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:_____

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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:_____

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)

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 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)

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)

Form W-4 (2019)

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

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. You may claim exemption from withholding for 2019 if **both** of the following apply.

- For 2018 you had a right to a refund of **all** federal income tax withheld because you had **no** tax liability, **and**
- For 2019 you expect a refund of **all** federal income tax withheld because you expect to have **no** tax liability.

If you're exempt, complete **only** lines 1, 2, 3, 4, and 7 and sign the form to validate it. Your exemption for 2019 expires February 17, 2020. See Pub. 505, Tax Withholding and Estimated Tax, to learn more about whether you qualify for exemption from withholding.

General Instructions

If you aren't exempt, follow the rest of these instructions to determine the number of withholding allowances you should claim for withholding for 2019 and any additional amount of tax to have withheld. For regular wages, withholding must be based on allowances you claimed and may not be a flat amount or percentage of wages.

You can also use the calculator at ***www.irs.gov/W4App*** to determine your tax withholding more accurately. Consider using this calculator if you have a more complicated tax situation, such as if you have a working spouse, more than one job, or a large amount of nonwage income not subject to withholding outside of your job. After your Form W-4 takes effect, you can also use this calculator to see how the amount of tax you're having withheld compares to your projected total tax for 2019. If you use the calculator, you don't need to complete any of the worksheets for Form W-4.

Note that if you have too much tax withheld, you will receive a refund when you file your tax return. If you have too little tax withheld, you will owe tax when you file your tax return, and you might owe a penalty.

Filers with multiple jobs or working spouses. If you have more than one job at a time, or if you're married filing jointly and your spouse is also working, read all of the instructions including the instructions for the Two-Earners/Multiple Jobs Worksheet before beginning.

Nonwage income. If you have a large amount of nonwage income not subject to withholding, such as interest or dividends, consider making estimated tax payments using Form 1040-ES, Estimated Tax for Individuals. Otherwise, you might owe additional tax. Or, you can use the Deductions, Adjustments, and Additional Income Worksheet on page 3 or the calculator at *www.irs.gov/W4App* to make sure you have enough tax withheld from your paycheck. If you have pension or annuity income, see Pub. 505 or use the calculator at *www.irs.gov/W4App* to find out if you should adjust your withholding on Form W-4 or W-4P.

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

Personal Allowances Worksheet

Complete this worksheet on page 3 first to determine the number of withholding allowances to claim.

Line C. ***Head of household please note:*** Generally, you may claim head of household filing status on your tax return only if you're unmarried and pay more than 50% of the costs of keeping up a home for yourself and a qualifying individual. See Pub. 501 for more information about filing status.

Line E. Child tax credit. When you file your tax return, you may be eligible to claim a child tax credit for each of your eligible children. To qualify, the child must be under age 17 as of December 31, must be your dependent who lives with you for more than half the year, and must have a valid social security number. To learn more about this credit, see Pub. 972, Child Tax Credit. To reduce the tax withheld from your pay by taking this credit into account, follow the instructions on line E of the worksheet. On the worksheet you will be asked about your total income. For this purpose, total income includes all of your wages and other income, including income earned by a spouse if you are filing a joint return.

Line F. Credit for other dependents. When you file your tax return, you may be eligible to claim a credit for other dependents for whom a child tax credit can't be claimed, such as a qualifying child who doesn't meet the age or social security number requirement for the child tax credit, or a qualifying relative. To learn more about this credit, see Pub. 972. To reduce the tax withheld from your pay by taking this credit into account, follow the instructions on line F of the worksheet. On the worksheet, you will be asked about your total income. For this purpose, total

---

Separate here and give Form W-4 to your employer. Keep the worksheet(s) for your records.

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

Employee's Withholding Allowance Certificate

▶ **Whether you're 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

2019

1 Your first name and middle initial	Last name	2 Your social security number

Home address (number and street or rural route)

City or town, state, and ZIP code

3 ☐ Single ☐ Married ☐ Married, but withhold at higher Single rate.
Note: If married filing separately, check "Married, but withhold at higher Single rate."

4 **If your last name differs from that shown on your social security card, check here. You must call 800-772-1213 for a replacement card.** ▶ ☐

5	Total number of allowances you're claiming (from the applicable worksheet on the following pages)	5	
6	Additional amount, if any, you want withheld from each paycheck	6	$
7	I claim exemption from withholding for 2019, 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 boxes 8 and 10 if sending to IRS and complete boxes 8, 9, and 10 if sending to State Directory of New Hires.)	9 First date of employment	10 Employer identification number (EIN)
Putnam County Board of County Commissioners, 2509 Crill Ave, Palatka, FL 32177		596000816

income includes all of your wages and other income, including income earned by a spouse if you are filing a joint return.

Line G. Other credits. You may be able to reduce the tax withheld from your paycheck if you expect to claim other tax credits, such as tax credits for education (see Pub. 970). If you do so, your paycheck will be larger, but the amount of any refund that you receive when you file your tax return will be smaller. Follow the instructions for Worksheet 1-6 in Pub. 505 if you want to reduce your withholding to take these credits into account. Enter "-0-" on lines E and F if you use Worksheet 1-6.

Deductions, Adjustments, and Additional Income Worksheet

Complete this worksheet to determine if you're able to reduce the tax withheld from your paycheck to account for your itemized deductions and other adjustments to income, such as IRA contributions. If you do so, your refund at the end of the year will be smaller, but your paycheck will be larger. You're not required to complete this worksheet or reduce your withholding if you don't wish to do so.

You can also use this worksheet to figure out how much to increase the tax withheld from your paycheck if you have a large amount of nonwage income not subject to withholding, such as interest or dividends.

Another option is to take these items into account and make your withholding more accurate by using the calculator at *www.irs.gov/W4App*. If you use the calculator, you don't need to complete any of the worksheets for Form W-4.

Two-Earners/Multiple Jobs Worksheet

Complete this worksheet if you have more than one job at a time or are married filing jointly and have a working spouse. If you don't complete this worksheet, you might have too little tax withheld. If so, you will owe tax when you file your tax return and might be subject to a penalty.

Figure the total number of allowances you're entitled to claim and any additional amount of tax to withhold on all jobs using worksheets from only one Form W-4. Claim all allowances on the W-4 that you or your spouse file for the highest paying job in your family and claim zero allowances on Forms W-4 filed for all other jobs. For example, if you earn $60,000 per year and your spouse earns $20,000, you should complete the worksheets to determine what to enter on lines 5 and 6 of your Form W-4, and your spouse should enter zero ("-0-") on lines 5 and 6 of his or her Form W-4. See Pub. 505 for details.

Another option is to use the calculator at *www.irs.gov/W4App* to make your withholding more accurate.

Tip: If you have a working spouse and your incomes are similar, you can check the "Married, but withhold at higher Single rate" box instead of using this worksheet. If you choose this option, then each spouse should fill out the Personal Allowances Worksheet and check the "Married, but withhold at higher Single rate" box on Form W-4, but only one spouse should claim any allowances for credits or fill out the Deductions, Adjustments, and Additional Income Worksheet.

Instructions for Employer

Employees, do not complete box 8, 9, or 10. Your employer will complete these boxes if necessary.

New hire reporting. Employers are required by law to report new employees to a designated State Directory of New Hires. Employers may use Form W-4, boxes 8, 9, and 10 to comply with the new hire reporting requirement for a newly hired employee. A newly hired employee is an employee who hasn't previously been employed by the employer, or who was previously employed by the employer but has been separated from such prior employment for at least 60 consecutive days. Employers should contact the appropriate State Directory of New Hires to find out how to submit a copy of the completed Form W-4. For information and links to each designated State Directory of New Hires (including for U.S. territories), go to ***www.acf.hhs.gov/css/employers.***

If an employer is sending a copy of Form W-4 to a designated State Directory of New Hires to comply with the new hire reporting requirement for a newly hired employee, complete boxes 8, 9, and 10 as follows.

Box 8. Enter the employer's name and address. If the employer is sending a copy of this form to a State Directory of New Hires, enter the address where child support agencies should send income withholding orders.

Box 9. If the employer is sending a copy of this form to a State Directory of New Hires, enter the employee's first date of employment, which is the date services for payment were first performed by the employee. If the employer rehired the employee after the employee had been separated from the employer's service for at least 60 days, enter the rehire date.

Box 10. Enter the employer's employer identification number (EIN).

Personal Allowances Worksheet (Keep for your records.)

A	Enter "1" for yourself	A	
B	Enter "1" if you will file as married filing jointly	B	
C	Enter "1" if you will file as head of household	C	
D	Enter "1" if: • You're single, or married filing separately, and have only one job; or • You're married filing jointly, have only one job, and your spouse doesn't work; or • Your wages from a second job or your spouse's wages (or the total of both) are $1,500 or less.	D	
E	**Child tax credit.** See Pub. 972, Child Tax Credit, for more information. • If your total income will be less than $71,201 ($103,351 if married filing jointly), enter "4" for each eligible child. • If your total income will be from $71,201 to $179,050 ($103,351 to $345,850 if married filing jointly), enter "2" for each eligible child. • If your total income will be from $179,051 to $200,000 ($345,851 to $400,000 if married filing jointly), enter "1" for each eligible child. • If your total income will be higher than $200,000 ($400,000 if married filing jointly), enter "-0-"	E	
F	**Credit for other dependents.** See Pub. 972, Child Tax Credit, for more information. • If your total income will be less than $71,201 ($103,351 if married filing jointly), enter "1" for each eligible dependent. • If your total income will be from $71,201 to $179,050 ($103,351 to $345,850 if married filing jointly), enter "1" for every two dependents (for example, "-0-" for one dependent, "1" if you have two or three dependents, and "2" if you have four dependents). • If your total income will be higher than $179,050 ($345,850 if married filing jointly), enter "-0-"	F	
G	**Other credits.** If you have other credits, see Worksheet 1-6 of Pub. 505 and enter the amount from that worksheet here. If you use Worksheet 1-6, enter "-0-" on lines E and F	G	
H	Add lines A through G and enter the total here ▶	H	

For accuracy, complete all worksheets that apply.

- If you plan to **itemize** or **claim adjustments to income** and want to reduce your withholding, or if you have a large amount of nonwage income not subject to withholding and want to increase your withholding, see the **Deductions, Adjustments, and Additional Income Worksheet** below.
- If you **have more than one job at a time** or are **married filing jointly and you and your spouse both work,** and the combined earnings from all jobs exceed $53,000 ($24,450 if married filing jointly), see the **Two-Earners/Multiple Jobs Worksheet** on page 4 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 above.

Deductions, Adjustments, and Additional Income Worksheet

Note: 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 2019 itemized deductions. These include qualifying home mortgage interest, charitable contributions, state and local taxes (up to $10,000), and medical expenses in excess of 10% of your income. See Pub. 505 for details	1	$
2	Enter: $24,400 if you're married filing jointly or qualifying widow(er); $18,350 if you're head of household; $12,200 if you're 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 2019 adjustments to income, qualified business income deduction, and any additional standard deduction for age or blindness (see Pub. 505 for information about these items)	4	$
5	**Add** lines 3 and 4 and enter the total	5	$
6	Enter an estimate of your 2019 nonwage income not subject to withholding (such as dividends or interest)	6	$
7	**Subtract** line 6 from line 5. If zero, enter "-0-". If less than zero, enter the amount in parentheses	7	$
8	**Divide** the amount on line 7 by $4,200 and enter the result here. If a negative amount, enter in parentheses. Drop any fraction	8	
9	Enter the number from the **Personal Allowances Worksheet,** line H, above	9	
10	**Add** lines 8 and 9 and enter the total here. If zero or less, enter "-0-". If you plan to use the **Two-Earners/Multiple Jobs Worksheet,** also enter this total on line 1 of that worksheet on page 4. Otherwise, **stop here** and enter this total on Form W-4, line 5, page 1	10	

Two-Earners/Multiple Jobs Worksheet

Note: Use this worksheet *only* if the instructions under line H from the **Personal Allowances Worksheet** direct you here.

1 Enter the number from the **Personal Allowances Worksheet,** line H, page 3 (or, if you used the **Deductions, Adjustments, and Additional Income Worksheet** on page 3, the number from line 10 of that worksheet) . . . . . 1 _____

2 Find the number in **Table 1** below that applies to the **LOWEST** paying job and enter it here. **However,** if you're married filing jointly and wages from the highest paying job are $75,000 or less and the combined wages for you and your spouse are $107,000 or less, don't 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 2019. For example, divide by 18 if you're paid every 2 weeks and you complete this form on a date in late April when there are 18 pay periods remaining in 2019. 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 - $5,000	0	$0 - $7,000	0
5,001 - 9,500	1	7,001 - 13,000	1
9,501 - 19,500	2	13,001 - 27,500	2
19,501 - 35,000	3	27,501 - 32,000	3
35,001 - 40,000	4	32,001 - 40,000	4
40,001 - 46,000	5	40,001 - 60,000	5
46,001 - 55,000	6	60,001 - 75,000	6
55,001 - 60,000	7	75,001 - 85,000	7
60,001 - 70,000	8	85,001 - 95,000	8
70,001 - 75,000	9	95,001 - 100,000	9
75,001 - 85,000	10	100,001 - 110,000	10
85,001 - 95,000	11	110,001 - 115,000	11
95,001 - 125,000	12	115,001 - 125,000	12
125,001 - 155,000	13	125,001 - 135,000	13
155,001 - 165,000	14	135,001 - 145,000	14
165,001 - 175,000	15	145,001 - 160,000	15
175,001 - 180,000	16	160,001 - 180,000	16
180,001 - 195,000	17	180,001 and over	17
195,001 - 205,000	18		
205,001 and over	19		

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 - $24,900	$420	$0 - $7,200	$420
24,901 - 84,450	500	7,201 - 36,975	500
84,451 - 173,900	910	36,976 - 81,700	910
173,901 - 326,950	1,000	81,701 - 158,225	1,000
326,951 - 413,700	1,330	158,226 - 201,600	1,330
413,701 - 617,850	1,450	201,601 - 507,800	1,450
617,851 and over	1,540	507,801 and over	1,540

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 aren't required to provide the information requested on a form that's 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 08/31/2019

▶ **START HERE:** Read instructions carefully before completing this form. The instructions must be available, either in paper or electronically, during completion of this form. Employers are liable for errors in the completion of this form.

ANTI-DISCRIMINATION NOTICE: It is illegal to discriminate against work-authorized individuals. Employers **CANNOT** specify which document(s) an employee may present to establish employment authorization and identity. The refusal to hire or continue to employ 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 Last 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	Employee's E-mail Address	Employee's 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 boxes):

☐ 1. A citizen of the United States

☐ 2. A noncitizen national of the United States *(See Instructions)*

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

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

Aliens authorized to work must provide only one of the following document numbers to complete Form I-9: An Alien Registration Number/USCIS Number OR Form I-94 Admission Number OR Foreign Passport Number.

1. Alien Registration Number/USCIS Number: _____
OR
2. Form I-94 Admission Number: _____
OR
3. Foreign Passport Number: _____
Country of Issuance: _____

QR Code - Section 1
Do Not Write In This Space

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

Preparer and/or Translator Certification (check one):

☐ I did not use a preparer or translator. ☐ A preparer(s) and/or translator(s) assisted the employee in completing Section 1.
(Fields below must be completed and signed when preparers and/or translators assist an employee in completing Section 1.)

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	Today's 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 a combination of one document from List B and one document from List C as listed on the "Lists of Acceptable Documents.")

Employee Info from Section 1	Last Name *(Family Name)*	First Name *(Given Name)*	M.I.	Citizenship/Immigration Status

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)*				

Additional Information

QR Code - Sections 2 & 3
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	Today's Date *(mm/dd/yyyy)*	Title of Employer or Authorized Representative

Last Name of Employer or Authorized Representative	First Name of Employer or Authorized Representative	Employer's Business or Organization Name

Employer's Business or Organization Address (Street Number and Name)	City or Town	State	ZIP Code

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

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

C. If the employee's previous grant of employment authorization has expired, provide the information for the document or receipt that establishes continuing 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	Today's Date *(mm/dd/yyyy)*	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 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 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. 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
		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:		
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		10. School record or report card		
		11. Clinic, doctor, or hospital record		
		12. Day-care or nursery school record		

Examples of many of these documents appear in Part 13 of the Handbook for Employers (M-274).

Refer to the instructions for more information about acceptable receipts.

DIRECT DEPOSIT AUTHORIZATION AGREEMENT
PUTNAM COUNTY

PO Box 758
Palatka, FL 32177
Phone: 386-329-0221

To sign up for or change your Direct Deposit:

(1) Complete the Authorization below;
(2) THIS FORM WILL REPLACE YOUR OLD FORM. IF YOU ARE ADDING OR CHANGING AN ACCOUNT, YOU MUST INCLUDE ALL PREVIOUS ACCOUNTS THAT YOU STILL WANT TO BE ACTIVE. For new accounts you must attach a photocopy of a voided personal check, savings deposit slip(s), and/or the account numbers from the bank representing the designated accounts to which funds will be deposited. Check with your financial institution(s) to verify the correct account and routing numbers to be used;
(3) Please circle the correct action below (add, change, or no change);
(4) FORWARD TO HUMAN RESOURCES. AFTER ACCOUNTS HAVE BEEN VERIFIED, CHANGES WILL TAKE EFFECT 2 WEEKS AFTER COMPLETED AGREEMENT IS RECEIVED BY PAYROLL.

You may designate a total of four accounts (two checking/two savings) at one financial institution or two accounts (one checking/one savings) at two separate financial institutions. Each payday you will receive a Notice of Deposit that will show the same information you are currently receiving on your pay stub. **You should never close out a bank account without canceling your Direct Deposit first. This will cause a delay in receiving your paycheck.**

AUTHORIZATION

I hereby authorize Putnam County Board of County Commissioners, hereinafter called the County, to verify my account and bank routing numbers. I hereby authorize the County to initiate deposits at the financial institution(s) indicated below.

1) Institution Name:					
Add/Change No Change	Checking Account No.	Bank Routing No.	Amount $_____	OR	Net Check ☐
Add/Change No Change	Savings Account No.	Bank Routing No.	Amount $_____	OR	Net Check ☐
2) Institution Name:					
Add/Change No Change	Checking Account No.	Bank Routing No.	Amount $_____	OR	Net Check ☐
Add/Change No Change	Savings Account No.	Bank Routing No.	Amount $_____	OR	Net Check ☐

☐ CANCEL - I choose to terminate my Direct Deposit Authorization Agreement.

Employee Name (Please Print)	Employee No.
Employee Signature	Date
Department	Phone Number

Rev: 06/12/09

For payroll purposes please provide:

1. Form I-9

2. Clear copy of: DL & SS or DL & birth certificate or Passport only (see attached for other documents that can be substituted for the above).

3. W-4 form (current year)

4. Direct deposit form and copy of voided check or something from bank (LETTER) verifying account and routing number.

Please make sure all forms are signed and dated before turning in

Thank you.