OFFICE USE ONLY
Hire Date:
Position:
Rate of Pay:
Supervisor:

Dieudonne Enterprises, Inc.
5800 River Oaks Rd S
Harahan, LA 70123

EMPLOYMENT APPLICATION

Valid for 60 days from application date unless renewed in person

PERSONAL INFO

APPLICATION DATE:_____

Name: _____ S.S. # _____ DOB: _____
Address: _____ Phone #: _____
City: _____ State: _____ Zip Code: _____

Are you 18 years old or older? Yes _____ No _____
Have you ever been bonded? Yes _____ No _____ If yes, with what employers? (Answer only if job related) _____
In the past 7 years, have you been convicted of a crime(s) other than a minor traffic violation?
Yes _____ No _____ Explanatory Details: _____
_____

GENERAL

Position Desired: _____ Date available to start work: _____

Employment Eligibility Status:
Are you eligible to be employed lawfully in the United States? Yes _____ No _____
(Proof of citizenship or immigration status is required upon employment)

EDUCATION

	Name of School	Location	Years Attended	Degree
Grade School:				
High School:				
College:				
Trade School:				

MILITARY SERVICE (Answer if experience/training is job related)

Did you ever serve in the armed forces? Yes _____ No _____
Branch of Service: _____ From: _____ To: _____ Duties: _____
_____

EMPLOYMENT HISTORY: List below all your previous employment. Account for all your time including periods of unemployment. (If you have been self-employed, please give details such as name of the firm, location, and why business was discontinued). Begin with your most recent job.

Company: _____ Type of Business: _____
Address: _____ Phone #: _____
Date Started: _____ Date Left: _____ Position: _____
Description of Duties: _____
Reason for Leaving: _____

Company: _____ Type of Business: _____
Address: _____ Phone #: _____
Date Started: _____ Date Left: _____ Position: _____
Description of Duties: _____
Reason for Leaving: _____

Company: _____ Type of Business: _____
Address: _____ Phone #: _____
Date Started: _____ Date Left: _____ Position: _____
Description of Duties: _____
Reason for Leaving: _____

Company: _____ Type of Business: _____
Address: _____ Phone #: _____
Date Started: _____ Date Left: _____ Position: _____
Description of Duties: _____
Reason for Leaving: _____

Please explain any periods of unemployment (except military service): _____
_____

Have you ever been terminated or asked to resign from a job? Yes _____ No _____
If yes, explain: _____

EMPLOYEE INFORMATION PAGE

In Case of an Emergency

Employee Name: _____

Date of Birth: _____ SS# or ID # _____

Emergency Contact Person: _____

Relationship: _____ Phone # _____

Employee Information:

Any known allergies: _____

List prior surgeries: _____

List Medications you are taking: _____

_____

Please list any other conditions we should know about: _____

_____

_____ _____

Signature Date

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

2026

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.)

Caution: To claim certain credits or deductions on your tax return, you (and/or your spouse if married filing jointly) are required to have a social security number valid for employment. See page 2 for more information.

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 Step 2(b) if pay at the lower paying job is more than half of the pay at the higher paying job. Otherwise, Step 2(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):

(a) Multiply the number of qualifying children under age 17 by $2,200 . . . . . **3(a)** $

(b) Multiply the number of other dependents by $500 . . . **3(b)** $

Add the amounts from Steps 3(a) and 3(b), plus the amount for other credits. Enter the total here . . . . . **3** $

Step 4: 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. Use the Deductions Worksheet on page 4 to determine the amount of deductions you may claim, which will reduce your withholding. (If you skip this line, your withholding will be based on the standard deduction.) Enter the result here . . **4(b)** $

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

Exempt from withholding

I claim exemption from withholding for 2026, and I certify that I meet **both** of the conditions for exemption for 2026. See *Exemption from withholding* on page 2. I understand I will need to submit a new Form W-4 for 2027 . ☐

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)
Dieudonne Enterprises, Inc. 5800 River Oaks Rd S Harahan, LA 70123		32-0159528

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 2026 if you meet both of the following conditions: you had no federal income tax liability in 2025 **and** you expect to have no federal income tax liability in 2026. You had no federal income tax liability in 2025 if (1) your total tax on line 24 on your 2025 Form 1040 or 1040-SR is zero (or less than the sum of lines 27a, 28, 29, and 30), 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 2026 tax return. To claim exemption from withholding, certify that you meet both of the conditions by checking the box in the *Exempt from withholding* section. 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 16, 2027.

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 of tax withheld 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 (and/or your spouse if married filing jointly) must have the required social security number to claim certain credits. 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.

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 15, if you expect to claim deductions other than the basic standard deduction on your 2026 tax return and want to reduce your withholding to account for these deductions. This includes both itemized deductions and other deductions such as for qualified tips, overtime compensation, and passenger vehicle loan interest; student loan interest; IRAs; and seniors. You (and/or your spouse if married filing jointly) must have the required social security number to claim certain deductions. For additional eligibility requirements, see Pub. 501.

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 when you file your tax return.

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 5. 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 5 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 5 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 (plus any other additional amount you want withheld) . . . . . **4** $

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

See the Instructions for Schedule 1-A (Form 1040) for more information about whether you qualify for the deductions on lines 1a, 1b, 1c, 3a, and 3b.

1 Deductions for qualified tips, overtime compensation, and passenger vehicle loan interest.

- **a** **Qualified tips.** If your total income is less than $150,000 ($300,000 if married filing jointly), enter an estimate of your qualified tips up to $25,000 . . . . . **1a** $
- **b** **Qualified overtime compensation.** If your total income is less than $150,000 ($300,000 if married filing jointly), enter an estimate of your qualified overtime compensation up to $12,500 ($25,000 if married filing jointly) of the "and-a-half" portion of time-and-a-half compensation . . . . . **1b** $
- **c** **Qualified passenger vehicle loan interest.** If your total income is less than $100,000 ($200,000 if married filing jointly), enter an estimate of your qualified passenger vehicle loan interest up to $10,000 **1c** $

2 Add lines 1a, 1b, and 1c. Enter the result here . . . . . **2** $

3 **Seniors age 65 or older.** If your total income is less than $75,000 ($150,000 if married filing jointly):

- **a** Enter $6,000 if you are age 65 or older before the end of the year . . . . . **3a** $
- **b** Enter $6,000 if your spouse is age 65 or older before the end of the year and has a social security number valid for employment . . . . . **3b** $

4 Add lines 3a and 3b. Enter the result here . . . . . **4** $

5 Enter an estimate of your student loan interest, deductible IRA contributions, educator expenses, alimony paid, and certain other adjustments from Schedule 1 (Form 1040), Part II. See Pub. 505 for more information . . . . . **5** $

6 **Itemized deductions.** Enter an estimate of your 2026 itemized deductions from Schedule A (Form 1040). Such deductions may include qualifying:

- **a** **Medical and dental expenses.** Enter expenses in excess of 7.5% (0.075) of your total income . **6a** $
- **b** **State and local taxes.** If your total income is less than $505,000 ($252,500 if married filing separately), enter state and local taxes paid up to $40,400 ($20,200 if married filing separately) . **6b** $
- **c** **Home mortgage interest.** If your home acquisition debt is less than $750,000 ($375,000 if married filing separately), enter your home mortgage interest expense (including mortgage insurance premiums) . . . . . **6c** $
- **d** **Gifts to charities.** Enter contributions in excess of 0.5% (0.005) of your total income . . . . **6d** $
- **e** **Other itemized deductions.** Enter the amount for other itemized deductions . . . . . **6e** $

7 Add lines 6a, 6b, 6c, 6d, and 6e. Enter the result here . . . . . **7** $

8 **Limitation on itemized deductions.**

- **a** Enter your total income . . . . . **8a** $
- **b** Subtract line 4 from line 8a. If line 4 is greater than line 8a, enter -0- here and on line 10. Skip line 9 **8b** $

9 Enter:
- $768,700 if you're married filing jointly or a qualifying surviving spouse
- $640,600 if you're single or head of household
- $384,350 if you're married filing separately

. . . . . **9** $

10 If line 9 is greater than line 8b, enter the amount from line 7. Otherwise, multiply line 7 by 94% (0.94) and enter the result here . . . . . **10** $

11 **Standard deduction.**

Enter:
- $32,200 if you're married filing jointly or a qualifying surviving spouse
- $24,150 if you're head of household
- $16,100 if you're single or married filing separately

. . . . . **11** $

12 **Cash gifts to charities.** If you take the standard deduction, enter cash contributions up to $1,000 ($2,000 if married filing jointly) . . . . . **12** $

13 Add lines 11 and 12. Enter the result here . . . . . **13** $

14 If line 10 is greater than line 13, subtract line 11 from line 10 and enter the result here. If line 13 is greater than line 10, enter the amount from line 12 . . . . . **14** $

15 Add lines 2, 4, 5, and 14. Enter the result here and in Step 4(b) of Form W-4 . . . . . **15** $

Privacy Act and Paperwork Reduction Act Notice. We ask for the information on this form to carry out the Internal Revenue laws of the United States. 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	$480	$850	$850	$1,020	$1,020	$1,020	$1,020	$1,020	$1,020	$1,020
$10,000 - 19,999	0	480	1,480	1,850	2,050	2,220	2,220	2,220	2,220	2,220	2,220	2,620
$20,000 - 29,999	480	1,480	2,480	3,050	3,250	3,420	3,420	3,420	3,420	3,420	3,820	4,820
$30,000 - 39,999	850	1,850	3,050	3,620	3,820	3,990	3,990	3,990	3,990	4,390	5,390	6,390
$40,000 - 49,999	850	2,050	3,250	3,820	4,020	4,190	4,190	4,190	4,590	5,590	6,590	7,590
$50,000 - 59,999	1,020	2,220	3,420	3,990	4,190	4,360	4,360	4,760	5,760	6,760	7,760	8,760
$60,000 - 69,999	1,020	2,220	3,420	3,990	4,190	4,360	4,760	5,760	6,760	7,760	8,760	9,760
$70,000 - 79,999	1,020	2,220	3,420	3,990	4,190	4,760	5,760	6,760	7,760	8,760	9,760	10,760
$80,000 - 99,999	1,020	2,220	3,420	4,240	5,440	6,610	7,610	8,610	9,610	10,610	11,610	12,610
$100,000 - 149,999	1,870	4,070	6,270	7,840	9,040	10,210	11,210	12,210	13,210	14,210	15,360	16,560
$150,000 - 239,999	1,870	4,100	6,500	8,270	9,670	11,040	12,240	13,440	14,640	15,840	17,040	18,240
$240,000 - 319,999	2,040	4,440	6,840	8,610	10,010	11,380	12,580	13,780	14,980	16,180	17,380	18,580
$320,000 - 364,999	2,040	4,440	6,840	8,610	10,010	11,380	12,580	13,860	15,860	17,860	19,860	21,860
$365,000 - 524,999	2,720	5,920	9,390	12,260	14,760	17,230	19,530	21,830	24,130	26,430	28,730	31,030
$525,000 and over	3,140	6,840	10,540	13,610	16,310	18,980	21,480	23,980	26,480	28,980	31,480	33,990

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	$90	$850	$1,020	$1,020	$1,020	$1,070	$1,870	$1,870	$1,870	$1,870	$1,870	$1,970
$10,000 - 19,999	850	1,780	1,980	1,980	2,030	3,030	3,830	3,830	3,830	3,830	3,930	4,130
$20,000 - 29,999	1,020	1,980	2,180	2,230	3,230	4,230	5,030	5,030	5,030	5,130	5,330	5,530
$30,000 - 39,999	1,020	1,980	2,230	3,230	4,230	5,230	6,030	6,030	6,130	6,330	6,530	6,730
$40,000 - 59,999	1,020	2,880	4,080	5,080	6,080	7,080	7,950	8,150	8,350	8,550	8,750	8,950
$60,000 - 79,999	1,870	3,830	5,030	6,030	7,100	8,300	9,300	9,500	9,700	9,900	10,100	10,300
$80,000 - 99,999	1,870	3,830	5,100	6,300	7,500	8,700	9,700	9,900	10,100	10,300	10,500	10,700
$100,000 - 124,999	2,030	4,190	5,590	6,790	7,990	9,190	10,190	10,390	10,590	10,940	11,940	12,940
$125,000 - 149,999	2,040	4,200	5,600	6,800	8,000	9,200	10,200	10,950	11,950	12,950	13,950	14,950
$150,000 - 174,999	2,040	4,200	5,600	6,800	8,150	10,150	11,950	12,950	13,950	14,950	16,170	17,470
$175,000 - 199,999	2,040	4,200	6,150	8,150	10,150	12,150	13,950	15,020	16,320	17,620	18,920	20,220
$200,000 - 249,999	2,720	5,680	7,880	10,140	12,440	14,740	16,840	18,140	19,440	20,740	22,040	23,340
$250,000 - 449,999	2,970	6,230	8,730	11,030	13,330	15,630	17,730	19,030	20,330	21,630	22,930	24,240
$450,000 and over	3,140	6,600	9,300	11,800	14,300	16,800	19,100	20,600	22,100	23,600	25,100	26,610

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	$280	$850	$950	$1,020	$1,020	$1,020	$1,020	$1,560	$1,870	$1,870	$1,870
$10,000 - 19,999	280	1,280	1,950	2,150	2,220	2,220	2,220	2,760	3,760	4,070	4,070	4,210
$20,000 - 29,999	850	1,950	2,720	2,920	2,980	2,980	3,520	4,520	5,520	5,830	5,980	6,180
$30,000 - 39,999	950	2,150	2,920	3,120	3,180	3,720	4,720	5,720	6,720	7,180	7,380	7,580
$40,000 - 59,999	1,020	2,220	2,980	3,570	4,640	5,640	6,640	7,750	8,950	9,460	9,660	9,860
$60,000 - 79,999	1,020	2,610	4,370	5,570	6,640	7,750	8,950	10,150	11,350	11,860	12,060	12,260
$80,000 - 99,999	1,870	4,070	5,830	7,150	8,410	9,610	10,810	12,010	13,210	13,720	13,920	14,120
$100,000 - 124,999	1,870	4,270	6,230	7,630	8,900	10,100	11,300	12,500	13,700	14,210	14,720	15,720
$125,000 - 149,999	2,040	4,440	6,400	7,800	9,070	10,270	11,470	12,670	14,580	15,890	16,890	17,890
$150,000 - 174,999	2,040	4,440	6,400	7,800	9,070	10,580	12,580	14,580	16,580	17,890	18,890	20,170
$175,000 - 199,999	2,040	4,440	6,400	8,510	10,580	12,580	14,580	16,580	18,710	20,320	21,620	22,920
$200,000 - 249,999	2,720	5,920	8,680	10,900	13,270	15,570	17,870	20,170	22,470	24,080	25,380	26,680
$250,000 - 449,999	2,970	6,470	9,540	12,040	14,410	16,710	19,010	21,310	23,610	25,220	26,520	27,820
$450,000 and over	3,140	6,840	10,110	12,810	15,380	17,880	20,380	22,880	25,380	27,190	28,690	30,190

R-1300 (1/25)

LOUISIANA DEPARTMENT of REVENUE

Employee's Withholding Certificate (L-4)

This form must be filed with your employer.

For Questions:
Phone: (855) 307-3893
Send an email by visiting www.revenue.louisiana.gov/Contact/ContactUs.

Purpose: Complete Form L-4 so that your employer can withhold the correct amount of state income tax from your salary.

Instructions: Employees who are subject to state withholding must provide their expected tax return filing status in Block A.

- Employees must file a new certificate within 10 days if the number of their deductions decreases, except if the change is the result of the death of a spouse.
- Employees may file a new certificate any time the number of their deductions increases.
- Line 7 should be used to increase or decrease the tax withheld for each pay period. Decreases should be indicated as a negative amount.

Penalties will be imposed for willfully supplying false information or willfully failing to supply information that would reduce the withholding amount.

This form must be filed with your employer. If an employee fails to complete this withholding certificate, the employer must withhold Louisiana income tax from the employee's wages without any standard deduction.

Note to Employer: Keep this certificate with your records.

Block A

- Enter "0" to claim no standard deduction and check the appropriate box under number 3 below. You may enter "0" if you are married, and have a working spouse or more than one job to avoid having too little tax withheld.
- Enter "1" to claim a standard deduction if your filing status is single or married filing separate and check the appropriate box under number 3 below if you did not claim this deduction in connection with other employment or if your spouse has not claimed a deduction.
- Enter "2" to claim a standard deduction if your filing status is married filing jointly, head of household, or qualifying surviving spouse and check the appropriate box under number 3 below.

A.

Cut here and give the bottom portion of certificate to your employer. Keep the top portion for your records.

Form **L-4**
Louisiana Department of Revenue

Employee's Withholding Certificate

1. First name and middle initial	Last name
2. Social security number	**3.** Select one: ☐ No deduction ☐ Single or married filing separately ☐ Married filing jointly, qualifying surviving spouse, or head of household
4. Home address (number and street or rural route)	
5. City / State / ZIP	
6. Total number of deductions claimed in Block A	**6.**
7. Adjustments. Enter any increase or decrease in the amount of tax to be withheld each pay period. Decreases should be indicated as a negative amount and cannot result in an amount less than zero to be withheld each pay period.	**7.**

I declare under the penalties imposed for filing false reports that the number of deductions claimed on this certificate do not exceed the number to which I am entitled.

Employee's signature	Date

The following is to be completed by employer.

8. Employer's name and address Dieudonne Enterprises, Inc. 5800 River Oaks Rd S., Harahan, LA 70123	**9.** Employer's state withholding account number 1980549-001-300

Employment Eligibility Verification

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Additional Information

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

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

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

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

Employer's Business or Organization Name	Employer's Business or Organization Address, City or Town, State, ZIP Code
Dieudonne Enterprises, Inc.	5800 River Oaks Rd S, Harahan, LA 70123

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.
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		**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		

Acceptable Receipts

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Supplement B,
Reverification and Rehire (formerly Section 3)

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

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

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

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

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

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

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

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

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

Additional Information (Initial and date each notation.)

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

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

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

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

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

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

Additional Information (Initial and date each notation.)

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

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

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

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

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

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

Additional Information (Initial and date each notation.)

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

DIEUDONNEENTERPRISES

To: All Supervisors

From: Dieudonne Enterprises Management

Re: Dieudonne Enterprises Insurance Requirements

Date: November 22, 2013

Please accept this letter as the terms and conditions for Insurance Requirements for ANY employee that receives compensation for a vehicle (i.e. Monthly truck allowance or Daily vehicle allowance).

Effective December 13, 2013, all employees receiving Vehicle Compensation are required to maintain at a MINIMUM, 50/100/50 insurance limits to continue to receive compensation. Proof of these limits must be submitted to the office before the effective date. Failure to do will result in loss of vehicle compensation.

Sincerely,

Dieudonne Enterprises Management

_____	_____	_____
PRINTED NAME	SIGNATURE	DATE

5800 RIVER OAKS RD SOUTH, HARAHAN, LA 70123 PHONE: 504-304-7794 FAX: 504-304-7933

DIEUDONNEENTERPRISES

MEMORANDUM

To: All Employees

From: Dieudonne Enterprises Management

Re: Damages/Liability

Date: May 26, 2010

It is the policy of this company, when an employee is involved in an accident while driving a company vehicle, or operating company equipment and the company is at fault, then the employee is responsible for paying a $500.00 deductable, toward the repairs.

The deductible can be paid to Dieudonne Enterprises in full, or can be withheld from the employee's pay at a rate to be agreed upon between the employee and management of the company.

Any questions regarding this policy, please contact our office at (504) 304-7794.

Thank You,

Management

| --- | --- | --- |
| (Print) | Signature | Date |

5800 RIVER OAKS RD. S, HARAHAN, LA 70123 PHONE: (504) 304-7794 FAX: (504) 304-7933

DIEUDONNEENTERPRISES

30-Day Work-Trial Employment Agreement

I, _____ understand that the first thirty days of my employment will be a training/probationary period. After the thirty-day period, Dieudonne Enterprises, Inc. ("DEI") will evaluate my work. If DEI determines, for any reason, I am not performing my job responsibilities adequately, I understand DEI has the right to terminate my employment.

I further understand that the purpose of the thirty-day training/probationary period is to provide me with a framework to ensure a mutual understanding of effective performance, to provide clarity of roles and expectations, to encourage feedback and open communication, to create opportunities for my development, and to ensure that my performance, goals and activities are aligned with the needs of DEI.

_____ Date:_____

Employee Signature

Dieudonne Enterprises, Inc.

By: _____ Date:_____

Amber Dieudonne, Vice President

5800 RIVER OAKS RD SOUTH, HARAHAN, LA 70123 PHONE: 504-304-7794 FAX: 504-304-7933

DIEUDONNEENTERPRISES

To: All Employees

From: Dieudonne Enterprises Management

Re: PPE Requirement Reminder

Date: November 22, 2013

As you all are aware, it is a company policy that Personal Protective Equipment (PPE) MUST be worn by ALL employees on the jobsite. This involves at a minimum, safety toe boots, safety vest, hard hat, long pants and sleeved shirts. Also, on certain jobs, the employee will be notified if more stringent gear must be worn (i.e. Safety glasses and gloves).

Failure to comply with these rules has become more and more prevalent. This reminder serves as a written warning to ALL employees (Foreman, Operators, Laborers, Saw-cutters and Drivers). Any employee found not complying with these procedures will be written up and further consequences will be dealt. If a Foreman is present when another employee is found failing to comply with these procedures, that Forman will also be written up and further consequences may be dealt.

Dieudonne spends a great deal of time and money to ensure that all employees are given proper PPE, as required, to complete the job in a safe manner. There are no excuses for failure to do so on the employee's part.

Please print name, sign and date for our official records.

Sincerely,

Dieudonne Enterprises Management

_____	_____	_____
PRINTED NAME	SIGNATURE	DATE

5800 RIVER OAKS RD SOUTH, HARAHAN, LA 70123 PHONE: 504-304-7794 FAX: 504-304-7933

DIEUDONNEENTERPRISES

MEMORANDUM

To: All Employees

From: Dieudonne Enterprises Management

Re: Safety Equipment/Equipment Repairs

Date: May 21, 2010

Safety equipment (hard hats, safety vests, safety glasses) must be worn at all times. Dieudonne Enterprises will supply these safety items upon employment with our company. Dieudonne Enterprises will replace these items if they are worn out or damaged, on the job. The item must however be returned to his or her supervisor for replacement. If an Employee's safety gear is stolen, or an employee loses their safety gear, it is his or her responsibility to replace it. The items may be purchased from the company at cost, or the employee can purchase them from a retailer of their choosing. The gear must, however, be replaced before returning to work.

Steel toe boots or shoes are required and are the responsibility of the Employee.

Any Employee who comes to work without his safety gear will be sent home for the day. These items are for your safety as well as for the safety of this Company.

If an Employee quits or is terminated, these items will be returned to Dieudonne Enterprises or the Employee will be responsible for payment of these items, on his last check.

Also, any equipment damaged due to an Employee's negligence, the Employee must repair the equipment to meet the DOTD specifications.

Any questions regarding this policy, please contact our office at (504) 304-7794.

Thank You,

Management

| --- | --- | --- |
| Print | Signature | Date |

5800 RIVER OAKS RD. S, HARAHAN, LA 70123 PHONE: (504) 304-7794 FAX: (504) 304-7933

DIEUDONNEENTERPRISES

MEMORANDUM

To: All Employees

From: Dieudonne Enterprises Management

Re: Weapon, Drug & Alcohol Policy

Date: October 14, 2010

Please be aware, that Dieudonne Enterprises, **AT NO TIME**, will excuse the carrying of weapons, drugs or alcohol in vehicles or on persons, on job sites. Anyone found with weapons, drugs or alcohol, in their vehicle, or on their persons, will be immediately terminated.

Any questions regarding this policy, please contact our office at (504) 304-7794.

Thank You,

Management

| --- | --- | --- |
| (Print) | Signature | Date |

5800 RIVER OAKS RD. S, HARAHAN, LA 70123 PHONE: (504) 304-7794 FAX: (504) 304-7933

DISCLOSURE TO CONSUMER

Dieudonne Enterprises, Inc.

Name of Company

As part of our employment process, we may obtain where permitted, one or more consumer reports or investigative consumer reports about you that we obtain from a consumer reporting agency, such as:

iiX, a Verisk Analytics Business
1716 Briarcrest Drive
Suite 200
Bryan, Texas 77802

- Consumer reports may include background, employment history, academic and/or professional credentials, military service, credit history, and driving history. The information gathered also may involve a criminal history and/or alcohol or drug use history, if any.
- An investigative consumer report may include information about your character, general reputation, personal characteristics and mode of living that may be obtained by interviews with individuals who may have knowledge concerning any such items of information. This also may include contacts of all listed prior employers to verify your employment history.
- If your employment falls under the federal Department of Transportation ("DOT") and the Federal Motor Carrier Safety Administration ("FMCSA"), including 49 CFR § 391.23, the report could include your driving, safety inspection and performance history from the FMCSA.

Under the provisions of the Fair Credit Reporting Act ("FCRA"), 15 U.S.C. § 1681 et seq.; FMCSA regulations in the Federal Code of Regulations, including 49 CRF § 40.329; and certain state laws, before we can seek such reports, where permitted, we must have your written permission to obtain the information.

You have the right, upon written request, to a complete and accurate disclosure of the nature and scope of the investigation. You also are entitled to a copy of that document entitled "Rights Under the Fair Credit Reporting Act". Under the FCRA, before we take adverse action on the basis, in whole or in part, of information in a consumer report, you will be provided a copy of that report, the name, address, and telephone number of the consumer reporting agency, and a summary of your rights under the FCRA.

- **Notice to California Applicants:** Under California law, the reports ordered about you for employment purposes within the State of California are defined as "investigative consumer reports." These reports may contain information on your character, general reputation, personal characteristics and mode of living. Under California Civil Code § 1786.22, you may view the report(s) maintained at iiX during normal business hours. You also may obtain a copy by submitting proper identification and paying the cost of duplication by appearing at iiX in person, by mail, or by telephone. iiX is required to have personnel available to explain the report(s) and to explain any coded information. If you appear in person, you may be accompanied by a person of your choice, if s/he furnishes proper identification.
- **Notice to Massachusetts Applicants:** Under Massachusetts law, an employer is prohibited from making written, pre-employment inquiries of an applicant about his or her criminal history. MASSACHUSETTS APPLICANTS SHOULD NOT RESPOND TO ANY OF THE QUESTIONS SEEKING CRIMINAL RECORD INFORMATION.

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[1]Customer is urged to consult with its own legal counsel to verify any Disclosure and Authorization created complies with regulatory requirements.

AUTHORIZATION TO OBTAIN INFORMATION
Dieudonne Enterprises, Inc.

I have read and understood the preceding Disclosure to Consumer. Under the Fair Credit Reporting Act ("FCRA"), 15 U.S.C. § 1681 et seq., the regulations applicable to the federal Department of Transportation's Federal Motor Carriers Safety Administration, including 49 CFR § 40.329, the Americans with Disabilities Act and all other applicable federal, state, and local laws, I hereby authorize and permit the above named company to obtain information about me, where permitted, which may pertain to my employment records, driving history records, driving performance and safety history, criminal history, credit history, civil records, workers; compensation (post-offer only), alcohol and drug testing, verification of my academic and/or professional credentials, and information and/or copies of documents from any military service records.

I understand an "investigative consumer report" may include information as to my character, general reputation, personal characteristics, and mode of living that may be obtained by interviews with individuals who may have knowledge concerning any such items of information. I authorize information to be obtained from my former employers to satisfy driver qualification regulations.

DOT Drivers. I understand that Title 49 of the Federal code of Regulations, § 391.23, requires that my prospective employer and/or its agent(s) may contact all former employers of a driver within the last three years under the regulation of the Department of Transportation. Information such as dates of employment, position, accident history, as well as information pertaining to my drug and alcohol testing history, may be requested from each employer in accordance with Section 391.23 and 49 CFR 40.25.

By signing below, I consent to and authorize the gathering of this information by my prospective employer or employer and those who my prospective employer or employer has engaged to request and obtain this information, including former employers, and/or from or through a consumer reporting agency, such as iiX, a Verisk Analytics Business.

I understand and acknowledge that the information provided in the consumer reports or investigative consumer reports may assist my employer or prospective employer to make a determination regarding my suitability as an employee.

I further understand that, under the FCRA, in the event of Adverse Action, I may request a copy of any consumer report from the consumer reporting agency that compiled the report, after I have provided proper identification.

I agree that a copy of this authorization has the same effect as an original. Where permitted, this authorization shall remain in effect over the course of my employment and reports may be ordered periodically during the course of my employment.

_____

Applicant's / Employee's Full Name (Print clearly)

_____ _____/_____/_____

Applicant's / Employee's Signature Date of Signature

[2] **Customer is urged to consult with its own legal counsel to verify the Disclosure and Authorization created complies with regulatory requirements.**

CONFIDENTIALITY AND NON-COMPETE AGREEMENT

This agreement ("Agreement") by and between Dieudonne Enterprises, Inc., hereinafter referred to as **COMPANY**, and _____, hereinafter referred to as **EMPLOYEE**, is executed on _____.

COMPANY and EMPLOYEE agree as follows:

1. **Prohibition Against Disclosure or Use of Confidential Information**

The EMPLOYEE, during his or her employment with COMPANY, may have access to and become familiar with confidential, proprietary and/or trade secret information or know how (collectively, the "Confidential Information") of COMPANY, at least some of which may be embodied in lists, manuals, and binders, brochures, training material, plans, methods, formulas, patterns, product samples, customer lists, price lists, processes, compilations of information, records, computer programs and computer files and/or specifications, which are owned by COMPANY or in the custody and control of COMPANY and which are used in the operation of the business of COMPANY. During the term of EMPLOYEE's employment with COMPANY and for a two (2) year period after the voluntary or involuntary termination of such employment, except as required in the course of employment with COMPANY, EMPLOYEE agrees not to:

(a) Directly or indirectly disclose to third parties any of the Confidential information; and/or
(b) Directly or indirectly use such Confidential Information in any way,

EMPLOYEE's obligation not to communicate or disclose Confidential Information shall not be deemed to apply to information that:

(a) Is or becomes generally available to the public other than as a result of a communication or disclosure by EMPLOYEE; or
(b) EMPLOYEE is legally required to disclose; provided, however, that in the event EMPLOYEE is legally required to disclose such information, EMPLOYEE agrees to provide the COMPANY with prompt notice thereof so that COMPANY may seek an appropriate protective order.

All tangible materials, including, but not limited to, files, records, documents, drawings, specifications, equipment, manuals and binders, product samples, brochures, customer lists, customer "lead" lists, training materials, manuals and binders, computer programs and computer files and other items relating to the business of COMPANY, whether prepared by EMPLOYEE or otherwise coming into EMPLOYEE's possession, shall remain the exclusive property of COMPANY and shell not be removed from the premises of COMPANY under any circumstances whatsoever without the prior written consent of COMPANY. The parties agree that the Confidential Information is not generally known and gives COMPANY an advantage over its competitors that do not know or use it.

2. **Obligation to Return Property**

EMPLOYEE agrees that within twenty-four (24) hours of any voluntary or involuntary termination of EMPLOYEE's employment with COMPANY, EMPLOYEE will return to COMPANY all tangible items of the Confidential Information, including, but not limited to, all

documents, lists, plans, records, equipment, computer programs (whether written on paper or fixed on computer storage media such as magnetic disks, electrical memory circuits, compact disks, etc.) in EMPLOYEE's custody, possession or control which are owed by COMPANY and/or which were directly or indirectly obtained or derived from COMPANY. The terms documents, records, equipment and computer programs include all copies and/or derivative works related to such materials.

3. Prohibition Against Employee Conflict of Interest

During employment by COMPANY, EMPLOYEE agrees not to engage in any activity whatsoever which conflicts with the interests of COMPANY.

During employment, EMPLOYEE must submit in writing a description of any activites which may be considered a conflict of interest at least 30-days prior to engaging in such activities. Within 30-days, COMPANY will determine whether or not such activities do in fact constitute a conflict of interest.

4. Noncompetition

Except as provided for in this paragraph 4, the EMPLOYEE, during his or her employment with COMPANY and for a period of two (2) years from the date of any voluntary or involuntary termination of EMPLOYEE's employment with COMPANY, the EMPLOYEE either alone, together or in conjunction with any other person, without the express, written consent of the COMPANY will not:

Directly or indirectly contact, solicit or contract with any customer or competitor of Company to provide the Services contemplated by this Agreement. This prohibition shall extend to and bar EMPLOYEE's from referring any customer of Company to an employee, agent or contractor affiliated with a competitor of the Company;

Compete with the business of the Company as a sole proprietor, or through a legal entity or by any other means by carrying on or engaging in a business similar to that of the Company, including becoming employed by a competing business; and

Induce, advise or counsel any employee, agent, or contractor of the Company to leave the services of the Company, or solicit or employ the services of the employees, agents, or contractors of the Company, or otherwise interfere with the relationship between the Company and its employees, agents, contractors or salesmen.

Company agrees and acknowledges that this provision shall be limited in effect to the following specific geographic areas St. Bernard, Orleans, and Jefferson Parishes hereto.

The Employee recognizes that economic damages may not provide the Company with sufficient recourse in the event of a breach of these covenants; and therefore, Employee agrees that the Company may seek equitable relief to preclude and/or ameliorate a breach of the foregoing covenants, in addition to all other legal remedies the Company has available.

5. Modification in Writing

This Agreement may only be modified or amended in writing signed by an authorized representative of COMPANY and EMPLOYEE.

6. **Choice of Law**

This Agreement shall be interpreted and construed in accordance with the laws of Louisiana, without regard to its conflict of law provisions.

7. **Construction**

It is understood and agreed that, should any portion of any clause or paragraph of this Agreement be deemed by a court of competent jurisdiction to be too broad to permit enforcement to its fullest extent, or should any portion of any clause or paragraph of this Agreement be deemed by a court of competent jurisdiction to be unreasonable or unenforceable, then said clause or paragraph shall be reformed and enforced to the maximum extent permitted by law. In the event that any such clause or any portion of any clause or paragraph is ever deemed by a court of competent jurisdiction to be incapable of reform, the offending language shall be severed, and the remaining terms and provisions of this Agreement shall remain unaffected, valid and enforceable for all purposes.

8. **Survival of Obligations Past Termination of Employment**

The obligations and promises of EMPLOYEE shall survive the voluntary or involuntary termination of EMPLOOYEE's employment with COMPANY according to the time period set forth in each applicable clause of this Agreement. If any such clause is silent as to the survival period, the applicable survival period shall be five (5) years after the voluntary or involuntary termination of EMPLOYEE's employment with COMPANY.

9. **Assignability of Rights**

This Agreement shall inure to the benefit of and be binding upon COMPANY its successors and assigns, and the heirs and legal representatives of EMPLOYEE. COMPANY's rights under this Agreement shall be assignable by COMPANY to any affiliate without any notice to EMPLOYEE. EMPLOYEE may not assign his or her rights or obligations under this Agreement.

10. **Remedies**

In the event of a breach, or a threatened or attempted breach, of any provision of this Agreement by EMPLOYEE, COMPANY shall, in addition to all other remedies, be entitled to: (a) a temporary, preliminary and/or permanent injunction against such breach without the necessity of showing any actual damages or any irreparable injury, (b) a decree for the specific performance of this Agreement, and/or (c) damages, attorney's fees and costs. The waiver by COMPANY of any breach by EMPLOYEE of any of the terms and conditions of, or any of COMPANY's rights under this Agreement, shall not be deemed to constitute the waiver of any similar right. No such waiver shall be binding or effective unless expressed in writing and signed by the party giving such waiver.

EMPLOYEE SIGNATURE: _____

COMPANY: Dieudonne Enterprises, Inc.:

By: _____

Amber Dieudonne, Vice President

LOUISIANA WORKFORCE COMMISSION

1001 North 23rd Street
Post Office Box 44187
Baton Rouge, LA 70804-4187

(O) 225-342-7866
800-201-2493
(F) 225-219-5968

Bobby Jindal, Governor
Curt Eysink, Executive Director

Office of Workers' Compensation Administration
Second Injury Board

LA OWCA Second Injury Board Knowledge Questionnaire

The following questionnaire should only be completed by individuals that have been hired for employment. Your employer may ask that you complete this questionnaire following your initial hire and periodically thereafter.

The questionnaire may be used in the establishment of prior knowledge for the purpose of obtaining Second Injury Fund relief from the Second Injury Board. The Second Injury Board may reimburse your employer for workers' compensation claims that meet certain criteria should you become injured on the job. This reimbursement in no way affects the benefits owed to you by your employer or their insurance company under the Louisiana Workers' Compensation Act, La. R.S. 23:1021-1361.

WARNING

FAILURE TO ANSWER TRUTHFULLY AND/OR CORRECTLY TO ANY OF THE QUESTIONS ON THIS FORM MAY RESULT IN A FORFEITURE OF YOUR WORKERS COMPENSATION BENEFITS UNDER LA R.S. 23:1208.1.

Employer: _____ Dieudonne Enterprises, Inc. _____

Employee Name: _____

Date of Birth: _____ Male: ____ Female: ____

Soc. Sec. # (last 4 digits only): _____

Home Address: _____

Telephone Number: _(____)_____

Employee Signature:_____ Date: _____

Employer Witness: _____ Date: _____

Please place a check in the box next to medical conditions you currently have or have had previously. For all conditions that you check, write a brief explanation on the Explanation Page. No check mark in the box will indicate that you do not have nor have you ever had the corresponding condition.

Disease and Other Medical Conditions

□ Diabetes	□ Cerebral Palsy	□ Arthritis	□ Heart Disease/Heart Attack
□ Silicosis	□ Tuberculosis	□ Parkinson's	□ Congestive Heart Failure
□ Varicose Veins	□ Multiple Sclerosis	□ Brain Damage	□ Vision Loss/one or both eyes
□ Asbestosis	□ Post Traumatic Stress	□ Asthma	□ Disability from Polio
□ Hyperinsulinism	□ Osteomyelitis	□ Dementia	□ Psychoneurotic Disability
□ Alzheimer's	□ Nervous Disorder	□ Thrombophlebitis	□ Ruptured or Herniated Disc
□ Emphysema	□ Muscular Distrophy	□ Arteriosclerosis	□ Ankylosis or Joint Stiffening
□ Hearing Loss	□ Migrane Headaches	□ Hodgkin's	□ High/Low Blood Pressure
□ COPD	□ Mental Retardation	□ Cancer	□ Carpal Tunnel Syndrome
□ Hypertension	□ Kidney Disorder	□ Double Vision	□ Compressed Air Sequelae
□ Head Injury	□ Loss of Use of Limb	□ Mental Disorders	□ Disease of the Lung
□ Epilepsy	□ Seizure Disorder	□ Hemophilia	□ Coronary Artery Disease
□ Stroke	□ Sickle Cell Disease	□ Bleeding Disorder	□ Heavy Metal Poisoning

Surgical Treatment

□ Spinal Disc Surgery Year (approximate if unsure) _____

□ Spinal Fusion Surgery Year (approximate if unsure) _____

□ Amputated foot Left ___ Right ___ Year (approx. if unsure) _____

□ Amputated leg Left ___ Right ___ Year (approx. if unsure) _____

□ Amputated arm Left ___ Right ___ Year (approx. if unsure) _____

□ Amputated hand Left ___ Right ___ Year (approx. if unsure) _____

□ Knee Replacement Left ___ Right ___ Year (approx. if unsure) _____

□ Hip Replacement Left ___ Right ___ Year (approx. if unsure) _____

□ Other Joint Replacement Joint _____ Year _____

□ Other Surgical Procedure Procedure _____Year _____

Employee Signature:_____ Date: _____

Employer Witness: _____ Date: _____

EXPLANATION PAGE

Please use the space below to explain the conditions that you checked or any other medical conditions that may not be listed on this form. Ask your employer for additional copies of this page if needed.

CONDITION: ___________________________ Year Diagnosed (approx): _____________

Are you still treating for this condition? ☐ Yes ☐ No

Are you taking medication for this condition? ☐ Yes ☐ No

Do you have any permanent restrictions for this condition? ☐ Yes ☐ No

Brief Explanation: ____

CONDITION: ___________________________ Year Diagnosed (approx): _____________

Are you still treating for this condition? ☐ Yes ☐ No

Are you taking medication for this condition? ☐ Yes ☐ No

Do you have any permanent restrictions for this condition? ☐ Yes ☐ No

Brief Explanation: ____

CONDITION: ___________________________ Year Diagnosed (approx): _____________

Are you still treating for this condition? ☐ Yes ☐ No

Are you taking medication for this condition? ☐ Yes ☐ No

Do you have any permanent restrictions for this condition? ☐ Yes ☐ No

Brief Explanation: ____

CONDITION: ___________________________ Year Diagnosed (approx): _____________

Are you still treating for this condition? ☐ Yes ☐ No

Are you taking medication for this condition? ☐ Yes ☐ No

Do you have any permanent restrictions for this condition? ☐ Yes ☐ No

Brief Explanation: ____

Employee Signature:____ Date: _______________

Employer Witness: ____ Date: _______________

Please answer the following questions.

1. Has any doctor ever restricted your activities? □ Yes □ No
   If Yes, please list the restrictions: _____
   Were the restrictions: Permanent ____ Temporary ____
   Are you currently restricted? Yes ___ No ___
   What is the medical condition for which you are restricted? _____

2. Are you presently treating with a doctor, chiropractor, psychiatrist, psychologist or other health care provider? □ Yes □ No
   Please list the medical condition being treated: _____

   Doctor's Name: _____ Specialty: _____
   Doctor's Address: _____

3. If you are presently taking prescription medication other than those listed on the Explanation Page, please complete the requested information below.

   Medication: _____ Prescribing Doctor: _____

   Medication: _____ Prescribing Doctor: _____

4. Have you ever had an on the job accident? □ Yes □ No
   If you answered YES, please provide the date for each injury and the nature of the injury.
   _____

   How long were you on compensation? _____

   Name of Employer: _____

5. Has a doctor recommended a surgical procedure, which has not been completed prior to this date, including but not limited to knee, hip or shoulder replacement? □ Yes □ No
   If you answered YES, please provide:
   Recommended surgery _____
   Approximate date of recommendation: _____

   Doctor's Name: _____ Specialty: _____
   Doctor's Address: _____

Employee Signature:_____ Date: _____

Employer Witness: _____ Date: _____

WARNING

FAILURE TO ANSWER TRUTHFULLY AND/OR CORRECTLY TO ANY OF THE QUESTIONS ON THIS FORM MAY RESULT IN A FORFEITURE OF YOUR WORKERS COMPENSATION BENEFITS UNDER LA R.S. 23:1208.1.

I have completed this form honestly and to the best of my knowledge. I understand that providing false information or omitting pertinent information could result in loss of my workers compensation benefits should I become injured on the job.

Employee Signature:_____ Date: _____

Employee Printed: _____

I am an authorized representative of the employer designated to obtain and review the information provided by the employee on this questionnaire. I have confirmed that the employee understands the consequences associated with providing false information or omitting pertinent information. I have confirmed that the employee is able to read and understand the information provided on this questionnaire or I have personally read the questionnaire to the employee. I have provided the employee with as many copies of the Explanation Page as needed. I have confirmed the number of and labeled the pages of this questionnaire.

Employer Witness: _____ Date: _____

Employer Witness Printed: _____

Title: _____

Company Drug, Alcohol and Substance Abuse Policy and Program

1. PURPOSE

Dieudonne Enterprises, Inc. (hereinafter referred to as the "Company") believes substance abuse to be a serious threat to the abusing employee, the Company's staff, the public, and more importantly, the Company's customers and guests. The Company values its customers, guests, and employees and recognizes the need for a safe and healthy work environment. Furthermore, the Company recognizes the problem of drug, alcohol and substance abuse in our society and is aware that employees using drugs, alcohol or other substances are less productive and are often a risk to the safety, security and welfare of the Company, its employees, its customers and others.

Therefore, the Company is introducing a workplace drug and alcohol testing policy to ensure that the Company will have a drug and alcohol-free environment.

2. COMPANY POLICY

It is the policy of the Company to maintain a workplace and workforce free of drugs, alcohol and other such substances. The presence of illegal drugs, alcohol or other such substances in one's system, on one's person, on Company Premises, while conducting Company Business or while operating Company vehicles, machinery or equipment is prohibited by this policy. Compliance with the policies and guidelines set forth herein below is a condition of beginning and continued employment with the Company. It supersedes any other Company policy or practice on this subject. At any time, the Company may, at its sole discretion, amend, supplement, modify or change any part of this policy without any prior notice whatsoever.

The policy does not represent or express an implied contract, and it does not affect an employee's status as an at-will employee under Louisiana law. If you have any questions about the policy, please immediately direct them to the Company administrator and/or his or her representatives.

The following policies, programs and guidelines with regard to the use, abuse, possession, presence of and sale of illegal drugs, alcohol or other such substances shall become effective immediately.

3. DEFINITIONS

For purposes of the Company's Drug and Alcohol Testing Program policies and guidelines (hereinafter referred to as the "Program"), the following definitions are applicable:

a.) "Company Premises" encompasses Company affiliates and subsidiaries and all their properties, offices, parking lots, facilities, lands, platforms, buildings, structures, fixtures, installations, boats, aircrafts, automobiles, trucks and all other vehicles, machinery and other equipment, whether owned, leased or used.

b.) "Company Business" shall encompass employees whenever on duty and under the Company's control, whether at other work sites or during transit to and from work sites or while in the course and scope of the Company's employment or pay status.

c.) "Employees" shall include all full-time, part-time, casual or contract employees and all employment applicants and candidates as well.

d.) "Illegal Drugs, Alcohol or Other Such Substances" includes illegal drugs, unauthorized controlled substances, look-a-likes, inhalants of abuse, designer and synthetic drugs and shall include any drug which is not legally obtainable or which is legally obtainable but has not been legally obtained or used. The term includes prescribed drugs not legally obtained and prescribed drugs not being used for prescribed purposes or in excessive dosages. The terms include, but are not limited to, central nervous systems stimulates such as cocaine and amphetamines; hallucinogens; PCP or Phencyclidine; narcotics analgesics as found in opiates or opium (like morphine and codeine) and opium derivatives (heroin); inhalants from volatile solvents like glue, paint or gasoline or from aerosols like hair sprays, deodorants, insecticides or from anesthetic gases like Ether, chloroform or amyl nitrate; cannabinoids; cannabis such as found in marijuana, hashish or hash oil; Propoxyphene (Darvon); Barbiturates; Methadone; and Benzodiazepines (Valium).

4. PROHIBITION OF ILLEGAL DRUGS, ALCOHOL OR OTHER SUCH SUBSTANCES

At any time while an Employee is on Company Premises or on Company Business, the following activities are strictly prohibited:

a.) The use of or abuse of any Illegal Drug, Alcohol or Other Such Substances;
b.) The possession, transport, transfer or purchase of Illegal Drugs, Alcohol or Other Such Substances
c.) The presence in the body, presence on one's person or reporting to work under the influence or Illegal Drugs, Alcohol or Other Such Substances
d.) The sale of marketing of Illegal Drugs, Alcohol or Other Such Substances or other drug related paraphernalia;
e.) The use, abuse, presence in one's system or possessions of Illegal Drugs, Alcohol or Other Such Substances while utilizing, operating or in control or possession of Company property, including Company owned, leased or rented equipment and/or vehicles; and
f.) Using, consuming, transporting, distributing or attempting to distribute, manufacture, or dispense Illegal Drugs, Alcohol and Other Such Substances.

Any Employee involved in any of the foregoing activities at any time during a work shift or while working for, on behalf of or while representing the Company, whether or not on Company Business, Company Premises or Property is in violation of the Program and the Employee is subject to disciplinary action, including, but not limited to, immediate termination. Depending on the circumstances, other action, including, without limitation, (1) notification of the appropriate law enforcement, regulatory or licensing agencies and (2) denial, suspension or termination of workers' compensation benefits and unemployment compensation benefits may be taken against any Employee who violates these policies, mandates and prohibitions.

The Program equally applies to all Employees. Compliance with these policies mandates and prohibitions will be required as a condition of employment for all Employees. There shall be no exceptions.

5. UNAUTHORIZED USE OF INTOXICATING BEVERAGES

An Employee whose blood alcohol level is over 0.04% (40 MG/DL blood) while on Company Premises, during work hours, or while conducting Company Business is in violation of this Company policy and subject to immediate discharge or termination.

6. PRESCRIPTION DRUGS: (Legally Controlled Substances and All Off-the-Shelf or Over-the-Counter Medicines)

All Employees must report the use of any medically prescribed or authorized drugs or substances (including over-the-counter or off-the-shelf medication) which can impair or lessen job performance (whether allowed to be dispensed with or without prescription) to their immediate supervisor and upon request by the Employee's supervisor or the Company's Drug Policy Administrator, must provide proper written medical authorization to the Company from a physician. This includes, without limitation, drugs such as tranquilizers, muscle relaxers, pain medication and anti-depressants. It is the Employee's responsibility to determine from a physician(s) whether prescribed, off-the-shelf or over-the-counter drugs, medicines or other such substances that may impair job performance. Failure to report the use of such drugs, medicines or other substances, failure to provide proper evidence of medical authorization or the use (as evidenced by presence in an Employee's body fluids or otherwise) of such drugs, medicines or other such substances in amounts in excess of the label recommendations for over-the-counter or off-the-shelf drugs, medicines or other such substances may result in disciplinary actions, up to, and, including, immediate termination.

Employees must not consume prescribed drugs or off-the-shelf or over-the-counter drugs, medicines or other such substances more often than prescribed by their doctor or as directed on the off-the-shelf or over-the-counter medication label(s). All prescribed, off-the-shelf or over-the-counter medication must be in its original container with the Employoee's name, the doctor's name and prescription number on the label and each prescription must not be older than one year of the date issued. However, the Company at any time reserves the right to have a licensed physician determine whether the prescription drug use increases the risk of injury to the Employee, the Company's residents or guests while the Employee is working. If such a finding is made, the Company may limit, suspend or terminate the Employee's work activities during the period job safety may be adversely affected by the consumption of such medication.

Any Employee refusing to cooperate with submitting to questioning, medical or physical testing or examinations, when requested by the Company or its designee, is in violation of this Company policy and subject to disciplinary action, including, but not limited to, immediate termination.

7. DRUG AND ALCOHOL TESTING PROCEDURES

In order to achieve the objectives of this Policy, the Company asserts and reserves its legal right to test any and all Employees for the presence of Illegal Drugs, Alcohol or Other Such Substances in their system or for the use or abuse of Illegal Drugs, Alcohol or Other Such Substances. Employees may be asked to submit to a medical examination and/or to submit urine, saliva, breath and blood samples for testing for the presence of Illegal Drugs, Alcohol or Other Such

Substances. Any information obtained through such examinations and/or testing may be retained by the Company and is the property of the Company. The Company reserves the right, in its discretion and within the limits of federal and state laws, to examine, screen and/or test for the presence of Illegal Drugs, alcohol or Other Such Substances as stated herein in the following situation:

a.) **Pre-Hire Employment Testing:** All job applicants or newly hired employees may be required to undergo screening for the presence of Illegal Drugs, Alcohol or Other Such Substances as a condition of beginning employment with the Company. Applicants will be required to voluntarily submit to a urinalysis test conducted by a laboratory designated by the Company and by signing a Consent Agreement(s) in connection with such testing will release the Company and said laboratory from liability in connection therewith. Any Applicant with a positive test result may be denied employment with the Company. The company will not and cannot tolerate the current abuse of Illegal Drugs, Alcohol or Other Such Substances.

b.) **For Cause/Post-Accident or Incident Testing:** If an accident or in incident occurs involving an Employee while on Company Business or on company Premises, no matter how minor or insignificant, the Company will require a drug and/or alcohol test. A drug and/or alcohol test may also be required after any situation where there has been a “near miss” incident or accident, even though no injury or property damage occurs. When there is reasonable cause to suspect that an Employee’s behavior, performance, error in judgment, or unsafe actions are related to the use or abuse of Illegal Drugs, Alcohol or Other Such Substances, the Company may require that the Employee submit to a drug and/or alcohol test. Failure by an employee and/or his supervisor to report any accident or incident which meets the post-accident or post-incident testing criteria is in violation of this Company Policy and subject to disciplinary action which includes, without limitation, immediate termination. An Employee’s testing positive may make him or her ineligible for workers’ compensation benefits and/or unemployment compensation benefits.

c.) **Random Testing:** All Employees and/or specified Employees are subject to routine random drug and/or alcohol testing in order to detect the use, abuse, or presence in an Employee’s system of Illegal Drugs, Alcohol or Other Such Substances without any advance notice or prior warning.

d.) **Post-Treatment, Counseling, Rehabilitation or Return to Work Testing:** Employees who return to work following a (1) medical leave of absence, (2) a work-related injury, (3) drug, alcohol of substance abuse counseling or (4) rehabilitation may be subject to drug and/or alcohol testing upon return to work and for up to one year following the Employee’s return to work. A positive test result will constitute grounds for immediate termination. It is a condition of reinstatement of employment with the Company for an Employee, upon completion of a drug and/or alcohol counseling program, or any other return-to-work established procedure, to submit to an alcohol and/or drug screening test.

8. SEARCHES

In order to achieve the objective of the Company’s Policy, the Company reserves the right at all times to search Employees who are entering and departing the Company Premises, conducting Company Business or when circumstances warrant or when reasonable suspicion or cause exists to have properly authorized supervisors or search personnel (including drug detection dogs) conduct unannounced reasonable searches and inspections. These searches may extend to other Company Premises as described above as well as to the Employee’s personal effects. Employee personal property subject to inspection includes, but is not limited to, lockers, baggage, briefcases, boxes, bags, parcels, lunch-boxes or bags, food/beverage containers, desks, tools, clothing and vehicles. The purpose of said search is to determine if Employees or others on Company Premises, or conducting Company Business, are in possession of, using, abusing, transporting or concealing any Illegal Drugs, Alcohol or Other Such Substances, or other items prohibited by this policy. Searches may be initiated without prior notice or advanced warning and conducted at times and locations as deemed appropriate by the Company. Any Employee found to have Illegal Drugs, Alcohol or Other Such Substances in their possession, on their person or in their personal area (desks, car, and lunch container) will be subject to immediate termination or discharge. The Company reserves the right to conduct any search it deems appropriate as set forth in this Company Policy.

9. DRUG TESTING PROCEDURES

Drug and alcohol testing under this Company Policy will be performed by (SAMHSA-formerly NIDA) certified, professional laboratories that will collect urine, blood, breath and/or skin specimens at a qualified collection site or on Company Premises. All testing will be conducted in a professional and sanitary manner with due regard to the Employee’s privacy, dignity and confidentiality. A secure written chain of custody process is implemented from the time of collection of the specimen until the specimen is disposed of or secured in frozen, long-term storage. All Employee specimens will be analyzed by such (SAMHSA-formerly NIDA) certified professional laboratories for the presence of Illegal Drugs, Alcohol or Other Such Substances.

All specimens will undergo an initial screening test. Any positive test result will be confirmed through a Gas Chromatography with Mass Spectrometry (GC/MS) test. Any positive test result from this latter test will be reviewed by a

Medical Review Officer as defined by Louisiana Law and the Medical Review Officer must provide an opportunity for an interview with the Employee as part of the verification process prior to the positive test result being communicated back to the Company. This will ensure that positive test results are not due to authorized prescription, off-the-shelf or over-the-counter medications appropriately used or other factors which the Medical Review Officer feel justifies the presence of the drugs, alcohol or other such substances.

An Employee who is suspected of being under the influence of Illegal Drugs, Alcohol or Other Such Substances may, at the option of the Company, be suspended from work until the results of the drug and/or alcohol test are received and reviewed by the Company's Administrator. Employees who are tested under this Company Policy will have the right, upon request, to receive the results of his/her test. Employees whose tests are verified positive by the Medical Review Officer will be notified by either the Company, the certified laboratories conducting the testing/screening and/or the Medical Review Officer.

10. ALCOHOL TESTING

Testing Employees for the presence of alcohol will initially be performed through the use of breath, skin and/or other alcohol detector tests. If an Employee tests positive for alcohol in such a test, such positive result may, if challenged by the Employee, be confirmed through the use of a breath analyzer or blood alcohol test. A breath analyzer or blood alcohol test result (or breath scan/comparable alcohol detector test which is not challenged) showing a concentration of 0.04% or greater shall be ground for appropriate disciplinary action, including, without limitation, immediate discharge and/or termination.

11. CONSEQUENCES OF A POSITIVE DRUG OR ALCOHOL TEST

a.) In the event of a confirmed positive test result for the presence, use or abuse of Illegal Drugs, Alcohol or Other Such Substances during a pre-employment drug or alcohol screening, the applicant will not be hired.
b.) In the event of a confirmed positive test result for the presence, use or abuse of Illegal Drugs, Alcohol or Other Such Substances for current Employees during a drug/alcohol screen provided for by this Company Policy, the Employee (1) may be immediately terminated and discharged, for cause, (2) may be reported to state and federal authorities and agencies and (3) may be denied workers' compensation benefits or unemployment compensation benefits.

By Signing Herein Below:

1. **I expressly confirm that I have read and understood the Company's Policy;**
2. **I Understand that participation in the Company's policy is a mandatory condition on my employment; and**
3. **I further agree and expressly consent to all terms, conditions, mandates and prohibitions set forth in the Company's policy.**

Company Name: _____Dieudonne Enterprises, Inc._____

Applicant or Employee Name (Print): _____

Applicant Last Four of Social Security Number: _____

Applicant or Employee's Signature: _____

Date: _____

DIEUDONNEENTERPRISES

Return to Modified Duty Program

Prepared by: IUL Risk Solutions

Dieudonne Enterprises, Inc.
Location: 5800 River Oaks Road South, Harahan, LA 70123
Effective Date: (_____)
Revision Number: 0.0

PURPOSE

This policy is in place to ensure Dieudonne Enterprises, Inc. provides meaningful work activity for employees who are temporarily unable to perform all, or portions, of their regular work assignments or duties. This policy applies to employees suffering from either work or non-work related injury or illness. The goal is to allow valued company employees to return to productive, regular work as quickly as possible. By providing temporary transitional or modified work activity, injured employees remain an active and vital part of the company. Studies show that a well-constructed Return to Work Policy reduces lost time days, allows workers to recover more quickly and makes for a more positive work environment.

SCOPE

All active employees who become temporarily unable to perform their regular job due to a compensable work related or non-work related injury or illness may be eligible for transitory work duties within the provisions of this program. Return to work tasks may be in the form of:

- Changed duties within the scope of the employee's current position
- Other available jobs for which the employee qualifies outside the scope of his or her current position
- An altered schedule of work hours

DEFINITIONS

- **Transitional duty** is a therapeutic tool used to accelerate injured employees' return to work by addressing the physical, emotional, attitudinal, and environmental factors that otherwise inhibit a prompt return to work. These assignments are meant to be temporary and may not last longer than 90 days, though Dieudonne Enterprises, Inc. permits multiple 90-day assignments back-to-back if it is medically warranted.
- **Alternate duty** is a part of Dieudonne Enterprises, Inc.'s Return to Work Policy that is designed as a placement service for individuals who have reached maximum medical improvement and are still unable to perform the essential functions of their pre-injury job.

APPLICABILITY

Length of Duty

If work is available that meets the limitations or restrictions set forth by the employee's attending practitioner, that employee may be assigned transitional or modified work for a period not to exceed 90 days. Transitional or light duty is a *temporary program*, and an employee's eligibility in these reduced assignments will be based strictly on medical documentation and recovery progress.

Daily Application

An employee's limitations and restrictions are effective 24 hours a day. Any employee who fails to follow his or her restrictions may cause a delay in healing or may further aggravate the condition. Employees who disregard their established restrictions, whether they are at work or not, may be subject to disciplinary action up to and including termination.

Qualification

Transitional or modified duty will be available to all employees on a fair and equitable basis with temporary assignments based on skill and abilities. Eligibility will be based upon completion of the Return to Work Evaluation Form by the employee's attending medical professional. An employee on modified duty will be considered part of the regular shift staffing, with recognition of the employee's limitations within the department.

RESPONSIBILITIES

The following responsibilities apply to various levels within the company.

- **Senior management** will ensure the policy's enforcement among all levels at Dieudonne Enterprises, Inc. and will actively promote and support this policy and the Return to Work Program as a whole.
- **Supervisors** will support the employee's return to work by identifying appropriate modified assignments and ensuring the employee does not exceed the physician's set restrictions. Supervisors will also stay in regular contact with absent employees and communicate Dieudonne Enterprises, Inc.'s attendance expectations clearly. They are also responsible for reporting any problems with employees and this policy to the Return to Work manager or program supervisor.
- **Injured workers** will notify their supervisors in a timely manner when their condition requires an absence. They will closely follow their physician's medical treatment plan and actively participate in Dieudonne Enterprises, Inc.'s Return to Work Program, which includes following all the guidelines of this policy. Injured employees will also help supervisors identify potential options for transitional duties that they discover. While supervisors are responsible for maintaining constant communication with the injured employee, the worker also has the obligation to maintain contact with Dieudonne Enterprises, Inc. about their condition and status. The injured worker will complete all the required paperwork in a timely manner.
- **Return to Work Program Manager** will be trained in understanding the physical and psychosocial aspects of disability and will also understand the nuances of Dieudonne Enterprises, Inc.'s Return to Work Program, policies and all associated forms. This individual will also be able to testify in court as a vocational expert if necessary. He or she will provide program leadership by facilitating communication between union officials, employees, managers and medical providers. This manager will own the responsibility of creating the Dieudonne Enterprises, Inc. Job Bank and will assist supervisors with on-site problem solving.

PROCEDURE

Work Schedule

Dieudonne Enterprises, Inc. will do everything in its power to tailor the restricted work schedule to the injured employee's normal, pre-condition work schedule. However, depending on the job limitations, it may be necessary for the employee to take on a specifically designed, temporary schedule to accommodate these restrictions.

Payment of Wages

If qualified authorities determine an employee's injury is work related, Dieudonne Enterprises, Inc. will pay benefits and wages in accordance with the state workers' compensation statute and with the company's human resources policies. If an employee on modified duty is unable to report to work, the employee may then be charged for up to eight hours of sick leave per shift.

Employees performing modified duty on a restricted work week (during the first 90 days of workers' compensation leave) will receive payment for hours worked from the company, while hours not worked will be reimbursed according to workers' compensation guidelines.

An employee performing transitional duty for a non-work related injury or illness on a normal work schedule shall receive an hourly rate for all time worked that may not necessarily equal the full-duty hourly rate.

Employees performing transitional duty on a restricted work week following a period of Short Term Disability (STD) may receive a combination of regular pay and partial disability benefits. The employee and the Dieudonne Enterprises, Inc. Human Resources Department will work out this combination on a case-by-case basis.

If employees take vacation or there is a holiday during restricted duty, they are entitled to their regular vacation selection or holiday pay as it would apply to normal, non-restricted duty.

Communication Expectations

If an employee is unable to work in any capacity and the company approves of the absences, the employee must stay in constant communication with the Return to Work Program Manager and the direct supervisor. Each must receive an update of the employee's medical status on at least a weekly basis. Failure to do so may result in a reduction in available benefits and discipline up to and including termination.

Medical Appointments

Dieudonne Enterprises, Inc. does not allow employees to schedule medical appointments that interfere

with working hours. Employees may use time off for medical appointments if they have it available and if they coordinate the absence in advance with their supervisor. Non-emergency medical appointments *not* scheduled in advance may be cause for denial of time off.

The employee's physician must complete the Dieudonne Enterprises, Inc. Return to Work Evaluation Form for each visit to evaluate the impairment. It is the employee's responsibility to inform Dieudonne Enterprises, Inc. of his or her medical status after each doctor visit. This applies to both work related and non-work related injuries and illnesses that interfere with assigned.

Employee Procedures

1. In the event an injury or illness is work related, report it to your supervisor immediately, or no later than the end of the shift on which the injury occurs.
2. Complete and sign a Report of Injury Form.
3. Let your supervisor know that you are seeking medical treatment and obtain a Return to Work Evaluation Form. The Return to Work Evaluation form must be completed for each practitioner visit regardless of your choice of physician and regardless whether the condition is work related or not.
4. Participate in the Return to Work Program on temporary transitional work for up to 90 days while your physician and supervisor continuously review your condition.

REFUSAL TO PARTICIPATE

If you are unable to return to your regular job but are capable of performing transitional duty, you must return to transitional duty. Employees who choose not to participate in the Dieudonne Enterprises, Inc. Return to Work Program or follow all regulations in this Return to Work Policy may become ineligible for state workers' compensation benefits and, in some cases, refusal to participate may be a basis for termination. Unpaid Family Medical Leave will apply upon refusal and disability benefits will cease.

FAMILY MEDICAL LEAVE

In the case of reduced work time, the Family Medical Leave and Partial Disability programs may apply to compensate for lost wages due to fewer hours. Contact the Human Resources Department for further details.

Prepared by:	Date:	Approved by:	Date:

This Return to Work Policy is a guideline. It does not address potential compliance issues with Federal, State or local OSHA or any other regulatory agency standards. Nor is it meant to be exhaustive or construed as legal advice. Consult your licensed commercial Property and Casualty representative at IUL Risk Solutions LLC or legal counsel to address possible compliance requirements.

Return to Work Policy

Dieudonne Enterprises, Inc.'s primary goal is to accommodate injured workers by identifying or modifying jobs to meet their physical capacities and allowing them to return to work as quickly and smoothly as possible. The company is committed to individualizing return to work programs based around the individual's physical capabilities and will review all task assignments regularly to ensure duties are appropriate.

We are committed to early return to work and recognize that it speeds up the recovery process and reduces the likelihood of permanent disability. Dieudonne Enterprises, Inc. employees are expected to show the same commitment to the program by following the Return to Work Policy and all guidelines of the Return to Work Program. The Return to Work Program requires a team approach, so employees are expected to cooperate with the management team, supervisors and medical staff should they ever become injured and unable to perform your full job duties.

Prior to working on any Dieudonne Enterprises, Inc. job site, each employee is expected to have read the entire Return to Work Policy, which includes the following sections:

- Purpose
- Scope
- Applicability
- Responsibilities
- Procedure
- Refusal to Participate
- Family Medical Leave

If you have any uncertainty or questions regarding the content of these policies, you are required to consult your supervisor. This should be done prior to signing and agreeing to the Dieudonne Enterprises, Inc. Return to Work Policy.

I am aware of and have read Dieudonne Enterprises, Inc.'s Return to Work Policy, and I understand the requirements and expectations of me as an employee. Should I become injured or ill and unable to carry out my regular duties, whether it happens inside or outside the workplace, I fully recognize Dieudonne Enterprises, Inc.'s expectations of me during my recovery. I also know that Dieudonne Enterprises, Inc. reserves the right to pay less than my full-duty rate during transitional work if it is justified.

I understand that if I choose not to participate in the Return to Work Program or follow this policy's guidelines, I may become ineligible for state workers' compensation benefits and, in some cases, my refusal may be grounds for termination.

Employee Signature: _____

Date: _____

EMPLOYEE RESPONSIBILITIES WHEN INJURED ON-THE-JOB

1. Report all accidents or illnesses, no matter how minor, to your foreman
2. If you need to see a physician, please contact your supervisor immediately.
3. Written or verbal information regarding the availability of temporary transitional work should be given to the physician at the time of the first visit.
4. Immediately report to the office the results of each physician visit. This should be done in person unless other arrangements have been made.
5. Contact should be made with the office each doctor's visit for updates on your condition and your ability/needs to return to work. Any information from the company will be provided to you at this time.
6. All work releases must be reported to the office immediately so your return to work can be scheduled.
7. If the office is unavailable, you should contact your foreman.
8. If you have any questions or have concerns about the temporary transitional job, it is your responsibility to consult the office or your foreman immediately to discuss them. If they have any questions or concerns, they will discuss them with you.
9. Doctor or physical therapy appointments should be scheduled outside working hours if possible. If not possible, arrangements need to be made with your foreman.

I have read the above responsibilities information. I have been given the opportunity to ask questions about my responsibilities. I understand that failure to follow them may result in disciplinary action and/or adversely affect my workers' compensation benefits. I have received a copy of this document.

_____

Employee Signature Date

DECLARATION OF NO INJURIES

Upon starting my employment, I signed a letter of understanding that any and all injuries are to be reported immediately to my supervisor or [work comp coordinator]. I also agreed that as soon as reasonably possible, but no later than 24 hours after an incident, I am required to complete an Injury Report form.

If I was injured on the job during the below time period, I have already notified my supervisor or [work comp coordinator] and filled out the appropriate papers. By signing this statement, I am confirming that from _____ to today's date, I have not sustained an unreported injury while in the course and employment of the company.

I declare the above to be true and correct pursuant to the penalty of perjury of the laws of the State of Louisiana.

_____ _____

Employee Signature Date / /

_____

Employee Name (please print)