

PRINT OR TYPE

# COMPTROLLER GENERAL'S OFFICE

## EMPLOYEE'S WITHHOLDING & DEDUCTIONS

DEPARTMENT NAME \_\_\_\_\_ DEPT. NO (3 Positions) \_\_\_\_\_

NEW       CHANGE      EFFECTIVE DATE \_\_\_\_\_

(01) SOCIAL SECURITY \_\_\_\_\_

(02) NAME      First \_\_\_\_\_ (20 Positions)      Middle Initial \_\_\_\_\_      Last \_\_\_\_\_ (20 Positions)

(03) STREET \_\_\_\_\_ (25 Positions)

(04) CITY/STATE \_\_\_\_\_ (20 Positions)       (05) ZIP \_\_\_\_\_

(06) MARITAL STATUS      NUMBER WITHHOLDING EXEMPTIONS

SINGLE       MARRIED       (07) FEDERAL \_\_\_\_\_       (08) STATE \_\_\_\_\_

**W-4**

Form  
Department of the Treasury  
Internal Revenue Service

### Employee's Withholding Allowance Certificate

For Privacy Act and Paperwork Reduction Act Notice, see reverse.

OMB No. 1545-0010

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1 Type or print your first name and middle initial \_\_\_\_\_ Last name \_\_\_\_\_ 2 Your social security number \_\_\_\_\_

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Home address (number and street or rural route) \_\_\_\_\_ 3  Single  Married  Married, but withhold at higher single rate.  
*Note: if married, but legally separated, or spouse is a nonresident alien, check the Single box.*

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City or town, state, and ZIP Code \_\_\_\_\_ 4 If your last name differs from that on your social security card, check here and call 1-800-772-1213 for a new card - - - - - >

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5 Total number of allowances you are claiming (from line G above or from the worksheets on page 2 if they apply) 5 \_\_\_\_\_

6 Additional amount, if any, you want withheld from each paycheck 6 \_\_\_\_\_

7 I claim exemption from withholding for 2003 and I certify that I meet **BOTH** of the following conditions for exemption:

- Last year I had a right to a refund of **ALL** Federal income tax withheld because I had **NO** tax liability; **AND**
- This year I expect a refund of **ALL** Federal income tax withheld because I expect to have **NO** tax liability.

If you meet both conditions, enter "EXEMPT" here \_\_\_\_\_ > 7

Under penalties of perjury, I certify that I am entitled to the number of withholding allowances claimed on this certificate or entitled to claim exempt status

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Employee's signature > \_\_\_\_\_ Date > \_\_\_\_\_, 20\_\_

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8 Employer's name and address (Employer: Complete 8 and 10 only if sending to the IRS) \_\_\_\_\_ 9 Office code (optional) \_\_\_\_\_ 10 Employer Identification number \_\_\_\_\_

### INSURANCE AND OTHER DEDUCTIONS

CODE	DEDUCTION	AMOUNT	CODE	DEDUCTION	AMOUNT
<input type="checkbox"/> # 616		\$	<input type="checkbox"/>		\$
<input type="checkbox"/>		\$	<input type="checkbox"/>		\$
<input type="checkbox"/>		\$	<input type="checkbox"/>		\$
<input type="checkbox"/>		\$	<input type="checkbox"/>		\$
<input type="checkbox"/>		\$	<input type="checkbox"/>		\$

I hereby authorize my employer to deduct from my earnings the amounts indicated above to enable me to participate in the above salary deduction plans. I reserve the right to revoke the authorization at any time by giving written notice to my employer.

\_\_\_\_\_  
Authorized Agency Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Title

\_\_\_\_\_  
Employee's Signature