Registry Network
Incorporated

Dear Applicant:

Thank you for your interest in becoming an employee of Registry Network, Inc. Enclosed is an application packet and list of documents needed to complete your application. After completing all forms sent via Adobe Sign, they will come back automatically and is our preferred method. If not, please return them via US mail or by one of our 877 fax numbers. You will need to call the office that sent you the application to obtain the fax number for that office.

Please complete all the enclosed forms and place a copy of the following documents when returning your application:

1. Current Licenses or Certification.
2. American Heart Association cards only for BLS, ACLS, NRP, PALS (front & back of all cards or Digital eCard).
3. Current Statement of Good Health/Physical Exam.
4. Tuberculosis Screen (PPD/QuantiFERON/T-Spot) within the last year or a Chest X-Ray within the last four years if you are PPD positive.
5. Proof of Rubella, Rubeola, Mumps, and Varicella (Chicken Pox) Titers or signed immunization record showing 2 (two) immunizations.
6. Respirator Fit Test with type and size of N95 mask you are fitted for.
7. Hepatitis B record, signed declination, proof of immunization, or titer.
8. Influenza proof of immunization or if accepted declination.
9. Proof of Tdap immunization or declination.
10. I-9 Documentation that has been notarized unless you are able to come into one of our offices and we can verify the documents ourselves.
11. Voided Check if interested in having Direct Deposit
12. 2 (two) Professional References.
13. Drug Screen

Registry Network, Inc. has provided temporary medical staffing to government and civilian healthcare facilities for the past Thirty-Seven years. We are continually seeking qualified healthcare professionals in nursing, respiratory, and radiology specialties to staff acute care hospitals and clinics.

Please call 800-400-1145, if you have questions regarding the application and process.

We look forward to working with you soon.

Sincerely,

Registry Network, Inc.

PROFESSIONAL REFERENCE

The individual below has applied to Registry Network, Inc. and has listed you as a current or previous employer. We would appreciate your assistance in verifying employment and evaluating job performance. All information is **CONFIDENTIAL**. Fax to **Northern CA** at 877-349-3129 and **Southern CA** at 877-896-0460.

APPLICANTS RELEASE OF INFORMATION

Applicants: _____ _____
LAST FIRST MI MAIDEN

Employer Name: _____ Position Held: _____

Employer Telephone Number: _____ Dates Employed: From ____/____
To ____/_____

I hereby release the company or person completing this form from all liability and authorize them to provide all information regarding my employment with them. I also release Registry Network, Inc. from all liability for any damages arising from the disclosure of this information.

_____ _____
Applicant Signature Date

EMPLOYER RESPONSE

1. Do the employment dates above correspond with your records? ☐ YES ☐ NO

2. Is there anything in the individual's work history that would indicate a potential threat to patient safety? ☐ YES ☐ NO
Comments: _____

3. Would you rehire this employee? ☐ YES ☐ NO

PLEASE EVALUATE THE APPLICANT IN EACH OF THE FOLLOWING AREAS:

EVALUATION	POOR	AVERAGE	GOOD	EXCELLENT
Attendance				
Punctuality				
Dependability				
Quality of work				
Job knowledge/skills				
Judgment				
Accepts Supervision				
Appearance				
Attitude				

Name of Facility_____ Print Name _____
Signature_____ Title_____ Date_____
Telephone Verification by _____ Date _____

Form updated 9-3-26

PROFESSIONAL REFERENCE

The individual below has applied to Registry Network, Inc. and has listed you as a current or previous employer. We would appreciate your assistance in verifying employment and evaluating job performance. All information is **CONFIDENTIAL**. Fax to **Northern CA** at 877-349-3129 and **Southern CA** at 877-896-0460.

APPLICANTS RELEASE OF INFORMATION

Applicants: _____ _____
LAST FIRST MI MAIDEN

Employer Name: _____ Position Held: _____

Employer Telephone Number: _____ Dates Employed: From ____/____
To ____/_____

I hereby release the company or person completing this form from all liability and authorize them to provide all information regarding my employment with them. I also release Registry Network, Inc. from all liability for any damages arising from the disclosure of this information.

_____ _____
Applicant Signature Date

EMPLOYER RESPONSE

1. Do the employment dates above correspond with your records? ☐ YES ☐ NO

2. Is there anything in the individual's work history that would indicate a potential threat to patient safety? ☐ YES ☐ NO
Comments: _____

3. Would you rehire this employee? ☐ YES ☐ NO

PLEASE EVALUATE THE APPLICANT IN EACH OF THE FOLLOWING AREAS:

EVALUATION	POOR	AVERAGE	GOOD	EXCELLENT
Attendance				
Punctuality				
Dependability				
Quality of work				
Job knowledge/skills				
Judgment				
Accepts Supervision				
Appearance				
Attitude				

Name of Facility_____ Print Name _____
Signature_____ Title_____ Date_____
Telephone Verification by _____ Date _____

Form updated 9-3-26

Registry Network
Incorporated

Release of Records

I authorize Registry Network to receive and release my employment-related records, including education, experience, credentials, employment references, and medical records. I release Registry Network from liability related to receiving or releasing these records as authorized by this form.

_____ _____

Print Full Name Date

_____

Signature

Form updated 9-3-26

Registry Network
Incorporated

CONTINUING EDUCATION DOCUMENTATION

Registry Network encourages you to acquire your CEU's throughout your two year license period. RNI and our clients are interested in knowing what you are keeping up with. Please provide us with the names of the courses and the hours given, or simply provide us your CEU award certificate.

EMPLOYEE NAME: _____

OCCUPATION: _____

SPECIALTY: _____

CEU'S ATTENDED DURING: _____

	NAME OF CLASS	NUMBER OF CEU HOURS
1.	_____	
2.	_____	
3.	_____	
4.	_____	
5.	_____	
6.	_____	
7.	_____	
8.	_____	
9.	_____	

_____ _____

EMPLOYEE SIGNATURE DATE

Form Updated 9-3-26

Registry Network
Incorporated

CONFIDENTIAL POST-EMPLOYMENT EEOC DATA FORM

NAME (Last, First, Initial) _____

Sex: Female ☐ Male ☐

Date of Birth: ____/_____/_____

US Citizen? Yes ☐ No ☐

☐ Veteran (other than Vietnam era)

☐ Vietnam era Veteran (served on active duty between Aug. 5, 1964 and May 7, 1975)

☐ Handicapped

☐ Disabled Veteran (Vietnam era only)

☐ Disabled Veteran (other than Vietnam era)

RACE OR ETHNIC GROUP (please check only one box)

- ☐ White (Not of Hispanic origin)
- ☐ Black or African American (Not of Hispanic origin)
- ☐ Native Hawaiian or Pacific Islander: All persons having origins in any of the original peoples of the Far East, Southeast, Asia, the Pacific Islands, India or Pakistan.
- ☐ Asian: All persons having origins in any of the original peoples of the Far East, Southeast, Asia, India or Pakistan.
- ☐ Two or more Races:
- ☐ American Indian or Alaskan Native: Persons having origin in the original peoples of North America and who maintain cultural identification through tribal affiliation or community recognition.
- ☐ Hispanic or Latino: All persons of Mexican, Puerto Rican, Cuban, Central or South America, or other Spanish culture or origin.

Date Completed: _____ Signature: _____

Form Updated 9-3-26

Registry Network
Incorporated

Health Insurance Attestation Form

I, _____, attest that I have Health Insurance that meets the requirements of the Affordable Care Act (ACA) either through private insurance or Covered California. I understand it is my responsibility to inform RNI should my policy change or I no longer have coverage.

Print Name: _____

Signature: _____

Date: _____

Form Updated 9-3-26

Registry Network Incorporated

Hepatitis B Vaccine Evaluation Consent/Declination Form

Name: _____

To reduce unnecessary immunization of people previously immune (from prior vaccination or by natural infection), please complete the following questions:

1. Have you ever received any vaccine against Hepatitis B? Yes___ No___
   If yes, in what year? _____. How many shots were given? _____

2. Have you ever been told you were exposed to or infected with Hepatitis B?
   Yes ___ No___

3. Although the current vaccine is extremely safe, it is contraindicated for persons allergic to yeast products. Are you allergic to yeast? Yes___ No___

Healthcare workers are at increased risk of Hepatitis B Virus (HBV) infection because of contract with blood and other body fluids. The serious complications and results of HBV infection include liver damage, cirrhosis of the liver, chronic active hepatitis, cancer of the liver, and/or death. There is no specific treatment for HBV infection.

The Hepatitis B vaccine is 80-95% effective in preventing Hepatitis in susceptible people. The vaccine is given intramuscularly in three doses, with the second and third doses given one and six months after the first dose. The most common side effect has been limited to soreness or redness at the injection site. Systemic complaints could include fatigue/weakness, fever, headache, and malaise. The duration of protection is probably more than five years. However, this or the need for boosters is yet to be determined.

_____(Initials) **I request that the Hepatitis B vaccine be administered to me.**

I understand that due to my occupation exposure to blood and other potentially infectious materials that I may be at risk of acquiring HBV infection. I also understand that by declining this vaccine, I continue to be at risk of acquiring HBV, a serious disease. I understand I can change my mind and request to receive the vaccine at any time.

OR

_____(Initials) **I presently decline the Hepatitis B vaccine.**

Signature: _____ Date: _____

Form Updated 9-3-26

Registry Network
Incorporated

TB SURVEILLANCE SYMPTOMS REVIEW
FOR +PPD EMPLOYEES

Name: _____ Date: _____

1. Have you ever been treated for a + PPD skin test with INH? _____
   If yes, when? _____

2. Have you had any known exposure to TB? _____

_____

3. Have you experienced any of the following during the past year? Please check yes or no for each of the following.

A) Night sweats	Yes ____	No ____
B) Persistent coughing	Yes ____	No ____
C) Coughing up blood	Yes ____	No ____
D) Excessive weight loss	Yes ____	No ____
E) Excessive fatigue or tiredness	Yes ____	No ____
F) Fever of unknown origin	Yes ____	No ____

Signature: _____

Registry Network
Incorporated

Tetanus, Diphtheria & Pertussis (Tdap)
Proof of Immunization/ Declination

Registry Network, Inc. is pleased to offer all our field employees the Tdap Vaccine through our contracted provider. Please contact our Human Resources Department and they will schedule your appointment and then our Payroll Department will set up the payroll deduction. Please check the appropriate box below, sign, date, and print your name.

Healthcare Providers are at an increased risk of acquiring these serious diseases due to patient contact.

Tdap

- ❑ **I have already received the Tdap vaccine on_____. Please provide us with your immunization record showing proof.**

OR

- ❑ **I elect NOT to receive the Tdap vaccine at this time. Note that not all facilities will accept a declination.**

I understand that by my declining I may have a higher likelihood of acquiring and spreading the Virus.

I understand that it is my responsibility to ensure my good health and the health of my patients.

_____ _____
Employee Signature Date

_____
Printed Name

Form updated 9-3-26

COVID-19 (SARS-CoV-2) Vaccine
Declination Form

Registry Network, Inc. recommends that all members of the community, except those who have had a severe allergic reaction to a previous dose of the COVID-19 vaccine or to any of its components, receive a vaccination to protect against COVID-19 disease and get boosters as needed to stay up to date.

I am aware of the following facts:

- COVID-19 is a serious disease and has killed over 1 million people in the United States since February 2020, 110,936 in California alone as of May 2025.
- COVID-19 vaccine, and/or current monovalent booster, is recommended for me, other members of the community to protect our students, patients, faculty, and staff, and our families and communities, from COVID-19, its complications, and death.
- If I contract COVID-19, I can shed the virus for days even before any symptoms appear. During the time I shed the virus, I can transmit it to anyone I contact.
- If I become infected with SARS-CoV-2, the virus that causes COVID-19, even if my symptoms are mild or non-existent, I can spread the disease to others, and they can become seriously ill or die as a result.
- Nearly 1 in 6 American adults who have had COVID-19 is estimated to be suffering from "Long COVID" – symptoms that can last months or years after COVID-19 and can be debilitating.
- Contracting COVID-19 could have life-threatening consequences for my health and the health of everyone with whom I have contact, including my coworkers or peers and the most vulnerable members of our community.

Despite these facts, I am voluntarily choosing to decline the most recent COVID-19 booster. My reason(s) for declining are as follows (please select one option):

- ☐ Medical Contraindication
- ☐ Religious Beliefs
- ☐ Received previous COVID-19 Booster Vaccine or accepted exception.

I understand that I can change my mind at any time and accept the COVID-19 booster. I understand that as long as I am not Up-to-Date on COVID-19 boosters, I will be required to wear a mask in all clinical care areas where patients are present.

I have read the Vaccine Information Statement or Fact Sheet and the information on this declination form. I have had a chance to ask questions and all of my questions have been answered.

Signature: _____ *DOB:* _____

Print Name/Date: _____

Department: _____

Form updated 9-3-26

MEAL PERIOD WAIVER
10- & 12-HOUR SHIFT

This will acknowledge that I regularly work a shift more than eight (8) hours and wish to waive one of the two meal periods I would otherwise be entitled to receive under state law. In accordance with the requirements of Wage Order 5, this certifies my voluntary waiver of a meal period each day of work. I also understand that Registry Network, Inc., or I may revoke this "Meal Period Waiver" at any time by providing at least one day's advance notice in writing of the decision to do so. This waiver will remain in effect until I exercise, or the Registry Network, Inc. exercises, the option to revoke the waiver.

I acknowledge that I have read this waiver, understand it and voluntarily agree to its provisions.

- ❑ I acknowledge that I have read this waiver, understand it and voluntarily waive one of my meal periods.

OR

- ❑ I acknowledge that I have read this waiver, understand it and do not wish to waive one of my 2 meal periods. This means on a 10 or 12 hour shift you wish to take 2 unpaid 30-minute lunch breaks. RNI cannot guarantee the facility will grant you the second meal period, so going to a facility that has 10- or 12-hour shifts may not be an option for you

_____	_____
Employee Signature	Date
_____	_____
Print Name	Department

Form updated 9-3-26

Registry Network Incorporated

Permanent Tax Residence Declaration

The IRS requires that you pay taxes on housing benefits and travel expense reimbursements, unless you maintain a permanent residence while on a temporary assignment. If you qualify for permanent tax home exemption, we are required to keep your Permanent Tax Home Address on file.
If you do not return the completed form; or if you do not meet the "tax home" criteria, the IRS requires that we treat travel and housing benefits as income and taxes will be withheld accordingly.

Consult your tax advisor regarding tax liability of housing and travel benefits and permanent tax residence.

IRS criteria used to determine your tax home residence is as follows:

- You must meet at least one of the following criteria:
  a) You lived at your permanent tax residence immediately prior to your current assignment, **or**
  b) You have a family member utilizing the residence, or you utilized this residence frequently for purpose of your own lodging.

- There must be a realistic expectation that you will return to & live at your home; **and**
  a) Your tax home must be separate and distinct from your temporary address; and
  b) You pay to maintain your permanent tax residence while you are on assignment (i.e. mortgage, rent, room and board).

- The **Permanent Tax Residence** *must* be:
  a) Habitable living quarters at least 50 miles away from your temporary residence; and
  b) Payments to maintain your permanent tax residence must be real and substantial.

Please be advised, the IRS considers employment away from your home in a single location that exceeds or may exceed one year, to be indefinite, not temporary, and therefore housing and travel benefits would be subject to withholding.

NAME:_____

Do you qualify for a permanent tax-residence exemption? ___Yes ___No
If, "YES" is selected, please complete the following fields:

_____
STREET ADDRESS

_____
CITY STATE ZIP CODE

I acknowledge by signing this document that the information provided is true and correct. I understand that if I provide an incorrect statement, I may be subject to federal, state, and local taxes; penalties; and interest for which I agree to take full responsibility. I understand that I am responsible for notifying the Company in writing if my permanent tax-residence status should change and I become ineligible for the exemption.

_____ _____
SIGNATURE DATE

Form updated: 9-3-26

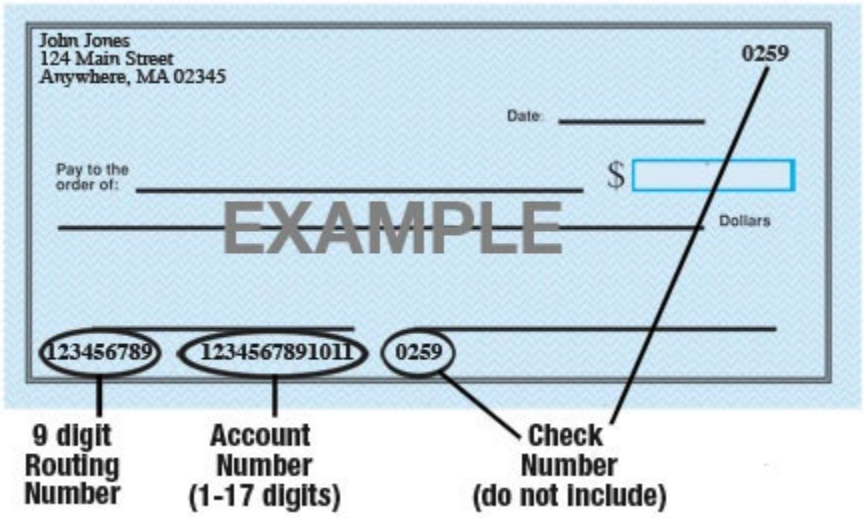
Direct Deposit Authorization Form

Please print and complete ALL the information below.

Name: _____

Address: _____

City, State, Zip: _____



Name of Bank: _____

Account #: _____

9-Digit Routing #: _____

Amount: _____% or ☐ Entire Paycheck

Type of Account: ☐Checking ☐Savings

Please attach a voided check for each bank account to which funds should be deposited. If no check copy is provided and an error occurs by you, your check will first have to be returned by the financial institution before we will reissue the funds.

Registry Network Inc. is hereby authorized to directly deposit my pay to the account listed above. This authorization will remain in effect until I modify or cancel it in writing.

Employee Signature: _____

Date: _____

Form Updated 9-3-26

Clear Form

Employee's Withholding Allowance Certificate

Complete this form so that your employer can withhold the correct California state income tax from your pay.

Personal Information	
First, Middle, Last Name	Social Security Number
Address City State ZIP Code	Filing Status ☐ Single or Married (with two or more incomes) ☐ Married (one income) ☐ Head of Household

1. Use Worksheet A for Regular Withholding allowances. Use other worksheets on the following pages as applicable.
   - 1a. Number of Regular Withholding Allowances (**Worksheet A**) _____
   - 1b. Number of allowances from the Estimated Deductions (**Worksheet B**) _____
   - 1c. Total Number of Allowances you are claiming _____
2. Additional amount, if any, you want withheld each pay period (if employer agrees), **(Worksheet C)** _____

OR

Exemption from Withholding

3. I claim exemption from withholding for 2026, and I certify I meet both conditions for exemption. (Check box here) ☐

OR

4. I certify under penalty of perjury that I am **not subject** to California withholding. I meet the conditions set forth under the Service Member Civil Relief Act, as amended by the Military Spouses Residency Relief Act and the Veterans Benefits and Transition Act of 2018. (Check box here) ☐

Under penalty of perjury, I certify that the number of withholding allowances claimed on this certificate does not exceed the number to which I am entitled or, if claiming exemption from withholding, that I am entitled to claim the exempt status.

Employee's Signature _____ Date _____

Employer's Section: Employer's Name and Address	California Employer Payroll Tax Account Number

The *Employee's Withholding Allowance Certificate* (DE 4) is for **California Personal Income Tax (PIT)** withholding purposes only. The DE 4 is used to compute the amount of taxes to be withheld from your wages, by your employer, to accurately reflect your state tax withholding obligation.

As of January 1, 2020, the *Employee's Withholding Allowance Certificate* (Form W-4) from the Internal Revenue Service (IRS) is used for federal income tax withholding **only**. You must file the state form DE 4 to determine the appropriate California PIT withholding.

If you do not provide your employer a completed DE 4, your employer must use Single with Zero withholding allowance.

Check Your Withholding: After your DE 4 takes effect, compare the state income tax withheld with your estimated total annual tax. For state withholding, use the worksheets on this form.

Exemption From Withholding: If you wish to claim exempt, complete the federal Form W-4 and the state DE 4. You may claim exempt from withholding California income tax if you meet both of the following conditions for exemption:

1. You did not owe any federal and state income tax last year, and
2. You do not expect to owe any federal and state income tax this year.

If you continue to qualify for the exempt filing status, a new DE 4 designating **exempt** must be submitted by February 15 each year to continue your exemption. If you are not having federal and state income tax withheld this year but expect to have a tax liability next year, you are required to give your employer a new DE 4 by December 1.

Member Service Civil Relief Act: Under this act, as provided by the Military Spouses Residency Relief Act and the Veterans Benefits and Transition Act of 2018, you may be exempt from California income tax withholding on your wages if

(i) Your spouse is a member of the armed forces present in California in compliance with military orders;

(ii) You are present in California solely to be with your spouse; and

(iii) You maintain your domicile in another state.

If you claim exemption under this act, **check the box on Line 4**. You may be required to provide proof of exemption upon request.

The *California Employer's Guide* (DE 44) (edd.ca.gov/pdf_pub_ctr/de44.pdf) provides the income tax withholding tables. This publication can be found by visiting Payroll Taxes - Forms and Publications (edd.ca.gov/Payroll_Taxes/Forms_and_Publications.htm). To assist you in calculating your tax liability, visit the Franchise Tax Board (FTB) (ftb.ca.gov).

If you need information on your last *California Resident Income Tax Return* (FTB Form 540), visit the FTB (ftb.ca.gov).

Notification: The burden of proof rests with the employee to show the correct California income tax withholding. Pursuant to section 4340-1(e) of Title 22, California Code of Regulations (CCR) (govt.westlaw.com/calregs/Search/Index), the FTB or the EDD may require an employer to submit a Form W-4 or DE 4 when such forms are necessary for the administration of the withholding tax programs.

Penalty: You may be fined $500 if you file, with no reasonable basis, a DE 4 that results in less tax being withheld than is properly allowable. Criminal penalties apply for willfully supplying false or fraudulent information or failing to supply information requiring an increase in withholding. This is provided by section 13101 of the California Unemployment Insurance Code (leginfo.legislature.ca.gov/faces/codes.xhtml) and section 19176 of the Revenue and Taxation Code (leginfo.legislature.ca.gov/faces/codes.xhtml).

Worksheets

Instructions — 1 — Allowances*

When determining your withholding allowances, you must consider your personal situation:
— Do you claim allowances for dependents or blindness?
— Will you itemize your deductions?
— Do you have more than one income coming into the household?

Two-Earners or Multiple Incomes: When earnings come from more than one source, under-withholding may occur. If you have a working spouse or more than one job, it is best to check the box "Single or Married (with two or more incomes)." Figure the total number of allowances you are entitled to claim on all jobs using only one DE 4 form. Claim allowances with **one** employer.

Do **not** claim the same allowances with more than one employer. Your withholding will usually be most accurate when all allowances are claimed on the DE 4 filed for the highest paying job and zero allowances are claimed for the others.

Married But Not Living With Your Spouse: You may check the "Head of Household" marital status box if you meet all of the following:
(1) Your spouse will not live with you **at any time** during the year;
(2) You will furnish over half of the cost of maintaining a home for the entire year for yourself and your child or stepchild who qualifies as your dependent; **and**
(3) You will file a separate return for the year.

Head of Household: To qualify, you must be unmarried or legally separated from your spouse and pay more than 50 percent of the costs of maintaining a home for the **entire** year for yourself and your dependent(s) or other qualifying individuals. Cost of maintaining the home includes such items as rent, property insurance, property taxes, mortgage interest, repairs, utilities, and cost of food. It does not include the individual's personal expenses or any amount which represents value of services performed by a member of the household of the taxpayer.

Worksheet A **Regular Withholding Allowances**

(A)	Allowance for yourself — enter 1	(A) _____
(B)	Allowance for your spouse (if not separately claimed by your spouse) — enter 1	(B) _____
(C)	Allowance for blindness — yourself — enter 1	(C) _____
(D)	Allowance for blindness — your spouse (if not separately claimed by your spouse) — enter 1	(D) _____
(E)	Allowance(s) for dependent(s) — do not include yourself or your spouse	(E) _____
(F)	Total — add lines (A) through (E) above and enter on line 1a of the DE 4	(F) _____

Instructions — 2 — Additional Withholding Allowances (Optional)

If you expect to itemize deductions on your California income tax return, you can claim additional withholding allowances. Use Worksheet B to determine whether your expected estimated deductions may entitle you to claim **one or more additional** withholding allowances. Use last year's FTB Form 540 as a model to calculate this year's withholding amounts.

Do not include deferred compensation, qualified pension payments, or flexible benefits, etc., that are deducted from your gross pay but are not taxed on this worksheet.

You may reduce the amount of tax withheld from your wages by claiming one additional withholding allowance for each $1,000, or fraction of $1,000, by which you expect your estimated deductions for the year to exceed your allowable standard deduction.

Worksheet B **Estimated Deductions**

Use this worksheet **only** if you plan to itemize deductions, claim certain adjustments to income, or have a large amount of nonwage income not subject to withholding.

1.	Enter an estimate of your itemized deductions for California taxes for this tax year as listed in the schedules in the FTB Form 540	1.	_____
2.	Enter $11,412 if married filing joint with two or more allowances, unmarried head of household, or qualifying widow(er) with dependent(s) or $5,706 if single or married filing separately, dual income married, or married with multiple employers	– 2.	_____
3.	Subtract line 2 from line 1, enter difference	= 3.	_____
4.	Enter an estimate of your adjustments to income (alimony payments, IRA deposits)	+ 4.	_____
5.	Add line 4 to line 3, enter sum	= 5.	_____
6.	Enter an estimate of your nonwage income (dividends, interest income, alimony receipts)	– 6.	_____
7.	If line 5 is greater than line 6 (if less, see below [go to line 9]); Subtract line 6 from line 5, enter difference	= 7.	_____
8.	Divide the amount on line 7 by $1,000, round any fraction to the nearest whole number enter this number on line 1b of the DE 4. Complete Worksheet C, if needed, otherwise **stop here**.	8.	_____
9.	If line 6 is greater than line 5; Enter amount from line 6 (nonwage income)	9.	_____
10.	Enter amount from line 5 (deductions)	10.	_____
11.	Subtract line 10 from line 9, enter difference. Then, complete Worksheet C.	11.	_____

*Wages paid to registered domestic partners will be treated the same for state income tax purposes as wages paid to spouses for California PIT withholding and PIT wages. This law does not impact federal income tax law. A registered domestic partner means an individual partner in a domestic partner relationship within the meaning of section 297 of the Family Code. For more information, call our Taxpayer Assistance Center at 1-888-745-3886.

Worksheet C **Additional Tax Withholding and Estimated Tax**

1.	Enter estimate of total wages for tax year 2026.	1. _____
2.	Enter estimate of nonwage income (line 6 of Worksheet B).	2. _____
3.	Add line 1 and line 2. Enter sum.	3. _____
4.	Enter itemized deductions or standard deduction (line 1 or 2 of Worksheet B, whichever is largest).	4. _____
5.	Enter adjustments to income (line 4 of Worksheet B).	5. _____
6.	Add line 4 and line 5. Enter sum.	6. _____
7.	Subtract line 6 from line 3. Enter difference.	7. _____
8.	Figure your tax liability for the amount on line 7 by using the 2026 tax rate schedules below.	8. _____
9.	Enter personal exemptions (line F of Worksheet A x $168.30).	9. _____
10.	Subtract line 9 from line 8. Enter difference.	10. _____
11.	Enter any tax credits. (See FTB Form 540).	11. _____
12.	Subtract line 11 from line 10. Enter difference. This is your total tax liability.	12. _____
13.	Calculate the tax withheld and estimated to be withheld during 2026. Contact your employer to request the amount that will be withheld on your wages based on the marital status and number of withholding allowances you will claim for 2026. Multiply the estimated amount to be withheld by the number of pay periods left in the year. Add the total to the amount already withheld for 2026.	13. _____
14.	Subtract line 13 from line 12. Enter difference. If this is less than zero, you do not need to have additional taxes withheld.	14. _____
15.	Divide line 14 by the number of pay periods remaining in the year. Enter this figure on line 2 of the DE 4.	15. _____

Note: Your employer is not required to withhold the additional amount requested on line 2 of your DE 4. If your employer does not agree to withhold the additional amount, you may increase your withholdings as much as possible by using the "single" status with "zero" allowances. If the amount withheld still results in an underpayment of state income taxes, you may need to file quarterly estimates on Form 540-ES with the FTB to avoid a penalty.

These Tables Are for Calculating Worksheet C and for 2026 Only

Single Persons, Dual Income Married or Married With Multiple Employers

IF THE TAXABLE INCOME IS		COMPUTED TAX IS		
OVER	BUT NOT OVER	OF AMOUNT OVER...		PLUS
$0	$11,079	1.100%	$0	$0.00
$11,079	$26,264	2.200%	$11,079	$121.87
$26,264	$41,452	4.400%	$26,264	$455.94
$41,452	$57,542	6.600%	$41,452	$1,124.21
$57,542	$72,724	8.800%	$57,542	$2,186.15
$72,724	$371,479	10.230%	$72,724	$3,522.17
$371,479	$445,771	11.330%	$371,479	$34,084.81
$445,771	$742,953	12.430%	$445,771	$42,502.09
$742,953	$1,000,000	13.530%	$742,953	$79,441.81
$1,000,000	and over	14.630%	$1,000,000	$114,220.27

Unmarried/Head of Household

IF THE TAXABLE INCOME IS		COMPUTED TAX IS		
OVER	BUT NOT OVER	OF AMOUNT OVER...		PLUS
$0	$22,173	1.100%	$0	$0.00
$22,173	$52,530	2.200%	$22,173	$243.90
$52,530	$67,716	4.400%	$52,530	$911.75
$67,716	$83,805	6.600%	$67,716	$1,579.93
$83,805	$98,990	8.800%	$83,805	$2,641.80
$98,990	$505,208	10.230%	$98,990	$3,978.08
$505,208	$606,251	11.330%	$505,208	$45,534.18
$606,251	$1,000,000	12.430%	$606,251	$56,982.35
$1,000,000	$1,010,417	13.530%	$1,000,000	$105,925.35
$1,010,417	and over	14.630%	$1,010,417	$107,334.77

Married Persons

IF THE TAXABLE INCOME IS		COMPUTED TAX IS		
OVER	BUT NOT OVER	OF AMOUNT OVER...		PLUS
$0	$22,158	1.100%	$0	$0.00
$22,158	$52,528	2.200%	$22,158	$243.74
$52,528	$82,904	4.400%	$52,528	$911.88
$82,904	$115,084	6.600%	$82,904	$2,248.42
$115,084	$145,448	8.800%	$115,084	$4,372.30
$145,448	$742,958	10.230%	$145,448	$7,044.33
$742,958	$891,542	11.330%	$742,958	$68,169.60
$891,542	$1,000,000	12.430%	$891,542	$85,004.17
$1,000,000	$1,485,906	13.530%	$1,000,000	$98,485.50
$1,485,906	and over	14.630%	$1,485,906	$164,228.58

If you need information on your last California Resident Income Tax Return, FTB Form 540, visit FTB (ftb.ca.gov).

The DE 4 information is collected for purposes of administering the PIT law and under the authority of Title 22, CCR, section 4340-1, and the California Revenue and Taxation Code, including section 18624. The Information Practices Act of 1977 requires that individuals be notified of how information they provide may be used. More information is in the instructions that came with your last California resident income tax return.