Destin Fire Control District
848 Airport Road - Destin, Florida 32541
Telephone (850) 837-8413 Fax (850) 837-6715

Beach Safety Division
2017 New Applicant

Thank you for your interest in becoming an employee of the Destin Fire Control District's Beach Safety Division. Attached is an employment application package for your completion.

Upon completion of this package, please **provide a copy of your Drivers' License, Social Security Card, First Responder Card, cancelled check and any additional information** which may be needed to complete your application.

If hired as a part time, seasonal employee, no work hours/shifts will be assigned until all items of the employment application package and additional information has been received.

Should you have any question in regards to this process, please call Beach Safety Division Chief, Joe D'Agostino at 850-837-3879, ext. 6. We look forward to working with you and having a great season in Destin.

APPLICATION FOR EMPLOYMENT

Destin Fire Control District

848 Airport Road - Destin, FL 32541

Telephone (850) 837-8413 - Fax (850) 837-6715

Personal Information

Name (Last name first)			Social Security #	
Present Address	City		State	Zip code
Previous Address	City		State	Zip code

Are you 18 years or older? ☐ Yes ☐ No	Telephone number	Email Address

Desired Employment

Position	Date you can start	Salary Desired

Are you employed now? ☐ Yes ☐ No	If so, may we inquire of your present employer? ☐ Yes ☐ No	
Ever applied to this District before? ☐ Yes ☐ No	When?	
Ever worked for this District before? ☐ Yes ☐ No	When?	

Reason for Leaving

Name of last supervisor at this District

Who referred you to this District?

Education

	Name of School:	Years of attendance:	Did you graduate? # years completed:	Type of Degree:
High School			( ) Yes ( ) No	Year
College			( ) Yes ( ) No	Year
Professional School			( ) Yes ( ) No	Year

General

Subjects of Special Study or Research Work:

Special Training:

Special Skills:

APPLICATION FOR EMPLOYMENT

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Employment History

Name of Present or Most Recent Employer				
Address		City	State	Zip code
Starting Date	Leaving Date	Job Title		
Weekly Starting Salary	Weekly Final Salary	May we contact your Supervisor? ☐ Yes ☐ No		
Name of Supervisor		Title		Phone
Description of Work				
Reason for leaving				
Name of Previous Employer				
Address		City	State	Zip code
Starting Date	Leaving Date	Job Title		
Weekly Starting Salary	Weekly Final Salary	May we contact your Supervisor? ☐ Yes ☐ No		
Name of Supervisor		Title		Phone
Description of Work				
Reason for leaving				
Name of Previous Employer				
Address		City	State	Zip code
Starting Date	Leaving Date	Job Title		
Weekly Starting Salary	Weekly Final Salary	May we contact your Supervisor? ☐ Yes ☐ No		
Name of Supervisor		Title		Phone
Description of Work				
Reason for leaving				

APPLICATION FOR EMPLOYMENT

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References

Below, Give the names of three (3) persons you are not related to, whom you have known at least one year.

	Name and Title	Relationship	Address	Phone
1.				
2.				
3.				

Service Record

Honorable Discharge? ( ) Yes ( ) No

Branch of Service:	Discharge Date:	Rank:
Duties:		

Have you been convicted of a felony within the last five (5) years? ( ) Yes ( ) No

If yes, explain (will not necessarily exclude you from consideration)

Authorization

I certify that the facts contained in this application are true and complete to the best of my knowledge and understand that, if employed, falsified statements on this application shall be grounds for dismissal.

I authorize investigation of all statements contained herein and the references and employers listed above to give you any and all the information concerning my previous employment and any pertinent information that may have, personal or otherwise, and release the company from all liability for any damage that may result from utilization of such information.

I also understand and agree that no representative of the company has any authority to enter into any agreement for employment for any specified period of time, or to make any agreement, contrary to the foregoing, unless it is in writing and signed by an authorized District representative.

Date _____ Signature _____

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.

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 Birth Abroad issued by the Department of State (Form FS-545)
3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa		3. School ID card with a photograph		3. Certification of Report of Birth issued by the Department of State (Form DS-1350)
4. Employment Authorization Document that contains a photograph (Form I-766)		4. Voter's registration card		4. Original or certified copy of birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal
5. For a nonimmigrant alien authorized to work for a specific employer because of his or her status: a. Foreign passport; and b. Form I-94 or Form I-94A that has the following: (1) The same name as the passport; and (2) An endorsement of the alien's nonimmigrant status as long as that period of endorsement has not yet expired and the proposed employment is not in conflict with any restrictions or limitations identified on the form.		5. U.S. Military card or draft record		5. Native American tribal document
		6. Military dependent's ID card		6. U.S. Citizen ID Card (Form I-197)
		7. U.S. Coast Guard Merchant Mariner Card		7. Identification Card for Use of Resident Citizen in the United States (Form I-179)
6. Passport from the Federated States of Micronesia (FSM) or the Republic of the Marshall Islands (RMI) with Form I-94 or Form I-94A indicating nonimmigrant admission under the Compact of Free Association Between the United States and the FSM or RMI		8. Native American tribal document		8. Employment authorization document issued by the Department of Homeland Security
		9. Driver's license issued by a Canadian government authority		
		For persons under age 18 who are unable to present a document listed above:		
		10. School record or report card		
		11. Clinic, doctor, or hospital record		
		12. Day-care or nursery school record		

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

Refer to the instructions for more information about acceptable receipts.

Destin Fire Control District
848 Airport Road - Destin, Florida 32541
Telephone (850) 837-8413 Fax (850) 837-6715

Beach Safety Program
2017 Job Description and Acknowledgement

1. Starting hourly rate, for new Beach Safety Employees, is $13.17 with no benefits.

2. Compensation will be received for scheduled and approved hours only.

3. Employment with the Beach Safety Division is offered on a part-time, seasonal basis.

4. The Beach Safety Program may be terminated at anytime and is considered to be on an as needed basis.

5. The Destin Fire Control District is a drug-free workplace. A drug screen will be required upon employment.

6. All employees of the Destin Fire Control District Beach Safety Division are expected to conduct themselves in a professional manner at all times; while on duty or off-duty if in uniform.

7. All employees of the Beach Safety Division are required to meet the appearance standards as determined by the Destin Fire Control District.

It is understood that this is a part-time, seasonal position for the Beach Safety Division and an hourly position with no benefits. This position will only be for the period of time the Beach Safety program is in effect. It is understood that your position can be terminated by Chief Sasser at anytime.

_____ _____

Employee Date

_____ _____

Joe D'Agostino, Division Chief Date

Destin Fire Control District
848 Airport Road - Destin, Florida 32541
Telephone (850) 837-8413 Fax (850) 837-6715

Direct Deposit Authorization Form

I hereby authorize Destin Fire Control District to initiate a CREDIT to my checking/savings account at the *Financial Institute* indicated below, and initiate adjustments (if necessary) for any transactions credited in error. This authority will remain in effect until Destin Fire Control District is notified by me, in writing, to cancel it in such time as to afford Destin Fire Control District and the *Financial Institution* a reasonable opportunity to act on it.

_____ _____
Name of Financial Institution Location (City, State)

Financial Institution's routing/transit number: _____

_____ _____
Employee signature Date

_____
Employee name – please print

Checking or account number: _____

Savings account number: _____

Please attach a copy of a voided check.

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848 Airport Road - Destin, Florida 32541
Telephone (850) 837-8413 Fax (850) 837-6715

Beach Safety Division
Overtime Policy

Overtime is considered any time worked in excess of 40 hours in one seven (7) day workweek beginning on Tuesday and ending on the following Monday. The Destin Fire Control District only recognizes authorized overtime for the Beach Safety Division. Authorized overtime and unauthorized overtime are defined as follows:

Authorized overtime can occur when the Beach Safety Division Chief or Command Officer requests that a Destin Beach Safety staff member remain in service longer than the designated shift creating a situation where the total hours worked for the workweek may be in excess of 40 hours. This request may be the result of situations such as: red or double red flag conditions, a late call received from dispatch, an extended rescue situation, etc. All situations will be reviewed by the Beach Safety Chief and/or the Fire Chief.

Unauthorized overtime occurs when a staff member works an excess of 40 hours in one seven (7) day workweek without the approval of the Beach Safety Division Chief or Command Officer. Any unauthorized overtime will result in the following discipline procedures:

- First offense — a written warning will be issued
- Second offense — a suspension of two shifts without pay
- Third offense — immediate termination from employment

Your signature certifies an understanding that the Destin Fire Control District's normal workweek begins on Tuesday of each week and ends on the following Monday and that you agree to the conditions listed above regarding overtime.

_____ _____

Employee signature Date

_____

Printed name

Destin Fire Control District
848 Airport Road - Destin, Florida 32541
Telephone (850) 837-8413 Fax (850) 837-6715

Background Investigation Waiver

I, _____, do hereby give my permission to the Destin Fire Control District and/or its agents to conduct a thorough investigation into my background. Said investigation may include, but is not limited to, criminal records, previous employment, matters of moral character, and any other pertinent information needed to verify application or to substantiate a complete and accurate background check. I agree the District will have my permission to contact any person, agency, or entity needed to complete same, previous to my consideration for employment.

_____ _____
Signature Witness

_____ _____
Joe D'Agostino, Division Chief Date

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Release of Driver Transcript Consent

A Destin Fire Control Vehicle may be provided to _____ for work as a Beach Safety Division employee. In order for you to be permitted to operate the vehicle, you must have a valid driver's license and a good driving record. Further, you must authorize the District to obtain a copy of your motor vehicle records or reports and provide a copy of your license and any other documentation necessary to obtain such records or reports. The District may access or obtain your motor vehicle records or reports in connection with your initial application for employment and at any time during the time period that you have permission to operate a District vehicle. The District may revoke your right to use the District's vehicle at any time and for any reason, including but not limited to your failure to maintain a valid driver's license and a good driving record, your failure to abide by District policies concerning the use of its vehicles, and/or your failure to provide authorization for the District to access or obtain your motor vehicle records or reports.

I, _____ do hereby give my permission to the Destin Fire Control District and/or its agents to access or obtain my motor vehicle records or reports. I understand and agree that the District may access or obtain such records or reports in connection with my initial application for employment and at any time during the time period that I have permission to operate a District vehicle.

I further understand that my authorization is voluntary and can be withdrawn in writing at any time, however, my failure to provide authorization will be grounds for the District to deny or revoke permission for me to operate a District vehicle.

_____ _____

Signature Witness

_____

Date

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Liability Release for Sun Exposure

I, _____, have been fully informed by the personnel of the Destin Fire Control District about the potential risk involved in working in a sun exposure environment, as well as the dangers associated with prolonged sun exposure. I fully understand the risk involved and further understand that participating in the Beach Safety program with the Destin Fire Control District could place my personal safety in danger, resulting in skin cancer and/or other ailments directly related to excess sun exposure. I, also, acknowledge that I have been informed about sun exposure and have been offered sunscreen, a wide brim hat and a long-sleeved shirt for my protection. I do hereby release the Destin Fire Control District, including commissioners, management and employees, from any sun exposure related liability as a result of my participation as Beach Safety personnel.

_____ _____
Employee Date

_____ _____
Joe D'Agostino, Division Chief Date

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Drug-Free Workplace Policy
Employee Acknowledgment of Receipt and Understanding

I hereby acknowledge that I have received and read a summary of the District's Drug-free Workplace Policy and a summary of the drugs which may alter or affect a drug test. I have had an opportunity to have all aspects of this material fully explained. I understand that the full text of the Drug-free Workplace Policy is available upon request. I also understand that I must abide by the policy as a condition of employment and any violation may result in disciplinary action up to and including discharge.

Further, I understand that during my employment I may be required to submit to testing for the presence of drugs or alcohol. I understand that submission to such testing is a condition of employment with the District, and disciplinary action up to and including discharge may result if:

1. I refuse to consent to such testing or
2. I refuse to execute all forms of consent and release of liability as are usually and reasonably attendant to such examinations or
3. I refuse to authorize the release of the test results to the District or
4. The tests establish a violation of the District Drug-Free Workplace Policy or
5. I, otherwise, violate the policy.

If I am injured in the course and scope of my employment and test positive, I forfeit my eligibility for medical and indemnity benefits under the Workers' Compensation Act upon exhaustion of the remedies provided in Florida Statute Code Section 440.102(5).

I also understand that the Drug-free Workplace Policy and related documents are not intended to constitute a contract between the company and me.

The undersigned further states that the applicant has read the foregoing acknowledgment and knows the contents thereof and signs the same of their own free will.

_____ _____
Signature Date

_____ _____
Witness Date

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Drug-free Workplace Policy Summary

Read carefully, ask any questions and initial each item separately.

_____ I have had the opportunity to read the District's Drug-Free Workplace program and receive satisfactory answers to any questions that I have. I also received a copy of the list of the over-the-counter and prescription drugs that could alter or affect the outcome of a drug test.

_____ I know that if I am taking medicine that could affect my ability to perform my job (i.e., there are warning labels on the container), I must inform my supervisor immediately.

_____ I know that if I refuse to submit to a pre-employment drug test, I will not be hired and my employment is conditioned upon a negative drug test result.

_____ I know that total compliance with the District's Drug-Free Workplace Policy is a condition of continued employment.

_____ I know that if I refuse a reasonable suspicion, post-injury, post accident, random, fitness-for-duty or post-treatment drug or alcohol test I may lose my job, my unemployment benefits and my workers' compensation medical and indemnity benefits.

_____ I know that if I am injured or cause or contribute to the cause of an injury or an accident and test positive for drugs or alcohol, I will be subject to discipline up to including discharge.

_____ I know that if I enter into a treatment program for drug or alcohol abuse and test positive for drugs or alcohol following the completion of the primary phase of my treatment, I will be subject to discipline up to and including discharge.

_____ I know that I have the right to challenge any positive test result and that I must notify the laboratory that I am challenging the test result.

_____ I know that if I am convicted of a drug related crime, I must notify my supervisor within five working days.

_____ I agree to comply with the drug and alcohol testing requirements of the District's Drug-Free Workplace Policy.

_____ I give my informed consent for the release of drug and/or alcohol test results to the District.

_____ I know that the District's Drug-Free Workplace Policy does not constitute an employment contract between the company and me.

_____ I have read and understood each of the preceding items that I have initialed. I have had the opportunity to question any item that I did not understand. I have voluntarily signed this form.

Employee	Date	Witness	Date

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Drugs which may alter or affect a Drug Test

The following list contains the most common medication which may alter or affect a drug test. The substances are listed by brand or common name including its chemical name. The Department of Health and Rehabilitative Services list of common medications are as follows:

1. **Alcohol** – All liquid medications containing ethyl alcohol (ethanol). Please read the label for alcohol content. As an example, Vick's Nyquil is 25% (50 proof) ethyl alcohol, Comtrex is 20% (40 proof), Contact Severe Cold Formula Night Strength is 25% (50 proof) and Listerine is 26.9% (54 proof).

2. **Amphetamines** – Obetrol, Biphetamine, Desoxyn, Dexedrine, Didrex

3. **Cannabinoids** – Marinol (Dronabinol, THC)

4. **Cocaine** – Cocaine HCI topical solution (Roxanne)

5. **Phencyclidine** – Not legal by prescription

6. **Methaqualone** – Not legal by prescription

7. **Opiates** – Paregoric, Parapectolin, Donnagel PG, Morphine, Tylenol with Codeine, Empirin with Codeine, APAP with Codeine, Aspirin with Codeine, Robitussin AC, Guiatuss AC, Novahistine DH, Novahistine Expectorant, Dilaudid (Hydromorphone), M-S Contin and Roxanol (morphine sulfate), Percodan, Vicodin, etc.

8. **Barbiturates** – Phenobarbital, Tuinal, Amytal, Nembutal, Seconal, Lotusate, Florinal, Floicet, Esgic, Butisol, Mebaral, Butabartital, Butabital, Phrenilin, Triad, etc.

9. **Benzodiazepines** – Ativan, Azene, Clonopin, Dalmane, Diazapam, Librium, Xanax, Serax, Tranxene, Valium, Verstran, Halcion, Paxipam, Restoril, Centrax.

10. **Methadone** – Dolophine, Methadose

11. **Propoxyphene** – Darvocet, Darvon N. Dolene, etc.

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Acknowledgement of Receipt of Medications List
And
Voluntary Disclosure of Use of Medicine

I, _____, hereby acknowledge that I have read a copy of the listing of over-the-counter and prescription medications which can affect the results of a drug or alcohol test.

The following is a list of all such medications which I have used in the past thirty (30) days, which I am providing voluntarily:

_____
_____
_____
_____
_____

I understand that the District shall treat this information as confidential.

_____ Witness

_____ Employee

_____ Date

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Applicant Drug Test Consent Agreement

As a prerequisite to employment, I hereby agree to allow an agent of the Destin Fire Control District to collect urine samples from me to determine the presence of illegal drugs in my body. Further, I give my consent to the release of my test results to authorized Destin Fire Control District management for appropriate review, and authorize the Destin Fire Control District, hereinafter called the "District" to use the test results as a defense to any legal action to which I am a party.

I understand that the results of the drug testing of my urine, if confirmed positive, will remove me from consideration for employment. I also understand that if I refuse to consent, I will be removed from further consideration for employment.

Further, I understand that if employed by the District, I must abide by the terms of the District's Drug-free Workplace Policy and may required to submit to testing for the presence of illegal drugs or alcohol. I understand that submission to such testing is a condition of employment with the District, and disciplinary action, up to and including discharge, may result if:

1. I refuse to consent to such testing or
2. I refuse to execute all forms of consent and releases of liability as are usually and reasonably attendant to such examinations or
3. I refuse to authorize release of the test results to the District, if the tests establish a violation of the District's Drug-free Workplace Policy or
4. I, otherwise, violate the policy.

* *

I hereby consent to the administration of the drug test and to the terms and conditions of the Consent Agreement.

Applicant	Date	Social Security Number
Witness	Date	

* *

I hereby **refuse** the drug detection urine test.

Applicant	Date	Social Security Number
Witness	Date	

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Chief Kevin Sasser

Physical Exam Requirement

The Destin Fire Control District requires that ALL employees meet the health and fitness standard of the United States Lifesaving Association.

> Health & Fitness – Possesses adequate vision, hearing acuity, physical ability and stamina to perform the duties of an open water lifeguard as documented by a medical doctor, or the doctor's designated physician's assistant or ARNP (advanced registered Nurse Practitioner).

The duties that pertain to Lifeguarding for the Destin Fire Control District include:

- Vision - Ability to see swimmers in distress from the shore out to 100 meters
- Hearing - Ability to hear people yelling in a crowd, whistles, and radio transmissions
- Physical ability - Run, swim, and lift heavy objects. You must be able to complete a 550 yard swim in 10 minutes or less.

Physicals should be performed at Sacred Heart Medical Group located at 36500 Emerald Coast Parkway, Destin FL 32541 **AFTER AUTHORIZATION IS RECEIVED FROM DIVISION CHIEF JOE D'AGOSTINO**. This is the same location as your drug screen. Please set an appointment for the physical by calling Betty Jo Billups at 850-278-3899.

Should you wish to have your personal physician perform this physical it will be at your own cost. The physical should clearly state that you have been cleared to perform the above duties. Your physician's signature must also be included on this documentation along with a date.

You will not be scheduled to work until this information is received.

heart ready COMMUNITY

A Heart Ready Community

An Advanced Life Support Service

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USLA Membership Dues – Voluntary Deduction Form

I _____ hereby authorize Destin Fire Control District to withhold a one time deduction in the amount of $45.00 from my paycheck, for dues in the United States Lifesaving Association, Destin Chapter. These funds will be remitted to the Chapter for the membership year beginning April 1, 2017 and ending March 31, 2018.

Please send all membership information to the following mailing address:

_____

_____

Date of Birth: _____

I authorize the release of my mailing address, provided above, to the Destin Fire Rescue USLA Chapter, Inc. and understand that I am waiving my rights, if any, to confidentiality and exemption under Florida Statues for this information.

I understand that participation in the USLA is not mandatory to be employed with the District. I also understand that the District offers this deduction as a convenience which can be withdrawn at any time.

_____ _____

Employee signature Date

New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 1-31-2017)

PART A: General Information

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by your employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.[1]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution -as well as your employee contribution to employer-offered coverage- is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact Kathryn L. Wagner (850) 837-8413.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

[1] An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer name		4. Employer Identification Number (EIN)
DESTIN FIRE CONTROL DISTRICT		59-1510380
5. Employer address		6. Employer phone number
848 AIRPORT ROAD		(850)837-8413
7. City	8. State	9. ZIP code
DESTIN	FL	32541
10. Who can we contact about employee health coverage at this job?		
Kathryn L. Wagner		
11. Phone number (if different from above)	12. Email address	
	kwagner@destinfire.com	

Here is some basic information about health coverage offered by this employer:

- As your employer, we offer a health plan to:
  - ☐ All employees. Eligible employees are:
  - ☑ Some employees. Eligible employees are:

    Full-time employees

- With respect to dependents:
  - ☑ We do offer coverage. Eligible dependents are:

    Please contact employer for eligibility requirements for dependents

  - ☐ We do not offer coverage.

☑ If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, HealthCare.gov will guide you through the process. Here's the employer information you'll enter when you visit HealthCare.gov to find out if you can get a tax credit to lower your monthly premiums.

The information below corresponds to the Marketplace Employer Coverage Tool. Completing this section is optional for employers, but will help ensure employees understand their coverage choices.

13. **Is the employee currently eligible for coverage offered by this employer, or will the employee be eligible in the next 3 months?**

☐ **Yes** (Continue)
13a. If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage?_____ (mm/dd/yyyy) (Continue)
☑ **No** (STOP and return this form to employee)

14. Does the employer offer a health plan that meets the minimum value standard*?
☐ Yes (Go to question 15) ☐ No (STOP and return form to employee)

15. For the lowest-cost plan that meets the minimum value standard* **offered only to the employee** (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/ she received the maximum discount for any tobacco cessation programs, and didn't receive any other discounts based on wellness programs.
a. How much would the employee have to pay in premiums for this plan? $_____
b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

If the plan year will end soon and you know that the health plans offered will change, go to question 16. If you don't know, STOP and return form to employee.

16. What change will the employer make for the new plan year?_____
☐ Employer won't offer health coverage
☐ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)
a. How much would the employee have to pay in premiums for this plan? $_____
b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

* An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)