne).

Phencyclidine

Not legal by prescription.

Metaqualone

Not legal by prescription.

Opiates

Paregoric, Parepectolin, Donnagel PG, Morphine, Tylenol with Codeine, Empirin with Codeine, APAP with Codeine, Aspirin with Codeine, Robitussin AC, Guaiacuss AG, Novahistine DR, Novahistine Expectorant, Dilaudid (Hydromorphone), M-S Contin and Roxanol (morphine sulfate), Percodan, Vicodin, etc.

Barbiturates

Phenobarbital, Tuinal, Amytal, Nembutal, Seconal, Lotusate, Fiorinal, Fioricet, Esgic, Butisol, Mebaral, Butabarbital, Butabital, Phrenilin, Triad, etc.

Benzodiazepines

Arivan, Azene, Clonopin, Dalmane, Diazepam, Librium, Xanax, Serax, Tranxene, Valium, Verstran, Halcion, Paxipam, Restorial Centrax.

Methadone

Dolophone, Methadose.

Propoxyphene

Darvocet, Darvon N, Dolene, etc.

Form W-4 (2009)

Purpose. Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay. Consider completing a new Form W-4 each year and when your personal or financial situation changes.

Exemption from withholding. If you are exempt, complete **only** lines 1, 2, 3, 4, and 7 and sign the form to validate it. Your exemption for 2009 expires February 16, 2010. See Pub. 505, Tax Withholding and Estimated Tax.

Note. You cannot claim exemption from withholding if (a) your income exceeds \$950 and includes more than \$300 of unearned income (for example, interest and dividends) and (b) another person can claim you as a dependent on their tax return.

Basic instructions. If you are not exempt, complete the **Personal Allowances Worksheet** below. The worksheets on page 2 further adjust your withholding allowances based on itemized deductions, certain credits, adjustments to income, or two-earner/multiple job situations.

Complete all worksheets that apply. However, you may claim fewer (or zero) allowances. For regular wages, withholding must be based on allowances you claimed and may not be a flat amount or percentage of wages.

Head of household. Generally, you may claim head of household filing status on your tax return only if you are unmarried and pay more than 50% of the costs of keeping up a home for yourself and your dependent(s) or other qualifying individuals. See Pub. 501, Exemptions, Standard Deduction, and Filing Information, for information.

Tax credits. You can take projected tax credits into account in figuring your allowable number of withholding allowances. Credits for child or dependent care expenses and the child tax credit may be claimed using the **Personal Allowances Worksheet** below. See Pub. 919, How Do I Adjust My Tax Withholding, for information on converting your other credits into withholding allowances.

Nonwage income. If you have a large amount of nonwage income, such as interest or

dividends, consider making estimated tax payments using Form 1040-ES, Estimated Tax for Individuals. Otherwise, you may owe additional tax. If you have pension or annuity income, see Pub. 919 to find out if you should adjust your withholding on Form W-4 or W-4P.

Two earners or multiple jobs. If you have a working spouse or more than one job, figure the total number of allowances you are entitled to claim on all jobs using worksheets from only one Form W-4. Your withholding usually will be most accurate when all allowances are claimed on the Form W-4 for the highest paying job and zero allowances are claimed on the others. See Pub. 919 for details.

Nonresident alien. If you are a nonresident alien, see the Instructions for Form 8233 before completing this Form W-4.

Check your withholding. After your Form W-4 takes effect, use Pub. 919 to see how the amount you are having withheld compares to your projected total tax for 2009. See Pub. 919, especially if your earnings exceed \$130,000 (Single) or \$180,000 (Married).

Personal Allowances Worksheet (Keep for your records.)

A Enter "1" for **yourself** if no one else can claim you as a dependent. **A** _____

B Enter "1" if: } **B** _____

- You are single and have only one job; or
- You are married, have only one job, and your spouse does not work; or
- Your wages from a second job or your spouse's wages (or the total of both) are \$1,500 or less.

C Enter "1" for your **spouse**. But, you may choose to enter "-0-" if you are married and have either a working spouse or more than one job. (Entering "-0-" may help you avoid having too little tax withheld.) **C** _____

D Enter number of **dependents** (other than your spouse or yourself) you will claim on your tax return **D** _____

E Enter "1" if you will file as **head of household** on your tax return (see conditions under **Head of household** above) **E** _____

F Enter "1" if you have at least \$1,800 of **child or dependent care expenses** for which you plan to claim a credit **F** _____

(Note. Do not include child support payments. See Pub. 503, Child and Dependent Care Expenses, for details.)

G **Child Tax Credit** (including additional child tax credit). See Pub. 972, Child Tax Credit, for more information.

- If your total income will be less than \$61,000 (\$90,000 if married), enter "2" for each eligible child; then less "1" if you have three or more eligible children.
- If your total income will be between \$61,000 and \$84,000 (\$90,000 and \$119,000 if married), enter "1" for each eligible child plus "1" **additional** if you have six or more eligible children.

H Add lines A through G and enter total here. **(Note.** This may be different from the number of exemptions you claim on your tax return.) **H** _____

For accuracy, **complete all worksheets that apply.** }

- If you plan to **itemize or claim adjustments to income** and want to reduce your withholding, see the **Deductions and Adjustments Worksheet** on page 2.
- If you have **more than one job** or are **married and you and your spouse both work** and the combined earnings from all jobs exceed \$40,000 (\$25,000 if married), see the **Two-Earners/Multiple Jobs Worksheet** on page 2 to avoid having too little tax withheld.
- If **neither** of the above situations applies, **stop here** and enter the number from line H on line 5 of Form W-4 below.

Cut here and give Form W-4 to your employer. Keep the top part for your records.

Form W-4 Department of the Treasury Internal Revenue Service	<h2 style="margin: 0;">Employee's Withholding Allowance Certificate</h2> <p style="margin: 0;">▶ Whether you are entitled to claim a certain number of allowances or exemption from withholding is subject to review by the IRS. Your employer may be required to send a copy of this form to the IRS.</p>	OMB No. 1545-0074 2009
1 Type or print your first name and middle initial. Last name		2 Your social security number
Home address (number and street or rural route)		3 <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Married, but withhold at higher Single rate. Note. If married, but legally separated, or spouse is a nonresident alien, check the "Single" box.
City or town, state, and ZIP code		4 If your last name differs from that shown on your social security card, check here. You must call 1-800-772-1213 for a replacement card. <input type="checkbox"/>
5 Total number of allowances you are claiming (from line H above or from the applicable worksheet on page 2)		5 _____
6 Additional amount, if any, you want withheld from each paycheck		6 \$ _____
7 I claim exemption from withholding for 2009, and I certify that I meet both of the following conditions for exemption. <ul style="list-style-type: none"> • Last year I had a right to a refund of all federal income tax withheld because I had no tax liability and • This year I expect a refund of all federal income tax withheld because I expect to have no tax liability. If you meet both conditions, write "Exempt" here		7 _____
Under penalties of perjury, I declare that I have examined this certificate and to the best of my knowledge and belief, it is true, correct, and complete.		
Employee's signature (Form is not valid unless you sign it.)		Date
8 Employer's name and address (Employer: Complete lines 8 and 10 only if sending to the IRS.)		9 Office code (optional)
		10 Employer identification number (EIN)

Deductions and Adjustments Worksheet

Note. Use this worksheet *only* if you plan to itemize deductions, claim certain credits, adjustments to income, or an additional standard deduction

- 1 Enter an estimate of your 2009 itemized deductions. These include qualifying home mortgage interest, charitable contributions, state and local taxes, medical expenses in excess of 7.5% of your income, and miscellaneous deductions. (For 2009, you may have to reduce your itemized deductions if your income is over \$166,800 (\$83,400 if married filing separately). See *Worksheet 2* in Pub. 919 for details.) 1 \$ _____
- 2 Enter:

{	\$11,400 if married filing jointly or qualifying widow(er)	}	2	\$	
\$ 8,350 if head of household						
\$ 5,700 if single or married filing separately						
- 3 **Subtract** line 2 from line 1. If zero or less, enter "-0-" 3 \$ _____
- 4 Enter an estimate of your 2009 adjustments to income and any additional standard deduction. (Pub. 919) 4 \$ _____
- 5 **Add** lines 3 and 4 and enter the total. (Include any amount for credits from *Worksheet 8* in Pub. 919.) 5 \$ _____
- 6 Enter an estimate of your 2009 nonwage income (such as dividends or interest) 6 \$ _____
- 7 **Subtract** line 6 from line 5. If zero or less, enter "-0-" 7 \$ _____
- 8 **Divide** the amount on line 7 by \$3,500 and enter the result here. Drop any fraction 8 _____
- 9 Enter the number from the **Personal Allowances Worksheet**, line H, page 1 9 _____
- 10 **Add** lines 8 and 9 and enter the total here. If you plan to use the **Two-Earners/Multiple Jobs Worksheet**, also enter this total on line 1 below. Otherwise, **stop here** and enter this total on Form W-4, line 5, page 1 10 _____

Two-Earners/Multiple Jobs Worksheet (See *Two earners or multiple jobs* on page 1.)

Note. Use this worksheet *only* if the instructions under line H on page 1 direct you here.

- 1 Enter the number from line H, page 1 (or from line 10 above if you used the **Deductions and Adjustments Worksheet**) 1 _____
- 2 Find the number in **Table 1** below that applies to the **LOWEST** paying job and enter it here. **However**, if you are married filing jointly and wages from the highest paying job are \$50,000 or less, do not enter more than "3." 2 _____
- 3 If line 1 is **more than or equal to** line 2, subtract line 2 from line 1. Enter the result here (if zero, enter "-0-") and on Form W-4, line 5, page 1. **Do not** use the rest of this worksheet 3 _____

Note. If line 1 is *less than* line 2, enter "-0-" on Form W-4, line 5, page 1. Complete lines 4-9 below to calculate the additional withholding amount necessary to avoid a year-end tax bill.

- 4 Enter the number from line 2 of this worksheet 4 _____
- 5 Enter the number from line 1 of this worksheet 5 _____
- 6 **Subtract** line 5 from line 4 6 _____
- 7 Find the amount in **Table 2** below that applies to the **HIGHEST** paying job and enter it here 7 \$ _____
- 8 **Multiply** line 7 by line 6 and enter the result here. This is the additional annual withholding needed 8 \$ _____
- 9 Divide line 8 by the number of pay periods remaining in 2009. For example, divide by 26 if you are paid every two weeks and you complete this form in December 2008. Enter the result here and on Form W-4, line 6, page 1. This is the additional amount to be withheld from each paycheck 9 \$ _____

Table 1

Table 2

Table 1				Table 2			
Married Filing Jointly		All Others		Married Filing Jointly		All Others	
If wages from LOWEST paying job are—	Enter on line 2 above	If wages from LOWEST paying job are—	Enter on line 2 above	If wages from HIGHEST paying job are—	Enter on line 7 above	If wages from HIGHEST paying job are—	Enter on line 7 above
\$0 - \$4,500	0	\$0 - \$6,000	0	\$0 - \$65,000	\$550	\$0 - \$35,000	\$550
4,501 - 9,000	1	6,001 - 12,000	1	65,001 - 120,000	910	35,001 - 90,000	910
9,001 - 18,000	2	12,001 - 19,000	2	120,001 - 185,000	1,020	90,001 - 165,000	1,020
18,001 - 22,000	3	19,001 - 26,000	3	185,001 - 330,000	1,200	165,001 - 370,000	1,200
22,001 - 26,000	4	26,001 - 35,000	4	330,001 and over	1,280	370,001 and over	1,280
26,001 - 32,000	5	35,001 - 50,000	5				
32,001 - 38,000	6	50,001 - 65,000	6				
38,001 - 46,000	7	65,001 - 80,000	7				
46,001 - 55,000	8	80,001 - 90,000	8				
55,001 - 60,000	9	90,001 - 120,000	9				
60,001 - 65,000	10	120,001 and over	10				
65,001 - 75,000	11						
75,001 - 95,000	12						
95,001 - 105,000	13						
105,001 - 120,000	14						
120,001 and over	15						

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. The Internal Revenue Code requires this information under sections 3402(f)(2)(A) and 6109 and their regulations. Failure to provide a properly completed form will result in your being treated as a single person who claims no withholding allowances; providing fraudulent information may also 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 possessions for use in administering their tax laws, and using it 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.

INSTRUCTIONS FOR COMPLETING FORM G-4

Enter your full name, address and social security number in boxes 1a through 2b.

Line 3: Write the number of allowances you are claiming in the brackets beside your marital status.

- A. Single - enter 1 if you are claiming yourself
- B. Married Filing Joint, both spouses working - enter 1 if you claim yourself or 2 if you claim yourself and your spouse
- C. Married Filing Joint, one spouse working - enter 1 if you claim yourself or 2 if you claim yourself and your spouse
- D. Married Filing Separate - enter 1 if you claim yourself or 2 if you claim yourself and your spouse
- E. Head of Household - enter 1 if you claim yourself but the individual(s) for whom you maintain a home does not qualify as a dependent; or 2 if you claim yourself and a qualified dependent for whom you maintain a home

Do not claim a deduction on Line 4 for a dependent used to qualify you as head of household

Line 4: Enter the number of dependent allowances you are entitled to claim.

Line 5: Complete the worksheet on Form G-4 if you claim additional allowances. Enter the number from Line H here.

Failure to complete and submit the worksheet will result in automatic denial of your claim.

Line 6: Enter a specific dollar amount that you authorize your employer to withhold in addition to the tax withheld based on your marital status and number of allowances.

Line 7: Enter the letter of your marital status from Line 3. Enter total of the numbers on Lines 3 - 5.

Line 8: Check the box if you qualify to claim exempt from withholding. You can claim exempt if you filed a Georgia income tax return last year and the amount on Line 4 of Form 500EZ or Line 16 of Form 500 was zero, **and** you expect to file a Georgia tax return this year and will not have a tax liability. You can not claim exempt if you did not file a Georgia income tax return for the previous tax year. **Receiving a refund for the previous tax year does not qualify you to claim exempt.**

Do not complete Lines 3 - 7 if claiming exempt.

EXAMPLES: Your employer withheld \$500 of Georgia income tax from your wages. The amount on Line 4 of Form 500EZ or Line 16 of Form 500 was \$100. Your tax liability is the amount on Line 4 or Line 16; therefore, **you do not qualify** to claim exempt.

Your employer withheld \$500 of Georgia income tax from your wages. The amount on Line 4 of Form 500EZ or Line 16 of Form 500 was \$0 (zero) and you filed a prior year income tax return. Your tax liability is the amount on Line 4 or Line 16; therefore, **you qualify** to claim exempt.

NOTE: Effective January 1, 2003, the deduction allowed for the dependents increased from \$2,700 to \$3,000. This does not apply to the deduction allowed for you or your spouse.

O.C.G.A. § 48-7-102 requires you to complete and submit Form G-4 to your employer in order to have tax withheld from your wages. By correctly completing this form, you can adjust the amount of tax withheld to meet your tax liability. Failure to submit a properly completed Form G-4 will result in your employer withholding tax as though you are single with zero allowances.

Employers are required to mail any Form G-4 claiming more than 14 allowances or exempt from withholding to the Georgia Department of Revenue for approval. Employers will honor the properly completed form as submitted pending notification from the Withholding Tax Unit. Upon approval, such forms remain in effect until changed or until February 15 of the following year. Employers who know that a G-4 is erroneous should not honor the form and should withhold as if the employee is single claiming zero allowances until a corrected form has been received.

Health Management Associates, Inc. Retirement Savings Plan
Automatic Enrollment Notice

Your participation in the Health Management Associates, Inc. Retirement Savings Plan is automatic. All newly hired full-time and part-time employees will automatically be enrolled in the HMA Retirement Savings Plan for a 4% pre-tax contribution, unless you make a different election as described below.

After the Hospital has transmitted your new hire status to Prudential, (after your first payroll) you should access Prudential's Interactive Voice Response (IVR) system (1-877-778-2100) or Website (www.prudential.com/online/retirement) to establish your PIN and choose investment elections.

You have 45 days from the date Prudential is notified of your employment or eligibility to decline your participation by calling Prudential's Interactive Voice Response (IVR) system (1-877-778-2100) or accessing your account on the Website. Otherwise, the following will take place:

• **Payroll Deduction Option**

4% of your compensation will be deducted from your paycheck and will be contributed to your Retirement Savings Plan account. Please refer to the definition of "Compensation" as defined in the "GLOSSARY" section of your Summary Plan Description for a detailed description of the compensation that is used for the purposes of the Plan.

• **Investment Fund Option**

As with all funds contributed to your account under the Plan, you have the right at any time to direct how your account balance will be invested in the available funds. Unless you direct otherwise, all contributions will be invested in the age appropriate conservative Goalmaker Portfolio Line Up. A description of this investment fund, including a description of the investment objectives, risk and return characteristics, and fees and expenses is attached. If your deferrals are placed in this investment option, you can, at any time and without penalty, transfer them to any other investment allowed under the Plan.

Employer Match

You will become eligible to begin receiving an Employer Match following 1 year of service (12 consecutive months from date of hire) provided that you are making a payroll deduction to the plan (Salary Deferral Contribution). Employer Match is discretionary and currently no matching contributions are made. For a complete description of the most up to date Employer Match contribution information, as well as any other contributions that HMA may make to the plan, please refer to the sections of your SPD titled: "Employer Contributions" and refer to the Prudential Website (www.prudential.com/online/retirement).

The HMA Match funds (if any) and, profit sharing contributions (if any) are vested at 20% per year after 2 years of service. Each year thereafter, you vest an additional 20% per year until you become 100% vested after 6 years of service. You are always 100% vested in your own contributions.

Contributions

You have the right at any time to make a different payroll deduction option, select different investment fund options, or to decline enrollment. To do so or to obtain information about any other investment funds offered by the Plan, you must call Prudential's Interactive Voice Response (IVR) system (1-877-778-2100) or access Prudential's Website (www.prudential.com/online/retirement). You may choose to:

1. Begin to contribute Pre-Tax contributions immediately, rather than wait for the automatic payroll deductions to begin after the 45-day waiting period.
2. Contribute more than the automatic 4% of your eligible pay (up to a maximum of 75%).
3. Contribute less than the automatic 4% (must be in whole percentage increments).
4. Allocate your contributions to a fund or fund(s) other than the Goalmaker Portfolio Line Up.
5. Decline participation in the Plan by choosing zero percent (0%) when you call the AnswerLine number.

Withdrawals

Under the Automatic Enrollment feature, the Plan will allow you to make a “permissible withdrawal” of funds automatically contributed by you if you notify the Plan **within 90 days** after the first contribution is deducted from your pay. This feature is not permitted if you select a specific deferral percentage different than the 4% Automatic Enrollment percentage. The amount distributed will be adjusted for investment gains or losses and will be subject to income tax in the year the distribution is made. The amount distributed will not be subject to the 10% early distribution tax under the IRS tax code. To request a “permissible withdrawal” a participant should contact Prudential via the Interactive Voice Response System or the Internet site listed below.

Prudential’s Website - www.prudential.com/online/retirement

The contributions that you make to the plan and HMA contributions are available for withdrawal under the following conditions:

- o Loans are available from your account. If you qualify for and take a loan, generally you will be required to repay the loan amount within 5 years (10 years if the loan is needed for the purchase of your primary residence).
- o Rollover contributions (money that you rolled into the plan) can be withdrawn at any time with no limitations.
- o At age 59 ½ or older: In addition to rollover contributions, you can withdraw all or any portion of your account attributable to your pre-tax deferral contributions and the vested portion of any HMA contributions.
- o Upon financial hardship: Rollover contributions, your pre-tax contributions and any vested HMA contributions (except contributions designated as Qualified Matching or Non Elective Contributions, as defined in the Glossary of your SPD) are available to satisfy your financial hardship.
- o Upon severance of employment including, death or disability: your entire vested account is available in a lump sum.

More details on the description of Plan provisions, as well as information about your rights and obligations under the Plan, may be found in the Plan’s Summary Plan Description. If you have any questions about the Plan, please contact Prudential at 877.PRU.2100 (877.778.2100); press *0 to speak with a Prudential Representative.

Signature _____ Date _____

Print Name _____

**BARROW REGIONAL MEDICAL CENTER
CAFETERIA CHARGE
PAYROLL DEDUCTION AUTHORIZATION FORM**

Directions: Complete lines 1 through 4. Read the payroll deduction authorization agreement and sign at the bottom. Return completed form to the BRMC Human Resources Department.

1. Date _____
2. Name (print last, first, MI) _____
3. SSN# _____ - _____ - _____
4. Badge# _____

I would like to participate in the Barrow Regional Medical Center Foodservices Payroll Deduction Charging Plan Benefit. I fully understand the Cafeteria Charging Program as stated below.

I hereby authorize the BRMC Payroll Department to make payroll deductions of ALL Food Service purchases transacted using my Kronos/Identification badge. I further understand that it is my responsibility to maintain the security of my badge and to report it to the Human Resources Department at anytime I discover it missing or misplaced.

As such, I agree to cover all unauthorized purchases which occur before I report my badge missing. I agree not to hold BRMC responsible for any deductions from my check caused by charges which I may dispute.

I fully understand that upon termination of my employment, any remaining balance will be deducted from my final paycheck.

If I choose to discontinue the Cafeteria Charging Benefit, it is my responsibility to notify the Human Resources Department in writing. I fully understand the deactivation process for charging using the ID badge will be within 72 hours of receipt of the written notification by the BRMC Human Resource Department.

I fully understand and agree to the above and ALL Cafeteria Charging policies and procedures.

Signature _____

Date _____

A Summary of Your Rights under the Fair Credit Reporting Act

The Federal Fair Credit Reporting Act (FCRA) is designed to promote accuracy, fairness, and privacy of information in the files of every "consumer reporting agency" (CRA). Most CRAs are credit bureaus that gather and sell information about you -- such as if you pay your bills on time or have filed bankruptcy -- to creditors, employers, landlords, and other businesses. You can find the complete text of the FCRA, 15 U.S.C. 1681-1681u, at the Federal Trade Commission's web site (<http://www.ftc.gov>). The FCRA gives you specific rights, as outlined below. You may have additional rights under state law. You may contact a state or local consumer protection agency or a state attorney general to learn those rights.

- **You must be told if information in your file has been used against you.** Anyone who uses information from a CRA to take action against you -- such as denying an application for credit, insurance, or employment -- must tell you, and give you the name, address, and phone number of the CRA that provided the consumer report.
- **You can find out what is in your file.** At your request, a CRA must give you the information in your file, and a list of everyone who has requested it recently. There is no charge for the report if a person has taken action against you because of information supplied by the CRA, if you request the report within 60 days of receiving notice of the action. You also are entitled to one free report every twelve months upon request if you certify that (1) you are unemployed and plan to seek employment within 60 days, (2) you are on welfare, or (3) your report is inaccurate due to fraud. Otherwise, a CRA may charge you up to eight dollars.
- **You can dispute inaccurate information with the CRA.** If you tell a CRA that your file contains inaccurate information, the CRA must investigate the items (usually within 30 days) by presenting to its information source all relevant evidence you submit, unless your dispute is frivolous. The source must review your evidence and report its findings to the CRA. (The source also must advise national CRAs -- to which it has provided the data -- of any error.) The CRA must give you a written report of the investigation, and a copy of your report if the investigation results in any change. If the CRA's investigation does not resolve the dispute, you may add a brief statement to your file. The CRA must normally include a summary of your statement in future reports. If an item is deleted or a dispute statement is filed, you may ask that anyone who has recently received your report be notified of the change.
- **Inaccurate information must be corrected or deleted.** A CRA must remove or correct inaccurate or unverified information from its files, usually within 30 days after you dispute it. **However, the CRA is not required to remove accurate data from your file unless it is outdated (as described below) or cannot be verified.** If your dispute results in any change to your report, the CRA cannot reinsert into your file a disputed item unless the information source verifies its accuracy and completeness. In addition, the CRA must give you a written notice telling you it has reinserted the item. The notice must include the name, address and phone number of the information source.
- **You can dispute inaccurate items with the source of the information.** If you tell anyone -- such as a creditor who reports to a CRA -- that you dispute an item, they may not then report the information to a CRA without including a notice of your dispute. In addition, once you've notified the source of the error in writing, it may not continue to report the information if it is, in fact, an error.
- **Outdated information may not be reported.** In most cases, a CRA may not report negative information that is more than seven years old; ten years for bankruptcies.
- **Access to your file is limited.** A CRA may provide information about you only to people with a need recognized by the FCRA -- usually to consider an application with a creditor, insurer, employer, landlord, or other business.
- **Your consent is required for reports that are provided to employers, or reports that contain medical information.** A CRA may not give out information about you to your employer, or prospective employer, without your written consent. A CRA may not report medical information about you to creditors, insurers, or employers without your permission.

- **You may choose to exclude your name from CRA lists for unsolicited credit and insurance offers.** Creditors and insurers may use file information as the basis for sending you unsolicited offers of credit or insurance. Such offers must include a toll-free phone number for you to call if you want your name and address removed from future lists. If you call, you must be kept off the lists for two years. If you request, complete, and return the CRA form provided for this purpose, you must be taken off the lists indefinitely.
- **You may seek damages from violators.** If a CRA, a user or (in some cases) a provider of CRA data, violates the FCRA, you may sue them in state or federal court.

The FCRA gives several different federal agencies authority to enforce the FCRA:

FOR QUESTIONS OR CONCERNS REGARDING:	PLEASE CONTACT:
CRAs, creditors and others not listed below	Federal Trade Commission Consumer Response Center -- FCRA Washington, DC 20580 * 202-326-3761
National banks, federal branches/agencies of foreign banks (word "National" or initials "N.A." appear in or after bank's name)	Office of the Comptroller of the Currency Compliance Management, Mail Stop 6-6 Washington, DC 20219 * 800-613-6743
Federal Reserve System member banks (except national banks, and federal branches/agencies of foreign banks)	Federal Reserve Board Division of Consumer & Community Affairs Washington, DC 20551 * 202-452-3693
Savings associations and federally chartered savings banks (word "Federal" or initials "F.S.B." appear in federal institution's name)	Office of Thrift Supervision Consumer Programs Washington, DC 20552 * 800-842-6929
Federal credit unions (words "Federal Credit Union" appear in institution's name)	National Credit Union Administration 1775 Duke Street Alexandria, VA 22314 * 703-518-6360
State-chartered banks that are not members of the Federal Reserve System	Federal Deposit Insurance Corporation Division of Compliance & Consumer Affairs Washington, DC 20429 * 800-934-FDIC
Air, surface, or rail common carriers regulated by former Civil Aeronautics Board or Interstate Commerce Commission	Department of Transportation Office of Financial Management Washington, DC 20590 * 202-366-1306
Activities subject to the Packers and Stockyards Act, 1921	Department of Agriculture Office of Deputy Administrator - GIPSA Washington, DC 20250 * 202-720-7051

Written Disclosure to Applicant and Consent to Request Consumer Report and Investigative Consumer Report Information

I understand that Barrow Regional Medical Center may utilize the services of USDataLink as part of the procedure for processing my application for employment. I also understand if my application for employment is granted, Barrow Regional Medical Center may obtain further information through subsequent investigations by a consumer reporting agency so as to update, renew or extend my employment.

I understand a consumer reporting agency's investigation may include obtaining information covering up to the last 7 years, regarding my credit background, references, character, past employment, work habits, education, general reputation, personal characteristics, mode of living, civil judgments, and liens, as well as any information about my criminal conviction background consistent with federal and state law.

In the event an investigative consumer report is conducted, I understand such information may be obtained by personal interviews with my neighbors, friends, or associates or with others whom I am acquainted or who may have knowledge concerning my character, general reputation, personal characteristics or mode of living. I understand such information may also be obtained through direct or indirect contact with former employers, schools, financial institutions, landlords and public agencies or other person who may have such knowledge.

I acknowledge that I have received the attached summary of my rights under the Fair Credit Reporting Act.

I also understand that before I am denied employment based, in whole or part, on information obtained in the consumer or investigative consumer report, I will be provided a copy of the report and a description in writing of my rights under the Fair Credit Reporting Act. I understand if I disagree with the accuracy of any information in the report, I must notify Barrow Regional Medical Center within two days of my receipt of the report. If I notify Barrow Regional Medical Center within the two days of the receipt of the report that I am challenging information in the report, Barrow Regional Medical Center will not make a final decision on my employment status until I have had a reasonable opportunity to address the information contained in the report.

I hereby consent to this investigation and authorize Barrow Regional Medical Center to procure a consumer report and/or an investigative consumer report on my background as stated above from a consumer reporting agency.

Signature of Applicant

Date

Print Name

Pre-Screening Notice and Certification Request for the Work Opportunity Credit

OMB No. 1545-1500

▶ See separate instructions.

Job applicant: Fill in the lines below and check any boxes that apply. Complete only this side.

Your name _____ Social security number ▶ _____

Street address where you live _____

City or town, state, and ZIP code _____

County _____ Telephone number () - _____

If you are under age 40, enter your date of birth (month, day, year) ____ / ____ / ____

1 Check here if you are completing this form **before** August 28, 2009, and you lived in the area impacted by Hurricane Katrina on August 28, 2005. If so, please enter the address, including county or parish and state where you lived at that time.

2 Check here if you received a conditional certification from the state workforce agency (SWA) or a participating local agency for the work opportunity credit.

3 Check here if **any** of the following statements apply to you.

- I am a member of a family that has received assistance from Temporary Assistance for Needy Families (TANF) for any 9 months during the past 18 months.
- I am a veteran and a member of a family that received Supplemental Nutrition Assistance Program (SNAP) benefits (food stamps) for at least a 3-month period during the past 15 months.
- I was referred here by a rehabilitation agency approved by the state, an employment network under the Ticket to Work program, or the Department of Veterans Affairs.
- I am at least age 18 but **not** age 40 or older and I am a member of a family that:
 - a Received SNAP benefits (food stamps) for the past 6 months, **or**
 - b Received SNAP benefits (food stamps) for at least 3 of the past 5 months, **but** is no longer eligible to receive them.
- During the past year, I was convicted of a felony or released from prison for a felony.
- I received supplemental security income (SSI) benefits for any month ending during the past 60 days.
- I am a veteran and I was discharged or released from active duty in the U.S. Armed Forces during the past 5 years **and**, for at least 4 weeks during the past year, I received unemployment compensation.
- I am at least age 16 but **not** age 25 or older, **and**:
 - a During the past 6 months, I have not attended a secondary, technical, or post-secondary school for more than an average of 10 hours per week, not counting periods during which the school was closed for scheduled vacations, **and**
 - b During the past 6 months, if I was employed, during each consecutive 3-month period within the past 6 months, I earned less than I would have earned if I had worked for the applicable minimum wage 30 hours every week during the 3-month period, **and**
 - c I do not have a certificate of graduation from a secondary school or a General Education Development (GED) certificate **or** I have a certificate that was awarded at least 6 months ago and I have not held a job or been admitted to a technical or post-secondary school since I received the certificate.

4 Check here if you are a veteran entitled to compensation for a service-connected disability **and**, during the past year, you were:

- Discharged or released from active duty in the U.S. Armed Forces, **or**
- Unemployed for a period or periods totaling at least 6 months.

5 Check here if you are a member of a family that:

- Received TANF payments for at least the past 18 months, **or**
- Received TANF payments for any 18 months beginning after August 5, 1997, **and** the earliest 18-month period beginning after August 5, 1997, ended during the past 2 years, **or**
- Stopped being eligible for TANF payments during the past 2 years because federal or state law limited the maximum time those payments could be made.

Signature—All Applicants Must Sign

Under penalties of perjury, I declare that I gave the above information to the employer on or before the day I was offered a job, and it is, to the best of my knowledge, true, correct, and complete.

Job applicant's signature ▶ _____

Date ____ / ____ / ____

For Employer's Use Only

Employer's name _____ Telephone no. () - EIN ▶ _____

Street address _____

City or town, state, and ZIP code _____

Person to contact, if different from above _____ Telephone no. () - _____

Street address _____

City or town, state, and ZIP code _____

If, based on the individual's age and home address, he or she is a member of group 4 or 6 (as described under Members of Targeted Groups in the separate instructions), enter that group number (4 or 6) ▶ _____

Date applicant:

Gave information ____/____/____ Was offered job ____/____/____ Was hired ____/____/____ Started job ____/____/____

Complete Only If Box 1 on Page 1 is Checked

State and county or parish of job _____

Check if the individual was not your employee on August 28, 2005, and this is the first time the employee has been hired by you since August 28, 2005.

Under penalties of perjury, I declare that the applicant provided the information on this form on or before the day a job was offered to the applicant and that the information I have furnished is, to the best of my knowledge, true, correct, and complete. Based on the information the job applicant furnished on page 1, I believe the individual is a member of a targeted group. I hereby request a certification that the individual is a member of a targeted group.

Employer's signature ▶ _____ Title _____ Date ____/____/____

Privacy Act and Paperwork Reduction Act Notice

Section references are to the Internal Revenue Code.

Section 51(d)(13) permits a prospective employer to request the applicant to complete this form and give it to the prospective employer. The information will be used by the employer to complete the employer's federal tax return. Completion of this form is voluntary and may assist members of targeted groups in securing employment. Routine uses of this form include giving it to the state workforce agency (SWA), which will contact appropriate sources to confirm that the applicant is a member of a targeted group. This form may also be given to the Internal Revenue Service for administration of the Internal Revenue laws, to the Department of Justice for civil and

criminal litigation, to the Department of Labor for oversight of the certifications performed by the SWA, and to cities, states, and the District of Columbia for use in administering their tax laws. 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.

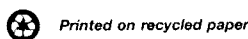
You are not required to provide the information requested on a form that is subject to the Paperwork Reduction Act unless the form displays a valid OMB control number. Books or records relating to a form or its instructions must be retained as long as their contents may become material in the administration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

The time needed to complete and file this form will vary depending on individual circumstances. The estimated average time is:

- Recordkeeping 3 hrs., 16 min.
Learning about the law or the form 46 min.
Preparing and sending this form to the SWA 42 min.

If you have comments concerning the accuracy of these time estimates or suggestions for making this form simpler, we would be happy to hear from you. You can write to the Internal Revenue Service, Tax Products Coordinating Committee, SE:W:CAR:MP:T:T:SP, 1111 Constitution Ave. NW, IR-6526, Washington, DC 20224.

Do not send this form to this address. Instead, see When and Where To File in the separate instructions.



SELF-IDENTIFICATION FORM

This Company is an equal employment opportunity employer. We are also subject to certain governmental recordkeeping and reporting requirements for the administration of civil rights laws and other similar laws and regulations. In order to comply with these laws, the Company invites employees to voluntarily self-identify their gender, race and ethnicity. Submission of this data is voluntary and will not affect your opportunity for employment or terms or conditions of employment. This form will be kept confidential and will only be used in accordance with the provision of applicable laws, executive orders, and regulations, including those which require the information to be summarized and reported to the federal government for civil rights enforcement.

Anti-Discrimination Notice: It is an unlawful employment practice for an employer to fail or refuse to hire, promote or discharge any individual, or otherwise to discriminate against an individual with respect to that individual's terms and conditions of employment, based on individual's race, color, religion, sex (including pregnancy), national origin, sexual orientation, gender identity, citizenship, disability, veteran status, age or any other protected category in accordance with applicable federal, state and local laws.

GENDER:

_____ Male _____ Female

RACE/ETHNICITY:

Please check if you are:

- Hispanic or Latino:** a person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin regardless of race.

If you are NOT Hispanic or Latino, please check the appropriate box below:

- White (Not Hispanic or Latino):** a person having origins in any of the original peoples of Europe, the Middle East, or North Africa
- Black or African American (Not Hispanic or Latino):** a person having origins in any of the black racial groups of Africa.
- Native Hawaiian or Other Pacific Islander (Not Hispanic or Latino):** a person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.
- Asian (Not Hispanic or Latino):** a person having origins in any of the original peoples of the Far East, Southeast Asia or the Indian subcontinent, including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.
- American Indian or Alaska Native (Not Hispanic or Latino):** a person having origins in any of the original peoples of North and South America (including Central America) who maintains tribal affiliation or community attachment.
- Two or More Races (Not Hispanic or Latino):** all persons who identify with more than one of the above five races.
- I do not wish to complete this self-identification. If you check this box, please complete your name and signature information below.**

Employee Name (Please print)

Employee Signature

Employee's Job Title

Date Completed

**AUTHORIZATION AGREEMENT FOR AUTOMATIC DEPOSIT
(ACH CREDIT)**

Insert Hospital Name Here utilizes *automatic deposit* as an optional payroll distribution method. To initiate this option please enter the information requested and return this form to the **Human Resources Department**.

NAME: _____ Social Security Number: _____

I (we) hereby authorize Insert Hospital Name Here to initiate credit entries and to initiate, if necessary, debit entries and adjustments for any credit entries in error to the account indicated below and the depository/bank listed below.

Name of Depository/Bank: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Please choose only *ONE* of the following accounts:

- Checking Account Number:** _____
Please staple a voided check to this form. (Not a deposit slip)
- Savings Account Number:** _____
Please staple a deposit slip to this form.
- Pay Card Number:** _____
Please staple completed pay card form

This authority is to remain in full force and effect until Insert Hospital Name Here receives written notification from me of its termination in such time and in such manner as to afford the **Human Resources Department** and the depository/bank to have a reasonable opportunity to act on it. I understand that the hospital reserves the right to cancel the automatic deposit option.

Signature of Employee: _____ Date: _____

<p>Please accept this written authorization to stop automatic deposits to:</p> <p>Checking Account Number: _____</p> <p>Savings Account Number: _____</p> <p>Signature: _____ Date: _____</p>

EMERGENCY CONTACT INFORMATION

Your cooperation in completing this form fully and accurately will supply us with information required for our records.

EMPLOYEE NAME _____ SSN: _____

ADDRESS _____

PHONE NUMBER(S) _____

IN CASE OF AN EMERGENCY NOTIFY:

NAME _____

ADDRESS _____

PHONE NUMBER(S) _____



Instructions for Choosing Your Beneficiary

Please print using blue or black ink. Keep a copy for your records and send the original form to your benefits/human resources office.

Plan Provisions

For Married Participants: Upon your death, any benefit will be payable to your spouse unless the Spousal Consent on the reverse side of this form is completed and witnessed.

If you die before you begin to receive benefits and the Spousal Consent has not been completed, the plan must automatically pay a spousal death benefit consisting of 100% of your account balance to your surviving spouse (if any) as beneficiary.

Note: Even if your current beneficiary is a trust or estate of which your spouse is a beneficiary, spousal consent is necessary. Without such waiver and consent, the spousal death benefit must be paid directly to your spouse.

Please be careful in completing the form; be sure that your designation is accurate, clear and understandable.

General Provisions

- A. The terms of the plan govern the payment of any benefit.
- B. Primary beneficiary(ies). If more than one person is named and no percentages are indicated, payment will be made in equal shares to the Primary beneficiary(ies) who is living at the time the benefit first becomes payable. If a percentage is indicated and a Primary beneficiary(ies) is not alive at the time the benefit first becomes payable, the percentage of that beneficiary's designated share will be divided equally among the surviving Primary beneficiary(ies).
- C. If there is no Primary beneficiary(ies) living at the time of the participant's death, any benefit that becomes payable will be distributed to the surviving Secondary beneficiary(ies) listed, if applicable.
- D. Payment to Secondary beneficiary(ies) will be made according to the rules of succession described under Primary beneficiary(ies) in provision B above. If no designated beneficiary(ies) is alive when payment is otherwise payable, payment will be made in accordance with the plan.
- E. If a Trust is named as beneficiary, any payment to the Trust will be made as if the Trustee is acting in such fiduciary capacity until written notice to the contrary is received.

Examples of Beneficiary Designations

If you feel that none of the examples below fit the type of beneficiary designation you want, please send a detailed description of what you propose to Prudential.

Use the term:

- 1. **"My Living Children"** if you want all your children (born or adopted of any marriage) living at the time of payment to equally share the benefit. This will also include all such children born or adopted after you completed the form. Do not include the names of your children if you use this term.
- 2. **"My Living Trust"** if you want to designate your Living Trust. You must also give the name(s) of the Trustee(s), name(s) of the successor Trustee(s) (Trustee and Successor Trustee cannot be the participant), the date of the Trust Agreement and the address if a bank or trust company is the Trustee.
- 3. **"My Testamentary Trust"** if you want to designate the Trust in your Last Will and Testament. Do not name your Trustee.
- 4. **"My Estate"** if you want the benefit to be paid to your estate.
- 5. **"(Name), Per Stirpes"** if you want the payment(s) to be paid up to and including the second generation of descendants. For example, if a beneficiary in such class is not living when a payment is due, such payment will be made in equal shares to any living sons and daughters (born or adopted of any marriage), of such beneficiary. If there are no living sons and daughters of such beneficiary when a payment is due, payment will be made to the estate of the last to die of the participant or such beneficiary. An example of a correct designation would be Jane Doe, Per Stirpes.

Beneficiary Designation Form
Health Management Associates, Inc. 401 (k) Plan

About You

(Please print using blue or black ink)

Plan number 7 6 6 7 6 2 Sub plan number Marital Status Married Single, widowed or legally divorced
Social Security number Daytime telephone number
First Name MI Last name

Are you still employed by the employer sponsoring the plan? Yes No

Your Beneficiary Designation

(See "Instructions for Choosing your Beneficiary")

I designate the following as beneficiary of my account with regard to the percentage(s) I have indicated below. Please list additional beneficiaries, along with percentages they are to receive on a separate page, if needed. Indicate whether the additional beneficiary(ies) is/are primary or secondary beneficiary(ies).

(A) Primary Beneficiary(ies)
FULL LEGAL NAME
Address
Social Security number Percentage
Date of Birth Relationship to you

(B) Secondary Beneficiary(ies)
FULL LEGAL NAME
Address
Social Security number Percentage
Date of Birth Relationship to you

Please use whole percentages - must total 100%

Spousal Consent

I am the spouse of the participant and, I understand that I am entitled to receive 100% of the account upon the participant's death. By signing this consent, I will not receive the benefit that would otherwise have been payable to me upon the participant's death. I voluntarily agree to the participant's designation of the beneficiary(ies) indicated above.

X Date
Spouse's signature - must be witnessed by a notary public OR authorized plan representative. Notary Stamp or Seal
Subscribed and sworn before me on the day of the year
State of County of
My commission expires
Signature of notary or authorized plan representative

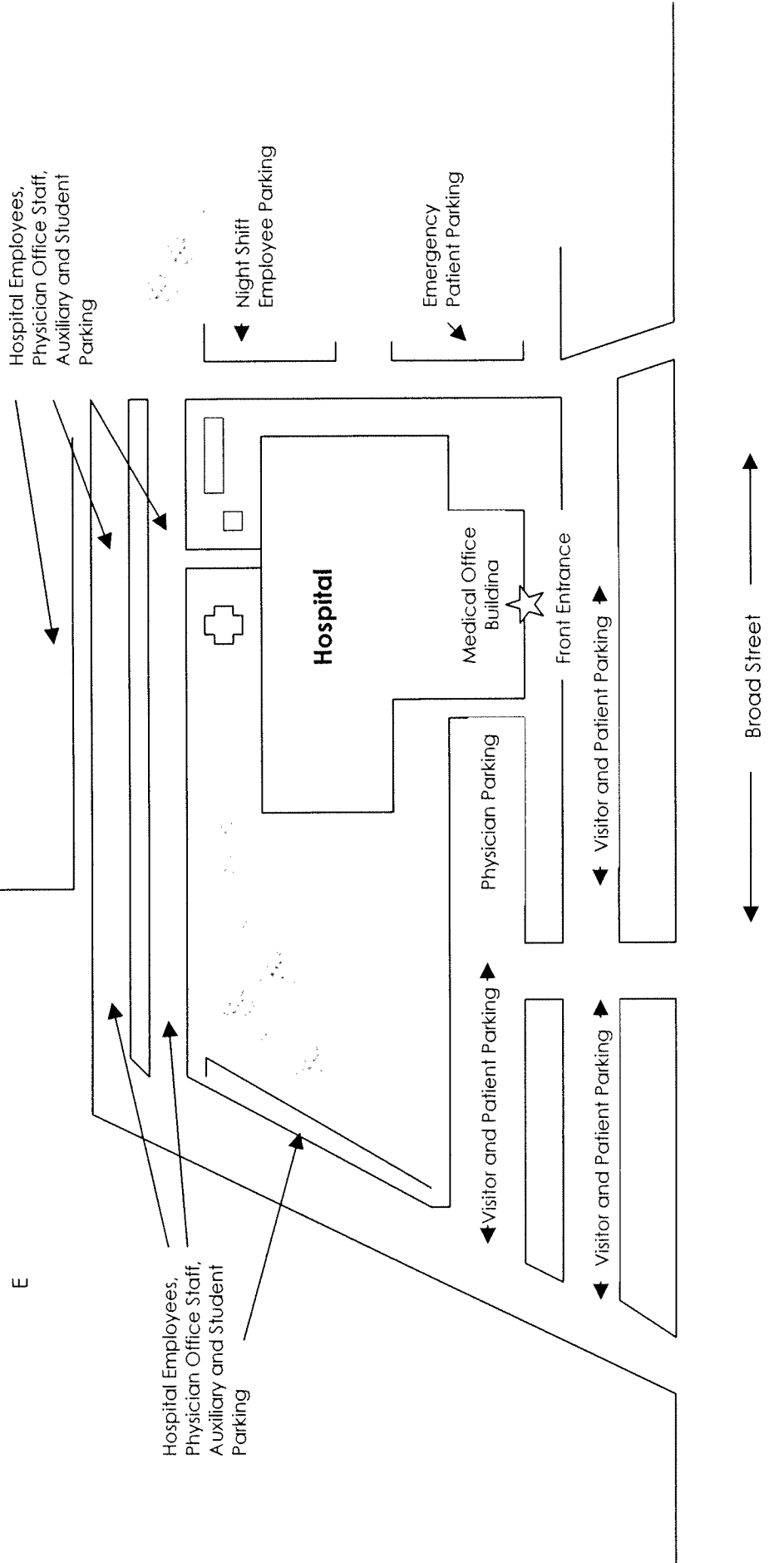
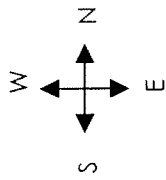
X Date

Your Authorization

Signature X Date

DID YOU REMEMBER TO:

- Sign the form Use whole numbers
Initial any changes Have your spouse's signature notarized



Barrow Regional Medical Center