EMPLOYEE DEMOGRAPHIC FORM

EMPLOYEE INFORMATION

Employee FIRST NAME:	**LAST NAME:**		**DATE:**
Social Security #:	**Date of Birth:**		
Address:	**City:**	**State:**	**Zip:**
County:	**E-mail Address:**		
Home Phone:	**Work Phone:**	**Cell Phone:**	
Gender: ☐ Male ☐ Female	**Marital Status:** ☐Married ☐Single ☐Divorced ☐Widowed	**Veteran:** ☐ Yes ☐ No	
Ethnic Group: ☐American Indian ☐Asian ☐African American ☐Hispanic ☐Caucasian ☐Multi-Racial			
Highest Level of Education: ☐High School Diploma or GED ☐Some College ☐Associates ☐Bachelors ☐Masters ☐Doctorate			

EMERGENCY CONTACT INFORMATION

PRIMARY Contact Full Name:			**Relationship:**
Address:	**City:**	**State:**	**Zip:**
County:	**Personal E-mail Address:**		
Day Time Phone #:	**Cell Phone:**		

SECONDARY Contact Full Name:			**Relationship:**
Address:	**City:**	**State:**	**Zip:**
County:	**E-mail Address:**		
Day Time Phone #:	**Cell Phone:**		

Form **W-4**

Department of the Treasury
Internal Revenue Service

Employee's Withholding Certificate

▶ **Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay.**
▶ **Give Form W-4 to your employer.**
▶ **Your withholding is subject to review by the IRS.**

OMB No. 1545-0074

2020

Step 1: Enter Personal Information

(a) First name and middle initial	Last name	(b) Social security number
Address		▶ **Does your name match the name on your social security card?** If not, to ensure you get credit for your earnings, contact SSA at 800-772-1213 or go to *www.ssa.gov*.
City or town, state, and ZIP code		

(c) ☐ **Single or Married filing separately**
☐ **Married filing jointly** (or Qualifying widow(er))
☐ **Head of household** (Check only if you're unmarried and pay more than half the costs of keeping up a home for yourself and a qualifying individual.)

Complete Steps 2–4 ONLY if they apply to you; otherwise, skip to Step 5. See page 2 for more information on each step, who can claim exemption from withholding, when to use the online estimator, and privacy.

Step 2: Multiple Jobs or Spouse Works

Complete this step if you (1) hold more than one job at a time, or (2) are married filing jointly and your spouse also works. The correct amount of withholding depends on income earned from all of these jobs.

Do **only one** of the following.

(a) Use the estimator at *www.irs.gov/W4App* for most accurate withholding for this step (and Steps 3–4); **or**

(b) Use the Multiple Jobs Worksheet on page 3 and enter the result in Step 4(c) below for roughly accurate withholding; **or**

(c) If there are only two jobs total, you may check this box. Do the same on Form W-4 for the other job. This option is accurate for jobs with similar pay; otherwise, more tax than necessary may be withheld . . . . . ▶ ☐

TIP: To be accurate, submit a 2020 Form W-4 for all other jobs. If you (or your spouse) have self-employment income, including as an independent contractor, use the estimator.

Complete Steps 3–4(b) on Form W-4 for only ONE of these jobs. Leave those steps blank for the other jobs. (Your withholding will be most accurate if you complete Steps 3–4(b) on the Form W-4 for the highest paying job.)

Step 3: Claim Dependents

If your income will be $200,000 or less ($400,000 or less if married filing jointly):

Multiply the number of qualifying children under age 17 by $2,000 ▶ $ _____

Multiply the number of other dependents by $500 . . . . ▶ $ _____

Add the amounts above and enter the total here . . . . . **3** $

Step 4 (optional): Other Adjustments

(a) Other income (not from jobs). If you want tax withheld for other income you expect this year that won't have withholding, enter the amount of other income here. This may include interest, dividends, and retirement income . . . . . **4(a)** $

(b) Deductions. If you expect to claim deductions other than the standard deduction and want to reduce your withholding, use the Deductions Worksheet on page 3 and enter the result here . . . . . **4(b)** $

(c) Extra withholding. Enter any additional tax you want withheld each **pay period** . **4(c)** $

Step 5: Sign Here

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

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

Employers Only

Employer's name and address	First date of employment	Employer identification number (EIN)

General Instructions

Future Developments

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

Purpose of Form

Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay. If too little is withheld, you will generally owe tax when you file your tax return and may owe a penalty. If too much is withheld, you will generally be due a refund. Complete a new Form W-4 when changes to your personal or financial situation would change the entries on the form. For more information on withholding and when you must furnish a new Form W-4, see Pub. 505.

Exemption from withholding. You may claim exemption from withholding for 2020 if you meet both of the following conditions: you had no federal income tax liability in 2019 **and** you expect to have no federal income tax liability in 2020. You had no federal income tax liability in 2019 if (1) your total tax on line 16 on your 2019 Form 1040 or 1040-SR is zero (or less than the sum of lines 18a, 18b, and 18c), or (2) you were not required to file a return because your income was below the filing threshold for your correct filing status. If you claim exemption, you will have no income tax withheld from your paycheck and may owe taxes and penalties when you file your 2020 tax return. To claim exemption from withholding, certify that you meet both of the conditions above by writing "Exempt" on Form W-4 in the space below Step 4(c). Then, complete Steps 1(a), 1(b), and 5. Do not complete any other steps. You will need to submit a new Form W-4 by February 16, 2021.

Your privacy. If you prefer to limit information provided in Steps 2 through 4, use the online estimator, which will also increase accuracy.

As an alternative to the estimator: if you have concerns with Step 2(c), you may choose Step 2(b); if you have concerns with Step 4(a), you may enter an additional amount you want withheld per pay period in Step 4(c). If this is the only job in your household, you may instead check the box in Step 2(c), which will increase your withholding and significantly reduce your paycheck (often by thousands of dollars over the year).

When to use the estimator. Consider using the estimator at *www.irs.gov/W4App* if you:

1. Expect to work only part of the year;

2. Have dividend or capital gain income, or are subject to additional taxes, such as the additional Medicare tax;

3. Have self-employment income (see below); or

4. Prefer the most accurate withholding for multiple job situations.

Self-employment. Generally, you will owe both income and self-employment taxes on any self-employment income you receive separate from the wages you receive as an employee. If you want to pay these taxes through withholding from your wages, use the estimator at *www.irs.gov/W4App* to figure the amount to have withheld.

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

Step 1(c). Check your anticipated filing status. This will determine the standard deduction and tax rates used to compute your withholding.

Step 2. Use this step if you (1) have more than one job at the same time, or (2) are married filing jointly and you and your spouse both work.

Option **(a)** most accurately calculates the additional tax you need to have withheld, while option **(b)** does so with a little less accuracy.

If you (and your spouse) have a total of only two jobs, you may instead check the box in option **(c)**. The box must also be checked on the Form W-4 for the other job. If the box is checked, the standard deduction and tax brackets will be cut in half for each job to calculate withholding. This option is roughly accurate for jobs with similar pay; otherwise, more tax than necessary may be withheld, and this extra amount will be larger the greater the difference in pay is between the two jobs.

Multiple jobs. *Complete Steps 3 through 4(b) on only one Form W-4. Withholding will be most accurate if you do this on the Form W-4 for the highest paying job.*

Step 3. Step 3 of Form W-4 provides instructions for determining the amount of the child tax credit and the credit for other dependents that you may be able to claim when you file your tax return. To qualify for the child tax credit, the child must be under age 17 as of December 31, must be your dependent who generally lives with you for more than half the year, and must have the required social security number. You may be able to claim a credit for other dependents for whom a child tax credit can't be claimed, such as an older child or a qualifying relative. For additional eligibility requirements for these credits, see Pub. 972, Child Tax Credit and Credit for Other Dependents. You can also include **other tax credits** in this step, such as education tax credits and the foreign tax credit. To do so, add an estimate of the amount for the year to your credits for dependents and enter the total amount in Step 3. Including these credits will increase your paycheck and reduce the amount of any refund you may receive when you file your tax return.

Step 4 (optional).

Step 4(a). Enter in this step the total of your other estimated income for the year, if any. You shouldn't include income from any jobs or self-employment. If you complete Step 4(a), you likely won't have to make estimated tax payments for that income. If you prefer to pay estimated tax rather than having tax on other income withheld from your paycheck, see Form 1040-ES, Estimated Tax for Individuals.

Step 4(b). Enter in this step the amount from the Deductions Worksheet, line 5, if you expect to claim deductions other than the basic standard deduction on your 2020 tax return and want to reduce your withholding to account for these deductions. This includes both itemized deductions and other deductions such as for student loan interest and IRAs.

Step 4(c). Enter in this step any additional tax you want withheld from your pay **each pay period**, including any amounts from the Multiple Jobs Worksheet, line 4. Entering an amount here will reduce your paycheck and will either increase your refund or reduce any amount of tax that you owe.

Step 2(b)—Multiple Jobs Worksheet *(Keep for your records.)*

If you choose the option in Step 2(b) on Form W-4, complete this worksheet (which calculates the total extra tax for all jobs) on **only ONE** Form W-4. Withholding will be most accurate if you complete the worksheet and enter the result on the Form W-4 for the highest paying job.

Note: If more than one job has annual wages of more than $120,000 or there are more than three jobs, see Pub. 505 for additional tables; or, you can use the online withholding estimator at *www.irs.gov/W4App*.

1 **Two jobs.** If you have two jobs or you're married filing jointly and you and your spouse each have one job, find the amount from the appropriate table on page 4. Using the "Higher Paying Job" row and the "Lower Paying Job" column, find the value at the intersection of the two household salaries and enter that value on line 1. Then, **skip** to line 3 . . . . . 1 $

2 **Three jobs.** If you and/or your spouse have three jobs at the same time, complete lines 2a, 2b, and 2c below. Otherwise, skip to line 3.

a Find the amount from the appropriate table on page 4 using the annual wages from the highest paying job in the "Higher Paying Job" row and the annual wages for your next highest paying job in the "Lower Paying Job" column. Find the value at the intersection of the two household salaries and enter that value on line 2a . . . . . 2a $

b Add the annual wages of the two highest paying jobs from line 2a together and use the total as the wages in the "Higher Paying Job" row and use the annual wages for your third job in the "Lower Paying Job" column to find the amount from the appropriate table on page 4 and enter this amount on line 2b . . . . . 2b $

c Add the amounts from lines 2a and 2b and enter the result on line 2c . . . . . 2c $

3 Enter the number of pay periods per year for the highest paying job. For example, if that job pays weekly, enter 52; if it pays every other week, enter 26; if it pays monthly, enter 12, etc. 3

4 **Divide** the annual amount on line 1 or line 2c by the number of pay periods on line 3. Enter this amount here and in **Step 4(c)** of Form W-4 for the highest paying job (along with any other additional amount you want withheld) . . . . . 4 $

Step 4(b)—Deductions Worksheet *(Keep for your records.)*

1 Enter an estimate of your 2020 itemized deductions (from Schedule A (Form 1040 or 1040-SR)). Such deductions may include qualifying home mortgage interest, charitable contributions, state and local taxes (up to $10,000), and medical expenses in excess of 7.5% of your income . . . . . 1 $

2 Enter:
- $24,800 if you're married filing jointly or qualifying widow(er)
- $18,650 if you're head of household
- $12,400 if you're single or married filing separately

. . . . . 2 $

3 If line 1 is greater than line 2, subtract line 2 from line 1. If line 2 is greater than line 1, enter "-0-" . . 3 $

4 Enter an estimate of your student loan interest, deductible IRA contributions, and certain other adjustments (from Part II of Schedule 1 (Form 1040 or 1040-SR)). See Pub. 505 for more information 4 $

5 **Add** lines 3 and 4. Enter the result here and in **Step 4(b)** of Form W-4 . . . . . 5 $

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 with no other entries on the form; 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.

Married Filing Jointly or Qualifying Widow(er)

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	$0 - 9,999	$10,000 - 19,999	$20,000 - 29,999	$30,000 - 39,999	$40,000 - 49,999	$50,000 - 59,999	$60,000 - 69,999	$70,000 - 79,999	$80,000 - 89,999	$90,000 - 99,999	$100,000 - 109,999	$110,000 - 120,000
$0 - 9,999	$0	$220	$850	$900	$1,020	$1,020	$1,020	$1,020	$1,020	$1,210	$1,870	$1,870
$10,000 - 19,999	220	1,220	1,900	2,100	2,220	2,220	2,220	2,220	2,410	3,410	4,070	4,070
$20,000 - 29,999	850	1,900	2,730	2,930	3,050	3,050	3,050	3,240	4,240	5,240	5,900	5,900
$30,000 - 39,999	900	2,100	2,930	3,130	3,250	3,250	3,440	4,440	5,440	6,440	7,100	7,100
$40,000 - 49,999	1,020	2,220	3,050	3,250	3,370	3,570	4,570	5,570	6,570	7,570	8,220	8,220
$50,000 - 59,999	1,020	2,220	3,050	3,250	3,570	4,570	5,570	6,570	7,570	8,570	9,220	9,220
$60,000 - 69,999	1,020	2,220	3,050	3,440	4,570	5,570	6,570	7,570	8,570	9,570	10,220	10,220
$70,000 - 79,999	1,020	2,220	3,240	4,440	5,570	6,570	7,570	8,570	9,570	10,570	11,220	11,240
$80,000 - 99,999	1,060	3,260	5,090	6,290	7,420	8,420	9,420	10,420	11,420	12,420	13,260	13,460
$100,000 - 149,999	1,870	4,070	5,900	7,100	8,220	9,320	10,520	11,720	12,920	14,120	14,980	15,180
$150,000 - 239,999	2,040	4,440	6,470	7,870	9,190	10,390	11,590	12,790	13,990	15,190	16,050	16,250
$240,000 - 259,999	2,040	4,440	6,470	7,870	9,190	10,390	11,590	12,790	13,990	15,520	17,170	18,170
$260,000 - 279,999	2,040	4,440	6,470	7,870	9,190	10,390	11,590	13,120	15,120	17,120	18,770	19,770
$280,000 - 299,999	2,040	4,440	6,470	7,870	9,190	10,720	12,720	14,720	16,720	18,720	20,370	21,370
$300,000 - 319,999	2,040	4,440	6,470	8,200	10,320	12,320	14,320	16,320	18,320	20,320	21,970	22,970
$320,000 - 364,999	2,720	5,920	8,750	10,950	13,070	15,070	17,070	19,070	21,290	23,590	25,540	26,840
$365,000 - 524,999	2,970	6,470	9,600	12,100	14,530	16,830	19,130	21,430	23,730	26,030	27,980	29,280
$525,000 and over	3,140	6,840	10,170	12,870	15,500	18,000	20,500	23,000	25,500	28,000	30,150	31,650

Single or Married Filing Separately

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	$0 - 9,999	$10,000 - 19,999	$20,000 - 29,999	$30,000 - 39,999	$40,000 - 49,999	$50,000 - 59,999	$60,000 - 69,999	$70,000 - 79,999	$80,000 - 89,999	$90,000 - 99,999	$100,000 - 109,999	$110,000 - 120,000
$0 - 9,999	$460	$940	$1,020	$1,020	$1,470	$1,870	$1,870	$1,870	$1,870	$2,040	$2,040	$2,040
$10,000 - 19,999	940	1,530	1,610	2,060	3,060	3,460	3,460	3,460	3,640	3,830	3,830	3,830
$20,000 - 29,999	1,020	1,610	2,130	3,130	4,130	4,540	4,540	4,720	4,920	5,110	5,110	5,110
$30,000 - 39,999	1,020	2,060	3,130	4,130	5,130	5,540	5,720	5,920	6,120	6,310	6,310	6,310
$40,000 - 59,999	1,870	3,460	4,540	5,540	6,690	7,290	7,490	7,690	7,890	8,080	8,080	8,080
$60,000 - 79,999	1,870	3,460	4,690	5,890	7,090	7,690	7,890	8,090	8,290	8,480	9,260	10,060
$80,000 - 99,999	2,020	3,810	5,090	6,290	7,490	8,090	8,290	8,490	9,470	10,460	11,260	12,060
$100,000 - 124,999	2,040	3,830	5,110	6,310	7,510	8,430	9,430	10,430	11,430	12,420	13,520	14,620
$125,000 - 149,999	2,040	3,830	5,110	7,030	9,030	10,430	11,430	12,580	13,880	15,170	16,270	17,370
$150,000 - 174,999	2,360	4,950	7,030	9,030	11,030	12,730	14,030	15,330	16,630	17,920	19,020	20,120
$175,000 - 199,999	2,720	5,310	7,540	9,840	12,140	13,840	15,140	16,440	17,740	19,030	20,130	21,230
$200,000 - 249,999	2,970	5,860	8,240	10,540	12,840	14,540	15,840	17,140	18,440	19,730	20,830	21,930
$250,000 - 399,999	2,970	5,860	8,240	10,540	12,840	14,540	15,840	17,140	18,440	19,730	20,830	21,930
$400,000 - 449,999	2,970	5,860	8,240	10,540	12,840	14,540	15,840	17,140	18,450	19,940	21,240	22,540
$450,000 and over	3,140	6,230	8,810	11,310	13,810	15,710	17,210	18,710	20,210	21,700	23,000	24,300

Head of Household

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	$0 - 9,999	$10,000 - 19,999	$20,000 - 29,999	$30,000 - 39,999	$40,000 - 49,999	$50,000 - 59,999	$60,000 - 69,999	$70,000 - 79,999	$80,000 - 89,999	$90,000 - 99,999	$100,000 - 109,999	$110,000 - 120,000
$0 - 9,999	$0	$830	$930	$1,020	$1,020	$1,020	$1,480	$1,870	$1,870	$1,930	$2,040	$2,040
$10,000 - 19,999	830	1,920	2,130	2,220	2,220	2,680	3,680	4,070	4,130	4,330	4,440	4,440
$20,000 - 29,999	930	2,130	2,350	2,430	2,900	3,900	4,900	5,340	5,540	5,740	5,850	5,850
$30,000 - 39,999	1,020	2,220	2,430	2,980	3,980	4,980	6,040	6,630	6,830	7,030	7,140	7,140
$40,000 - 59,999	1,020	2,530	3,750	4,830	5,860	7,060	8,260	8,850	9,050	9,250	9,360	9,360
$60,000 - 79,999	1,870	4,070	5,310	6,600	7,800	9,000	10,200	10,780	10,980	11,180	11,580	12,380
$80,000 - 99,999	1,900	4,300	5,710	7,000	8,200	9,400	10,600	11,180	11,670	12,670	13,580	14,380
$100,000 - 124,999	2,040	4,440	5,850	7,140	8,340	9,540	11,360	12,750	13,750	14,750	15,770	16,870
$125,000 - 149,999	2,040	4,440	5,850	7,360	9,360	11,360	13,360	14,750	16,010	17,310	18,520	19,620
$150,000 - 174,999	2,040	5,060	7,280	9,360	11,360	13,480	15,780	17,460	18,760	20,060	21,270	22,370
$175,000 - 199,999	2,720	5,920	8,130	10,480	12,780	15,080	17,380	19,070	20,370	21,670	22,880	23,980
$200,000 - 249,999	2,970	6,470	8,990	11,370	13,670	15,970	18,270	19,960	21,260	22,560	23,770	24,870
$250,000 - 349,999	2,970	6,470	8,990	11,370	13,670	15,970	18,270	19,960	21,260	22,560	23,770	24,870
$350,000 - 449,999	2,970	6,470	8,990	11,370	13,670	15,970	18,270	19,960	21,260	22,560	23,900	25,200
$450,000 and over	3,140	6,840	9,560	12,140	14,640	17,140	19,640	21,530	23,030	24,530	25,940	27,240

Form G-4 (Rev. 05/22/18)

1811004012

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 (If Itemizing Deductions) ..... $_____

B. Georgia Standard Deduction (enter one): Single/Head of Household $4,600
Each Spouse $3,000 $_____

C. Subtract Line B from Line A (If zero or less, enter zero) ..... $_____

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 10/31/2022

►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 the Handbook for Employers (M-274).

Refer to the instructions for more information about acceptable receipts.

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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.

Public Health

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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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**

DISTRICT 2 PUBLIC HEALTH EMPLOYEE ACKNOWLEDGEMENT, AWARENESS AND ACCOUNTABILITY STATEMENT FOR D2PH POLICIES AND PROCEDURES

Public Health
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EMPLOYEE NAME:	
EMPLOYEE ID #:	
DATE OF HIRE OR DATE OF ASSIGNMENT:	

As an employee (temporary or regular) working for District 2 Public Health (D2PH) you are responsible for reviewing the D2PH Policies and Procedures, which can be found on our District 2 website, Employee Resources, District Policy Library link at www.phdistrict2.org. Review everything from the sections marked Facilities, Human Resources-General and Information Technology: Social Media Policy. The direct link is: http://phdistrict2.org/?page_id=986

Complete this form, sign and date; get supervisor's approval.

In order to ensure that you are aware of the D2PH Policies and Procedures, you are required to sign this statement within 30 days of your date of hire or within 30 days of assignment (for temporary agency employees).

By my signature below, I acknowledge that I am aware of and will be held accountable for compliance with the D2PH Policies and Procedures referenced above.

_____ _____

Signature Date

SUPERVISOR SECTION

As a supervisor or manager, it is your responsibility to ensure that all employees under your supervision are aware of the above referenced policies.

I acknowledge that it is my responsibility to ensure that all employees comply with D2PH Policies and Procedures and will advise Human Resources regarding violations.

_____ _____ _____

Printed Name Signature Date

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DISTRICT 2 PUBLIC HEALTH

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: _____

District 2 Public Health

Everbridge Notification System

District 2 uses the Everbridge Notification System to disseminate needed information in a timely manner to our staff. In the event of inclement weather, or the potential for travel or facility related issues, we will push critical messaging to you via this process. Everbridge allows us to notify employees of office closures, adjusted hours of operations, or any pertinent safety considerations. We want to rapidly provide relevant information so supervisors and staff have the most current data from which to make workplace decisions. Because not everyone will have access to their work email when away from the office, we must make use of redundant communications means. Please provide the demographic information below for entry into our notification system. Thank you.

Employee Name: _____

Location – County/Program: _____

Primary Contact #: _____ (circle) Work Home Cell

Secondary Contact # _____ (circle) Work Home Cell

Other Contact # _____ (circle) Work Home Cell

District Cell # (if applicable): _____

Work Email: _____

Personal Email: _____

*** District 2 tests the notification system on a quarterly basis; therefore, you will receive a message to your contact points at least four times a year. If your contact information changes, please submit the necessary updates to Dave Palmer at dave.palmer@dph.ga.gov

ERSGA
Employees' Retirement System of Georgia
Serving those who serve Georgia

PSR GaBreeze
Peach State Reserves

GSEPS Automatic Enrollment Acknowledgement Form

I, _____, do hereby acknowledge that as a Georgia State Employees' Pension & Savings Plan (GSEPS) member of the Employees' Retirement System of Georgia, I have been automatically enrolled in the Peach State Reserves 401(k) Plan at a contribution rate of 5% of my eligible before-tax salary. This contribution will be deducted each pay period. I understand that I may elect to change my contribution rate or opt out of the plan at any time by contacting GaBreeze.

I have also received the GSEPS Enrollment Information Notice as part of my new hire informational material from my Human Resources official.

(Please print name)

Employee Signature _____ Date _____

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.

Georgia Public Health District 2

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.

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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.

Public Health

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 REQUIRED 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 beimmediately 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 and 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 drug testing 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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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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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 _____

Designation for Outstanding Wage Payments

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IMPORTANT!! Please Read Instructions on the Last Page 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 Public Health, by this statement I authorize all such sums to be paid to the following individual listed below whom I hereby designate as my beneficiary of any such sums:

Employee's Name		SSN	
Employee's Signature		Date	

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 Public Health, 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 Name		SSN	
Employee's Signature		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(s)	
Address		Phone #	

NOTE: Please indicate, if known, the name and address of the duly qualified guardian.

C. DULY QUALIFIED GUARDIAN

Guardian's Name		SSN	
Address		Phone #	

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

DESIGNATION 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 DPH 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 section2.

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 DPH 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.

MEDICAL AND PHYSICAL EXAMINATION PROGRAM (MAPEP)

Inquiry Authority/Use Statement

The collection of this information is authorized by O.C.G.A. 45-2-40. This information will be used to determine fitness for duty and to provide protection to employees from potential harmful effects associated with this employment. Unless otherwise stated, this information may be disclosed to the hiring agency, State agencies responsible for State benefits and workers' compensation programs, and, where pertinent, to an appropriate law enforcement agency for investigation for prosecutive purposes or in a legal proceeding to which the hiring agency is a party. As provided by the Americans with disabilities Act of 1990 (Public Law 101-336), this information is to be filed separately from other personnel records and is to be used only for legitimate, non-discriminatory hiring and placement purposes with reasonable accommodation, where appropriate. Completion of this form is voluntary; however, if this information is not provided, the individual may not receive the requested benefits or employment.

A: Completed by Employee

1. Employee Name: _____ (Last / First / Middle) 2. _____-_____-_____ (Social Security Number)

3. Race: _____ 4. Sex: Female Male 5. _____ (Date of Birth) 6. _____ (Daytime Telephone Number)

7. Address: _____

_____

_____

8. Position Title: _____

9. Position Number: _____

10. Location of Position: _____

11. Direct Contact for Position Information

a. Name: _____

b. Title: _____

c. Telephone: _____

d. E-Mail: _____

e. Fax Number: _____

f. Dept.: _____

g. Unit: _____

h. Address: _____

_____

_____

_____

12. Have you been provided detailed information on the duties of this position? ☐Yes ☐No

13. Do you understand the functional requirements and environmental factors of this position? ☐Yes ☐No

14. Are you capable of performing the duties and responsibilities of this position (with reasonable accommodations, if necessary, as described in Section A, Item #17)? ☐Yes ☐No

For the following questions, explain a "Yes" answer in the space provided below

15. Have you ever been employed by the State of Georgia? ☐Yes ☐No

16. Have you had a physical examination for employment with the State of Georgia within the past twelve-month period? ☐Yes ☐No

17. Is there anything in your past medical history, of which you have knowledge, that would prevent you being able to perform the duties of this position? ☐Yes ☐No

Explanation of items 15-17 checked "Yes." Enter item number before each comment.

I certify that all information given by me in connection with this medical assessment is true to the best of my knowledge and belief. I agree and understand that any misstatements of material facts may cause forfeiture on my part of all right to employment in the service of the State of Georgia; may result in dismissal after appointment; or may result in loss of entitlement to disability retirement benefits. My signature also indicates that I understand all of the questions on this form.

18. _____ 19. _____
Signature of Employee Date

B: Completed by Employer

1. Indicate type of job information used for medical review (check all that apply):
   - ☐ Job description
   - ☐ Performance standards
   - ☐ Functional requirements analysis
   - ☐ Environmental factors analysis

   Other (please specify):

2. Check job category:
   - ☐ Category 1 Sedentary
   - ☐ Category 2 Active
   - ☐ Category 3 Food Handling
   - ☐ Category 4 Health-related
   - ☐ Category 5 Law Enforcement

3. Describe any notable or unusual job requirements or working conditions: (continue on separate page, if needed)

4. Were any "reasonable accommodations" needed? If "Yes," describe: ☐ Yes ☐ No

5. _____
(Type or Print Official Contact's Name)

6. _____ 7. _____
Signature of Official Contact Date

ADDITIONAL TEST(S) REQUESTED
Urinalysis
Pulmonary Function
Tuberculin Skin Test (TST)
EKG/Resting
EKG/Stress
Hemoglobin/Hematocrit
Chest X-Ray
Back X-Ray
Other Tests

STATE OF GEORGIA

MEDICAL AND PHYSICAL EXAMINATION PROGRAM

Medical Findings

NOTE TO EXAMINING PHYSICIAN

The person you are about to examine is being evaluated for the position described in job materials provided. In conducting your exam and reporting your findings and conclusions, take the job duty data into consideration.

ALL FIELDS IN THIS FORM MUST BE FILLED IN OR THE REVIEWING PHYSICIAN WILL RETURN THE FORM TO YOU.

1. Examinee's Name	2. SSN	3. Height (Feet, Inches)	4. Weight (pounds)

5. Vision Evaluation

Depth Perception	Within Normal Limits Yes ☐ No ☐	Peripheral Vision Right Eye _____ Left Eye _____
	Distant Vision	Near Vision
a. Without Glasses ☐	Right 20/ _____ Left 20/ _____	b. Without Glasses ☐ Right 20/ _____ Left 20/ _____
c. With Glasses ☐	Right 20/ _____ Left 20/ _____	d. With Glasses ☐ Right 20/ _____ Left 20/ _____
e. Is color vision normal when Ishihara or other color plate test is used? ☐ Yes ☐ No		f. If the answer is "No", can applicant pass lantern or other compatible? ☐ Yes ☐ No

6. Hearing Evaluation

a. OTOSCOPIC EXAMINATION: Right Ear _____ Left Ear _____

b. PURE TONE AIR CONDUCTION TEST RESULTS: (This section is to be used for all pre employment air conduction hearing testing.)

Right Ear								Left Ear							
250	500	1000	2000	3000	4000	6000	8000	250	500	1000	2000	3000	4000	6000	8000

c. SOUND FIELD PURE TONE/WARBLE TONE TEST RESULTS: (This section is to be used in conjunction with the pure tone air conduction testing section for all individuals with hearing aids who do not meet the guidelines on the air conduction test.)

	250	500	1000	2000	3000	4000	6000	8000
Sound Field Test								

If individual meets the stated hearing guideline, no further hearing testing is necessary for the purpose of employment. *However, if any single air conduction threshold is obtained outside the normal, 0-24dB range, the results of the test must be explained to the candidate and the recommendation made to obtain a complete audiological evaluation at the individual's expense.*

d. AUDIOMETER SERIAL #: _____ e. DATE OF CALIBRATION: _____

f. **MEETS HEARING GUIDELINES:** ☐ Yes ☐ No

RESTRICTED/MEDICAL

7. Blood Pressure/Pulse		
a. Systolic/diastolic	b. Two additional Readings if elevated	c. Pulse

8. Physical Examination

Clinical Evaluation	Normal	Abnormal	Remarks
a. Head, face, neck, and scalp			
b. Nose			
c. Mouth and Throat			
d. Ears			
e. Eyes			
f. Ophthalmoscopic			
g. Ocular motility			
h. Lungs and Chest (Breast, if indicated)			
I Heart			
j. Vascular system (Varicosities, etc.)			
k. Abdomen			
l. Anus and rectum (If indicated)			
m. Endocrine system			
n. Hernia (Any type)			
o. Upper extremities			
p. Feet			
q. Lower extremities			
r. Spine			
s. Identifying body marks, scars			
t. Skin, lymphatics			
u. Neurological			
v. Mental status			

9. Allergies

1.	3.
2.	4.

10. Surgery

Type of Surgery	Date (Mo/Yr)
1.	
2.	
3.	
4	

RESTRICTED/MEDICAL

11. Comments/Implications for Fitness for Duty

12. Physician Signature and Address

a. Physician's Name (Type or Print)	b. Physician Telephone	c. Address
d. Signature	e. Date	

13. Employer Name and Address

IMPORTANT: Examining Physician -- Return all materials supplied by the prospective employee to the employer address provided.	Return to:

In order to comply with "The Genetic Information Nondiscrimination Act of 2008 (GINA), we ask that you NOT provide any genetic information when responding to this request for medical information. This includes family medical history, results of genetic tests, information regarding genetic services, and genetic information about an individual's or family members' fetus or embryo.