PUTNAM COUNTY EMERGENCY SERVICES

410 South SR 19
Palatka, FL 32177
Phone (386) 329-1208 Fax (386) 329-0897

Applicant Records Check

(Revised 04/17/2009)

1. Print Name:_____
(Last) (First) (Middle) (Maiden)

2. Date of Birth:_____Race/Sex:_____

3. Mail Address:_____9-1-1:_____

City:_____State:_____Zip Code:_____

4. SSN:_____Home Phone:_____

5. DL #:_____Type:_____Endorsements:_____

6. Station:_____

I hereby authorize this Agency to check any and all records pertaining to criminal convictions and Driver License information, and for any law enforcement agency to release information regarding any violations under Florida Statutes or Statutes of other Jurisdiction.

Signature:_____Date:_____

PUTNAM COUNTY EMERGENCY SERVICES

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PERSONNEL RECORD FORM

(Revised 04/17/2009)

□ New Member
□ Add

□ Existing Member □ Update or Change
□ Personal Information
□ Role / Status
□ Other Change

Effective Date of change:_____

Name:_____
(Last) (First) (MI)

Date of Birth:_____ Race: W / B / O Sex: M / F

Mail Address:_____ 9-1-1:_____

City:_____ State:_____ Zip Code:_____

SSN:_____ Home Ph:_____ Fax:_____ E-Mail:_____

DL #:_____ Exp Date:_____ Type:_____ Endorsements:_____

Emerg Contact:_____ Relationship:_____ Ph:_____

Blood Type:_____ Last Medical Exam:_____ Dr:_____

Employer:_____ Phone:_____

****

TRAINING INFORMATION

Please attach copies of all training certificates, licenses (including DL) and SSN Card. (Needed to demonstrate training commensurate to duty)

****

Role: □ Combat FF □ Support

Status: □ New Member □ Re-instated □ Resigned □ Terminated

□ Dual Member with _____ □ Transfer from Station_____ to Station _____

Authorized to Drive Apparatus: Y □ / N □?

DL Copy attached: Y □ / N □? SSN Card copy attached: Y □ / N □?

Workers Comp acknowledgment form attached: Y □ / N □?

Insurance Beneficiary Designation form completed and attached: Y □ / N □?

Comments:_____

_____

_____

Verified by Chief:_____ Date:_____

Station ID:_____

VFIS®

Beneficiary Designation for Accident & Sickness Policy

Complete this block each time this form is used—Please Print

Name of Organization Putnam County BOCC State _____

Member's /Employee's Name _____

Member's Date of Birth _____ Date Member Joined Organization _____

Complete, sign and date this block if you wish to name or change your beneficiary.

I hereby designate the following beneficiary(ies) with respect to amounts payable as indemnity for loss of life under the referenced Accident & Sickness Policy and hereby revoke any designation of beneficiary thereunder heretofore made by me. I direct that any amounts payable under said policy to my beneficiary(ies) named below be paid to those of Primary Beneficiary who survive me, otherwise to those surviving in Contingent Beneficiary, in proportion to the percentages listed.

Primary (Please refer to back of form for examples)
Beneficiary: Name _____ Relationship _____ Date of Birth _____ Share _____%

Name _____ Relationship _____ Date of Birth _____ Share _____%

Contingent
Beneficiary: Name _____ Relationship _____ Date of Birth _____ Share _____%

Name _____ Relationship _____ Date of Birth _____ Share _____%

If none of the above-named beneficiaries are living at the time of my death, I direct that payment be made in accordance with the terms of the policy. I reserve the right to revoke or change this designation.

Signature _____ Date _____

This form should be retained in the files of your department or organization and reviewed and updated on a regular basis.

AIG Life Insurance Company
Beneficiary Designation

Insured Employee
Name (Print) _____
Last First Initial

Date Employed _____
Mo. Day Year

Death Benefits to be Paid to: _____

Relationship: _____

Policyholder: Putnam County BOCC

Name of Employer (if other than Policyholder): _____

Policy Number: SRG008048096

_____ _____
Signature of Insured Employee Date

AIG Life Insurance Company does not accept any responsibility for the validity or legal effect of this Form.

35965 (4/94)

WELCOME TO THE GENEX MANAGED CARE ARRANGEMENT FOR WORKERS' COMPENSATION

(EMPLOYER INFORMATION)

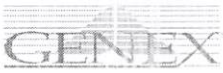
GENEX Services has been chosen to provide a Managed Care Arrangement for your employees who have suffered a work-related injury or illness. This program is being implemented in conjunction with Gallagher Bassett Services, your Workers' Compensation Claims Administrator as mandated by section 440.134 of the 1993 Florida Statute.

As required under this statue, all treatment for work related injuries and illnesses workers must be furnished through a Managed Care Arrangement. All medical treatment must be coordinated by a network "Medical Care Coordinator" (MCC) who is a primary care provider within the provider network. The MCC is responsible for managing the medical care of an injured employee including determining other health care providers and health care facilities to which the injured employee will be referred for evaluation or treatment. A MCC shall be a physician licensed under chapter 458 or an osteopath licensed under chapter 459 of section 440.134 (1) (i). **Medical treatment in a non-emergency situation must be provided through a certified physician in the managed care network.** In emergency situations send the injured employee to the nearest hospital or call 911. The enclosed wall card poster provides the name of network providers or instructions on how to obtain names of network providers. This wall card must be posted at your work site and injured employees should be channeled to these providers for initial medical care. If you should need any changes on your wall card, please contact Mara Roth (1-800-477-2083). GENEX Services will be providing certification for ongoing medical treatment in conjunction with your insurance adjuster.

It is important that all employees receive education about their Managed Care Arrangement and that the employer maintain documentation verifying that the employee has been informed of their rights and responsibilities under the Managed Care Arrangement. There is Employee Information and Grievance Procedures included in this packet which should be distributed to all employees. Ask the employee to sign this form and maintain a copy in their personnel record. This Employee Information and Grievance Procedures can also be incorporated into your new hire packet, however, it is still important to obtain verification that the employee has received this information. You may subsequently be asked to produce this verification during the course of a workers' compensation claim.

GENEX Managed Care Services will become involved after the workers' compensation Notice of Injury has been received. The Notice of Injury will be sent to GENEX from your insurance company. In order to ensure timely medical treatment, it is important to file the notice of injury as soon as possible

The following educational packet is to be used to implement your managed care program. It is important to distribute this information to your employees and to post the enclosed wall card to ensure compliance and protect all rights under the Managed Care Arrangement. Please feel free to contact your workers' compensation insurance adjuster if you need further clarification of GENEX's involvement or Mara Roth, GENEX Florida Account Manager, at 1-800-477-2083. *(This information is available in Spanish upon request)*



WORKERS' COMPENSATION MANAGED CARE ARRANGEMENT

(EMPLOYEE INFORMATION)

In accordance with section 440.134 of the 1993 Florida Statute, all medical treatment for work-related injuries and illnesses must be provided through a Managed Care Arrangement. GENEX Services has been chosen as your Managed Care Arrangement and will coordinate medical treatment should you be injured on the job. Medical treatment in non-emergency situations must be provided through a certified provider in the managed care network.

All medical treatment must be coordinated by a network "Medical Care Coordinator" (MCC) who is a primary care provider within the provider network. The MCC is responsible for managing medical care including determining other health care providers and health care facilities to which you will be referred for evaluation or treatment. A MCC shall be a physician licensed under chapter 458 or an osteopath licensed under chapter 459 of section 440.134 (1) (i). **Medical treatment in a non-emergency situation must be provided through a certified physician in the managed care network.** If your injury requires ongoing medical treatment, you may be contacted by a GENEX Case Manager.

You may receive medical treatment from a doctor outside the network in the following situations:

- In emergency situations, go to the nearest hospital or call 911
- The MCC or GENEX refers you to a physician outside the network when medically necessary treatment is not available and accessible in the provider network.

Your Rights and Responsibilities under the Managed Care Arrangement

- You are allowed one change to another provider within the same specialty and provider network as the authorized treating physician during the course of your medical treatment for a work-related injury. This change can be coordinated by contacting GENEX at 1-800-477-3502. Should you seek medical treatment outside the provider network, you may be held responsible for charges incurred.
- You are allowed one second medical opinion in the same specialty and within the provider network during the course of treatment for a work related injury.
- There is an informal and formal grievance procedure that is available for anyone who has a complaint involving the managed care system (see attached).
- Wall cards will be posted at the employer work site with outlined procedures and network provider information.

GENEX Services can be reached 24 hours a day at 1-800-477-3502. If you have a problem with your medical treatment, you may file a grievance by contacting the Grievance Coordinator at the above number. The entire PPO network can be accessed by contacting GENEX Services.

This managed care arrangement is for benefits related to occupational injuries only and does not apply to or change your employee medical benefits in any way.

I have received and understand the information regarding the above Managed Care Arrangement:

_____ _____

Employee's Signature Date

(SIGNED COPY TO BE MAINTAINED IN PERSONNEL FILE)

GENEX

WORKERS' COMPENSATION MANAGED CARE ARRANGEMENT

(EMPLOYEE INFORMATION)

In accordance with section 440.134 of the 1993 Florida Statute, all medical treatment for work-related injuries and illnesses must be provided through a Managed Care Arrangement. GENEX Services has been chosen as your Managed Care Arrangement and will coordinate medical treatment should you be injured on the job. Medical treatment in non-emergency situations must be provided through a certified provider in the managed care network.

All medical treatment must be coordinated by a network "Medical Care Coordinator" (MCC) who is a primary care provider within the provider network. The MCC is responsible for managing medical care including determining other health care providers and health care facilities to which you will be referred for evaluation or treatment. A MCC shall be a physician licensed under chapter 458 or an osteopath licensed under chapter 459 of section 440.134 (1) (i). **Medical treatment in a non-emergency situation must be provided through a certified physician in the managed care network.** If your injury requires ongoing medical treatment, you may be contacted by a GENEX Case Manager.

You may receive medical treatment from a doctor outside the network in the following situations:

- In emergency situations, go to the nearest hospital or call 911
- The MCC or GENEX refers you to a physician outside the network when medically necessary treatment is not available and accessible in the provider network.

RIGHTS AND RESPONSIBILITIES ENTITLED TO YOU UNDER THE MANAGED CARE ARRANGEMENT

- You are allowed one change to another provider within the same specialty and provider network as the authorized treating physician during the course of your medical treatment for a work-related injury. This change can be coordinated by contacting GENEX at 1-800-477-3502. Should you seek medical treatment outside the provider network, you may be held responsible for charges incurred.
- You are allowed to make one second medical opinion in the same specialty and within the provider network during the course of treatment for a work-related injury.
- There is an informal and formal grievance procedure that is available for anyone who may have a complaint involving the managed care system (see attached).
- Wall cards will be posted at the employer work site with outlined procedures and network provider information.

GENEX Services can be reached 24 hours a day at 1-800-477-3502. If you have a problem with your medical treatment, you may file a grievance by contacting the Grievance Coordinator at the above number. The entire PPO network can be accessed by contacting GENEX Services.

This managed care arrangement is for benefits related to occupational injuries only and does not apply to or change your employee medical benefits in any way.

I have received and understand the information regarding the above Managed Care Arrangement:

(EMPLOYEE COPY)

GENEX

GENEX FLORIDA
GRIEVANCE PROCEDURES

To the employee: Your employer desires each employee participating in the managed care arrangement for worker's compensation to promptly receive medical benefits with high quality care and courteous customer service.

In an effort to provide a Quality Assurance Program, we have a multi-tiered approach to resolving and monitoring problems and complaints of employees, medical providers, employers and insurers. There is an informal and formal grievance procedure that is available for anyone who may have a complaint involving the managed care system.

Any questions concerning the grievance procedures should be directed to:

Grievance Coordinator
1010 North Orlando Avenue, Suite A
Winter Park, FL 32789
1-800-477-3502

HOW DO I ACCESS THE GRIEVANCE PROCEDURE IF I HAVE A COMPLAINT?

Informal Grievance Process:

1. Upon verbal notice of a complaint, the Grievance Coordinator will complete the Internal Grievance/complaint form.
2. The telephone number for your verbal complaint is 1-800-477-3502. The Grievance Coordinator will seek telephonic resolution to the concern.
3. Physicians will review all medically related issues.
4. If the complaint is of an administrative matter, the review will be conducted by the administrator involving the area of concern.
5. An attempt will be made to resolve the complaint within ten (10) working days after receipt of the dispute.
6. Resolution of the complaint will be related to all concerned parties.

Formal Grievance Process:

1. Upon receipt of the Formal Grievance Form, the Grievance Coordinator will contact all involved parties to obtain resolution within 60 working days of receipt of the Formal Grievance.
2. If the grievance is concerning a medical care provider, the grievance will be reviewed by a board certified physician other than the health care provider or clinic against whom the complaint is directed.
3. If the dispute is not resolved in this process, the QA committee (composed of licensed physicians and nurses) will review the grievance and take necessary action to resolve the issue. The Review Committee may meet with the provider or employee (and/or their representative involved) to review the grievance.
4. A dispute shall be resolved within 60 working days of receipt of the grievance. All involved parties will be informed in writing of the resolution.
5. Each employee has a right to file an appeal with the Employee Assistance Office of the Division of Workers' Compensation, 2728 Centerview Drive, 103 Forrest Building, Tallahassee, FL 32399-0684 (1-800-342-1741).

All parties named in the grievance process will be notified in writing as to the outcome of the grievance within sixty (60) working days of our written receipt of the information. GENEX will maintain a record of this grievance for a period of two (2) years. All grievance reports and their resolutions will be filed with the Agency for Health Care Administration in Tallahassee by March 31 annually.

THE EMPLOYEE HAS UP TO ONE YEAR FROM THE DATE OF OCCURRENCE TO FILE A FORMAL GRIEVANCE.

(EMPLOYEE COPY)

Form W-4 (2016)

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

Exemption from withholding. If you are exempt, complete **only** lines 1, 2, 3, 4, and 7 and sign the form to validate it. Your exemption for 2016 expires February 15, 2017. See Pub. 505, Tax Withholding and Estimated Tax.

Note: If another person can claim you as a dependent on his or her tax return, you cannot claim exemption from withholding if your income exceeds $1,050 and includes more than $350 of unearned income (for example, interest and dividends).

Exceptions. An employee may be able to claim exemption from withholding even if the employee is a dependent, if the employee:

- Is age 65 or older,
- Is blind, or
- Will claim adjustments to income; tax credits; or itemized deductions, on his or her tax return.

The exceptions do not apply to supplemental wages greater than $1,000,000.

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

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

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

Tax credits. You can take projected tax credits into account in figuring your allowable number of withholding allowances. Credits for child or dependent care expenses and the child tax credit may be claimed using the **Personal Allowances Worksheet** below. See Pub. 505 for information on converting your other credits into withholding allowances.

Nonwage income. If you have a large amount of nonwage income, such as interest or dividends, consider making estimated tax payments using Form 1040-ES, Estimated Tax for Individuals. Otherwise, you may owe additional tax. If you have pension or annuity income, see Pub. 505 to find out if you should adjust your withholding on Form W-4 or W-4P.

Two earners or multiple jobs. If you have a working spouse or more than one job, figure the total number of allowances you are entitled to claim on all jobs using worksheets from only one Form W-4. Your withholding usually will be most accurate when all allowances are claimed on the Form W-4 for the highest paying job and zero allowances are claimed on the others. See Pub. 505 for details.

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

Check your withholding. After your Form W-4 takes effect, use Pub. 505 to see how the amount you are having withheld compares to your projected total tax for 2016. See Pub. 505, especially if your earnings exceed $130,000 (Single) or $180,000 (Married).

Future developments. Information about any future developments affecting Form W-4 (such as legislation enacted after we release it) will be posted at *www.irs.gov/w4*.

Personal Allowances Worksheet (Keep for your records.)

A	Enter "1" for **yourself** if no one else can claim you as a dependent	**A** _____
B	Enter "1" if: • You are single and have only one job; or • You are married, have only one job, and your spouse does not work; or • Your wages from a second job or your spouse's wages (or the total of both) are $1,500 or less.	**B** _____
C	Enter "1" for your **spouse.** But, you may choose to enter "-0-" if you are married and have either a working spouse or more than one job. (Entering "-0-" may help you avoid having too little tax withheld.)	**C** _____
D	Enter number of **dependents** (other than your spouse or yourself) you will claim on your tax return	**D** _____
E	Enter "1" if you will file as **head of household** on your tax return (see conditions under **Head of household** above)	**E** _____
F	Enter "1" if you have at least $2,000 of **child or dependent care expenses** for which you plan to claim a credit (**Note:** Do **not** include child support payments. See Pub. 503, Child and Dependent Care Expenses, for details.)	**F** _____
G	**Child Tax Credit** (including additional child tax credit). See Pub. 972, Child Tax Credit, for more information. • If your total income will be less than $70,000 ($100,000 if married), enter "2" for each eligible child; then **less** "1" if you have two to four eligible children or **less** "2" if you have five or more eligible children. • If your total income will be between $70,000 and $84,000 ($100,000 and $119,000 if married), enter "1" for each eligible child	**G** _____
H	Add lines A through G and enter total here. (**Note:** This may be different from the number of exemptions you claim on your tax return.) ►	**H** _____

For accuracy, complete all worksheets that apply.

- If you plan to **itemize** or **claim adjustments to income** and want to reduce your withholding, see the **Deductions and Adjustments Worksheet** on page 2.
- If you are **single and have more than one job** or are **married and you and your spouse both work** and the combined earnings from all jobs exceed $50,000 ($20,000 if married), see the **Two-Earners/Multiple Jobs Worksheet** on page 2 to avoid having too little tax withheld.
- If **neither** of the above situations applies, **stop here** and enter the number from line H on line 5 of Form W-4 below.

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

Form **W-4**
Department of the Treasury
Internal Revenue Service

Employee's Withholding Allowance Certificate

► **Whether you are entitled to claim a certain number of allowances or exemption from withholding is subject to review by the IRS. Your employer may be required to send a copy of this form to the IRS.**

OMB No. 1545-0074

2016

1	Your first name and middle initial	Last name	**2** **Your social security number**
	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.	
	City or town, state, and ZIP code	**4** **If your last name differs from that shown on your social security card, check here. You must call 1-800-772-1213 for a replacement card.** ► ☐	

5	Total number of allowances you are claiming (from line **H** above **or** from the applicable worksheet on page 2)	**5**	
6	Additional amount, if any, you want withheld from each paycheck	**6**	$
7	I claim exemption from withholding for 2016, 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, write "Exempt" here ►	**7**	

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

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

8	Employer's name and address (Employer: Complete lines 8 and 10 only if sending to the IRS.)	**9** Office code (optional)	**10** Employer identification number (EIN)

Deductions and Adjustments Worksheet

Note: Use this worksheet *only* if you plan to itemize deductions or claim certain credits or adjustments to income.

1	Enter an estimate of your 2016 itemized deductions. These include qualifying home mortgage interest, charitable contributions, state and local taxes, medical expenses in excess of 10% (7.5% if either you or your spouse was born before January 2, 1952) of your income, and miscellaneous deductions. For 2016, you may have to reduce your itemized deductions if your income is over $311,300 and you are married filing jointly or are a qualifying widow(er); $285,350 if you are head of household; $259,400 if you are single and not head of household or a qualifying widow(er); or $155,650 if you are married filing separately. See Pub. 505 for details	1	$
2	Enter: { $12,600 if married filing jointly or qualifying widow(er); $9,300 if head of household; $6,300 if single or married filing separately }	2	$
3	**Subtract** line 2 from line 1. If zero or less, enter "-0-"	3	$
4	Enter an estimate of your 2016 adjustments to income and any additional standard deduction (see Pub. 505)	4	$
5	**Add** lines 3 and 4 and enter the total. (Include any amount for credits from the *Converting Credits to Withholding Allowances for 2016 Form W-4* worksheet in Pub. 505.)	5	$
6	Enter an estimate of your 2016 nonwage income (such as dividends or interest)	6	$
7	**Subtract** line 6 from line 5. If zero or less, enter "-0-"	7	$
8	**Divide** the amount on line 7 by $4,050 and enter the result here. Drop any fraction	8	
9	Enter the number from the **Personal Allowances Worksheet,** line H, page 1	9	
10	**Add** lines 8 and 9 and enter the total here. If you plan to use the **Two-Earners/Multiple Jobs Worksheet,** also enter this total on line 1 below. Otherwise, **stop here** and enter this total on Form W-4, line 5, page 1	10	

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

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

1	Enter the number from line H, page 1 (or from line 10 above if you used the **Deductions and Adjustments Worksheet**)	1	
2	Find the number in **Table 1** below that applies to the **LOWEST** paying job and enter it here. **However,** if you are married filing jointly and wages from the highest paying job are $65,000 or less, do not enter more than "3"	2	
3	If line 1 is **more than or equal to** line 2, subtract line 2 from line 1. Enter the result here (if zero, enter "-0-") and on Form W-4, line 5, page 1. **Do not** use the rest of this worksheet	3	

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

4	Enter the number from line 2 of this worksheet	4	
5	Enter the number from line 1 of this worksheet	5	
6	**Subtract** line 5 from line 4	6	
7	Find the amount in **Table 2** below that applies to the **HIGHEST** paying job and enter it here	7	$
8	**Multiply** line 7 by line 6 and enter the result here. This is the additional annual withholding needed	8	$
9	Divide line 8 by the number of pay periods remaining in 2016. For example, divide by 25 if you are paid every two weeks and you complete this form on a date in January when there are 25 pay periods remaining in 2016. Enter the result here and on Form W-4, line 6, page 1. This is the additional amount to be withheld from each paycheck	9	$

Table 1

Married Filing Jointly		All Others	
If wages from **LOWEST** paying job are—	Enter on line 2 above	If wages from **LOWEST** paying job are—	Enter on line 2 above
$0 - $6,000	0	$0 - $9,000	0
6,001 - 14,000	1	9,001 - 17,000	1
14,001 - 25,000	2	17,001 - 26,000	2
25,001 - 27,000	3	26,001 - 34,000	3
27,001 - 35,000	4	34,001 - 44,000	4
35,001 - 44,000	5	44,001 - 75,000	5
44,001 - 55,000	6	75,001 - 85,000	6
55,001 - 65,000	7	85,001 - 110,000	7
65,001 - 75,000	8	110,001 - 125,000	8
75,001 - 80,000	9	125,001 - 140,000	9
80,001 - 100,000	10	140,001 and over	10
100,001 - 115,000	11		
115,001 - 130,000	12		
130,001 - 140,000	13		
140,001 - 150,000	14		
150,001 and over	15		

Table 2

Married Filing Jointly		All Others	
If wages from **HIGHEST** paying job are—	Enter on line 7 above	If wages from **HIGHEST** paying job are—	Enter on line 7 above
$0 - $75,000	$610	$0 - $38,000	$610
75,001 - 135,000	1,010	38,001 - 85,000	1,010
135,001 - 205,000	1,130	85,001 - 185,000	1,130
205,001 - 360,000	1,340	185,001 - 400,000	1,340
360,001 - 405,000	1,420	400,001 and over	1,600
405,001 and over	1,600		

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 who claims no withholding allowances; 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 possessions 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.

Employment Eligibility Verification

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

USCIS
Form I-9
OMB No. 1615-0047
Expires 03/31/2016

▶START HERE. Read instructions carefully before completing this form. The instructions must be available during completion of this form.
ANTI-DISCRIMINATION NOTICE: It is illegal to discriminate against work-authorized individuals. Employers **CANNOT** specify which document(s) they will accept from an employee. The refusal to hire an individual because the documentation presented has a future expiration date may also constitute illegal discrimination.

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	Other Names Used *(if any)*

Address *(Street Number and Name)*	Apt. Number	City or Town	State	Zip Code

Date of Birth *(mm/dd/yyyy)*	U.S. Social Security Number	E-mail Address	Telephone Number
	___-___-____		

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

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

☐ A citizen of the United States

☐ A noncitizen national of the United States *(See instructions)*

☐ A lawful permanent resident (Alien Registration Number/USCIS Number): _____

☐ An alien authorized to work until (expiration date, if applicable, mm/dd/yyyy) _____. Some aliens may write "N/A" in this field. *(See instructions)*

*For aliens authorized to work, provide your Alien Registration Number/USCIS Number **OR** Form I-94 Admission Number:*

1. Alien Registration Number/USCIS Number: _____

OR

2. Form I-94 Admission Number: _____

If you obtained your admission number from CBP in connection with your arrival in the United States, include the following:

Foreign Passport Number: _____

Country of Issuance: _____

Some aliens may write "N/A" on the Foreign Passport Number and Country of Issuance fields. (*See instructions*)

3-D Barcode
Do Not Write in This Space

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

Preparer and/or Translator Certification *(To be completed and signed if Section 1 is prepared by a person other than the employee.)*

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

Signature of Preparer or Translator:	Date *(mm/dd/yyyy)*:

Last Name *(Family Name)*	First Name *(Given Name)*

Address *(Street Number and Name)*	City or Town	State	Zip Code

STOP ***Employer Completes Next Page*** STOP

Section 2. Employer or Authorized Representative Review and Verification

(Employers or their authorized representative must complete and sign Section 2 within 3 business days of the employee's first day of employment. You must physically examine one document from List A OR examine a combination of one document from List B and one document from List C as listed on the "Lists of Acceptable Documents" on the next page of this form. For each document you review, record the following information: document title, issuing authority, document number, and expiration date, if any.)

Employee Last Name, First Name and Middle Initial from Section 1:

List A Identity and Employment Authorization	OR	List B Identity	AND	List C Employment Authorization
Document Title:		Document Title:		Document Title:
Issuing Authority:		Issuing Authority:		Issuing Authority:
Document Number:		Document Number:		Document Number:
Expiration Date *(if any)(mm/dd/yyyy)*:		Expiration Date *(if any)(mm/dd/yyyy)*:		Expiration Date *(if any)(mm/dd/yyyy)*:
Document Title:				
Issuing Authority:				
Document Number:				
Expiration Date *(if any)(mm/dd/yyyy)*:				
Document Title:				
Issuing Authority:				
Document Number:				
Expiration Date *(if any)(mm/dd/yyyy)*:				

3-D Barcode
Do Not Write in This Space

Certification

I attest, under penalty of perjury, that (1) I have examined the document(s) presented by the above-named employee, (2) the above-listed document(s) appear 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.

The employee's first day of employment *(mm/dd/yyyy)*: _____ ***(See instructions for exemptions.)***

Signature of Employer or Authorized Representative	Date *(mm/dd/yyyy)*	Title of Employer or Authorized Representative
Last Name *(Family Name)* First Name *(Given Name)*		Employer's Business or Organization Name Putnam County Board of County Comm.
Employer's Business or Organization Address *(Street Number and Name)* 2509 Crill Avenue	City or Town Palatka	State FL	Zip Code 32177

Section 3. Reverification and Rehires *(To be completed and signed by employer or authorized representative.)*

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

C. If employee's previous grant of employment authorization has expired, provide the information for the document from List A or List C the employee presented that establishes current employment authorization in the space provided below.

Document Title:	Document Number:	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 document(s), the document(s) I have examined appear to be genuine and to relate to the individual.

Signature of Employer or Authorized Representative:	Date *(mm/dd/yyyy)*:	Print Name of Employer or Authorized Representative:

LISTS OF ACCEPTABLE DOCUMENTS
All documents must be UNEXPIRED

Employees may present one selection from List A
or a combination of one selection from List B and one selection from List C.

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 Birth Abroad issued by the Department of State (Form FS-545)
3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa		3. School ID card with a photograph		3. Certification of Report of Birth issued by the Department of State (Form DS-1350)
4. Employment Authorization Document that contains a photograph (Form I-766)		4. Voter's registration card		4. Original or certified copy of birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal
5. For a nonimmigrant alien authorized to work for a specific employer because of his or her status: 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 alien's nonimmigrant status 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. Native American tribal document
		6. Military dependent's ID card		6. U.S. Citizen ID Card (Form I-197)
		7. U.S. Coast Guard Merchant Mariner Card		7. Identification Card for Use of Resident Citizen in the United States (Form I-179)
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		8. Employment authorization document issued by the Department of Homeland Security
		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		

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

Refer to Section 2 of the instructions, titled "Employer or Authorized Representative Review and Verification," for more information about acceptable receipts.