Public Health
Prevent. Promote. Protect.

District 2 Public Health

Employee Information

Personal Information

Full Name: _____
Last *First* *M.I.*

Address: _____
Street Address *Apartment/Unit #*

_____
City *State* *ZIP Code and County*

Home Phone: _____ Alternate Phone: _____

Email _____ Ethnic Group: _____ Veteran: Yes□ No □

SSN _____

Birth Date: _____ Marital Status(Optional): _____ Gender: Male □ Female □

Spouse's Name: _____

Spouse's Employer: _____ Spouse's Work Phone: _____

Job Information

Title: _____ Employee ID: _____

Supervisor: _____ Department: _____

Work Location: _____ Email: _____

Work Phone: _____ Cell Phone: _____

Start Date: _____ Salary: $ _____

Emergency Contact Information

Full Name: _____
Last *First* *M.I.*

Address: _____
Street Address *Apartment/Unit #*

_____
City *State* *ZIP Code and County*

Primary Phone: _____ Alternate Phone: _____

Relationship: _____

Form W-4 (2017)

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 2017 expires February 15, 2018. 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 can't claim exemption from withholding if your total 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 don't apply to supplemental wages greater than $1,000,000.

Basic instructions. If you aren't 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 2017. 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're single and have only one job; or • You're married, 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.	**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

2017

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 2017, 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 2017 itemized deductions. These include qualifying home mortgage interest, charitable contributions, state and local taxes, medical expenses in excess of 10% of your income, and miscellaneous deductions. For 2017, you may have to reduce your itemized deductions if your income is over $313,800 and you're married filing jointly or you're a qualifying widow(er); $287,650 if you're head of household; $261,500 if you're single, not head of household and not a qualifying widow(er); or $156,900 if you're married filing separately. See Pub. 505 for details . . . . . 1 $

2 Enter: { $12,700 if married filing jointly or qualifying widow(er) / $9,350 if head of household / $6,350 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 2017 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 2017 Form W-4* worksheet in Pub. 505.) . . . . . 5 $

6 Enter an estimate of your 2017 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 2017. 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 2017. 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 - $7,000	0	$0 - $8,000	0
7,001 - 14,000	1	8,001 - 16,000	1
14,001 - 22,000	2	16,001 - 26,000	2
22,001 - 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 - 70,000	5
44,001 - 55,000	6	70,001 - 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 - 95,000	10	140,001 and over	10
95,001 - 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.

Form G-4 (Rev. 7/14)

1511004011

STATE OF GEORGIA EMPLOYEE'S WITHHOLDING ALLOWANCE CERTIFICATE

1a. YOUR FULL NAME	1b. YOUR SOCIAL SECURITY NUMBER
2a. HOME ADDRESS (Number, Street, or Rural Route)	2b. CITY, STATE AND ZIP CODE

PLEASE READ INSTRUCTIONS ON REVERSE SIDE BEFORE COMPLETING LINES 3 – 8

3. MARITAL STATUS
(If you do not wish to claim an allowance, enter "0" in the brackets beside your marital status.)

A. Single: Enter 0 or 1 ..... [ ]
B. Married Filing Joint, both spouses working:
Enter 0 or 1 ..... [ ]
C. Married Filing Joint, one spouse working:
Enter 0 or 1 or 2 ..... [ ]
D. Married Filing Separate:
Enter 0 or 1 ..... [ ]
E. Head of Household:
Enter 0 or 1 ..... [ ]

4. DEPENDENT ALLOWANCES [ ]

5. ADDITIONAL ALLOWANCES [ ]
(worksheet below must be completed)

6. ADDITIONAL WITHHOLDING $_____

WORKSHEET FOR CALCULATING ADDITIONAL ALLOWANCES
(Must be completed in order to enter an amount on step 5)

1. COMPLETE THIS LINE ONLY IF USING STANDARD DEDUCTION:
Yourself: ☐ Age 65 or over ☐ Blind
Spouse: ☐ Age 65 or over ☐ Blind Number of boxes checked _____ x 1300 ..... $_____
2. ADDITIONAL ALLOWANCES FOR DEDUCTIONS:
A. Federal Estimated Itemized Deductions ..... $_____
B. Georgia Standard Deduction (enter one): Single/Head of Household $2,300
Each Spouse $1,500 $_____
C. Subtract Line B from Line A ..... $_____
D. Allowable Deductions to Federal Adjusted Gross Income ..... $_____
E. Add the Amounts on Lines 1, 2C, and 2D ..... $_____
F. Estimate of Taxable Income not Subject to Withholding ..... $_____
G. Subtract Line F from Line E (if zero or less, stop here) ..... $_____
H. Divide the Amount on Line G by $3,000. Enter total here and on Line 5 above ..... _____
(This is the maximum number of additional allowances you can claim. If the remainder is over $1,500 round up)

7. LETTER USED (Marital Status A, B, C, D, or E) _____ **TOTAL ALLOWANCES** (Total of Lines 3 - 5) _____
(Employer: The letter indicates the tax tables in Employer's Tax Guide)

8. EXEMPT: (Do not complete Lines 3 - 7 if claiming exempt) **Read the Line 8 instructions on page 2 before completing this section.**
a) I claim exemption from withholding because I incurred no Georgia income tax liability last year **and** I do not expect to have a Georgia income tax liability this year. **Check here** ☐
b) I certify that I am not subject to Georgia withholding because I meet the conditions set forth under the Servicemembers Civil Relief Act as amended by the Military Spouses Residency Relief Act as provided on page 2. My state of residence is _____. My spouse's (servicemember) state of residence is _____. The states of residence must be the same to be exempt. **Check here** ☐

I certify under penalty of perjury that I am entitled to the number of withholding allowances or the exemption from withholding status claimed on this Form G-4. Also, I authorize my employer to deduct per pay period the additional amount listed above.

Employee's Signature _____ Date _____

Employer: Complete Line 9 and mail entire form only if the employee claims over 14 allowances or exempt from withholding.
If necessary, mail form to: Georgia Department of Revenue, Withholding Tax Unit, P.O. Box 49432, Atlanta, GA 30359.

9. EMPLOYER'S NAME AND ADDRESS:

EMPLOYER'S FEIN: _____

EMPLOYER'S WH#: _____

Do not accept forms claiming additional allowances unless the worksheet has been completed. Do not accept forms claiming exempt if numbers are written on Lines 3 - 7.

INSTRUCTIONS FOR COMPLETING FORM G-4

Enter your full name, address and social security number in boxes 1a through 2b.

Line 3: Write the number of allowances you are claiming in the brackets beside your marital status.

A. Single – enter 1 if your are claiming yourself
B. Married Filing Joint, both spouses working – enter 1 if you claim yourself
C. Married Filing Joint, one spouse working – enter 1 if your claim yourself or 2 if you claim yourself and your spouse
D. Married Filing Separate – enter 1 if you claim yourself
E. Head of Household – enter 1 if you claim yourself

Line 4: Enter the number of dependent allowances you are entitled to claim.

Line 5: Complete the worksheet on Form G-4 if you claim additional allowances. Enter the number on Line H here. **Failure to complete and submit the worksheet will result in automatic denial on your claim.**

Line 6: Enter a specific dollar amount that you authorize your employer to withhold in addition to the tax withheld based on your marital status and number of allowances.

Line 7: Enter the letter of your marital status from Line 3. Enter total of the numbers on Lines 3-5.

Line 8:

a) Check the first box if you qualify to claim exempt from withholding. You can claim exempt if you filed a Georgia income tax return last year and the amount of Line 4 of Form 500EZ or Line 16 of Form 500 was zero, **and** you expect to file a Georgia tax return this year and will not have a tax liability. You can not claim exempt if you did not file a Georgia income tax return for the previous tax year. **Receiving a refund in the previous tax year does not qualify you to claim exempt.**

EXAMPLES: Your employer withheld $500 of Georgia income tax from your wages. The amount on Line 4 of Form 500EZ (or Line 16 of Form 500) was $100. Your tax liability is the amount on Line 4 (or Line 16); therefore, you **do not qualify** to claim exempt.

Your employer withheld $500 of Georgia income tax from your wages. The amount on Line 4 of Form 500EZ (or Line 16 of Form 500) was $0 (zero). Your tax liability is the amount on Line 4 (or Line 16) and you filed a prior year income tax return; therefore you **qualify** to claim exempt.

b) Check the second box if you are not subject to Georgia withholding and meet the conditions set forth under the Servicemembers Civil Relief Act, as amended by the Military Spouses Residency Relief Act. Under the Act, a spouse of a servicemember may be exempt from Georgia income tax on income from services performed in Georgia if:

1. The servicemember is present in Georgia in compliance with military orders;
2. The spouse is in Georgia solely to be with the servicemember;
3. The spouse maintains domicile in another state; and
4. The domicile of the spouse is the same as the domicile of the servicemember.

Additional information for employers regarding the Military Spouses Residency Relief Act:

1. On the W-2 for 2010 and any year thereafter, the employer should not report any of the wages as Georgia wages on the W-2.
2. If the spouse of a servicemember is entitled to the protection of the Military Spouses Residency Relief Act in another state and files a withholding exemption form in such other state, the spouse is required to submit a Georgia Form G-4 so that withholding will occur as is required by Georgia Law when a Georgia domiciliary works in another state and withholding is not required by such other state. If the spouse does not fill out the form, the employer shall withhold Georgia income tax as if the spouse is single with zero allowances.

Worksheet for calculating additional allowances. Enter the information as requested by each line. For Line 2D, enter items such as Retirement Income Exclusion, U.S. Obligations, and other allowable deductions per Georgia Law, see the IT-511 booklet for more information.

Do not complete Lines 3-7 if claiming exempt.

O.C.G.A. § 48-7-102 requires you to complete and submit Form G-4 to your employer in order to have tax withheld from your wages. By correctly completing this form, you can adjust the amount of tax withheld to meet your tax liability. Failure to submit a properly completed Form G-4 will result in your employer withholding tax as though you are single with zero allowances.

Employers are required to mail any Form G-4 claiming more than 14 allowances or exempt from withholding to the Georgia Department of Revenue for approval. Employers will honor the properly completed form as submitted pending notification from the Withholding Tax Unit. Upon approval, such forms remain in effect until changed or until February 15 of the following year. Employers who know that a G-4 is erroneous should not honor the form and should withhold as if the employee is single claiming zero allowances until a corrected form has been received.

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:		
		10. School record or report card		
		11. Clinic, doctor, or hospital record		
		12. Day-care or nursery school record		
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				

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.

STATE OF GEORGIA
STATE SECURITY QUESTIONNAIRE
LOYALTY OATH

NOTICE TO APPLICANTS/EMPLOYEES: The Sedition and Subversive Activities Act of 1953 (Ga. Laws, 1953), as amended, requires each applicant/employee/intern to complete and sign, prior to his/her employment in State government, a questionnaire which is designed to establish that there are no reasonable grounds to believe that he/she is a subversive person. A subversive person is defined as one who commits acts, advocates, or teaches the overthrow of the government of the United States or government of the State of Georgia by force or violence, or who is a knowing member of a subversive organization. Georgia Code 45-3-11 requires all employees of State government to take an oath that they will support the Constitution of the United States and the Constitution of the State of Georgia.

INSTRUCTIONS: All items must be completed and printed on a computer or hand printed in ink. If more space is needed for any item, or explanation, continue under item 10. This questionnaire and loyalty oath will be filed in the employee's personnel file in the employing agency. The employee may request that a copy be executed for his/her personal files.

FULL NAME, INCLUDING MAIDEN NAME, NAMES OF FORMER MARRIAGES, FORMER NAMES CHANGED LEGALLY OR OTHERWISE, ALIASES AND NICKNAMES AND THE DATES USED.

1. LAST NAME | FIRST NAME | MIDDLE NAME | PHONE NO.

MAIDEN NAME	DATES USED	NICKNAMES	DATES USED

OTHER NAMES, INCLUDING ALIASES & FORMER MARRIAGES	DATES USED

2. ADDRESS (No. and Street of Residence) APT. NO. CITY STATE COUNTY ZIP CODE

3. DATE OF BIRTH U.S. CITIZEN ☐ Yes ☐ No (Nationality _____) RACE SEX

4. Are you now or have you been within the last ten (10) years a member of any organization which to your knowledge at the time of membership advocates or has as one of its objectives, the overthrow of the government of the United States or of the government of the State of Georgia by force or violence? ☐Yes ☐ No
If YES, state the name of the organization

NOTE: If the answer to the above question is "Yes" and the employing authority deems further inquiry necessary, you will be notified of such determination. No action adverse to your application will be taken because of an affirmative answer until after such an inquiry, with notice to you and an opportunity for you to present evidence, and only if the result of such inquiry brings your application within the prohibition within the Sedition and Subversive Activities Act of 1953.

5. LIST CHRONOLOGICALLY ALL OF YOUR PREVIOUS RESIDENCES FOR THE PAST TEN YEARS:

DATES From	DATES To	STREET	CITY	STATE

6. LIST NAMES AND ADDRESSES OF THE FOLLOWING:

SPOUSE (MAIDEN NAME)	ADDRESS
FATHER	ADDRESS
MOTHER	ADDRESS

7.	MILITARY SERVICE: (Past or Present)						
	SERIAL NUMBER	BRANCH	ACTIVE SERVICE		ACTIVE OR INACTIVE SERVICE		DISCHARGED ☐ Honorably ☐ Dishonorably ☐ Other If discharged other than honorably, explain in item 10.
			From	To	From	To	

8.	Have you ever been convicted by Federal, State, or other law-enforcement authorities, for any violation of any federal law, state law, county or municipal law, regulation, or ordinance? (Do not include anything that happened before your sixteenth birthday. Do not include minor traffic violations for which a fine of $35.00 or less was imposed. All other convictions must be included even if they are pardoned.) ☐ Yes ☐ No If the answer is YES, state the reason convicted, the date convicted and the place where convicted.			
	CHARGE ON WHICH CONVICTED	DATE CONVICTED	NAME OF COURT & PLACE WHERE CONVICTED	PARDONED (yes or no)

9.	Are there any charges now pending against you by Federal, State, or other law enforcement authorities, for any violation of any federal law, State law, county or municipal law, regulation or ordinance? (Do not include anything that happened before your sixteenth birthday. Do not include minor traffic violations for which a fine of $35.00 or less would likely be imposed.) ☐ Yes ☐ No If the answer is YES, provide the following information.		
	VIOLATION CHARGED	NAME OF GOVERNMENT	NAME OF COURT & LOCATION WHERE PENDING

10.	SPACE FOR CONTINUING ANSWERS OR EXPLANATIONS: (Show item numbers to which answers or explanations apply. Attach a separate sheet if more space is needed.)

NOTE: Before signing this form, check all answers and explanations to see that you have answered all questions fully and correctly. This form is to be executed under oath subject to the penalties of false swearing as prescribed in Code Section 16-10-71 of the Criminal Code of Georgia.

LOYALTY OATH

I, _____, a citizen of _____and being an employee of the Department of Public Health and the recipient of public funds for services rendered as such employee, do hereby solemnly swear and affirm that I will support the Constitution of the United States and the Constitution of the State of Georgia, and I am not a member of the Communist Party.

AFFIDAVIT OF VERIFICATION

Georgia _____ County

Personally appeared before the undersigned officer, duly authorized to administer oaths _____, who, after being duly sworn, deposes and says and declares under penalties of false swearing that he is the person who executed the foregoing instrument; that he has read and completed the same and knows and understands the contents thereof; that the matters stated therein and the answers and information furnished by him in the foregoing questionnaire, and loyalty oath, including any attachments thereto, are true and correct.

SWORN TO AND SUBSCRIBED BEFORE ME:

_____
(Signature of Affiant)

This _____ day of _____, 20____

_____
(Notary Public)

My commission expires _____

GEORGIA DEPARTMENT OF HUMAN RESOURCES

UNDERSTANDING CONCERNING
FLSA COMPENSATORY TIME

I, _____, acknowledge and understand that, as part of the terms and conditions of my employment with the Georgia Department of Human Resources, _____ (DPH organizational unit), I may be required to work more than forty (40) hours in a work period. All overtime hours must be approved in advance by my supervisor.

I further understand that if I am a non-exempt employee, I will receive FLSA compensatory time at the rate of time and one-half for overtime worked, in lieu of overtime payment. I understand that I must at all times maintain an accurate and truthful record of my hours worked each day and each work period. I am to sign-in and sign-out recording the exact minute that I begin work, take meal periods and leave work each day.

EMPLOYEE SIGNATURE: _____

DATE: _____

NOTE: All employees are to complete this form. Only FLSA non-exempt employees are entitled to FLSA compensatory time for overtime worked. FLSA exempt employees are not entitled to FLSA compensatory time. If unsure of FLSA status, please check with the hiring official.

MEDICAL AND PHYSICAL EXAMINATION PROGRAM (MAPEP)

Health Information Checklist

This checklist contains questions regarding your medical history and health. The primary use of this information will be to alert the employer and applicant of conditions that could negatively impact the health of customers or co-workers. This information may be used to determine fitness to perform job duties. This information will be handled in a confidential manner. It is essential that you answer all questions truthfully and completely. False or incomplete information may result in disqualification or termination if hired.

Completed by Applicant/Employee

(Type or Print in Ink)

Section I

Date: _____

Employee Name: _____ Social Security Number _____-_____-_____

Last, First Middle

Employing Agency: _____ Date Employed: _____

Section II

Have you now, or ever had the following?	Yes	No
1. Loss of sight of both eyes. Loss of uncorrected (without glasses or contact lens) vision of more than 75% bilaterally (vision of 20/160 or J* or worse using both eyes).	○	○
2. Diabetes	○	○
3. Tuberculosis	○	○
4. Epilepsy (convulsions, seizures or fits)	○	○
5. Ankylosis (immobility) of major weight bearing joints (ankles, knee, hip)	○	○
6. Any permanent condition which causes 20% (or more) impairment of a foot, leg, hand, arm, back, or the body as a whole	○	○
7. Arthritis which is a hindrance to employment	○	○
9. Amputated (loss of) foot, leg, arm, or hand	○	○
10. Parkinson's disease (Paralysis Agitans)	○	○
11. Cerebral palsy	○	○
12. Multiple sclerosis	○	○
13. Mental retardation (intelligence quotient within the lowest two percent of the general population)	○	○

	Yes	No
14. Psychoneurotic disability following confinement for treatment in a recognized medical or mental hospital for a period in excess of six months.	○	○
15. Hemophilia	○	○
16. Sickle cell anemia	○	○
17. Cardiovascular (heart or blood vessel) disease	○	○
18. Total occupational loss of hearing (loss of over half of hearing in each ear)	○	○
19. Compressed air sequelae (damage to lungs, ruptured ear drum, etc to air concussion, blasting, explosion, etc.)	○	○
20. Muscular dystrophy	○	○
21 Hyperinsulinism (hypoglycemia)	○	○
22. Residual disability from poliomyelitis (Disability due to polio)	○	○
23. Ruptured intervertebral (back) disc	○	○
23. Chronic osteomyelitis (bone infection)	○	○
24. Hepatitis	○	○

REMARKS: _____

_____

_____

_____

_____ _____

Signature of Employee Date

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DESIGNATION OF BENEFICIARY FOR OUTSTANDING WAGE PAYMENTS
IMPORTANT!! Please Read Instructions on Reverse Side Before Completing This Form.

1 - EMPLOYEE'S DESIGNATION OF BENEFICIARY (To Receive Any Outstanding Wages Or Other Moneys Upon the Employee's Death)
* In the event that upon my death I have wages or other moneys due me from the State of Georgia, Department of Human Services, by this statement I authorize all such sums to be paid to the following individual whom I hereby designate as my beneficiary of any such sums:

Employee's Signature _____ SSN _____

Employee's Name _____ Date _____

(please print)

Please provide the following information:
A. BENEFICIARY
Beneficiary's Name _____ SSN _____

Address _____ Phone # _____

NOTE: *Where the above beneficiary is under a legal incapacity to receive such sums, please indicate, if known, the name and address of the duly qualified guardian of the beneficiary.*
B. DULY QUALIFIED GUARDIAN
Guardian's Name _____ SSN _____

Address _____ Phone # _____

2 - SURVIVING SPOUSE OR SURVIVING MINOR CHILDREN (To Receive Any Outstanding Wages Or Other Moneys Upon the Employee's Death)
* In the event that upon my death I have wages or other moneys due me from the State of Georgia, Department of Human Services, and in the absence of a designated beneficiary, by this statement, I authorize all such sums to be paid to my surviving spouse and in the absence of a surviving spouse, I authorize all such sums to be paid to the duly qualified guardian of my surviving minor child or children:

Employee's Signature _____ SSN _____

Employee's Name _____ Date _____

Please provide the following information:
A. SPOUSE
Spouse's Name _____ SSN _____

Address _____ Phone # _____

B. MINOR CHILD OR CHILDREN
Child's/Children's Name(s) _____ SSN _____

Address _____ Phone # _____

NOTE: Please indicate, if known, the name and address of the duly qualified guardian.
C. DULY QUALIFIED GUARDIAN
Guardian's Name(s) _____ SSN _____

Address _____ Phone # _____

° **NOTE: It is the responsibility of the employee to furnish and to keep this information current!!**

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DESIGNATION OF BENEFICIARY FOR OUTSTANDING WAGE PAYMENTS

Chapter 7 of Title 34 of the Official Code of Georgia, Annotated, as amended, provides for the payment of a deceased employee's outstanding wagers or other moneys **either** to a designated beneficiary or to a surviving spouse. In the absence of a surviving spouse, outstanding wages would then be paid to the employee's surviving minor child or children.

The following information is presented to help you decide and properly designate the recipient of any outstanding wages of yours.

1 - Designating a Beneficiary
a Where a beneficiary is designated, he/she will be the **primary** recipient of outstanding wages over any other individual.

b. A beneficiary may be an organization or an individual. An individual designated as a beneficiary may or may not be related to you.

c. Where the designated beneficiary is under a legal incapacity that will act to prevent the beneficiary from directly receiving the outstanding wages, please indicate in the appropriate area, the name and address of the duly qualified guardian of the beneficiary.

d. For DHS record-keeping purposes, where a beneficiary has been designated but you also have a wife and a minor child or children, please give the requested information in the appropriate spaces in section 2.
NOTE: If at the time of your death the designated beneficiary cannot receive your outstanding wages, these wages will then pass to your surviving spouse, and in the absence of a surviving spouse, to a minor child or children.

2 - Designating a Surviving Spouse or Surviving Minor Children

a. The law provides that if at the time of your death you have outstanding wages and you have not designated a beneficiary of your wages, any outstanding wages must first go to your surviving spouse. In the absence of a surviving spouse at the time of your death, your wages will pass to your surviving minor child or children. A minor child is age 18 years or under.

b. If your minor child (or children) has a duly qualified guardian (other than yourself), please indicate in the appropriate area, the name and address of the individual.

In compliance with the above referenced law, you are requested to complete the DESIGNATION FOR OUTSTANDING WAGES form on the reverse side of this sheet and submit it as soon as possible to your supervisor. The form will be forwarded through appropriate channels for inclusion in your official DHS personnel file. **Please be aware that beneficiary designations listed in section 1 will supersede any previous beneficiary designations which you have made.**

Any sums payable under this Code Section may be paid pursuant to the designation made by the employee to a beneficiary, or to the employee's spouse, or to the employee's minor child or children. **It is the responsibility of the employee to furnish and keep any such information and designation current.**

****

WHEN CLAIMING OUTSTANDING WAGES, it is the responsibility of the individual designated to receive any outstanding wages to present to the Personnel Manager a copy of the death certificate of the deceased employee.

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STANDARDS OF CONDUCT ACKNOWLEDGMENT

Employees of the District 2 Public Health (DPH) have a duty of trust to the State of Georgia and its citizens. It is expected that employees will maintain and exercise the highest moral and ethical standards in carrying out their duties and responsibilities. Guidelines for employee conduct have been developed and published in the DPH Human Resource/Personnel Policy Manual to prevent the appearance of impropriety, placement of self-interest above public interest, partiality, prejudice, threats, favoritism and undue influence.

As a condition of employment, employees are required to review and comply with the provisions of DPH Human Resource/Personnel Policy #1201 – *Standards of Conduct and Ethics in Government* and Policy #1205 – *Use of State Property*. These policies are available on the HR/Personnel Policies page of the District 2 Public Health Internet Web Site:

www.phdistrict2.org

Employees who do not have Internet access should contact their supervisor or human resource/personnel representative for printed copies of these policies.

Questions regarding these policies should be directed to:

- Supervisors
- Human Resource/Personnel Representatives; or,
- The Office of Human Resource Management – Employment Practices and Concerns Section at 404/656-6757 (or 1-800-362-0951 if outside of area codes 404, 678 and 770).

****

My signature below signifies my understanding that I am responsible for reviewing and complying with DPH Human Resource/Personnel Policy #1201 – *Standards of Conduct and Ethics in Government* and Policy #1205 – *Use of State Property* as a condition of employment.

_____ _____

Signature Name (Please print)

_____ _____

DPH Organization Unit Date

This completed form is to be maintained in the official personnel file.

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Direct Deposit Notification Form
(To be signed by all new hires and rehires on and after May 1, 2012)

In accordance with the Mandatory Direct Deposit policy issued May 1, 2010, as a condition of employment, a person hired or rehired to a position in a State organization on or after May 1, 2012, is required to accept all payroll related payments by direct deposit. District 2 Public Health follows this State policy for both payroll and reimbursements payments. The complete policy and related documents can be found on SAO's website at the following location: State Accounting Office Accounting Policy Manual.

I understand that as a condition of employment, because I am a new hire or rehire applicant, I must comply with the policy and enroll in direct deposit within 30 days of being hired or rehired and remain enrolled in direct deposit during the tenure of my employment. I understand that I can apply for an exemption from this requirement as provided by the policy. I understand that if I am not granted exemption, and still refuse to utilize direct deposit, I may be subject to dismissal.

Employee Name (Please Print) _____

Employee Signature: _____

To be completed by employing organization:

Employee ID Number: _____ Position Title: _____

Organization Name: _____

Hiring Supervisor or HR Official: _____

Copy: HR Office & Employee

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AUTHORIZATION AGREEMENT FOR AUTOMATIC DEPOSITS
Originating Company Name: DISTRICT 2 PUBLIC HEALTH

I authorize the above named originating company to initiate entries to the account indicated below as follows:

They may initiate CREDIT entries, which moves money into my account according to the schedule and conditions to which the originating company and I have agreed.

They may initiate DEBIT entries to reverse any transactions they have originated to my account in error.

NAME(S): _____

ACCOUNT NUMBER: _____

NAME OF DEPOSITORY

FINANCIAL INSITUTION: _____

LOCATION OF DEPOSITORY FINANCIAL INSTITUTION

CITY: _____ **STATE** _____ **ZIP**_____

Please enter your banks' routing and transit number below *and* staple a VOIDED CHECK.

_ _ _ _ _ _ _ _ _

This authority is to remain in effect until the Originator has received written notification of its termination and has had a reasonable opportunity to act upon it.

Employee information:

E-mail address: _____ **Last 4 digits of SS #:** _____

Address: _____

_____

Information applies to: Payroll: _____ **Travel Reimbursement:** _____

Sign: _____ **Date:** _____

DO NOT USE A DEPOSIT SLIP. Many banks print internal transaction codes instead of their routing and transit numbers on their deposit slips. Using an invalid routing number will prevent your transaction from being directed to the correct bank, resulting in delays in the posting of your payment.

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ACKNOWLEDGEMENT OF WORKERS' COMPENSATION TREATMENT

My signature below indicates that I have been advised that as an employee of the District 2 Public Health I am covered by the Georgia Workers' Compensation Law. I have been informed that I am to immediately report all on-the-job injuries ***regardless of the extent of the injuries*** to my supervisor, HR/Personnel Representative or other authorized official. I realize that a delay in notification can result in denial of payment for any medical services rendered.

I understand that if I am injured while on the job and emergency treatment IS necessary, I will receive emergency treatment as soon as possible. All follow up care, however, must be provided by a Workers' Compensation physician listed on the **OFFICIAL NOTICE** which is posted in my work area.

I further understand that if emergency treatment is **NOT** necessary, I must receive treatment from Workers' Compensation physician listed on the **OFFICIAL NOTICE**. If I obtain non-emergency medical treatment from a physician not on the **OFFICAL NOTICE**, I will be responsible for any medical expenses.

I have been advised that if I am dissatisfied with the physician selected, I may make one change without permission to a second physician on the **OFFICIAL NOTICE**. Any further changes of physicians will require the permission of the Office of Human Resource Management or the State Board of Workers' Compensation.

If I have any questions regarding the above, I should discuss them with my supervisor or other authorized official.

_____

Signature of Employee Date

_____

Signature of HR/Personnel Representative/Supervisor/ Date
Other Authorized Official

For additional information, please review District 2 Public Health – Workers' Compensation and Special Injury Return-To-Work Program

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ACKNOWLEDGEMENT OF UNCLASSIFIED POSITION

I hereby acknowledge that the position I have accepted, _____,

with the District 2 Public Health, _____,
[Organizational Unit]

is in the unclassified service. I understand that as an employee in the unclassified service, my employment is "at-will" and I may be separated at any time without notice or statement of reasons. *I further understand that in accepting this unclassified position, any employment rights I may have had in a position in the classified service no longer exist.

_____
[Name of Employee – Please Print]

_____
[Signature of Employee]

_____
[Date]

- Employees who first established membership in the Employee's Retirement System prior to April 1, 1972, and who have a minimum of eighteen (18) years of State employment, may have involuntary separation rights under the Georgia Retirement System Law.

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EMPLOYEE NOTICE AND ACKNOWLEDGEMENT OF CONFIDENTIALITY REQUIREMENTS

As an employee of District 2 Public Health, I recognize that I will have access to very sensitive personal records and information. I hereby acknowledge and agree that I will access and use such records and information solely and exclusively for official, authorized purposes.

I understand that if I access or use records or information obtained through my employment for any non-official purpose, I will be subject to disciplinary action up to and including dismissal from employment, as well as possible civil or criminal liability, depending on the circumstances.

I acknowledge by my signature below that I have read this Notice, that I understand and agree to what is stated, and that I have been given an opportunity to ask any questions prior to my signing this document. I further understand that a copy of this notice will be maintained in my personnel file.

Name (Print): _____

Signature: _____

Date Signed: _____

COGENT
a 3M Company
3M

Applicant Fingerprinting Online Services

Applicant Registration

Last Name	
First Name	
Middle Name	
Date of Birth	
Place of Birth	
SSN (no dashes)	
Sex	
Race	
Eye Color	
Hair Color	
Height	
Weight	
Country of Citizenship	
Driver's License No.	
Driver's License State	
Address	
City	
State	
Zip	
Phone #	

Georgia Applicant Processing Service

ACKNOWLEDGEMENT

I authorize Cogent Systems, Inc. to conduct a fingerprint based criminal history record check of me.

I understand that Cogent Systems, Inc. will send fingerprints to the Georgia Crime Information Center for search of criminal history information in its files and to the Federal Bureau of Investigation for search of its files when a federal record check is so authorized.

I understand that the electronic results of this fingerprint check will be received by Cogent Systems, Inc. and forwarded to the agency responsible for determining my suitability for the position for which I have applied.

I further understand that Cogent Systems, Inc. will not maintain a copy of my record and that Cogent Systems, Inc. meets all confidentiality and security requirements for handling and dissemination of state and federal criminal history record information.

Name:_____

Date:_____

Fee: $36.25

APPLICANT SELECTED FOR THIS POSITION WILL BE RESPONSIBLE FOR THE FEE TO PROCESS BACKGROUND CHECK.

METHOD OF PAYMENT: MONEY ORDER PAYABLE TO COGENT SYSTEMS, CREDIT AND DEBIT CARDS.

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DPH DRUG-FREE WORKPLACE NOTICE

It is the policy of the District 2 Public Health (DPH) to provide a drug-free work place. Illegal drug use significantly impacts the work place and is a serious threat to public health, safety and welfare. DPH employees are PROHIBITED from engaging in the UNLAWFUL/ILLEGAL manufacture, distribution, dispensation, possession or use of a controlled substance in the work place or while performing assigned duties. Employees are REQUIRD to notify their supervisors and/or other authorized officials of ANY criminal drug arrests or convictions within five (5) calendar days of the occurrence. Violations of the above may result in disciplinary action, up to and, including separation from employment.

As condition of employment, while in the work place or performing assigned duties (including work time while in travel status), employees are:

- Required to be free of illegal drugs;
- Prohibited from abusive use of legal drugs or other substances, which create the potential for significant risk of harm to themselves or others;
- Prohibited from using someone else's prescription drugs since it is against the law;
- Required to be free of alcohol: and
- Prohibited from possessing *or* consuming alcohol.

Any DPH employee may be required to submit to alcohol and/or drug testing due to reasonable suspicion. In addition, based on your position, you are subject to be tested based on the following:

(Supervisor or other authorized official is to check appropriate blocks before giving to employee)

- ☐ *Pre-employment* (drug testing only)
- ☐ *Board directed* random (drug testing only)
- ☐ *P.O.S.T* Certified random (drug testing only)
- ☐ *Commercial Drivers License (CDL) (alcohol* and/or drug testing)
- ☐ *No additional* alcohol and/or drug test

Drug testing is conducted for the presence of the following illegal drugs:

Marijuana/cannabinoids (THC) - amphetamines/methamphetamines Cocaine
phencyclidine (PCP) opiates

Alcohol Testing and Results

Employees who refuse to submit to alcohol testing when directed will be immediately separated from employment. Employees whose test shows the presence of alcohol are subject to disciplinary action, up to and including separation from employment. In addition, when employees are separated, future employment with DPH could be jeopardized. A determination of appropriate action regarding alcohol testing will be made on a case by case basis.

DPH DRUG-FREE WORKPLACE NOTICE

Drug Testing and Results

DPH employees who refuse to submit to drug testing when directed, or whose test results indicates an illegal drug(s), will be immediately separated from employment and will not be eligible for future employment with DPH for a period of two (2) years.

Individuals currently employed with State government outside of DPH who refuse pre-employment drug testing, or whose test results indicates illegal drug(s), will not be employed by the department and will not be eligible for future employment with DPH for a period of two (2) years.

Applicants not currently employed with the State government who refuse pre-employment drug testing, or whose test result indicates an Illegal drug (s), will not be employed by the Department ad will not be eligible for any State employment for a period of two (2) years.

Please refer to District 2Public Health Policy - for more specific Information regarding the alcohol and d rug 1esting programs.

Assistance

The District 2 Public Health is willing to assist employees with alcohol and/or drug-related problems. Employees must advise their supervisors or other authorized official in writing of the need the need for assistance prior to being notified of required testing and prior to being arrested for a criminal drug offense. Employees may also seek assistance with alcohol and/or drug-related problems through their health insurance providers or health maintenance organizations.

ACKNOWLEDGEMENT

I understand that I must abide by the conditions outlined in this notice. I will notify my supervisor, appropriate Human Resource personnel representative or other authorized official of any criminal drug arrest or conviction within five (S) calendar days of the arrest or conviction. I realize that Federal law may require that my employer communication conviction Information to a Federal agency.

I also understand that I am to be free of alcohol and illegal drugs in the work place or while performing assigned duties. I have been advised that I will be subject to the alcohol and/or drug tests indicated on this notice.

Applicant/Employee's Name (Please Print) _____ Social Security #_____

Applicant/Employee's Signature_____ Date_____

DPH Organizational Unit_____ Date_____

This signed form will be placed in your official personnel file.
Questions should be directed to your supervisor or other authorized official

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EMPLOYMENT OF RELATIVES

Definition of Relatives:

- ☐ Spouse
- ☐ Child/Grandchild *(includes biological, adopted or foster child, step child, legal ward, or child for who the employee stands in loco parentis)*
- ☐ Sister/Brother *(includes step/half relationships)*
- ☐ *Parent/Grandparent (includes step relationships)*
- ☐ Aunt/Uncle
- ☐ Niece/Nephew
- ☐ First Cousin
- ☐ Immediate in-law *(i.e., mother-in-law, father-in-law, sister-in-law, brother-in-law, daughter-in-law or son-in-law)*
- ☐ Guardian *(as defined by law)*

Employees must report relationships involving relatives

_____I have no relative(s) working at District 2 Public Health

_____ I have a relative(s) working at _____

Employee's Name_____

Signature_____

Date _____

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TOBACCO FREE CAMPUS

Effective July 1, 2006, District 2 Public Health became a Tobacco Free Campus. This means that smoking or other use of tobacco will not be allowed anywhere on the District 2 Public Health workplace or grounds

Do you see that District 2 Public Health being a Tobacco Free Campus would prevent you from performing the job responsibilities of the position that you are applying for?

_____Yes _____No

Signature_____

Date _____

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District 2 Public Health
Pamela Logan, M.D., M.P.H., M.A., Health Director
1280 Athens Street • Gainesville, Georgia 30507
PH: 770-535-5743 • FAX: 770-535-5958 • www.phdistrict2.org

Banks, Dawson, Forsyth, Franklin, Habersham, Hall, Hart, Lumpkin, Rabun, Stephens, Towns, Union and White Counties

MEMORANDUM

TO: John Doe

FROM: District 2 PH Human Resources (Tracy Olivaria)

RE: Immunization Requirements

DATE: April 5, 2017

You have been selected for the Customer Service Representative position with the Banks & Franklin County Health Department effective April 17, 2017.

As a District 2 Public Health employee in the position of Customer Service Representative you will be required to show proof of:

- ☐ Hep. B (three shot series)
- ☐ MMR (two Measles, two Mumps, and one Rubella)
- ☐ PPD (if no documentation of a PPD in the last year, a two-step test will be necessary)
- ☐ Tdap (Tetanus, Diptheria, and Pertussis, once every 10 years)
- ☐ Flu (annually)

OR

If you do not have the documentation of the required immunizations, you can receive these tests/vaccines in the Health Department. Please discuss with your supervisor and upon completion of the requirements your supervisor or the County Nurse Manager should complete and sign the attached form and forward with required documentation to the Human Resources Office.

Acknowledgement of District 2 Public Health Policies

Policies ensure well-being, provide common understanding, and serve as a guide for our staff, patients, volunteers, and the communities in which we serve. Policies help new staff members familiarize themselves with our organization's practices and are vital to building a knowledgeable and productive staff.

Our policies are easily accessible on our website. Please go to www.phdistrict2.org, click on the "Employee Resources" tab, and then choose the icon labeled "District Policy Library". All employees are required to read the following policies:

Clinic Operations:

- 183 HIPAA Policy

Facilities:

- Tobacco Free Campus

Human Resources General:

- 173 Employee Immunizations
- 225 Harassment
- 227 Standards of Conduct
- 233 District Dress Code

Information Technology:

- Social Media Policy

By signing this form you are indicating that you have read and understand the policies listed above.

Signature Date