Hawk Mountain Council
5027 Pottsville Pike
Reading, PA 19605

SUBJECT: Welcome and Employee File

Dear Hawk Mountain Scout Reservation Staff Member:

Welcome to the Hawk Mountain Scout Reservation 2025 team! We are gearing up for an excellent season and we look forward to serving with you this summer. Please check out the list below for what paperwork is needed to ensure the completion of your employee file prior to our staff training week unless prior arrangements are made. These must be received prior to arrival or you risk forfeit of your employment offer. You can use this sheet as a checklist to ensure that you have everything ready to go. When ready to submit, we ask that you submit everything together. Your options for submission are listed on page 2.

Required Items

Required FORMS follow these instructions – fillable forms available by clicking the links

- ☐ **Contract**: sign and return – these were sent by Morgan Baxter from his email address, morgan.baxter@scouting.org. Even if you have already sent it back, we would like you to review yours one more time to ensure accuracy.
- ☐ **Pennsylvania Background Checks/Clearances** (three clearances needed)
  - PA Child Abuse History
  - PA State Police Criminal History
  - FBI Criminal History Clearance (**fingerprinting required**)
  - PA Background Check FAQs for Employees
  - The cost for all clearances is $59.95. Hawk Mountain Council will reimburse the cost of clearances on submission of obtained clearances and receipts.
- ☐ **FORM**: W-4 Employee's Withholding Certificate: complete all indicated sections
- ☐ **FORM**: Residency PA Local EIT Certification: complete all indicated sections
- ☐ **FORM**: I-9 Employment Eligibility Verification: complete and return the top half of the form. Please refer to the back of the I-9 form for required documents that must be presented.
  - Original documents must be presented and reviewed **in person** prior to or on the day you report for training. Copies will be taken and securely filed. You can schedule an appointment with Cole at the main office.

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- ☐ FORM: Annual Health and Medical Record: all parts (A, B, & C) required for all staff. Part C requires a medical professional physical. Specific professionals that qualify are listed on the form. Please keep the original and provide us a copy. We understand timing of yearly physicals so this one can be done after May 15th but must be done prior to reporting for training. Most doctor offices will sign forms using information from an appointment earlier in the year. If you do not have a primary care physician, please reach out and we will help you identify a place to get a physical.
- ☐ FORM: Worker's Compensation Acknowledgement: review and sign
- ☐ FORM: Wage Payment Election and Consent:
  - This is where you decide how you will be paid this summer – your options are **direct deposit, prepaid card, or paper check**.
- ☐ FORM: Adult Application (over 18 only): please complete and return
- ☐ FORM: Youth Application (under 18 only): please complete and return
- ☐ **Work Permit – under 18 only** or if have not yet graduated high school.
  Visit your school's office for more information on their specific procedure.
- ☐ **REQUIRED TRAININGS** – these must be obtained prior to staff training week
  - Youth Protection Training
    - To take Youth Protection training, navigate to my.Scouting.org and create an account if you do not have one. Once logged in, click Menu > My Training > Youth Protection Training. Once completed, please submit the training certificate to us.
  - Hazardous Weather Training
    - This training is also through my.Scouting.org. Once logged in, click Menu > My Training > Expanded Learning > Program Safety > scroll down to Hazardous Weather. **You do not need to take any others in the Program Safety track**. Once completed, please submit the training certificate to us.
  - Workplace Harassment Prevention for Employees
    - Click THIS LINK to navigate to a separate system. You will need to create an account here as well if you do not have one.

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Please be sure to return the required paperwork to the Hawk Mountain Council by **May 15, 2025** unless prior arrangements are made. If you have any questions, please call our office at 610.926.3406 or email hawk.mountain@scouting.org.

You have three options for submission (you only need to do one):

1. Upload your files HERE. Please name your files Last Name_What It Is (example: Baxter_W4)
    a. **If able to combine your files into one packet, please do so**. If not, that is fine – just please ensure the file name identifies who it is for. Please note that this is a secure, upload only folder so you will not be able to view your files once uploaded.
2. Mail completed forms (in one packet) to
   Attn: Camp Staff Paperwork
   5027 Pottsville Pike
   Reading, PA 19605
3. Book an appointment HERE to turn them in in person at our office (address above). If you do not see a time that you are available, please contact Cole directly at 610.926.3406 or cole.mitchell@scouting.org.

Sincerely,

The 2025 Reservation Leadership Team

Form **W-4**

Department of the Treasury
Internal Revenue Service

Employee's Withholding Certificate

Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay.
Give Form W-4 to your employer.
Your withholding is subject to review by the IRS.

OMB No. 1545-0074

2025

Step 1: Enter Personal Information

(a) First name and middle initial	Last name	(b) Social security number
Address		**Does your name match the name on your social security card?** If not, to ensure you get credit for your earnings, contact SSA at 800-772-1213 or go to *www.ssa.gov*.
City or town, state, and ZIP code		

(c) ☐ **Single** or **Married filing separately**
☐ **Married filing jointly** or **Qualifying surviving spouse**
☐ **Head of household** (Check only if you're unmarried and pay more than half the costs of keeping up a home for yourself and a qualifying individual.)

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

Complete Steps 2–4 ONLY if they apply to you; otherwise, skip to Step 5. See page 2 for more information on each step, who can claim exemption from withholding, and when to use the estimator at *www.irs.gov/W4App*.

Step 2: Multiple Jobs or Spouse Works

Complete this step if you (1) hold more than one job at a time, or (2) are married filing jointly and your spouse also works. The correct amount of withholding depends on income earned from all of these jobs.

Do **only one** of the following.

(a) Use the estimator at *www.irs.gov/W4App* for the most accurate withholding for this step (and Steps 3–4). If you or your spouse have self-employment income, use this option; **or**

(b) Use the Multiple Jobs Worksheet on page 3 and enter the result in Step 4(c) below; **or**

(c) If there are only two jobs total, you may check this box. Do the same on Form W-4 for the other job. This option is generally more accurate than (b) if pay at the lower paying job is more than half of the pay at the higher paying job. Otherwise, (b) is more accurate . . . . . ☐

Complete Steps 3–4(b) on Form W-4 for only ONE of these jobs. Leave those steps blank for the other jobs. (Your withholding will be most accurate if you complete Steps 3–4(b) on the Form W-4 for the highest paying job.)

Step 3: Claim Dependent and Other Credits

If your total income will be $200,000 or less ($400,000 or less if married filing jointly):

Multiply the number of qualifying children under age 17 by $2,000 $ _____

Multiply the number of other dependents by $500 . . . . . $ _____

Add the amounts above for qualifying children and other dependents. You may add to this the amount of any other credits. Enter the total here . . . . . **3** $

Step 4 (optional): Other Adjustments

(a) Other income (not from jobs). If you want tax withheld for other income you expect this year that won't have withholding, enter the amount of other income here. This may include interest, dividends, and retirement income . . . . . **4(a)** $

(b) Deductions. If you expect to claim deductions other than the standard deduction and want to reduce your withholding, use the Deductions Worksheet on page 3 and enter the result here . . . . . **4(b)** $

(c) Extra withholding. Enter any additional tax you want withheld each **pay period** . . **4(c)** $

Step 5: Sign Here

Under penalties of perjury, I declare that this certificate, to the best of my knowledge and belief, is true, correct, and complete.

Employee's signature (This form is not valid unless you sign it.) _____ **Date** _____

Employers Only

Employer's name and address	First date of employment	Employer identification number (EIN)

General Instructions

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

Future Developments

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

Purpose of Form

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

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

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

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

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

2. Expect to work only part of the year;

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

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

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

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

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

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

Specific Instructions

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

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

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

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

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

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

Step 4 (optional).

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

. . . . . **2** $

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

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

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

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

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

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

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

Married Filing Jointly or Qualifying Surviving Spouse

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

Single or Married Filing Separately

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

Head of Household

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

CLGS-32-6 (05/17)

RESIDENCY CERTIFICATION FORM
Local Earned Income Tax Withholding

TO EMPLOYERS/TAXPAYERS:

This form is to be used by employers and taxpayers to report essential information for the collection and distribution of Local Earned Income Taxes to the local EIT collector. This form must be used by employers when a new employee is hired or when a current employee notifies employer of a name or address change. Use the Address Search Application at dced.pa.gov/Act32 to determine PSD codes, EIT rates, and tax collector contact information.

EMPLOYEE INFORMATION – RESIDENCE LOCATION

NAME (Last Name, First Name, Middle Initial)			SOCIAL SECURITY NUMBER
STREET ADDRESS **(No PO Box, RD or RR)**			
ADDRESS LINE 2			
CITY	STATE	ZIP CODE	DAYTIME PHONE NUMBER
MUNICIPALITY (City, Borough or Township)			
COUNTY	RESIDENT PSD CODE		TOTAL RESIDENT EIT RATE

EMPLOYER INFORMATION – EMPLOYMENT LOCATION

EMPLOYER BUSINESS NAME (Use Federal ID Name)			EMPLOYER FEIN
STREET ADDRESS WHERE ABOVE EMPLOYEE REPORTS TO WORK **(No PO Box, RD or RR)**			
ADDRESS LINE 2			
CITY	STATE	ZIP CODE	PHONE NUMBER
MUNICIPALITY (City, Borough or Township)			
COUNTY	WORK LOCATION PSD CODE		WORK LOCATION NON-RESIDENT EIT RATE

CERTIFICATION

Under penalties of perjury, I (we) declare that I (we) have examined this information, including all accompanying schedules and statements and to the best of my (our) belief, they are true, correct and complete.

SIGNATURE OF EMPLOYEE	DATE (MM/DD/YYYY)
PHONE NUMBER	EMAIL ADDRESS

For information on obtaining the appropriate MUNICIPALITY (City, Borough, Township), PSD CODES, and EIT (Earned Income Tax) RATES, please refer to the Pennsylvania Department of Community & Economic Development website:

dced.pa.gov/Act32

Employment Eligibility Verification

Department of Homeland Security

U.S. Citizenship and Immigration Services

USCIS
Form I-9
OMB No.1615-0047
Expires 05/31/2027

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

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

Section 1. Employee Information and Attestation: Employees must complete and sign Section 1 of Form I-9 no later than the first day of employment, but not before accepting a job offer.

Last Name (Family Name)	First Name (Given Name)	Middle Initial (if any)	Other Last Names Used (if any)

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

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

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

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

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

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

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

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

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

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

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

Additional Information

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

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

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

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

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

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

LISTS OF ACCEPTABLE DOCUMENTS

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

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

Acceptable Receipts

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

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

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

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

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

USCIS Form I-9 Supplement A
OMB No. 1615-0047
Expires 05/31/2027

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

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

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

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

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

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

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

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

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

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

Supplement B,

Reverification and Rehire (formerly Section 3)

Department of Homeland Security

U.S. Citizenship and Immigration Services

USCIS
Form I-9
Supplement B
OMB No. 1615-0047
Expires 05/31/2027

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

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

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

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

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

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

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

Additional Information (Initial and date each notation.)

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

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

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

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

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

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

Additional Information (Initial and date each notation.)

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

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

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

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

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

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

Additional Information (Initial and date each notation.)

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

Part A: Informed Consent, Release Agreement, and Authorization

A

Full name: _____

Date of birth: _____

High-adventure base participants:

Expedition/crew No.: _____

or staff position: _____

Informed Consent, Release Agreement, and Authorization

I understand that participation in Scouting activities involves the risk of personal injury, including death, due to the physical, mental, and emotional challenges in the activities offered. Information about those activities may be obtained from the venue, activity coordinators, or your local council. I also understand that participation in these activities is entirely voluntary and requires participants to follow instructions and abide by all applicable rules and the standards of conduct.

In case of an emergency involving me or my child, I understand that efforts will be made to contact the individual listed as the emergency contact person by the medical provider and/or adult leader. In the event that this person cannot be reached, permission is hereby given to the medical provider selected by the adult leader in charge to secure proper treatment, including hospitalization, anesthesia, surgery, or injections of medication for me or my child. Medical providers are authorized to disclose protected health information to the adult in charge, camp medical staff, camp management, and/or any physician or health-care provider involved in providing medical care to the participant. Protected Health Information/Confidential Health Information (PHI/CHI) under the Standards for Privacy of Individually Identifiable Health Information, 45 C.F.R. §§160.103, 164.501, etc. seq., as amended from time to time, includes examination findings, test results, and treatment provided for purposes of medical evaluation of the participant, follow-up and communication with the participant's parents or guardian, and/or determination of the participant's ability to continue in the program activities.

(If applicable) I have carefully considered the risk involved and hereby give my informed consent for my child to participate in all activities offered in the program. I further authorize the sharing of the information on this form with any BSA volunteers or professionals who need to know of medical conditions that may require special consideration in conducting Scouting activities.

With appreciation of the dangers and risks associated with programs and activities, on my own behalf and/or on behalf of my child, I hereby fully and completely release and waive any and all claims for personal injury, death, or loss that may arise against the Boy Scouts of America, the local council, the activity coordinators, and all employees, volunteers, related parties, or other organizations associated with any program or activity.

I also hereby assign and grant to the local council and the Boy Scouts of America, as well as their authorized representatives, the right and permission to use and publish the photographs/film/videotapes/electronic representations and/or sound recordings made of me or my child at all Scouting activities, and I hereby release the Boy Scouts of America, the local council, the activity coordinators, and all employees, volunteers, related parties, or other organizations associated with the activity from any and all liability from such use and publication. I further authorize the reproduction, sale, copyright, exhibit, broadcast, electronic storage, and/or distribution of said photographs/film/videotapes/electronic representations and/or sound recordings without limitation at the discretion of the BSA, and I specifically waive any right to any compensation I may have for any of the foregoing.

Every person who furnishes any BB device to any minor, without the express or implied permission of the parent or legal guardian of the minor, is guilty of a misdemeanor. (California Penal Code Section 19915[a]) My signature below on this form indicates my permission.

I give permission for my child to use a BB device. (Note: Not all events will include BB devices.)

☐ **Checking this box indicates you DO NOT want your child to use a BB device.**

NOTE: Due to the nature of programs and activities, the Boy Scouts of America and local councils cannot continually monitor compliance of program participants or any limitations imposed upon them by parents or medical providers. However, so that leaders can be as familiar as possible with any limitations, list any restrictions imposed on a child participant in connection with programs or activities below.

List participant restrictions, if any: ☐ **None**

_____

I understand that, if any information I/we have provided is found to be inaccurate, it may limit and/or eliminate the opportunity for participation in any event or activity. If I am participating at Philmont Scout Ranch, Philmont Training Center, Northern Tier, Sea Base, or the Summit Bechtel Reserve, **I have also read and understand the supplemental risk advisories, including height and weight requirements and restrictions, and understand that the participant will not be allowed to participate in applicable high-adventure programs if those requirements are not met.** The participant has permission to engage in all high-adventure activities described, except as specifically noted by me or the health-care provider. If the participant is under the age of 18, a parent or guardian's signature is required.

Participant's signature: _____ Date: _____

Parent/guardian signature for youth: _____ Date: _____

(If participant is under the age of 18)

Complete this section for youth participants only:

Adults Authorized to Take Youth to and From Events:

You must designate at least one adult. Please include a phone number.

Name: _____ Name: _____

Phone: _____ Phone: _____

Adults NOT Authorized to Take Youth to and From Events:

Name: _____ Name: _____

Phone: _____ Phone: _____

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Part B1: General Information/Health History

B1

Full name: _____

Date of birth: _____

High-adventure base participants:

Expedition/crew No.: _____

or staff position: _____

Age: _____ Gender: _____ Height (inches): _____ Weight (lbs.): _____

Address: _____

City: _____ State: _____ ZIP code: _____ Phone: _____

Unit leader: _____ Unit leader's mobile #: _____

Council Name/No.: _____ Unit No.: _____

Health/Accident Insurance Company: _____ Policy No.: _____

Please attach a photocopy of both sides of the insurance card. If you do not have medical insurance, enter "none" above.

In case of emergency, notify the person below:

Name: _____ Relationship: _____

Address: _____ Home phone: _____ Other phone: _____

Alternate contact name: _____ Alternate's phone: _____

Health History

Do you currently have or have you ever been treated for any of the following?

Yes	No	Condition	Explain
☐	☐	Diabetes	**Last HbA1c percentage and date:** **Insulin pump: Yes** ☐ **No** ☐
☐	☐	Hypertension (high blood pressure)	
☐	☐	Adult or congenital heart disease/heart attack/chest pain (angina)/ heart murmur/coronary artery disease. Any heart surgery or procedure. Explain all "yes" answers.	
☐	☐	Family history of heart disease or any sudden heart-related death of a family member before age 50.	
☐	☐	Stroke/TIA	
☐	☐	Asthma/reactive airway disease	**Last attack date:**
☐	☐	Lung/respiratory disease	
☐	☐	COPD	
☐	☐	Ear/eyes/nose/sinus problems	
☐	☐	Muscular/skeletal condition/muscle or bone issues	
☐	☐	Head injury/concussion/TBI	
☐	☐	Altitude sickness	
☐	☐	Psychiatric/psychological or emotional difficulties	
☐	☐	Neurological/behavioral disorders	
☐	☐	Blood disorders/sickle cell disease	
☐	☐	Fainting spells and dizziness	
☐	☐	Kidney disease	
☐	☐	Seizures or epilepsy	**Last seizure date:**
☐	☐	Abdominal/stomach/digestive problems	
☐	☐	Thyroid disease	
☐	☐	Skin issues	
☐	☐	Obstructive sleep apnea/sleep disorders	**CPAP: Yes** ☐ **No** ☐
☐	☐	List all surgeries and hospitalizations	**Last surgery date:**
☐	☐	List any other medical conditions not covered above	

Part B2: General Information/Health History

B2

Full name: _____

Date of birth: _____

High-adventure base participants:
Expedition/crew No.: _____
or staff position: _____

Allergies/Medications

DO YOU USE AN EPINEPHRINE AUTOINJECTOR? ☐ YES ☐ NO Exp. date (if yes) _____

DO YOU USE AN ASTHMA RESCUE INHALER? ☐ YES ☐ NO Exp. date (if yes) _____

Are you allergic to or do you have any adverse reaction to any of the following?

Yes	No	Allergies or Reactions	Explain
☐	☐	Medication	
☐	☐	Food	

Yes	No	Allergies or Reactions	Explain
☐	☐	Plants	
☐	☐	Insect bites/stings	

List all medications currently used, including any over-the-counter medications.

☐ Check here if no medications are routinely taken. ☐ If additional space is needed, please list on a separate sheet and attach.

Medication	Dose	Frequency	Reason

☐ YES ☐ NO Non-prescription medication administration is authorized with these exceptions: _____

Administration of the above medications is approved for youth by:

_____ / _____

Parent/guardian signature — MD/DO, NP, or PA signature (if your state requires signature)

Bring enough medications in sufficient quantities and in the original containers. Make sure that they are NOT expired, including inhalers and EpiPens. You SHOULD NOT STOP taking any maintenance medication unless instructed to do so by your doctor.

Immunization

The following immunizations are recommended. Tetanus immunization is required and must have been received within the last 10 years. If you had the disease, check the disease column and list the date. If immunized, check yes and provide the year received.

Yes	No	Had Disease	Immunization	Date(s)
☐	☐		Tetanus	
☐	☐		Pertussis	
☐	☐		Diphtheria	
☐	☐		Measles/mumps/rubella	
☐	☐		Polio	
☐	☐		Chicken Pox	
☐	☐		Hepatitis A	
☐	☐		Hepatitis B	
☐	☐		Meningitis	
☐	☐		Influenza	
☐	☐		Other (i.e., HIB)	
☐	☐		Exemption to immunizations **(form required)**	

Please list any additional information about your medical history:

_____

_____

_____

_____

DO NOT WRITE IN THIS BOX.
Review for camp or special activity.

Reviewed by: _____

Date: _____

Further approval required: ☐ Yes ☐ No

Reason: _____

Approved by: _____

Date: _____

Part C: Pre-Participation Physical

C

This part must be completed by certified and licensed physicians (MD, DO), nurse practitioners, or physician assistants.

Full name: _____

Date of birth: _____

High-adventure base participants:

Expedition/crew No.: _____

or staff position: _____

You are being asked to certify that this individual has no contraindication for participation in a Scouting experience. For individuals who will be attending a high-adventure program, including one of the national high-adventure bases, please refer to the supplemental information on the following pages or the form provided by your patient. You can also visit www.scouting.org/health-and-safety/ahmr to view this information online.

Please fill in the following information:

	Yes	No	Explain
Medical restrictions to participate	☐	☐	

Yes	No	Allergies or Reactions	Explain
☐	☐	Medication	
☐	☐	Food	

Yes	No	Allergies or Reactions	Explain
☐	☐	Plants	
☐	☐	Insect bites/stings	

Height (inches)	Weight (lbs.)	BMI	Blood Pressure	Pulse
			/	

	Normal	Abnormal	Explain Abnormalities
Eyes	☐	☐	
Ears/nose/throat	☐	☐	
Lungs	☐	☐	
Heart	☐	☐	
Abdomen	☐	☐	
Genitalia/hernia	☐	☐	
Musculoskeletal	☐	☐	
Neurological	☐	☐	
Skin issues	☐	☐	
Other	☐	☐	

Examiner's Certification

I certify that I have reviewed the health history and examined this person and find no contraindications for participation in a Scouting experience. This participant (with noted restrictions):

True	False	Explain
☐	☐	Meets height/weight requirements.
☐	☐	Has no uncontrolled heart disease, lung disease, or hypertension.
☐	☐	Has not had an orthopedic injury, musculoskeletal problems, or orthopedic surgery in the last six months or possesses a letter of clearance from his or her orthopedic surgeon or treating physician.
☐	☐	Has no uncontrolled psychiatric disorders.
☐	☐	Has had no seizures in the last year.
☐	☐	Does not have poorly controlled diabetes.
☐	☐	If planning to scuba dive, does not have diabetes, asthma, or seizures.

Examiner's signature: _____ **Date:** _____

Examiner's printed name: _____

Address: _____

City: _____ State: _____ ZIP code: _____

Office phone: _____

Height/Weight Restrictions

If you exceed the maximum weight for height as explained in the following chart and your planned high-adventure activity will take you more than 30 minutes away from an emergency vehicle/accessible roadway, you may not be allowed to participate.

Maximum weight for height:

Height (inches)	Max. Weight	Height (inches)	Max. Weight	Height (inches)	Max. Weight	Height (inches)	Max. Weight
60	166	65	195	70	226	75	260
61	172	66	201	71	233	76	267
62	178	67	207	72	239	77	274
63	183	68	214	73	246	78	281
64	189	69	220	74	252	79 and over	295

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Scouting America
Hawk Mountain Council

WORKERS' COMPENSATION INFORMATION

In Pennsylvania, the workers' compensation law provides wage loss and medical benefits to employees who cannot work, or who need medical care, because of a work-related injury.

Benefits are required to be paid by your employer when self-insured, or through insurance provided by your employer. Your employer is required to post the name of the company responsible for paying workers' compensation benefits at its primary place of business and at its sites of employment in a prominent and easily accessible place, including, without limitation, areas used for the treatment of injured employees or for the administration of first aid.

You should report immediately any injury or work-related illness to your employer.

Your benefits could be delayed or denied if you do not notify your employer immediately.

If your claim is denied by your employer, you have the right to request a hearing before a workers' compensation judge.

The Bureau of Workers' Compensation cannot provide legal advice. However, you may contact the Bureau of Workers' Compensation for additional general information at:

Bureau of Workers' Compensation
1171 South Cameron Street, Room 103
Harrisburg, Pennsylvania 17104-2501
Telephone number within Pennsylvania (800) 482-2383
Telephone number outside of this Commonwealth (717) 772-4447
TTY (800) 362-4228 (for hearing and speech impaired only) www.dli.pa.gov - PA Keyword: workers comp.

ACKNOWLEDGMENT

I, _____, employee of
(PLEASE PRINT NAME)

Hawk Mountain Council, BSA hereby certify that I was provided with the above statement on ____/____/_____ (date).

_____
Employee Signature

NOTICE TO EMPLOYEES

Your employer has provided for the payment of
Benefits under the Workers' Compensation Act of this State

IN CASE OF WORK-RELATED INJURY

IN THE EVENT OF AN EMERGENCY, PLEASE GO TO THE NEAREST HOSPITAL FOR TREATMENT.

- If you suffer a work-related injury, your employer or its insurance company must pay for reasonable surgical and medical services and supplies, orthopedic appliances and prostheses, including training in their use.
- In order to ensure that your medical treatment will be paid for by your employer or the insurance company, **you must immediately notify (advise) your supervisor of your injury** , and be treated by one of the licensed physicians or practitioners of the healing arts listed below:

DESIGNATED PHYSICIANS
(including address, telephone number, and area of medical specialty)

GSL Hospital
Hospital
Hospital: General Acute Care
100 Paramount Blvd
Orwigsburg, PA 17961
866-785-8537
Est Dist: 9.6 mi

LVPG Orthopedics and Sports Medicine - Mauch Chunk
Surgery: Orthopedic
316 Mauch Chunk St
Pottsville, PA 17901
570-621-9380
Est Dist: 10.0 mi

†MedExpress Urgent Care - St. Clair
Urgent Care Clinic
4 Clover Dr
Saint Clair, PA 17970
570-429-1012
Est Dist: 13.9 mi

Sears, Carol D., MD
UPMC Primary Care Fredericksburg
Family Practice
120 South Tan Aly Suite 1
Fredericksburg, PA 17026
717-865-6644
Est Dist: 12.7 mi

St. Lukes Care Now - Hamburg
Occupational Medicine Clinic
Urgent Care Clinic
9 Daves Way
Hamburg, PA 19526
610-628-7201
Est Dist: 12.7 mi

†Sherpa, Tshering Wangdi, MD
Myerstown Family Practice Associates PC
Family Practice
431 W Lincoln Ave
Myerstown, PA 17067
717-866-5755
Est Dist: 12.5 mi

Bethesda Physical Therapy LLC
Physical Therapy
219 N Route 183
Schuylkill Haven, PA 17972
570-691-8986, 570-739-0905
Est Dist: 5.3 mi

Patel, Tapan, MD
Eye Consultants of Pennsylvania PC
Ophthalmology
100 Schuylkill Medical Plz Ste 100
Pottsville, PA 17901
570-621-5690
Est Dist: 10.0 mi

Lehigh Valley Healthplex
Hospital
Hospital: General Acute Care
420 S Jackson St
Pottsville, PA 17901
570-621-5000, 570-621-4561, 570-621-5050
Est Dist: 10.1 mi

DARCO, Daniel J., MD
Eastern Pennsylvania Radiation Oncology
Pennsylvania Muscle Bone and Joint LLC
Surgery: Orthopedic
15 Alliance St
New Philadelphia, PA 17959
570-277-6218, 570-628-6858
Est Dist: 13.6 mi

Weaver, Brendon J., OD
Weaver Eye Care Associates
Ophthalmology
7185 Bernville Rd Ste B
Bernville, PA 19506
610-488-5315
Est Dist: 8.6 mi

John, Denny, MD
Neurology
205 E Laurel Blvd
Pottsville, PA 17901
570-624-4742
Est Dist: 10.3 mi

Chawluk, John B., MD
Neurology
700 Schuylkill Manor Rd #3
Pottsville, PA 17901
570-622-7704
Est Dist: 10.7 mi

Hawley, Ryan J., DO
Surgery: General Surgery
82 Tunnel Rd
Pottsville, PA 17901
570-622-5455
Est Dist: 11.5 mi

† = Denotes that the original provider record has been changed or a new record has been added.

- You must continue to visit one of these persons listed above, if you need treatment, for ninety (90) day from the date of your first visit. If you do not, your employer may not be required to pay these services.
- After this ninety (90) day period, if you still need treatment and your employer had provided a list as set forth above, you may choose to go to another licensed physician or practitioner of the healing arts for treatment. You must notify your employer of this action within five (5) days of your visit to the person of your choice, or your employer may not be required to pay for these services.
- Your bills will be paid for IF: your licensed physician or practitioner of the healing arts files reports as required. (These reports must be filed within ten (10) days after your first visit and at least once a month for as long as treatment continues.)
- In the event a posted panel physician recommends invasive surgery, you may seek a second opinion with a physician of your choice. If you choose to undergo the invasive surgery, you must use a posted physician for the treatment.
- If no list is provided as above, you may go to a licensed physician of practitioner of the healing arts of your choice.
- If one of the persons listed above refers you to another licensed specialist, your employer or his insurer will pay the bill for these services.

REMEMBER, IT IS IMPORTANT TO TELL YOUR EMPLOYER ABOUT YOUR INJURY

Hawk Mountain Scout Reservation
402 Blue Mountain Rd
Schuylkill Haven, PA 17972

If you need medical attention, you may choose one of the providers listed here. Your Employer and its Insurance Carrier utilize the Genex Services, LLC Network. For a complete listing of providers, or verify whether a particular doctor is part of the network, please send an email to: GPPPanelRequests@genexservices.com. If your situation is a medical emergency requiring immediate attention, dial 911 or proceed to the nearest hospital which provides emergency services. Use of network does not confirm or verify compensability under the Workers' Compensation Act, which is determined solely by the claims administrator.

Above is a listing of physicians and medical facilities for your use in obtaining workers' compensation medical care. The physicians and medical facilities listed above are independent contractors and are not the agents or employees of Genex Services, LLC. The physician and medical facility information is intended to assist in directing the medical care of employees with workers compensation claims where allowed by state law. The information contained herein is subject to change without notice and Genex does not warrant the accuracy of the information or the quality of medical care.

ADVIERTA A EMPLEADOS

Su empleador ha proporcionado para el pago de
Beneficios bajo el Acto de la Compensación de Trabajadores de este Estado

EN CASO DE HERIDA de TRABAJO-RELACIONO

EN CASO DE UNA EMERGENCIA, VA POR FAVOR AL MAS CERCANO HOSPITAL PARA EL TRATAMIENTO.

- Si usted sufre una herida trabajo-relacionado, su empleador o su compañía de seguros deben pagar por servicios y suministros razonables quirúrgicos y médicos, aparatos y prótesis ortopédicos, inclusive la instrucción en su uso.
- Asegurar que su tratamiento médico será pagó por su empleador o la compañía de seguros, **usted debe notificar inmediatamente (aconseja) su supervisor de su herida** , y es tratado por uno de los médicos o facultativos licenciados de las artes curativas listó abajo:

MEDICOS DESIGNADOS
(inclusive la dirección, el número de teléfono, y el área de la especialidad médica)

GSL Hospital
Hospital
Hospital: General Acute Care
100 Paramount Blvd
Orwigsburg, PA 17961
866-785-8537
Est Dist: 9.6 mi

LVPG Orthopedics and Sports Medicine - Mauch Chunk
Surgery: Orthopedic
316 Mauch Chunk St
Pottsville, PA 17901
570-621-9380
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Urgent Care Clinic
4 Clover Dr
Saint Clair, PA 17970
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Sears, Carol D., MD
UPMC Primary Care Fredericksburg
Family Practice
120 South Tan Aly Suite 1
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717-865-6644
Est Dist: 12.7 mi

St. Lukes Care Now - Hamburg
Occupational Medicine Clinic
Urgent Care Clinic
9 Daves Way
Hamburg, PA 19526
610-628-7201
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†Sherpa, Tshering Wangdi, MD
Myerstown Family Practice Associates PC
Family Practice
431 W Lincoln Ave
Myerstown, PA 17067
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Physical Therapy
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Ophthalmology
100 Schuylkill Medical Plz Ste 100
Pottsville, PA 17901
570-621-5690
Est Dist: 10.0 mi

Lehigh Valley Healthplex
Hospital
Hospital: General Acute Care
420 S Jackson St
Pottsville, PA 17901
570-621-5000, 570-621-4561, 570-621-5050
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Eastern Pennsylvania Radiation Oncology
Pennsylvania Muscle Bone and Joint LLC
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Est Dist: 13.6 mi

Weaver, Brendon J., OD
Weaver Eye Care Associates
Ophthalmology
7185 Bernville Rd Ste B
Bernville, PA 19506
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John, Denny, MD
Neurology
205 E Laurel Blvd
Pottsville, PA 17901
570-624-4742
Est Dist: 10.3 mi

Chawluk, John B., MD
Neurology
700 Schuylkill Manor Rd #3
Pottsville, PA 17901
570-622-7704
Est Dist: 10.7 mi

Hawley, Ryan J., DO
Surgery: General Surgery
82 Tunnel Rd
Pottsville, PA 17901
570-622-5455
Est Dist: 11.5 mi

- Usted debe continuar visitar uno de estas personas listó arriba, si usted necesita el tratamiento, por noventa (90) día de la fecha de su primera visita. Si usted hace no, su empleador no puede ser requerido a pagar estos servicios.
- Después de este noventa (90) período de día, si usted necesita todavía el tratamiento y su empleador había proporcionado una lista como conjunto adelante arriba, usted puede escoger ir a otro médico o el facultativo licenciados de la artes curativa para el tratamiento. Usted debe notificar a su empleador de esta acción dentro de cinco (5) días de su visita a la persona de su elección, o de su empleador no puede ser requerido a pagar por estos servicios.
- Sus cuentas serán pagó SI: su médico o el facultativo licenciados de los informes curativos de archivos de artes requirieron como. (Estos informes se deben archivar dentro de diez (10) días después que su primera visita y por lo menos una vez al mes mientras el tratamiento continúa.)
- En caso un médico anunciado de entrepaño recomienda la cirugía invasiva, usted puede buscar una segunda opinión con un médico de su elección. Si usted escoge experimentar la cirugía invasiva, usted debe utilizar a un médico anunciado para el tratamiento.
- Si ninguna lista se proporciona como arriba, usted puede ir a un médico licenciado de facultativo de la artes curativa de su elección.
- Si uno de las personas listó encima de le se refiere a otro especialista licenciado, su empleador o su asegurador pagarán la cuenta para estos servicios.

RECUERDE, ES IMPORTANTE DECIR A SU EMPLEADOR ACERCA DE SU HERIDA

Hawk Mountain Scout Reservation
402 Blue Mountain Rd
Schuylkill Haven, PA 17972

Si usted necesita atención médica, usted puede escoger uno de los proveedores en esta lista. Su Empleador y el Portador de Seguros utilizan la cadena de Proveedores médicos Genex Services, LLC. Para una lista completa de proveedores o para verificar si un médico particular forma parte de la cadena, envíe por favor un correo electrónico a: GPPPanelRequests@genexservices.com. Si su situación es emergencia médica que requiere la atención inmediata, llame al 911 o diríjase al hospital más cercano que proporcione servicios de emergencia. El uso de la cadena de Proveedores no confirma ni verifica la compensabilidad bajo el Artículo de Compensación al Trabajador, esto es determinado únicamente por el administrador de reclamos.

Esta lista de médicos y facilidades médicas es para obtener tratamiento medico relacionado con su lesión en el trabajo. Los médicos y las clínicas médicas en esta lista son contratistas independientes y no son agentes ni empleados de Genex Services, LLC. La información de los médicos y clínicas en esta lista es para asistir en el cuidado médico de empleados con reclamos de Compensación al Trabajador, donde sea permitido por la ley del estado. La información contenida aquí es sujeto ha cambiar sin aviso previo y Genex no garantiza la certeza ni garantiza la calidad del servicio médico.

NOTICE: MEDICAL TREATMENT FOR YOUR WORK INJURY OR OCCUPATIONAL ILLNESS

Your employer has selected a list of 6 or more physicians and other health care providers who are available to treat your work-related injuries and illnesses during the first 90 days of treatment. This list is posted at **Staff Lounge Bulletin Board** for you to view. Also, you may get a copy of this list from **Morgan Baxter or Cole Mitchell.**

If you are injured at work or suffer an occupational illness, you have certain legal RIGHTS and DUTIES under section 306(f.1)(1)(i) of the Workers' Compensation Act regarding your medical treatment. These rights and duties are summarized below.

MEDICAL TREATMENT: DURING THE FIRST 90 DAYS

- You have the RIGHT to receive reasonable and necessary medical treatment for your work injury or occupational illness. Your employer must pay for the treatment, as long as the treatment is by one of the listed providers.
- You have the RIGHT to choose which of the listed providers will treat you for your work injury or illness.
- You have the RIGHT to switch among any of the listed providers when you receive treatment; and if a listed provider refers you to a provider not on your employer's list, you have the RIGHT to receive treatment from the referral provider.
- You have the RIGHT to receive emergency medical treatment from any provider. However, non-emergency treatment must be given by a listed provider.
- If a listed provider prescribes surgery for you, you have the RIGHT to receive a second opinion from any provider of your choice. If that opinion is different from the opinion of the listed provider, you have the RIGHT to choose which course of treatment to follow. If you choose the treatment prescribed in the second opinion, you must receive the treatment from a listed provider for a period of 90 days after the date of your visit to the provider of the second opinion.
- You have the DUTY to visit one or more of the listed providers for the first 90 days of treatment for your work injury or illness if you expect your employer to pay for the medical treatment you receive.
- If you seek treatment for your work injury or illness from a provider who is not on the list, your employer may not have to pay for this medical treatment during this 90-day period. Therefore, you should talk to your employer before seeking treatment from a provider who is not on the list.

IMPORTANT: The requirements your employer must meet to have a valid list of at least 6 providers are shown on the reverse of this form. If the list does not meet these requirements, it is not a valid list, and you have the right to seek medical treatment for your work injury or occupational illness from any health care provider of your choice.

MEDICAL TREATMENT: AFTER THE FIRST 90 DAYS

- You have the RIGHT to receive treatment from any physician or other health care provider of your choice, whether or not they are listed by your employer. Your employer must pay for this treatment, as long as it is reasonable and necessary for your work injury or occupational illness and has been properly documented by the physician or other health care provider.
- You have the DUTY to notify your employer if you receive treatment from a physician or other health care provider who is not listed by your employer. You must notify your employer within five days of the first visit to any provider who is not on your employer's list. The employer may not be required to pay for treatment received until you have given this notice.

Your signature on this form indicates that you have been informed of and you understand these rights and duties. **If you have questions, be sure you have your rights and duties explained to you before signing this form.**

I HAVE BEEN INFORMED OF MY MEDICAL TREATMENT RIGHTS AND DUTIES WITH REGARD TO WORK-RELATED INJURIES AND OCCUPATIONAL ILLNESSES. THIS NOTICE WAS PRESENTED TO ME AT (check one):

☒ TIME OF HIRE ☐ WHEN I WAS INJURED ☐ OTHER

EMPLOYEE: **(sign here)** DATE:

EMPLOYEE REPRESENTATIVE: DATE:

REQUIREMENTS FOR EMPLOYER'S LIST OF HEALTH CARE PROVIDERS

1. There must be at least 6 health care providers on the list, but there may be more than 6 listed.
2. At least 3 of the health care providers on the list must be physicians.
3. No more than 4 of the health care providers on the list may be coordinated care organizations (CCOs).
4. The names, address, phone numbers and areas of medical specialties of all health care providers must be included on the list.
5. The health care providers on the list must be geographically accessible and must have specialties that are appropriate based on the anticipated work-related medical problems of the employees.
6. Your employer must specify on the list if any of the health care providers on the list are employed, owned or controlled by your employer or its workers' compensation insurance company.

NOTE: Your employer's list of health care providers must meet all of the above requirements. **If** the list does not meet all of these requirements, you do not have to choose a provider from the list. Instead, you have the right to seek medical treatment with any health care provider of your choice.

BUREAU OF WORKERS' COMPENSATION
HELPLINE INFORMATION CENTER
1-800-482-2383 (long-distance calls inside PA)
(717) 772-4447 (long-distance calls outside PA)

RIGHTS AND DUTIES FORM - SIDE 1

NOTIFICATION TO EMPLOYEES OF THEIR RIGHTS AND DUTIES UNDER SECTION 306 (f.1)(1)(i) OF THE PA. WORKERS' COMPENSATION ACT

The Pennsylvania Workers' Compensation Act requires that employees be given written notification of their rights and duties under Sec. 306 (f.1)(1)(i) of the Act if a list of designated health care providers is established by the employer. Below are your rights and duties under Sec. 306 (f.1)(1)(i) and an acknowledgment signature line. This acknowledgment, signed by you, is to be returned to your employer.

A brief summary: You have the right to seek emergency medical treatment from any provider; for post-emergency and other injuries, you must obtain treatment for work-related injuries and illnesses from a designated health care provider for 90 days. The penalty for not using a designated health care provider is that your employer is not liable for the medical bills incurred.

As an employee of the Commonwealth working at a location where a list of designated health care providers has been established and posted, you have:

- The duty to obtain treatment for work-related injuries and illnesses from one or more of the designated health care providers for 90 days from the date of the first visit to a designated provider.
- The right to seek emergency medical treatment from any provider, but subsequent non-emergency treatment shall be by a designated provider for the remainder of the 90-day period.
- The right to have all reasonable medical supplies and treatment related to the injury paid for by your employer as long as treatment is obtained from a designated provider during the 90-day period.
- The right, during this 90-day period, to switch from one designated health care provider to another designated provider.
- The right to seek treatment from a provider if you are referred to that provider by a designated provider.
- The right to an additional opinion from a provider of your choice when invasive surgery is prescribed by the designated provider.
- The right to seek treatment or medical consultation from a non designated provider during the 90-day period, but the services shall be **at your expense** for the applicable 90 days.
- The right to seek treatment from any health care provider after the 90-day period has ended.
- The duty to **notify your employer of treatment by a non designated provider (after the 90 day period) within 5 days of the first visit to that provider.** The employer may not be required to pay for treatment rendered by a non designated provider prior to receiving this notification.

I acknowledge that I have been informed of my rights and duties under Sec. 306 (f.1)(1)(i) and that I understand them to the extent that they are explained above.

Print Name Employee Signature Date

See reverse for a complete text of Section 306 (f.1)(1)(i)
If you have any questions, ask your human resources office representative or call
The Bureau of Workers' Compensation at 1-800-482-2383

RIGHTS AND DUTIES FORM - SIDE 2

PENNSYLVANIA WORKERS' COMPENSATION ACT SECTION 306 (f.1)(1)(i)

The employer shall provide payment in accordance with this section for reasonable surgical and medical services, services rendered by physicians or other health care providers, including an additional opinion when invasive surgery may be necessary, medicines and supplies, as and when needed. Provided an employer establishes a list of at least six designated health care providers, no more than four of whom may be a coordinated care organization and no fewer than three of whom shall be physicians, the employee shall be required to visit one of the physicians or other health care providers so designated and shall continue to visit the same or another designated physician or health care provider for a period of ninety (90) days from the date of the first visit: provided, however, that the employer shall not include on the list a physician or other health care provider who is employed, owned or controlled by the employer or the employer's insurer unless employment, ownership or control is disclosed on the list. Should invasive surgery for an employee be prescribed by a physician or other health care provider so designated by the employer, the employee shall be permitted to receive an additional opinion from any health care provider of the employee's own choice. If the additional opinion differs from the opinion provided by the physician or health care provider so designated by the employer, the employee shall determine which course of treatment to follow: provided, that the second opinion provides a specific and detailed course of treatment. If the employee chooses to follow the procedures designated in the second opinion, such procedures shall be performed by one of the physicians or other health care providers so designated by the employer for a period of ninety (90) days from the date of the visit to the physician or other health care provider of the employee's own choice. Should the employee not comply with the foregoing, the employer will be relieved from liability for the payment for the services rendered during such applicable period. It shall be the duty of the employer to provide a clearly written notification of the employee's rights and duties under this section to the employee. The employer shall further ensure that the employee has been informed and that he understands these rights and duties. This duty shall be evidenced only by the employee's written acknowledgment of having been informed and having understood his rights and duties. Any failure of the employer to provide and evidence such notification shall relieve the employee from any notification duty owed, notwithstanding any provision of this act to the contrary, and the employer shall remain liable for all rendered treatment. Subsequent treatment may be provided by any health care provider of the employee's own choice. Any employee who, next following termination of the applicable period, is provided treatment from a nondesignated health care provider shall notify the employer within five (5) days of the first visit to said health care provider. Failure to so notify the employer will relieve the employer from liability for the payment for the services rendered prior to appropriate notice if such services are determined pursuant to paragraph (6) to have been unreasonable or unnecessary.

WAGE PAYMENT CONSENT FORM

EMPLOYEE INFORMATION *(print and complete all fields)*

First Name	Middle Initial	Last Name
Employee ID		

WAGE PAYMENT ELECTION

☐ Direct Deposit	☐ Wisely Paycard	☐ Check
(indicate account type and provide Account and routing numbers): ☐ Checking Account ☐ Savings Account _____ *account number* _____ *routing number*	I confirm my voluntary authorization to be paid through the payroll card. I acknowledge I have received and read the payroll card Fee Schedule, Cardholder Agreement and Privacy Notice. I understand that in order to use the payroll card, I will need to accept and agree to the Cardholder Agreement and Fee Schedule by activating my payroll card. By electing payroll card as my wage payment choice, I am consenting to provide my personal information to ADP to enroll in and request a payroll card.	I understand that by selecting check that my check may be mailed per company policy, if applicable.

Offcycle Payment Election

I confirm my voluntary authorization to be paid any offcycle payments, such as but not limited to bonuses, commissions, termination, and expense reimbursements:

☐ Same method as indicated above
☐ Check

IMPORTANT INFORMATION ABOUT APPLYING FOR A NEW PREPAID CARD ACCOUNT - To help the government fight the funding of terrorism and money laundering activities, Federal law requires all financial institutions to obtain, verify, and record information that identifies each person who opens an account. What this means for you: When you open a Prepaid Card account, ADP may require your name, address, date of birth, Social Security number, tax identification number and other information that will allow ADP to identify you. ADP may also ask to see your driver's license or other identifying documents. You will not be subject to a credit check.

WAGE PAYMENT CONSENT FORM

AUTHORIZATION TO DEBIT/CREDIT ACCOUNT

I authorize my employer (or its payroll service provider) to initiate credit entries each pay date to deposit my pay (either net or a portion thereof) into the checking, savings or Wisely Pay card account selected in this election and consent (the "Account") in accordance to applicable regulations and/or law. If funds to which I am not entitled are deposited to my Account, I authorize my employer (or its payroll service provider), to initiate any action to reverse or correct an erroneous credit entry to my Account and to direct the bank to return said funds to my employer (either directly or through its payroll service provider), to the extent permitted by applicable law. I will review my pay statement to ensure that my wages are being deposited correctly into my Account each payroll period.

CONSENT TO ELECTRONIC PAY STATEMENTS

I agree to receive and access all of my pay statements on or before each regular pay day electronically on myADP.com, a secure website, rather than receiving a paper statement, until I withdraw my consent. I understand that I may retain a copy of the pay statement by saving it to my computer or by printing a hard copy of it. I understand that I should not save my statement to a public computer as others may see my statement. (Note: Your statements will remain on the secure website for 3 years. If you want to retain a copy for a longer period, you must either print a copy or save an electronic copy.)

I understand that I may withdraw this authorization at any time by informing the Scouting America Hawk Mountain Council main office at 610.926.3406. I acknowledge that the mere request for a paper pay statement will not be considered withdrawal of my consent. I understand this consent applies to pay statements furnished every pay period until my consent is withdrawn. (Note: The withdrawal of your consent will not be effective and you will not start receiving paper statements for 1 or 2 additional payroll cycles.)

I understand that I can change my election at any time by contacting my employer and that this authorization replaces any previous authorizations and will remain in full force and effect until my employer (or its payroll service provider) has received written notification from me of its termination and my employer (or its payroll service provider) and the bank has had a reasonable opportunity to act on said termination. I further understand that if I choose not to make a selection that my employer may default me to a Check until I provide a selection.

_____ _____

Employee Signature Date

ADULT APPLICATION

This application is also available in Spanish. Esta solicitud también está disponible en español.

MISSION

The mission of Scouting America is to prepare young people to make ethical and moral choices over their lifetimes by instilling in them the values of the Scout Oath and Scout Law.

Your participation in Scouting America can help youth become better citizens.

Adult leaders serve as important role models for youth in Scouting America and this application aids the chartered organization in selecting qualified adult volunteer leaders.

YOUTH PROTECTION TRAINING

All adult applicants are required to take this training in order to complete the adult application process. Go to my.scouting.org to create an account and take the training online, or contact your local council for classroom training. Include a copy of your completion certificate with this application.

CRIMINAL BACKGROUND CHECK*

In order to complete the adult application process, you will need to review the different disclosures that have been separately provided to you. The separate authorization form must be signed and returned when you submit your application.

EXCERPT FROM THE DECLARATION OF RELIGIOUS PRINCIPLE

Scouting America maintains that no member can grow into the best kind of citizen without recognizing an obligation to God and, therefore, recognizes the religious element in the training of the member, but it is absolutely nonsectarian in its attitude toward that religious training. Its policy is that the home and organization or group with which the member is connected shall give definite attention to religious life. Only persons willing to subscribe to these precepts from the Declaration of Religious Principle and the Bylaws of Scouting America shall be entitled to register.

All adult leaders agree to comply with the Scouter Code of Conduct.
https://www.scouting.org/health-and-safety/guidelines-policies/

***The three different background check forms must be torn off and each separately given to the applicant.**

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03/2025

Scouting America

Leader Requirements

Scouting America is open to all who meet the requirements, and leaders are selected based on individual merit. Adult leaders must possess the moral, educational, and emotional qualities that Scouting America deems necessary for positive leadership to youth. They must also:

- Abide by the Scout Oath, Scout Law, and Scouter Code of Conduct. The Scouter Code of Conduct can be found at www.scouting.org/health-and-safety/gss/bsa-scouter-code-of-conduct/.
- Subscribe to the precepts of the Declaration of Religious Principle.
- Reside within the USA or a U.S. territory, or be a U.S. citizen residing outside the USA.
- Be 21 years of age or older for primary leadership positions.
- Be 18 years of age or older for assistant leadership positions.
- Complete Youth Protection training (YPT) before application is processed and renew training as required by going to my.scouting.org and creating an account.
- Review the disclosure information related to Scouting America's background check process and complete and sign a Background Check Authorization form.
- Take leader position-specific training at my.scouting.org. Classroom training may also be available through your local council.

It is the philosophy of Scouting to welcome all eligible adults, regardless of gender, race, ethnic background, sexual orientation, or gender identification, who are willing to accept Scouting's values and meet any other requirements of membership.

APPROVAL REQUIRED—UNIT ADULTS

The chartered organization representative is approved by the head of the chartered organization. All other adult leader applications must be accepted and approved by the head of the chartered organization or the chartered organization representative.

Scout executive or designee must approve any adults who answer "yes" to any Additional Information question.

APPROVAL REQUIRED—COUNCIL and DISTRICT ADULTS

Scout executive or designee must accept and approve all council and district adults.

Scout executive or designee must approve any adults who answer "yes" to any Additional Information question.

The adult leader application process will not be complete until Youth Protection training has been completed and a criminal background check has been obtained.

Health information. You should inform your unit leadership of any condition that might limit your participation. Before participating in activities with your unit, please fill out the Annual Health and Medical Record, No. 680-001, found on www.scouting.org/forms and provide it to your unit leadership.

Scout Life. Registered adults get a special $15 rate. For a subscription to a magazine that helps children grow in the Scouting program, just fill in the *Scout Life* circle on the application and pay the subscription price.

THE ANNUAL NATIONAL REGISTRATION FEE IS NONREFUNDABLE.

Scouting America Privacy Policy

Scouting America protects the confidentiality of the names and personal information of those who are affiliated with the organization. No commercial or unauthorized use is made of the names, addresses, and other confidential information. Scouting America and its affinity groups may use registration information to notify registrants of benefit opportunities.

For general questions, contact your Scouting America local council or visit www.scouting.org for current policies.

What Is the Scouting America Program?

The Scouting America program is outlined in the official publications of Scouting America. Activities that are not in these publications are not a part of the Scouting program. Leaders must not allow youth members or program participants to engage in any unauthorized or prohibited activities.

Training for New Leaders

Scouting America is committed to your success as a volunteer while serving young people. To help you be successful, there are training materials designed for you. Training resources are available through your local council and at my.scouting.org.

What Makes a Trained Leader?

You are considered a trained leader when you have completed leader position-specific training for your position and have current Youth Protection training.

Youth Protection Begins With You™

Child abuse is a serious problem in our society, and unfortunately, it can occur anywhere, even in Scouting. For that reason, Scouting America continues to create barriers to abuse beyond what have previously existed in Scouting.

Scouting America is committed to providing a safe environment for young people. All adult leaders must complete Youth Protection training as part of the registration process and renew their training as required. It is highly recommended that parents who participate in Scouting activities complete YPT. To learn more about Scouting America's Youth Protection resources, go to www.scouting.org/training/youth-protection/.

Mandatory Reporting

All persons involved in Scouting must immediately report to local authorities any good-faith suspicion or belief that any child is or has been physically or sexually abused; physically or emotionally neglected; exposed to any form of violence or threat; or exposed to any form of sexual exploitation including the possession, manufacture, or distribution of child pornography, online solicitation, enticement, or showing of obscene material. No person may abdicate this reporting responsibility to any other person.

Additionally, any **known or suspected abuse or behavior that might put a youth at risk** must also be reported to the local Scout executive or the Scouts First Helpline (1-844-SCOUTS1 or 1-844-726-8871) if your Scout executive or local council cannot be reached.

Youth Protection Policies

- Two registered adult leaders 21 years of age or over are required at all Scouting activities, including meetings. There must be a registered female adult leader over 21 in every unit serving females. A registered female adult leader over 21 must be present for any activity involving female youth.
- One-on-one contact between adult leaders and youth members is prohibited both inside and outside of Scouting.

These and other key Youth Protection policies are addressed in the training and at www.scouting.org/training/youth-protection/.

To learn about Scouting America's other health and safety policies, please review the online version of the *Guide to Safe Scouting*, the Scouter Code of Conduct, and the SAFE Checklist, which are available at www.scouting.org/health-and-safety/.

Scout Oath

On my honor I will do my best to do my duty to God and my country
and to obey the Scout Law; to help other people at all times;
to keep myself physically strong, mentally awake, and morally straight.

Scout Law

A Scout is trustworthy, loyal, helpful, friendly, courteous, kind,
obedient, cheerful, thrifty, brave, clean, and reverent.

SCOUTING AMERICA ADULT APPLICATION

All fields must be completed in order to process your registration.

First name **(Full legal name)** | Middle name | Last name | Suffix

Country | Home Address | Date of Birth (mm/dd/yyyy)

City | County | State | Zip | Social Security Number **(required)**

Ethnic background: ◯ Black/African ◯ Caucasian/White ◯ Native American ◯ Hispanic/Latino ◯ Alaska Native ◯ Pacific Islander ◯ Asian ◯ Other | Gender: ◯ M ◯ F

Primary phone | Alternate phone | Extension | ◯ ***Scout Life*** **subscription**

Please select your preference of communication: ◯ Email ◯ Phone Call ◯ SMS/Text

Email address | Occupation

Are you an Eagle Scout? Yes ◯ No ◯ If so, enter date earned Eagle (mm/dd/yyyy) | Employer

All questions MUST be answered. Write NONE if not applicable.

1. Scouting background.
   POSITION COUNCIL YEAR
   _____
   _____
   _____

2. Experience working with youth in other organizations.
   Please provide contact information for at least two below.
   Organization _____
   Contact name _____
   Phone _____
   Organization _____
   Contact name _____
   Phone _____
   Organization _____
   Contact name _____
   Phone _____

3. Previous residences (for last 10 years).
   CITY STATE
   _____ _____
   _____ _____
   _____ _____

4. Current memberships (religious, community, business, labor, or professional organizations).
   _____
   _____
   _____

5. Additional information. (Mark each answer.)
   a. Have you ever been removed from or asked to leave a leadership position in an organization due to allegations regarding your personal conduct or behavior? Explain: Yes ◯ No ◯
   _____

   b. Have you ever been arrested for a criminal offense (other than minor traffic violations)? Explain: Yes ◯ No ◯
   _____

   c. Has your driver's license ever been suspended or revoked? Explain: Yes ◯ No ◯
   _____

   d. Have you ever been investigated for, accused of, or charged with abuse or neglect of a minor child? Explain: Yes ◯ No ◯
   _____

I hereby certify that

1. I have read and affirm that I accept the Declaration of Religious Principle. I agree to comply with the rules and regulations of Scouting America and the local council, including the Scouter Code of Conduct. **INITIALS REQUIRED** _____
2. I affirm that the information contained in this application is true and accurate to the best of my knowledge and belief. _____

Signature of applicant | Date

◯ YPT completion certificate attached and Background Check Authorization form attached

TO BE COMPLETED BY UNIT

Careful review of the information provided on this application is a significant step in Scouting's efforts to protect its youth members and deliver a quality program.

All applications should be submitted to the local council within 5 business days.

APPROVALS FOR UNIT ADULTS: I have reviewed this application and the responses to any questions answered "Yes," and have made any follow-up inquiries necessary to be satisfied that the applicant possesses the moral, educational, and emotional qualities to be an adult leader in Scouting America.

Signature of Chartered Organization Head or representative or council representative | Date

Unit type: ◯ Pack ◯ Troop ◯ Crew ◯ Ship

◯ New leader ◯ Former leader ◯ Position change ◯ Participant

Unit No. or District name

Scouting Position Code | Scouting Position Title

$ Registration fee | $ Council fee | $ *Scout Life* fee

PAID: ◯ Cash ◯ Check No. _____ ◯ Credit card

APPROVAL FOR COUNCIL AND DISTRICT ADULTS: I have reviewed this application and have made any follow-up inquiries necessary to be satisfied that the applicant possesses the moral, educational, and emotional qualities to be an adult leader in Scouting America.

Signature of Scout Executive or designee | Date

If applicant has a current registration in another unit or local council, the registration may be completed at no charge by transferring the registration or multiple registering.

Unit No. or District name

Transferring from Unit/Council:

◯ Transfer application ◯ Multiple application ◯ Pack ◯ Troop ◯ Crew ◯ Ship

Enter membership number from unexpired registration:

Tear off the following pages and provide to applicant separately.

BACKGROUND CHECK
DISCLOSURE

A consumer report is a background check in which information (which may include, but is not limited to, criminal background, driving background, character, general reputation, personal characteristics, and mode of living) about you is gathered and communicated by a consumer reporting agency ("CRA") to Scouting America and/or its subsidiaries, affiliates, other related entities, and/or successors (the "Company").

The Company may obtain a consumer report on you to be used for employment purposes (in your case, this means for the purpose of evaluating you as a new or existing volunteer).

The consumer reporting agency is **Sterling**, a First Advantage company, with its principal office located at 6150 Oak Tree Boulevard - Suite 490, Independence, OH 44131

Sterling's website is: https://www.sterlingcheck.com/

Sterling's Data Privacy practices can be found here: https://privacy.sterlingcheck.com/

DISPUTES

The candidate may dispute the accuracy or completeness of a consumer report. To initiate a dispute, you are encouraged to call Sterling at 1-888-889-5248. You may also reach out to us via email regarding disputed information on your background check at dispute.resolution@sterlingcheck.com. In general, a CRA has up to 30 days to resolve a dispute, although Sterling generally handles disputes more quickly than this. You will be notified via email of the resolution.

HOW TO GET A COPY OF YOUR BACKGROUND CHECK REPORT

If Sterling has prepared a consumer report or investigative consumer report in your name — as per the FACT (Fair and Accurate Credit Transactions) Act — you are entitled to a free copy of the completed report during each 12-month period. To receive a free copy of the report(s) in your file, please complete our online contact form.

CALIFORNIA
STATE LAW DISCLOSURES
(Non-Credit)

Under California law, an "investigative consumer report" is a consumer report in which information on a consumer's character, general reputation, personal characteristics, or mode of living is obtained through any means. Scouting America and/or its subsidiaries, affiliates, other related entities, and/or successors (the "Company") may obtain an investigative consumer report (which may include information described above) from an investigative consumer reporting agency ("ICRA") on you in connection with your status as a volunteer (i.e., for employment purposes under California law). The nature and scope of this investigation includes your character, general reputation, personal characteristics, or mode of living information, including criminal history and driving record.

The ICRA preparing the investigative consumer report and conducting the investigation will be First Advantage, P.O. Box 105292, Atlanta, GA 30348, 800-845-6004. Information regarding First Advantage's privacy practices can be found at https://fadv.com/privacy-policy/.

Under California Civil Code section 1786.22, you are entitled to a visual inspection of files maintained on you by an ICRA, as follows:

(1) In person, if you appear in person and furnish proper identification, during normal business hours and on reasonable notice. A copy of your file shall also be available to you for a fee not to exceed the actual costs of duplication services provided;

(2) By certified mail, if you make a written request, with proper identification, for copies to be sent to a specified addressee. An ICRA complying with requests for certified mailings under California Civil Code section 1786.22 shall not be liable for disclosures to third parties caused by mishandling of mail after such mailings leave the ICRA;

(3) A summary of all information contained in your files and required to be provided by the California Civil Code section 1786.10 shall be provided to you by telephone, if you have made a written request, with proper identification for telephone disclosure, and the toll charges, if any, for the telephone call are prepaid by you or charged directly to you.

"Proper Identification" as used above, means information generally deemed sufficient to identify you, which includes documents such as a valid driver's license, social security number, military identification card, and credit cards. Only if you cannot identify yourself with such information may the ICRA require additional information concerning your employment and personal or family history in order to verify your identity.

The ICRA will provide trained personnel to explain any information furnished to you pursuant to California Civil Code section 1786.10 and will provide a written explanation of any coded information contained in files maintained on you. This written explanation will be provided whenever a file is provided to you for visual inspection under California Civil Code section 1786.22.

You may be accompanied by one other person of your choosing, who must furnish reasonable identification. An ICRA may require you to furnish a written statement granting permission to the ICRA to discuss your file in such person's presence.

ADDITIONAL DISCLOSURES & BACKGROUND CHECK AUTHORIZATION

Additional Disclosures

The state disclosures below are included because state law requires them to be provided in writing. Some of the below rights, notices, or information also may apply to individuals from, applying to, or volunteering in states not listed below. There may be additional requirements, options, or provisions applicable to you and you may have additional rights under applicable law that are not required to be disclosed to you in writing.

Minnesota: You have the right to request a complete and accurate disclosure of the nature and scope of any consumer report from First Advantage, P.O. Box 105292, Atlanta, GA 30348, 800-845-6004.

New York: Scouting America and/or its subsidiaries, affiliates, other related entities, and/or successors (the "Company") may request or utilize subsequent consumer reports (other than investigative consumer reports) on you throughout your volunteer relationship with the Company. Upon request, you will be informed whether or not a consumer report was requested, and if such report was requested, informed of the name and address of the CRA that furnished the report. Your written request should be made to Scouting America, Membership Standards Team S201, 1325 West Walnut Hill Lane, P.O. Box 152079, Irving, TX 75015-2079. You may also contact the Company by email at MembershipStandards@scouting.org

AUTHORIZATION

(Please print)

Name: First _____ Middle _____ Last _____ Suffix _____

List any other names used (nickname, maiden/married last names: _____

Date of Birth: _____ Unit Type and Number: _____

To the extent permitted by applicable law, I hereby consent to and authorize Scouting America and/or its subsidiaries, affiliates, other related entities, and/or successors (the "Company") to procure consumer report(s) (as defined by federal law) and/or investigative consumer report(s) (as defined by applicable California state law), which in my case means criminal background check(s)/driving record(s), on my background from a consumer reporting agency ("CRA") or from an investigative consumer reporting agency ("ICRA"), as described in the **Background Check Disclosure** and the **California State Law Disclosures (Non-Credit)** (each of which I have received separately from the Company), as well as these **Additional Disclosures & Background Check Authorization**. This authorization applies only to criminal checks/driving records and does not allow the Company to obtain credit checks. I have reviewed and understand the information, statements, and notices in the **Background Check Disclosure** and the **California State Law Disclosures (Non-Credit)**, as well as these **Additional Disclosures & Background Check Authorization**. My authorization remains valid throughout my volunteer relationship with the Company, such that, to the extent permitted by applicable law, I agree the Company can procure additional consumer report(s), which in my case means criminal background check(s)/driving record(s), during my volunteer relationship without providing additional disclosures or obtaining additional authorizations. Except as otherwise prohibited by applicable law, I consent to and authorize the Company to share this information with the Company's local councils and/or chartered organizations for business reasons (e.g., to place me in certain positions, work sites, etc.). I understand that, if I am selected for a volunteer position, a consumer report will have been conducted on me.

☐ **For California, Minnesota, or Oklahoma individuals:** If you would like to receive from the CRA, the ICRA, or the Company (as applicable) a copy of the report that the Company may procure, please check this box.

Signature _____ Date _____

YOUTH APPLICATION

This application is also available in Spanish. Esta solicitud también está disponible en español.

Cub Scouting

Scouts BSA

Venturing

Sea Scouting

Scout Oath

On my honor I will do my best
to do my duty to God and my country
and to obey the Scout Law;
to help other people at all times;
to keep myself physically strong,
mentally awake, and morally straight.

Scout Law

A Scout is trustworthy, loyal,
helpful, friendly, courteous, kind,
obedient, cheerful, thrifty, brave,
clean, and reverent.

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Scouting America

03/2025

Welcome to Scouting America!

Scouting America makes Scouting available to our nation's youth by chartering community organizations to operate Cub Scout packs, Scouts BSA troops, Venturing crews, and Sea Scout ships.

The chartered organization provides an adequate and safe meeting place as well as capable adult leadership, and requires adherence to the principles and policies of Scouting America. The local and national councils provide training, program, outdoor facilities, literature, professional guidance, and liability insurance protection.

Parent/Legal Guardian Role in Scouting

Scouting uses a fun program to promote character development, citizenship training, leadership, and mental and physical fitness. You can help by encouraging attendance, assisting with your child's advancement, attending meetings for parents, and assisting the unit when called upon to help. The unit cannot provide a quality program without your help.

Parent Agreement. I have read the Scout Oath and Scout Law, and I want my child to join Scouting. I will assist them in abiding by the policies of Scouting America and the chartered organization. I will:

- *Serve as an adult partner while my child is a Lion or Tiger.*
- *Help my Scout grow through completion of advancements.*
- *Help the unit with activities and assist as needed.*

Health Information. You should inform your unit leader of any condition that might limit your child's participation. Please fill out the Annual Health and Medical Record, No. 680-001, found on www.scouting.org/forms and give it to the unit leader.

Youth Protection Begins With You™. Child abuse is a serious problem in our society, and unfortunately, it can occur anywhere, even in Scouting. Youth safety is of paramount importance to Scouting. For that reason, Scouting America continues to create and consistently improve its barriers to abuse.

Scouting America is committed to providing a safe environment for young people. To maintain a safe environment, Scouting America provides parents and adult leaders with numerous online and printed resources and adult leaders must complete Youth Protection Training (YPT) and renew their training as required. Parents who participate in Scouting activities are highly recommended to complete YPT. To learn more about Scouting America's Youth Protection resources, go to www.scouting.org/training/youth-protection/.

Mandatory Reporting

All persons involved in Scouting must immediately report to local authorities any good-faith suspicion or belief that any child is or has been physically or sexually abused; physically or emotionally neglected; exposed to any form of violence or threat; or exposed to any form of sexual exploitation including the possession, manufacture, or distribution of child pornography, online solicitation, enticement, or showing of obscene material. No person may abdicate this reporting responsibility to any other person.

Additionally, any known or suspected abuse or behavior that might put a youth at risk must also be reported to the local Scout executive or the Scouts First Helpline (1-844-SCOUTS1 or 1-844-726-8871) if your Scout executive or local council cannot be reached.

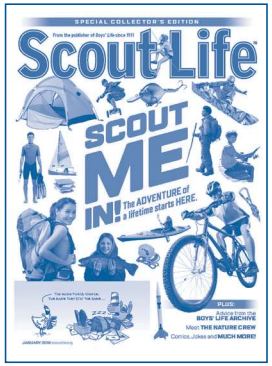
All parents must review the *How to Protect Your Children From Child Abuse: A Parent's Guide* booklet in the Cub Scout or Scouts BSA handbooks or at www.scouting.org/training/youth-protection/.

Youth Protection Policies

- Two registered adult leaders 21 years of age or over are required at all Scouting activities, including meetings. There must be a registered female adult leader over 21 in every unit serving females. A registered female adult leader over 21 must be present for any activity involving female youth.
- One-on-one contact between adult leaders and youth members is prohibited both inside and outside of Scouting.

These and other key Youth Protection policies are addressed in the training and at www.scouting.org/training/youth-protection/.

To learn about Scouting America's other health and safety policies, please review the online version of the *Guide to Safe Scouting,* the Scouter Code of Conduct, and the SAFE Checklist, which are available at www.scouting.org/health-and-safety.



Scout Life Magazine

For a subscription to a magazine that will help your child grow in the Scouting program, just fill in the *Scout Life* circle on the application and pay the special Scout subscription price.

For details, go to subscribe.scoutlife.org

Who Can Join?

It is the philosophy of Scouting to welcome all eligible youth, regardless of gender, race, ethnic background, sexual orientation, or gender identification, who are willing to accept Scouting's values and meet any other requirements of membership.

Joining Requirements

Cub Scout Pack

Pack membership is open to youth in kindergarten through fifth grade.

***Lion**—Kindergarten (year before first grade) **Bear**—Third grade

***Tiger**—First grade **Webelos Scout**—Fourth grade

Wolf—Second grade **Arrow of Light Scout**—Fifth grade

Lions and Tigers must have an adult partner. If the parent is not serving as the adult partner, the parental signature on the application indicates their approval of the adult partner. In addition, if the adult partner does not live at the same address as the Lion or Tiger, an adult application is required.

Scouts BSA Troop

Youth can be Scouts if they are at least 10 years old, currently in the fifth grade and register on or after March 1; OR have earned the Arrow of Light Award and are at least 10 years old, OR are age 11 but have not reached age 18.

Venturing Crew/Sea Scout Ship

Venturing and Sea Scouting are for young men and women at least 13 years old who have completed the eighth grade, or are age 14 and not yet 21. **Applicants age 18 and older must complete a Scouting America adult application.**

Excerpt From the Declaration of Religious Principle

Scouting America maintains that no member can grow into the best kind of citizen without recognizing an obligation to God and, therefore, recognizes the religious element in the training of the member, but is absolutely nonsectarian in its attitude toward that religious training. Its policy is that the home and the organization or group with which the member is connected shall give definite attention to religious life. Only persons willing to subscribe to this Declaration of Religious Principle and to the Bylaws of Scouting America shall be entitled to certificates of membership.

THE ANNUAL NATIONAL REGISTRATION FEE IS NONREFUNDABLE.

For general questions, contact your Scouting America local council or visit www.scouting.org for current policies.

SCOUTING AMERICA YOUTH MEMBER APPLICATION—Must be completed by the youth's parent or legal guardian

YOUTH INFORMATION

First name **(Full legal name)** | Middle name | Last name | Suffix | Preferred nickname

Country | Home address | City | State | Zip code

Phone - - | Date of birth (mm/dd/yyyy) / / | Grade

Ethnic background:
- Black/African American
- Caucasian/White
- Hispanic/Latino
- Native American
- Pacific Islander
- Other
- Alaska Native
- Asian

Gender: Male Female

☐ ***Scout Life*** **subscription**

School | Youth email address

PARENT/LEGAL GUARDIAN INFORMATION

☐ Mark here if address is same as above. ☐ Mark here if you are the Lion or Tiger adult partner.

Select relationship: ☐ Parent ☐ Legal Guardian

☐ Mark here if the Lion or Tiger adult partner is not the parent or legal guardian. Have the adult partner complete and attach an adult application and indicate their relationship below.

First name **(Full legal name)** | Middle name | Last name | Suffix | Preferred nickname

Country | Home address | City | State | Zip code

Primary phone - - | Date of birth (mm/dd/yyyy) / / | Occupation | Employer | Gender: Male Female

Alternate phone - - x | Ext. | Previous Scouting experience

I have read the attached information for parents and approve the application. I affirm that I have or will review *How to Protect Your Children From Child Abuse: A Parent's Guide.*

Signature of parent/legal guardian | Date / / | Parent/legal guardian email address

To be completed by unit

Signature of unit leader (or designee) | Date / /

Unit type: ☐ Pack ☐ Troop ☐ Crew ☐ Ship ☐ Lone Cub Scout ☐ Lone Scout | ☐ Has earned Arrow of Light

Unit No.: For pack registration select one: ☐ Lion ☐ Tiger ☐ Wolf ☐ Bear ☐ Webelos

Registration fee $ | Council fee $

Scout Life fee $ 15.00 PAID: ☐ Cash ☐ Check No. _____ ☐ Credit card

If applicant has unexpired membership certificate, registration may be accomplished at no charge by transferring the registration or multiple registering.

☐ Transfer application
☐ Multiple application

Enter membership number from unexpired certificate:

Council No.:

Unit type: ☐ Pack ☐ Troop ☐ Crew ☐ Ship

Unit No. or district name: