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

Beach Safety Division
2024 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, CPR Card, cancelled check and any additional information** which may be needed to complete your applicaiton.

Should you need assistance becoming CPR certified or need to renew your certification, the Destin Fire Control District can assist. **Pre-registration is required** and your employment status must be approved by Division Chief D'Agostino. To register, please call 850-797-9449.

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.

Some of the forms are required to be signed in front of a witness. ***Please ensure these forms are signed in front of a witness and have the witness sign where indicated.***

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

EMPLOYEE EMERGENCY CONTACT FORM

Employee Information

First Name _____

Last Name _____

Grade _____

Address _____

City/State/Zip _____

Phone _____ Alt Phone _____

Email _____

Primary Emergency Contact

Name _____

Relationship _____

Cell Phone _____ Work Phone _____

Email _____

Employer _____

Secondary Emergency Contact

Name _____

Relationship _____

Cell Phone _____ Work Phone _____

Email _____

Employer _____

☐ I have voluntarily provided the above contact information and authorize Destin Fire Control District and its representatives to contact any of the above on my behalf in the event of an emergency.

Employee Signature _____

Date _____

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

2024

Step 1: Enter Personal Information

(a) First name and middle initial | Last name | (b) **Social security number**

Address

City or town, state, and ZIP code

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*.

(c) ☐ **Single** or **Married filing separately**
☐ **Married filing jointly** or **Qualifying surviving spouse**
☐ **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, and when to use the estimator at *www.irs.gov/W4App*.

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). If you or your spouse have self-employment income, use this option; **or**

(b) Use the Multiple Jobs Worksheet on page 3 and enter the result in Step 4(c) below; **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 generally more accurate than (b) if pay at the lower paying job is more than half of the pay at the higher paying job. Otherwise, (b) is more accurate . . . . . ☐

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 Dependent and Other Credits

If your total 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 for qualifying children and other dependents. You may add to this the amount of any other credits. 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

Section references are to the Internal Revenue Code.

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, Tax Withholding and Estimated Tax.

Exemption from withholding. You may claim exemption from withholding for 2024 if you meet both of the following conditions: you had no federal income tax liability in 2023 **and** you expect to have no federal income tax liability in 2024. You had no federal income tax liability in 2023 if (1) your total tax on line 24 on your 2023 Form 1040 or 1040-SR is zero (or less than the sum of lines 27, 28, and 29), 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 2024 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 15, 2025.

Your privacy. Steps 2(c) and 4(a) ask for information regarding income you received from sources other than the job associated with this Form W-4. If you have concerns with providing the information asked for in Step 2(c), you may choose Step 2(b) as an alternative; if you have concerns with providing the information asked for in Step 4(a), you may enter an additional amount you want withheld per pay period in Step 4(c) as an alternative.

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. Receive dividends, capital gains, social security, bonuses, or business income, or are subject to the Additional Medicare Tax or Net Investment Income Tax; or

3. 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.

Instead, if you (and your spouse) have a total of only two jobs, you may 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 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. This step 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. 501, Dependents, Standard Deduction, and Filing Information. You can also include **other tax credits** for which you are eligible in this step, such as the foreign tax credit and the education tax credits. 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 2024 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. To be accurate, submit a new Form W-4 for all other jobs if you have not updated your withholding since 2019.

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 2024 itemized deductions (from Schedule A (Form 1040)). 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:
- $29,200 if you're married filing jointly or a qualifying surviving spouse
- $21,900 if you're head of household
- $14,600 if you're single or married filing separately

. . . . . 2 $

3 If line 1 is greater than line 2, subtract line 2 from line 1 and enter the result here. 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)). 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 territories 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 Surviving Spouse

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	$0	$780	$850	$940	$1,020	$1,020	$1,020	$1,020	$1,020	$1,020	$1,370
$10,000 - 19,999	0	780	1,780	1,940	2,140	2,220	2,220	2,220	2,220	2,220	2,570	3,570
$20,000 - 29,999	780	1,780	2,870	3,140	3,340	3,420	3,420	3,420	3,420	3,770	4,770	5,770
$30,000 - 39,999	850	1,940	3,140	3,410	3,610	3,690	3,690	3,690	4,040	5,040	6,040	7,040
$40,000 - 49,999	940	2,140	3,340	3,610	3,810	3,890	3,890	4,240	5,240	6,240	7,240	8,240
$50,000 - 59,999	1,020	2,220	3,420	3,690	3,890	3,970	4,320	5,320	6,320	7,320	8,320	9,320
$60,000 - 69,999	1,020	2,220	3,420	3,690	3,890	4,320	5,320	6,320	7,320	8,320	9,320	10,320
$70,000 - 79,999	1,020	2,220	3,420	3,690	4,240	5,320	6,320	7,320	8,320	9,320	10,320	11,320
$80,000 - 99,999	1,020	2,220	3,620	4,890	6,090	7,170	8,170	9,170	10,170	11,170	12,170	13,170
$100,000 - 149,999	1,870	4,070	6,270	7,540	8,740	9,820	10,820	11,820	12,830	14,030	15,230	16,430
$150,000 - 239,999	1,960	4,360	6,760	8,230	9,630	10,910	12,110	13,310	14,510	15,710	16,910	18,110
$240,000 - 259,999	2,040	4,440	6,840	8,310	9,710	10,990	12,190	13,390	14,590	15,790	16,990	18,190
$260,000 - 279,999	2,040	4,440	6,840	8,310	9,710	10,990	12,190	13,390	14,590	15,790	16,990	18,190
$280,000 - 299,999	2,040	4,440	6,840	8,310	9,710	10,990	12,190	13,390	14,590	15,790	16,990	18,380
$300,000 - 319,999	2,040	4,440	6,840	8,310	9,710	10,990	12,190	13,390	14,590	15,980	17,980	19,980
$320,000 - 364,999	2,040	4,440	6,840	8,310	9,710	11,280	13,280	15,280	17,280	19,280	21,280	23,280
$365,000 - 524,999	2,720	6,010	9,510	12,080	14,580	16,950	19,250	21,550	23,850	26,150	28,450	30,750
$525,000 and over	3,140	6,840	10,540	13,310	16,010	18,590	21,090	23,590	26,090	28,590	31,090	33,590

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	$240	$870	$1,020	$1,020	$1,020	$1,540	$1,870	$1,870	$1,870	$1,870	$1,910	$2,040
$10,000 - 19,999	870	1,680	1,830	1,830	2,350	3,350	3,680	3,680	3,680	3,720	3,920	4,050
$20,000 - 29,999	1,020	1,830	1,980	2,510	3,510	4,510	4,830	4,830	4,870	5,070	5,270	5,400
$30,000 - 39,999	1,020	1,830	2,510	3,510	4,510	5,510	5,830	5,870	6,070	6,270	6,470	6,600
$40,000 - 59,999	1,390	3,200	4,360	5,360	6,360	7,370	7,890	8,090	8,290	8,490	8,690	8,820
$60,000 - 79,999	1,870	3,680	4,830	5,840	7,040	8,240	8,770	8,970	9,170	9,370	9,570	9,700
$80,000 - 99,999	1,870	3,690	5,040	6,240	7,440	8,640	9,170	9,370	9,570	9,770	9,970	10,810
$100,000 - 124,999	2,040	4,050	5,400	6,600	7,800	9,000	9,530	9,730	10,180	11,180	12,180	13,120
$125,000 - 149,999	2,040	4,050	5,400	6,600	7,800	9,000	10,180	11,180	12,180	13,180	14,180	15,310
$150,000 - 174,999	2,040	4,050	5,400	6,860	8,860	10,860	12,180	13,180	14,230	15,530	16,830	18,060
$175,000 - 199,999	2,040	4,710	6,860	8,860	10,860	12,860	14,380	15,680	16,980	18,280	19,580	20,810
$200,000 - 249,999	2,720	5,610	8,060	10,360	12,660	14,960	16,590	17,890	19,190	20,490	21,790	23,020
$250,000 - 399,999	2,970	6,080	8,540	10,840	13,140	15,440	17,060	18,360	19,660	20,960	22,260	23,500
$400,000 - 449,999	2,970	6,080	8,540	10,840	13,140	15,440	17,060	18,360	19,660	20,960	22,260	23,500
$450,000 and over	3,140	6,450	9,110	11,610	14,110	16,610	18,430	19,930	21,430	22,930	24,430	25,870

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	$510	$850	$1,020	$1,020	$1,020	$1,020	$1,220	$1,870	$1,870	$1,870	$1,960
$10,000 - 19,999	510	1,510	2,020	2,220	2,220	2,220	2,420	3,420	4,070	4,070	4,160	4,360
$20,000 - 29,999	850	2,020	2,560	2,760	2,760	2,960	3,960	4,960	5,610	5,700	5,900	6,100
$30,000 - 39,999	1,020	2,220	2,760	2,960	3,160	4,160	5,160	6,160	6,900	7,100	7,300	7,500
$40,000 - 59,999	1,020	2,220	2,810	4,010	5,010	6,010	7,070	8,270	9,120	9,320	9,520	9,720
$60,000 - 79,999	1,070	3,270	4,810	6,010	7,070	8,270	9,470	10,670	11,520	11,720	11,920	12,120
$80,000 - 99,999	1,870	4,070	5,670	7,070	8,270	9,470	10,670	11,870	12,720	12,920	13,120	13,450
$100,000 - 124,999	2,020	4,420	6,160	7,560	8,760	9,960	11,160	12,360	13,210	13,880	14,880	15,880
$125,000 - 149,999	2,040	4,440	6,180	7,580	8,780	9,980	11,250	13,250	14,900	15,900	16,900	17,900
$150,000 - 174,999	2,040	4,440	6,180	7,580	9,250	11,250	13,250	15,250	16,900	18,030	19,330	20,630
$175,000 - 199,999	2,040	4,510	7,050	9,250	11,250	13,250	15,250	17,530	19,480	20,780	22,080	23,380
$200,000 - 249,999	2,720	5,920	8,620	11,120	13,420	15,720	18,020	20,320	22,270	23,570	24,870	26,170
$250,000 - 449,999	2,970	6,470	9,310	11,810	14,110	16,410	18,710	21,010	22,960	24,260	25,560	26,860
$450,000 and over	3,140	6,840	9,880	12,580	15,080	17,580	20,080	22,580	24,730	26,230	27,730	29,230

Employment Eligibility Verification

Department of Homeland Security

U.S. Citizenship and Immigration Services

USCIS Form I-9

OMB No.1615-0047

Expires 07/31/2026

START HERE: Employers must ensure the form instructions are available to employees when completing this form. Employers are liable for failing to comply with the requirements for completing this form. See below and the Instructions.

ANTI-DISCRIMINATION NOTICE: All employees can choose which acceptable documentation to present for Form I-9. Employers cannot ask employees for documentation to verify information in **Section 1**, or specify which acceptable documentation employees must present for **Section 2** or Supplement B, Reverification and Rehire. Treating employees differently based on their citizenship, immigration status, or national origin may be illegal.

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 (if any)	Other Last Names Used (if any)

Address (Street Number and Name)	Apt. Number (if any)	City or Town	State	ZIP Code

Date of Birth (mm/dd/yyyy)	U.S. Social Security Number	Employee's Email Address	Employee's Telephone Number

I am aware that federal law provides for imprisonment and/or fines for false statements, or the use of false documents, in connection with the completion of this form. I attest, under penalty of perjury, that this information, including my selection of the box attesting to my citizenship or immigration status, is true and correct.

Check one of the following boxes to attest to your citizenship or immigration status (See page 2 and 3 of the instructions.):

- ☐ 1. A citizen of the United States
- ☐ 2. A noncitizen national of the United States (See Instructions.)
- ☐ 3. A lawful permanent resident (Enter USCIS or A-Number.)
- ☐ 4. A noncitizen (other than **Item Numbers 2.** and **3.** above) authorized to work until (exp. date, if any)

If you check **Item Number 4.**, enter one of these:

USCIS A-Number	OR	Form I-94 Admission Number	OR	Foreign Passport Number and Country of Issuance

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

If a preparer and/or translator assisted you in completing Section 1, that person MUST complete the Preparer and/or Translator Certification on Page 3.

Section 2. Employer Review and Verification: Employers or their authorized representative must complete and sign Section 2 within three business days after the employee's first day of employment, and must physically examine, or examine consistent with an alternative procedure authorized by the Secretary of DHS, documentation from List A OR a combination of documentation from List B and List C. Enter any additional documentation in the Additional Information box; see Instructions.

	List A	OR	List B	AND	List C
Document Title 1					
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					
Document Title 2 (if any)					
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					
Document Title 3 (if any)					
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					

Additional Information

☐ Check here if you used an alternative procedure authorized by DHS to examine documents.

Certification: I attest, under penalty of perjury, that (1) I have examined the documentation presented by the above-named employee, (2) the above-listed documentation appears 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.

First Day of Employment (mm/dd/yyyy):

Last Name, First Name and Title of Employer or Authorized Representative	Signature of Employer or Authorized Representative	Today's Date (mm/dd/yyyy)

Employer's Business or Organization Name	Employer's Business or Organization Address, City or Town, State, ZIP Code

For reverification or rehire, complete Supplement B, Reverification and Rehire on Page 4.

LISTS OF ACCEPTABLE DOCUMENTS

All documents containing an expiration date must be unexpired.
* Documents extended by the issuing authority are considered unexpired.
Employees may present one selection from List A or a
combination of one selection from List B and one selection from List C.
Examples of many of these documents appear in the Handbook for Employers (M-274).

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 an individual temporarily authorized to work for a specific employer because of his or her status or parole: **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 individual's status or parole 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 For examples, see **Section 7** and **Section 13** of the M-274 on **uscis.gov/i-9-central**. The Form I-766, Employment Authorization Document, is a List A, **Item Number 4.** document, not a List C document.
		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				

Acceptable Receipts

May be presented in lieu of a document listed above for a temporary period.
For receipt validity dates, see the M-274.

• Receipt for a replacement of a lost, stolen, or damaged List A document. • Form I-94 issued to a lawful permanent resident that contains an I-551 stamp and a photograph of the individual. • Form I-94 with "RE" notation or refugee stamp issued to a refugee.	**OR**	Receipt for a replacement of a lost, stolen, or damaged List B document.	Receipt for a replacement of a lost, stolen, or damaged List C document.

*Refer to the Employment Authorization Extensions page on **I-9 Central** for more information.

Supplement A,
Preparer and/or Translator Certification for Section 1

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

USCIS
Form I-9
Supplement A
OMB No. 1615-0047
Expires 07/31/2026

Last Name *(Family Name)* from **Section 1.**	First Name *(Given Name)* from **Section 1.**	Middle initial (if any) from **Section 1.**

Instructions: This supplement must be completed by any preparer and/or translator who assists an employee in completing Section 1 of Form I-9. The preparer and/or translator must enter the employee's name in the spaces provided above. Each preparer or translator must complete, sign, and date a separate certification area. Employers must retain completed supplement sheets with the employee's completed Form I-9.

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			Date *(mm/dd/yyyy)*
Last Name *(Family Name)*	First Name *(Given Name)*		Middle Initial *(if any)*
Address *(Street Number and Name)*	City or Town	State	ZIP Code

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			Date *(mm/dd/yyyy)*
Last Name *(Family Name)*	First Name *(Given Name)*		Middle Initial *(if any)*
Address *(Street Number and Name)*	City or Town	State	ZIP Code

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			Date *(mm/dd/yyyy)*
Last Name *(Family Name)*	First Name *(Given Name)*		Middle Initial *(if any)*
Address *(Street Number and Name)*	City or Town	State	ZIP Code

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			Date *(mm/dd/yyyy)*
Last Name *(Family Name)*	First Name *(Given Name)*		Middle Initial *(if any)*
Address *(Street Number and Name)*	City or Town	State	ZIP Code

Supplement B, Reverification and Rehire (formerly Section 3)

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

USCIS Form I-9 Supplement B
OMB No. 1615-0047
Expires 07/31/2026

Last Name *(Family Name)* from **Section 1.**	First Name *(Given Name)* from **Section 1.**	Middle initial (if any) from **Section 1.**

Instructions: This supplement replaces Section 3 on the previous version of Form I-9. Only use this page if your employee requires reverification, is rehired within three years of the date the original Form I-9 was completed, or provides proof of a legal name change. Enter the employee's name in the fields above. Use a new section for each reverification or rehire. Review the Form I-9 instructions before completing this page. Keep this page as part of the employee's Form I-9 record. Additional guidance can be found in the Handbook for Employers: Guidance for Completing Form I-9 (M-274)

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

Reverification: If the employee requires reverification, your employee can choose to present any acceptable List A or List C documentation to show continued employment authorization. Enter the document information in the spaces below.

Document Title	Document Number (if any)	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 documentation, the documentation I examined appears to be genuine and to relate to the individual who presented it.

Name of Employer or Authorized Representative	Signature of Employer or Authorized Representative	Today's Date *(mm/dd/yyyy)*

Additional Information (Initial and date each notation.)

☐ Check here if you used an alternative procedure authorized by DHS to examine documents.

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

Reverification: If the employee requires reverification, your employee can choose to present any acceptable List A or List C documentation to show continued employment authorization. Enter the document information in the spaces below.

Document Title	Document Number (if any)	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 documentation, the documentation I examined appears to be genuine and to relate to the individual who presented it.

Name of Employer or Authorized Representative	Signature of Employer or Authorized Representative	Today's Date *(mm/dd/yyyy)*

Additional Information (Initial and date each notation.)

☐ Check here if you used an alternative procedure authorized by DHS to examine documents.

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

Reverification: If the employee requires reverification, your employee can choose to present any acceptable List A or List C documentation to show continued employment authorization. Enter the document information in the spaces below.

Document Title	Document Number (if any)	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 documentation, the documentation I examined appears to be genuine and to relate to the individual who presented it.

Name of Employer or Authorized Representative	Signature of Employer or Authorized Representative	Today's Date *(mm/dd/yyyy)*

Additional Information (Initial and date each notation.)

☐ Check here if you used an alternative procedure authorized by DHS to examine documents.

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

Please attach a copy of a voided check or letter from bank.

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: _____

Checking or account number: _____
or
Savings account number: _____

_____ _____
Employee signature Date

_____
Employee name – please print

Please attach a copy of a voided check or letter from bank.

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

Beach Safety Program
2024 Job Description and Acknowledgement

1. Starting hourly rate, for new Beach Safety Employees, is to be determined 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 at any time by the Beach Safety Division Chief or the Fire Chief.

_____ _____

Employee Date

_____ _____

Joe D'Agostino, Division Chief Date

Updated 12/18/2023

Destin Fire Control District
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 Division 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.

Notification is herein given that the Destin Fire Control District participates in E-Verify and will provide the federal government with your Form I-9 information to confirm that you are authorized to work in the U.S.

_____ _____
Signature Witness

_____ _____
Joe D'Agostino, Division Chief Date

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

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

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

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

Destin Fire Control District
848 Airport Road - Destin, Florida 32541
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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, 2024 and ending March 31, 2025.

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

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

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

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

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 printed name

_____ _____
Employee signature Date

_____ _____
Witness Date

Destin Fire Control District
848 Airport Road - Destin, Florida 32541
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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:

_____
_____
_____
_____
_____

If none, check this box ☐

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

_____ Witness

_____ Employee

_____ Date

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

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

Created 1/27/2011

Emerald Coast Fitness Foundation, Inc.

INDEMNITY AND HOLD HARMLESS AGREEMENT

I _____, who is a participant in the **DFCD EMPLOYEE LAP SWIM** Program, acknowledge that by signing this document, I am releasing Emerald Coast Fitness Foundation, Inc., Mattie Kelly Arts Foundation, Inc., Liza Jackson Preparatory School, Inc., City of Fort Walton Beach, instructors and coaches, and its officers, agents and employees from liability. This is a contract with legal consequences. I have been advised to read it carefully before signing.

The undersigned hereby covenants and agrees to investigate all claims of every nature at its own expense and to indemnify, protect, defend, hold and save harmless the Emerald Coast Fitness Foundation, Inc., Mattie Kelly Arts Foundation, Inc., Liza Jackson Preparatory School, Inc., City of Fort Walton Beach, their officers, agents and employees, from any and all claims, actions, lawsuits and demands of any kind or nature arising out of this agreement.

For and in consideration of the opportunity to participate in swimming and related activities at the Aquatic Center in Destin at 4345 Commons Drive West, Destin, Florida, and the Bernie R. Lefebvre Aquatic Center at 1127 Hospital Road, Fort Walton Beach, Florida, the undersigned participant, my heirs, successor and assigns, forever hold harmless the Emerald Coast Fitness Foundation, Inc., Mattie Kelly Arts Foundation, Inc., Liza Jackson Preparatory School, Inc., City of Fort Walton Beach, their officers, agents and employees, from any and all liability whatsoever for any personal property damage or for any personal injury that may result from said participation.

I agree, for myself, my successors and assignee, that the above representations are contractually binding and are not mere recitals, and that should I or my successors assert any claim in contravention of this agreement, the asserting party shall be liable to the expenses (including legal fees) incurred by the other party or parties.

This agreement may not be modified orally, and waiver of any provision shall not be constructed as a modification of any provision herein or as consent to any subsequent waiver or modification. I am at least 18 years of age and suffer from no physical, mental, legal or other disabilities that prevent me from fully understanding the terms of signing this agreement.

PROGRAM NAME: DFCD EMPLOYEE LAP SWIM (both pools)

REGISTRANT'S NAME (printed): _____

REGISTRANT SIGNATURE: _____

PARENT/GUARDIAN NAME (if participant is under 18): _____

ADDRESS: _____

CITY: _____ **STATE:** ____ **ZIP:** _____ **PHONE#:** _____

DATE: _____

Employees under Age of 18

Emerald Coast Fitness Foundation, Inc.

GENERAL RELEASE, INDEMNITY, AND HOLD HARMLESS AGREEMENT

I, _____, the undersigned participant or parent/guardian of _____ (minor child) (the "Participant"), who participates in any program or event at the Aquatic Center in Destin at 4345 Commons Drive West, Destin, Florida (the "Facility") acknowledge that by signing this document, I am releasing Emerald Coast Fitness Foundation, Inc., Mattie Kelly Arts Foundation, Inc., their officers, agents and employees, including instructors and coaches, (the "Releasees") from liability. This is a contract with legal consequences. I have been advised to read it carefully before signing and I acknowledge I have the right to have legal counsel review it before participating in the program.

IN CONSIDERATION OF, AND AS A CONDITION TO MY ENTERING, BEING PRESENT OR PARTICIPATING IN ANY PROGRAM OR EVENT AT THE FACILITY, I HEREBY KNOWINGLY AND INTENTIONALLY RELEASE, WAIVE, DISCHARGE AND COVENANT NOT TO SUE, the Releasees from any and all claims, causes of action, suits, controversies or liabilities of any kind whatsoever against any of the Releasees which in any way directly or indirectly arise from or are connected with my entry, presence or participation at the Facility, or to the risks associated with a swimming pool, including, without limitation, any claim or cause of action involving death, mutilation, bodily injury, emotional distress, or loss or damage to property whether caused by the active, passive or grossly negligent act or omission of Releasees, myself or any other person or entity, and further, from any and all liability to me, my personal representatives, assigns, and heirs for any and all loss or damage, and any claims or demands therefore on account of injury to me or resulting in my death, whether caused by the negligence of the Releasees or otherwise, while I am present at the Facility or while participating in any activity at the Facility.

I HEREBY AGREE TO INDEMNIFY, DEFEND AND HOLD HARMLESS the Releasees from any and all loss, liability, damage, or cost, including attorney's fees and costs, as a result of any claims, demands, actions, causes of action, damages, or judgments, that Releasees may incur arising out of, claimed on account of, or in any manner predicated upon my use of the Facility and/or while participating in any activity while at the Facility including any and all loss or damage to property, personal or otherwise, personal injury or death of any person, which occurs as a result of me, my guest(s)'s or my family member(s)'s use of the Facility or while participating in any activity at the Facility, even where the loss, damage, personal injury or death is caused or contributed to by the Releasees, whether caused by their negligence or otherwise.

I FURTHER HEREBY HOLD EACH OF THE RELEASED PARTIES HARMLESS from and against all of the above described claims, and hereby indemnify each of the Releasees with respect to any claim, cause of action, suit, controversy or liability of any kind whatsoever arising from my own acts or omissions in connection with my entry, presence or participation at the Facility, or to the risks associated with a swimming pool, whether my acts or omissions are actively, passively, or grossly negligent or intentional. I hereby covenant and agree to indemnify, protect, defend, hold and save harmless the Releasees, from any and all claims, actions, lawsuits and demands of any kind or nature arising out of this Agreement. For and in consideration of the opportunity to participate in swimming and related activities at the Facility, I, my heirs, successors and assigns, forever release, hold harmless and indemnify the Releasees from any and all liability whatsoever for any personal property damage or for any personal injury that may result from said participation.

I agree, for myself, my heirs, successors and assigns, that the above representations are contractually binding and are not mere recitals, and that should I, my Personal Representative, heirs, successors or assigns, assert any claim in contravention of this Agreement, the asserting party shall be liable for the expenses (including reasonable attorney fees and costs) incurred by the other party or parties. This Agreement may not be modified orally, and waiver of any provision shall not be construed as a modification of any provision herein or as consent to any subsequent waiver or modification. I am at least 18 years of age and suffer from no physical, mental, legal or other disabilities that prevent me from fully understanding the terms of signing this Agreement.

PARTICIPANT (OR GUARDIAN) SIGNATURE: _____ **DATE:** _____

PARTICIPANT NAME (printed): _____ **PARENT/GUARDIAN NAME (if participant is under 18):** _____

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

TELEPHONE: _____

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

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 Wendy Potter 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

A Heart Ready Community

An Advanced Life Support Service

Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 12-31-2026)

PART A: General Information

Even if you are offered health coverage through your employment, you may have other coverage options through the Health Insurance Marketplace ("Marketplace"). To assist you as you evaluate options for you and your family, this notice provides some basic information about the Health Insurance Marketplace and health coverage offered through your employment.

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 in your geographic area.

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

You may qualify to save money and lower your monthly premium and other out-of-pocket costs, but only if your employer does not offer coverage, or offers coverage that is not considered affordable for you and doesn't meet certain minimum value standards (discussed below). The savings that you're eligible for depends on your household income. You may also be eligible for a tax credit that lowers your costs.

Does Employment-Based Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that is considered affordable for you and meets certain minimum value standards, you will not be eligible for a tax credit, or advance payment of the tax credit, for your Marketplace coverage and may wish to enroll in your employment-based health plan. However, you may be eligible for a tax credit, and advance payments of the 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 is considered affordable for you or meet minimum value standards. If your share of the premium cost of all plans offered to you through your employment is more than 9.12%[1] of your annual household income, or if the coverage through your employment does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit, and advance payment of the credit, if you do not enroll in the employment-based health coverage. For family members of the employee, coverage is considered affordable if the employee's cost of premiums for the lowest-cost plan that would cover all family members does not exceed 9.12% of the employee's household income.[1,2]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered through your employment, then you may lose access to whatever the employer contributes to the employment-based coverage. Also, this employer contribution -as well as your employee contribution to employment-based coverage- is generally excluded from income for federal and state income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis. In addition, note that if the health coverage offered through your employment does not meet the affordability or minimum value standards, but you accept that coverage anyway, you will not be eligible for a tax credit. You should consider all of these factors in determining whether to purchase a health plan through the Marketplace.

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[1] Indexed annually; see https://www.irs.gov/pub/irs-drop/rp-22-34.pdf for 2023.

[2] An employer-sponsored or other employment-based 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. For purposes of eligibility for the premium tax credit, to meet the "minimum value standard," the health plan must also provide substantial coverage of both inpatient hospital services and physician services.

When Can I Enroll in Health Insurance Coverage through the Marketplace?

You can enroll in a Marketplace health insurance plan during the annual Marketplace Open Enrollment Period. Open Enrollment varies by state but generally starts November 1 and continues through at least December 15.

Outside the annual Open Enrollment Period, you can sign up for health insurance if you qualify for a Special Enrollment Period. In general, you qualify for a Special Enrollment Period if you've had certain qualifying life events, such as getting married, having a baby, adopting a child, or losing eligibility for other health coverage. Depending on your Special Enrollment Period type, you may have 60 days before or 60 days following the qualifying life event to enroll in a Marketplace plan.

There is also a Marketplace Special Enrollment Period for individuals and their families who lose eligibility for Medicaid or Children's Health Insurance Program (CHIP) coverage on or after March 31, 2023, through July 31, 2024. Since the onset of the nationwide COVID-19 public health emergency, state Medicaid and CHIP agencies generally have not terminated the enrollment of any Medicaid or CHIP beneficiary who was enrolled on or after March 18, 2020, through March 31, 2023. As state Medicaid and CHIP agencies resume regular eligibility and enrollment practices, many individuals may no longer be eligible for Medicaid or CHIP coverage starting as early as March 31, 2023. The U.S. Department of Health and Human Services **is offering a temporary Marketplace Special Enrollment period to allow these individuals to enroll in Marketplace coverage.**

Marketplace-eligible individuals who live in states served by HealthCare.gov and either- submit a new application or update an existing application on HealthCare.gov between March 31, 2023 and July 31, 2024, and attest to a termination date of Medicaid or CHIP coverage within the same time period, are eligible for a 60-day Special Enrollment Period. **That means that if you lose Medicaid or CHIP coverage between March 31, 2023, and July 31, 2024, you may be able to enroll in Marketplace coverage within 60 days of when you lost Medicaid or CHIP coverage.** In addition, if you or your family members are enrolled in Medicaid or CHIP coverage, it is important to make sure that your contact information is up to date to make sure you get any information about changes to your eligibility. To learn more, visit HealthCare.gov or call the Marketplace Call Center at 1-800-318-2596. TTY users can call 1-855-889-4325.

What about Alternatives to Marketplace Health Insurance Coverage?

If you or your family are eligible for coverage in an employment-based health plan (such as an employer-sponsored health plan), you or your family may also be eligible for a Special Enrollment Period to enroll in that health plan in certain circumstances, including if you or your dependents were enrolled in Medicaid or CHIP coverage and lost that coverage. Generally, you have 60 days after the loss of Medicaid or CHIP coverage to enroll in an employment-based health plan, but if you and your family lost eligibility for Medicaid or CHIP coverage between March 31, 2023 and July 10, 2023, you can request this special enrollment in the employment-based health plan through September 8, 2023. Confirm the deadline with your employer or your employment-based health plan.

Alternatively, you can enroll in Medicaid or CHIP coverage at any time by filling out an application through the Marketplace or applying directly through your state Medicaid agency. Visit https://www.healthcare.gov/medicaid-chip/getting-medicaid-chip/ for more details.

How Can I Get More Information?

For more information about your coverage offered through your employment, please check your health plan's summary plan description or contact Administrative Division Chief Kathryn Wagner at 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.

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 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:

    Please contact employer for eligiblity and coverage for dependents

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

    Please contact employer for eligiblity and coverage 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)