APPLICANT WAIVER AGREEMENT AND STATEMENT

For Criminal History Record Checks

This form shall be completed and signed by every applicant for non-criminal justice purposes.

I hereby authorize **Bradford County School District** to submit a set of my fingerprints to the Florida Department of Law Enforcement (FDLE) for the purpose of accessing and reviewing Florida and national criminal history records that may pertain to me. I understand that I would be able to receive any national criminal history record that may pertain to me directly from the Federal Bureau of Investigation (FBI). Pursuant to Title 28m Code of Federal Regulations (CFR), Sections 16.30-16.34 and that I could then freely disclose any such information to whomever I choose.

I understand that, my fingerprints may be retained at FDLE and the FBI for the purpose of providing any subsequent arrest notifications, upon request you my provide me a copy of the criminal history record report if any, you receive on me and that I am entitled to challenge the accuracy and completeness of any information contained in any such report. I am aware that procedures for obtaining a change, correction, or updating of the FDLE or FBI criminal history are set forth in F.S. 943.056 and Title 28, CFR, Section 16.34. I may obtain a prompt determination as to the validity of my challenge before you make a final decision about my status as an employee, volunteer, contractor, or subcontractor.

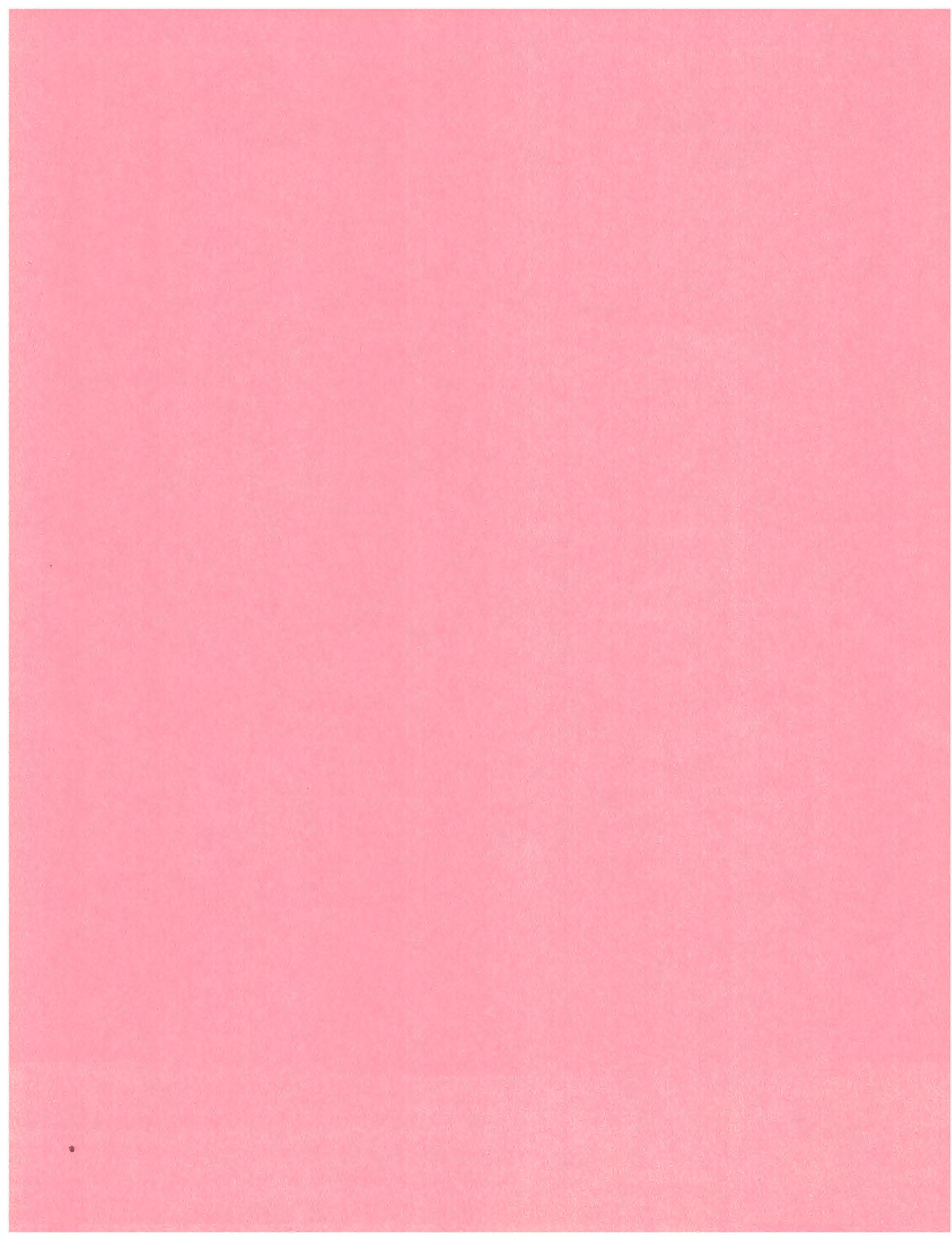
Signature: ______________________________ Date: ______________

Printed Name: ______________________________ Date of Birth: ______________

Address: ____

____

ORIGINAL-MUST BE RETAINED BY NON-CRIMINAL JUSTICE AGENCY



School Board of Bradford County

Bloodborne Pathogens Training

QUIZ

1. True False Bloodborne pathogens are a threat that anyone exposed to blood or other bodily fluids might face.
2. True False The hepatitis B virus can go unnoticed in an infected person.
3. True False A protective vaccine for HIV exists.
4. True False People infected with HIV always show symptoms right away.
5. True False In many cases, HIV – infected people go on to develop AIDS.
6. True False You can usually tell if someone's carrying a bloodborne pathogen just by looking at him or her.
7. True False If you're exposed to a BBP, you 're automatically infected.
8. True False Personal Protective Equipment is your first line of defense against BBP.
9. True False When washing your hands to remove contaminates, you should make sure your fingers are pointing upwards.
10. True False When using protective gloves, you should bandage any cuts before putting them on.
11. True False Using a hand sanitizer is good enough to clean your hands after an incident.
12. True False You should always wash your hands] after an incident.
13. True False If you ever intend to give CPR, and are trained to do so, you should carry a pocket mask to avoid direct contact with the victim's blood or bodily fluids.
14. True False Never smash down the overflowing trash containers with your hands or feet.
15. True False Contaminated sharps should go in the regular trash at your facility.
16. True False When dealing with any incident, you should first assess the situation.
17. True False If you don't agree with parts of your facility's Exposure Control Plan, you should follow your own instincts and ignore the ECP.
18. True False Spills should be absorbed with a paper towel, the cleaned with an approved cleaning agent.
19. True False In a pinch, it's ok to use disposable single – use gloves at least a few times.
20. True False Don't attempt to clean up blood or other bodily fluids unless you are trained and authorized to do so.

ACKNOWLEDEMENT OF TRAINING

I have read and understand the training handbook, Real, Real-Life for Schools: Bloodborne Pathogens: I have also completed and passed the comprehensive quiz at the conclusion of this handbook.

______________________________ ____________________

Employee's Signature Date

______________________________ ____________________

Trainer's Name Date

NOTE: This record may be included in the employee's personnel or training file.

BRADFORD COUNTY SCHOOL DISTRICT
DIRECT DEPOSIT AUTHORIZATION

PLEASE ATTACH A VOIDED CHECK

Name____

SS#____

School/Cost Center #____________________________

Deposit my check into my: (Check one)
(1) Checking Account_______ (2) Savings Account_______

Direct Deposit action requested: (Check one)
(1) Start_______ (2) Stop_______

Your DIRECT DEPOSIT CANNOT be processed until verified by you. I request that the School Board of Bradford County direct deposit my payroll check to the requested banking institution and I am aware that a pre-note must be sent to the indicated institution ten (10) days prior to actual direct deposit. I understand that it is my responsibility to notify the institution of the proper disposition of the funds once the check reaches said institution. I further understand that I must notify the School Board at least thirty (30) days in advance if I wish to discontinue direct deposit.

Signature____________________________________ Date_________________________

Place check here

PLEASE RETURN TO HUMAN RESOURCES

BCSB OFFICIAL USE ONLY

Pre-note date__________ Payroll date __________Bank# __________

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

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

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		Additional Information		QR Code - Sections 2 & 3 Do Not Write In This Space
Document Number				
Expiration Date *(if any)(mm/dd/yyyy)*				
Document Title				
Issuing Authority				
Document Number				
Expiration Date *(if any)(mm/dd/yyyy)*				

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 2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551) 3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa 4. Employment Authorization Document that contains a photograph (Form I-766) 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. 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		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 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 3. School ID card with a photograph 4. Voter's registration card 5. U.S. Military card or draft record 6. Military dependent's ID card 7. U.S. Coast Guard Merchant Mariner Card 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		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. Certification of report of birth issued by the Department of State (Forms DS-1350, FS-545, FS-240) 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. Native American tribal document 5. U.S. Citizen ID Card (Form I-197) 6. Identification Card for Use of Resident Citizen in the United States (Form I-179) 7. Employment authorization document issued by the Department of Homeland Security

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

Refer to the instructions for more information about acceptable receipts.

BRADFORD COUNTY SCHOOL DISTRICT
Employment Verification Form

Name____ School______________________________

Please note the following areas listed below to determine what experience has been received and granted to you for salary purposes:

Date Received	School System/Occupational Experience	Date of Service	# of Years/***	Total #/Steps	Keyed/Initials
				/	
				/	
				/	
				/	
				/	
				/	
				/	
				/	
				/	
				/	

***Your experience has NOT been approved due to the following reasons:

A. The school/university was not accredited
B. The year was not a full year as defined under Florida Statutes and Bradford County School Board
C. The teaching experience was not verified as full-time teaching (or counseling) experience.
D. The experience at a college/university was as an adjunct, coach, or as an instructor while attending the college
E. The experience was not acceptable as teaching experience as determined by BCSB Contract or School Board Policy.
F. The verification form was incomplete. The form has been returned back to your former employer for additional information.
G. The verification form did not release evaluation information for each year of employment.
We will accept a copy of your final evaluation for each of the following years: ____________________

Experience verifications must be received by the end of the current school year for you to receive retro-active pay. If you have any questions about the verification of your experience, please contact Human Resources at (904) 966-6031 and fax is (904)966-6011.

****<u>Do not contact payroll about experience on paychecks. HR processes all documentations for number of years granted for salary step/level placement.</u>

(Revised 11/1/2018)

Florida Retirement System (FRS) - Certification Form

This form is **not** an offer of employment or an enrollment form. If hired, a Retirement Choice kit may be mailed to your home with enrollment instructions.

Name ______________________________ SSN (last 4 digits) ______________

Agency Name ______________________________

Previous or Current FRS Employer ______________________________

Complete Section I if you have never been a member of a State of Florida administered retirement plan.
Complete Section II if you are a current or previous member AND Section III if not retired OR Section IV if retired.

I. I have **never** been a member of a State of Florida administered retirement plan.

STOP HERE

SIGNATURE ______________________________ DATE ______________

II. I was or currently am a member of the following State of Florida administered retirement plan (**also complete Section III or IV**)[1]

- ☐ FRS Pension Plan (incl. DROP)
- ☐ FRS Investment Plan
- ☐ State University System Optional Retirement Program (SUSORP)
- ☐ State Community College System Optional Retirement Program (SCCSORP)
- ☐ Senior Management Service Optional Annuity Program (SMSOAP)
- ☐ Other

III. I am **not retired** from any State of Florida administered retirement plan. I understand that if it is later determined that I was a retiree and was reemployed during the first 6 calendar months after I retired or after my DROP termination date, or at any time during the 7th through the 12th months after I retired or after my DROP termination date, I **must repay** all unauthorized benefits received (see Section IV for details), or, if in the Investment Plan, terminate my employment. **My employer may also be liable for repaying any unauthorized benefits I received.**

SIGNATURE ______________________________ DATE ______________

IV. I am **retired** from a State of Florida administered retirement plan. My FRS Pension Plan retirement effective date, DROP termination date, or date I received my first distribution from the FRS Investment Plan, SUSORP, SCCSORP, SMSOAP, or other plan was ______________.

Effective July 1, 2017, retirees of the Investment Plan, SUSORP, SCCSORP, and SMSOAP are eligible for renewed membership in the Investment Plan, SUSORP, or SCCSORP.

I understand that as a Pension Plan retiree:

a. If I am employed by an FRS-covered employer in **any type of position**[2] during the **first 6 calendar months** after I retired or after my DROP termination date, my retirement and DROP status are voided, all retirement and DROP benefits I received **must be repaid**,[3] and I must reapply for retirement in order to receive future benefits.

b. If I am reemployed by an FRS-covered employer at any time during the 7th through the 12th months after I retired or after my DROP termination date, my monthly retirement benefit must be suspended[4] and any unauthorized benefits received must be repaid.[3] **My employer may also be liable for repaying any unauthorized benefits I received.**

I understand that as an Investment Plan, SUSORP, SCCSORP, or SMSOAP retiree:

a. If I am employed by an FRS-covered employer in **any type of position**[2] during the **first 6 calendar months** after I retired, **I must repay**[3] any benefits received or terminate employment for an additional period to satisfy the 6 calendar month termination requirement.

b. If I am reemployed by an FRS-covered employer at any time during the 7th through the 12th months after my retirement, I will not be eligible for additional distributions until I terminate employment or complete 12 calendar months of retirement.[4]

SIGNATURE ______________________________ DATE ______________

Retiree Definition

You are considered retired if:

1. You have received any benefits under the FRS Pension Plan including DROP (does not include a withdrawal of employee contributions), or
2. You have taken any distribution (including a rollover) from the FRS Investment Plan, or other state administered retirement programs offered by state universities (SUSORP), state community colleges (SCCSORP), state government for senior managers (SMSOAP), or local governments for senior managers.

---

[1] If you are not retired and earned FRS service after certain periods in 2002 (depending on your employer), you must rejoin the FRS retirement plan you were enrolled in when you terminated FRS-covered employment. You may have a one-time 2nd Election to switch FRS retirement plans. Also, alternative retirement programs are available to certain employees. Contact your employer for deadline and other information.

[2] Positions include OPS, temporary, seasonal, substitute teachers, adjunct professors, part-time, full-time, regularly established, etc.

[3] Florida law requires a return of all unauthorized Pension Plan benefit payments or Investment Plan distributions received by a member who has violated the FRS termination or reemployment provisions. Similar provisions apply to unauthorized SUSORP, SCCSORP, or other state-administered plan distributions – contact that plan's administrator for details.

[4] There is one exception to the restrictions on reemployment limitations after retirement. If you are a retired law enforcement officer, you may only be reemployed as a school resource officer by an FRS-covered employer during the 7th through 12th months after your retirement date or after your DROP termination date and receive both your salary and retirement benefits.

EMPLOYERS: RETAIN THIS FORM IN THE EMPLOYEE'S PERSONNEL FILE. DO NOT SEND THIS FORM TO THE FRS, UNLESS REQUESTED.

SCHOOL BOARD OF BRADFORD COUNTY

Human Resources Department

501 W. Washington Street, Starke, FL 32091 * (904) 966-6023

Emily Mecusker
Director

Bret Dukes
H.R. Coordinator

MEMORANDUM

Human Resources Department

To: All New Employees

From: Emily Mecusker, Director

Subject: Insurance

Please be advised that the School Board of Bradford County provides a limited amount of life insurance benefits to all new employees at no expense to the employee. However, this life insurance benefit must be activated by the employee. All health insurance benefits are the responsibility of the employee and may be arranged through the District. If the new employee desires to purchase additional life insurance and/or any health benefits, he/she has thirty (30) days from their initial hire date with the School Board of Bradford County to secure insurance if they desire to do so. If this additional insurance is not secured during this initial thirty day enrollment window of time, the employee must wait until the next November open enrollment period to add additional insurance.

New employees should see Mrs. Dana Bell in the Finance Department located at the District Office to activate the School Board provided life insurance and/or take care of adding any additional life or health insurance coverage. Please remember that securing of insurance must be done within the first thirty (30) days of employment.

My signature below indicates that I have been informed of the "30 day" policy to secure insurance from the School Board of Bradford County.

Signature____

New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 5-31-2020)

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 ______________________________.

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.

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[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)
5. Employer address		6. Employer phone number
7. City	8. State	9. ZIP code
10. Who can we contact about employee health coverage at this job?		
11. Phone number (if different from above)	12. Email address	

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

BC BRADFORD COUNTY
SD SCHOOL DISTRICT

Network Acceptable Use Agreement

I. The network system of the District is available for all employees and students of the District in order to provide them with equal access to the computing resources which serve public education. The network system is an electronic highway which connects thousands of computers all over the world and millions of individual subscribers. The term network may include electronic mail, worldwide Web browsing, or any method of connecting with other computer equipment. All personnel having authorization to use the network will have access to a variety of information.

II. Some material of the network on the network might not be considered to be of educational value in the context of the school setting. In addition, some material, individual contacts, or communications may not be suitable for school-aged children. The District views information retrieval from the network in the same capacity as information retrieval from reference materials identified by schools. Specifically, the District supports information retrieval from the network which enhances the research and inquiry if the learner and faculty and staff direct. The District network will filter inappropriate material. At each school, each student's access to use of the network will be under the teacher's direction and monitored as a regular instructional activity.

III. The District cannot prevent the possibility that some users may access material that is not consistent with the educational mission, goals and policies of the District. This is particularly possible since access to the network may be obtained at sites other than school.

IV. At each school and facility owned and operated by the District, in each room where computers are present, notices shall be conspicuously posted that states the following: "Users of the network system of the School District of Bradford County are responsible for their activity on the network. The School District has developed a data network acceptable use policy. All users of the network are bound by that policy. Any violation of the policy will result in the suspension of access privileges or other disciplinary action, including student expulsion and employee dismissal." This notice shall also become part of the login process.

V. The use of the network shall be consistent with the mission, goals, policies, and priorities of the District. Successful participation in the network requires that all its users regard it as a shared resource and that members conduct themselves in a responsible, ethical, and legal manner while using the network.

Any use of the network for illegal, inappropriate, or obscene purposes, or in support of such activities, will not be tolerated. For compliance with the requirements of the Elementary and Secondary Education Act (ESEA) and the Children's Internet Protection Act (CIPA), please see procedures entitled "Student Internet Use Procedures."

Examples of unacceptable uses of the network include, but are not limited to:

1. Violating the conditions of the Code of Ethics and Principles of Professional Conduct of the Education Profession of Florida dealing with student's rights to privacy, employee rights to privacy, or violating any other section of the Code;
2. Using, accessing, visiting, downloading, or transmitting inappropriate material, messages or images such as pornography, profanity or obscenity;
3. Reposting personal communications without the author's consent.
4. Copying, sending (uploading) or receiving (downloading) commercial software in violation of copyright law or other copyright protection of trademarked material;
5. Using the network for financial gain or other commercial or illegal activity;
6. Using the network for political advertisement or political activity;
7. Taking any actions that affect the ability of the District to retrieve or retain any information contained on the computer equipment, in the data network system or acting to modify any software or any data without specific written permission.
8. In accordance with applicable Family Educational Rights and Privacy Act (FERPA) and Health Insurance Portability and Accountability Act (HIPAA) rules, sending any student identifying information, via e-mail, is strictly prohibited;

9. Creating and/or forwarding advertisements, chain letters, mass mailings, get rich quick schemes, and pyramid schemes to individual mailboxes and/or mailing lists;
10. Gambling or conducting any illegal activity;
11. Posting personal views on social, political, religious or other nonbusiness related matters;
12. Creating and/or forwarding messages, jokes, etc., which violate School Board harassment policies and/or create an intimidating or hostile environment.

VI. The e-mail system developed by the District and the hardware owned by the District are intended for District business use. Minor personal use of e-mail and the internet by school district employees is acceptable, but should not interfere or conflict with District business.

VII. District business conducted by e-mail must be done using the e-mail account provided by the district. When an employee conducts official business of the District via e-mail, the employee must retain a copy of the e-mail including attachments in paper form or store these documents electronically on district owned equipment in accordance with the Florida Public Records law.

VIII. Failure to adhere to this agreement may result in suspending or revoking the offender's privilege of access to the network and other disciplinary action up to and including termination of the employee or expulsion in the case of a student.

IX. Any student shall be exempt from accessing the internet upon written request from the parents, as defined by Florida Statutes, to the principal. The request for exemption shall expire at the end of each school year. It shall be the responsibility of the parent to renew the request yearly.

X. The District reserves the right to monitor and/or retrieve the contents of email messages for legitimate reasons such as, but not limited to, ensuring the integrity of the system, complying with investigations of wrongful acts, or recovering from a system failure.

XI. District employees' and students' passwords are confidential, and in order to maintain network security, employees shall:

1. Change passwords at least four (4) times a year, or whenever the employee feels his/her password may have been compromised;
2. Use passwords that contain letters and numbers and that are difficult to guess;
3. Not share passwords and shall not set passwords to automatic log in mode;
4. Give his/her password to authorized computer maintenance personnel, only as part of maintenance activities, and shall change his/her password at the completion of the activity.
5. Student passwords are maintained by the District Office.

XII. All Web sites representing any District employee pursuant to their official District role and duties must have their Web site hosted on a school district server or a district sponsored Web site. Using other free or paid outside Web servers for public dissemination of District business is not permitted.

STATUTORY AUTHORITY: 100.41, 100.42, FS LAW(S) IMPLEMENTED: 1000.21, 1001.43

BY SIGNING THIS DOCUMENT, I AGREE TO ALL TERMS AND CONDITIONS.

______________________________ ________________

Employee or Student printed name Date

____

Signature

SCHOOL BOARD OF BRADFORD COUNTY

Non-Instructional Experience Verification

TO: ______________________________

____

____

Employee's Name______________________________ SS#______________________

Please complete the employment verification for the designated employee. **LIST EACH YEAR SEPARATELY. VERIFY ONLY PERMANENT EMPLOYMENT (NOT OPS, SUBSTITUTING, OR TEMPORARY EMPLOYMENT).**

Job Title	Dates of Service From To	Duties

I certify that all information listed above is complete and correct according to the official records on file.

______________________________ ______________________
Signature Date

____
Title

Return Form to: Bradford County School District
Attn: Human Resources
501 W. Washington Street
Starke, FL 32091

AFFIX
BOARD SEAL
HERE

SCHOOL BOARD OF BRADFORD COUNTY

Human Resources Department

501 W. Washington Street, Starke, FL 32091 * (904) 966-6023

Emily Mecusker
Director

Bret Dukes
H.R. Coordinator

OATH OF LOYALTY

State of Florida
County of Bradford

I, ____, a citizen of the State of Florida and the United States of America, and being employed by or an officer of the Bradford County School District and a recipient of public funds as such employee or officer, do hereby solemnly swear or affirm that I will support the constitution of the United States of America and of the State of Florida.

____
Superintendent or Designee

____
Employee

SCHOOL BOARD OF BRADFORD COUNTY
Human Resources Department
501 W. Washington Street, Starke, FL 32091 * (904) 966-6023

Emilee Mecusker
Director

Bret Dukes
H.R. Coordinator

Right to Know - OSHA Training

OSHA Safety Training Acknowledgement Form

I hereby acknowledge that on this date, I participated in a training session in which the following items were presented:

The OSHA HAZARD COMMUNICATION STANDARD and THE FLORIDA RIGHT-TO-KNOW LAW.

As part of this training, I received the following information:

- A brief description of the above reference standards
- An example of a Material Safety Data Sheet (MSDS)
- How to obtain an MSDA from my employer
- The requirements for maintaining and making MSDS's available
- How to determine the health effects of a chemical by using the MSDS
- Emergency treatment as described on a MSDS
- Procedures for cleanup of leaks and spills as described on an MSDS
- The potential for flammability, explosion, or reactivity as described on a MSDS
- Appropriate first aid procedures in the event of overexposure or improper exposure, and
- My right and duties as stated in the OSHA HAZARD COMMUNICATION STANDARD and The FLORIDA RIGHT-TO-KNOW LAW.

I also acknowledge that I have been given the opportunity to ask any questions that I had during the presentation (in person or by phone), and I understand the training that I have received. In addition, I understand it is my responsibility to ask questions concerning the above-mentioned topics that may arise in the future. I also agree to follow all practices and procedures that were addressed in the training that I received and obey all safety rules in the performance of my job duties.

______________________________   _______-_______-_______

Employee's Name (Printed)   ***Employee's Social Security Number***

______________________________   ______________________

Employee's Signature   ***Date of Training***

____

Employee's Work Location

Over

QUIZ

1. Potentially dangerous chemicals are never found in schools.

   TRUE or FALSE

2. Exposure to carcinogens can never cause cancer.

   TRUE or FALSE

3. A fire is which type of hazard?

   a. A health hazard
   b. An obstructive hazard
   c. A physical hazard
   d. A dangerous hazard

4. An acute hazard is when you die immediately when you breathe poisonous vapors.

   TRUE or FALSE

5. Stomach aches and headaches are effects of Chemical hazards.

   TRUE or FALSE

6. Where are Material Safety Data Sheets (MSDS) located?

   a. In the front office in safety file
   b. In the clinic
   c. In the custodial area
   d. In the kitchen
   e. All of the above

7. What should be done if there is no label on a container?

   a. Do not bother to replace the label
   b. Treat it as hazardous material & report the missing label to your supervisor
   c. Throw the product out
   d. Report it to your supervisor

8. What do you do with a leaking container?

   a. Keep product on the shelf
   b. Store the product in a cool place
   c. Pour down the sink
   d. Report it to your supervisor

9. We keep the MSDS sheet for only 15 years following the discontinued use of a product.

   TRUE or FALSE

10. It's okay to bring in a product (i.e. Windex, 409, etc.) to the workplace as long as it is in its original container with the original label.

    TRUE or FALSE

BRADFORD COUNTY SCHOOL DISTRICT

Pre-Employment Drug Screening Policy

DRUG FREE WORKPLACE

Purpose:

In an effort to meet it's commitment to provide children with a quality education and to eliminate future substance abuse related costs from its operations, the School Board of Bradford County has established a pre-employment drug screening policy (including alcohol). The School Board of Bradford County is committed to a drug-free work place and a drug-free work force. The School Board's Policy is not directed at employee conduct off the job, unless that conduct affects on-duty performance. As a condition of employment, new hirees are required to fully comply with the provisions of the School Board's Pre-Employment Drug Screening Policy. All new employees shall receive and be asked to read this Policy with regard to alcohol and drug usage and sign a statement indicating their understanding of the Policy

Notice of Implementation of the School Board of Bradford County's Pre-Employment Drug Screening Policy:

A. The implementation of the Pre-Employment Drug Screening Policy, contained within the confines of this document, constitutes general notice to all applicants to the School Board of Bradford County that each individual is required, as a condition of employment with the School Board, to fully comply with the provisions of the Pre-Employment Drug Screening Policy, and to fully cooperate with the implementation and enforcement of the Policy, including execution of the necessary authorization form.

B. The implementation of this Policy further constitutes general notice to all employees of the School Board of Bradford County that it is a condition of employment for an employee to refrain from reporting to work or working with levels in excess of Florida Administrative Code Chapter (59A-24).

C. A notice of this Policy is to be posted on the bulletin board at each work site and copies are available upon request at the Risk Management Office.

Types of Testing

The School Board of Bradford County reserves the right to conduct Pre-Employment Drug Testing. The scope and description of each particular category of testing is described below:

Job Applicant Testing

A. The School Board of Bradford County requires all individuals hired by the School Board to be free of alcohol and controlled substances. All job applicants offered a position with the School Board will be required to submit to a drug screen. A job applicant's refusal to submit to a pre-employment drug test shall constitute a basis for the Superintendent's refusal to hire that individual. All prospective employment candidates will be provided notice of the test and assurance that highly reliable testing procedures will be used. **Prior to and after testing, applicants are given an opportunity to confidentially report to a Medical Review Officer the use of any prescription or nonprescription medicines which may alter their test results by filling out a form.** Additionally, applicants may consult with a Medical Review Officer for any further technical information regarding such medications.

B. All job applicants' prospects of employment with the School Board of Bradford County will be conditioned upon their being qualified for work and any individual who tests positive for any drug described herein will not be considered qualified for employment with the School Board of Bradford County.

C. The results of the laboratory test will be restricted to whether or not the applicant's specimen tested positive for drugs, the particular drug involved and the amount found within the specimen tested.

Drugs to be Tested

A list of drugs for which the employer will test job applicants is as follows:

ALCOHOL: (including a distilled spirit, wine, a malt beverage or an intoxicating liquor).

AMPHETAMINES: (Obetrol, Biphetamine, Desoxyn, Dexedrine, Didrex, Ionamine, and Fastin).

CANNABINOID: (Marijuana, THC).

COCAINE

PHENCYCLIDINE (pcp)

METHAQUALONE

OPIATES: (Paregoric, Parepectolin, Donnegel PG, Morphine, Tylenol with Codeine, Empirin with Codeine, APAP with Codeine, Aspirin with Codeine, Robitussin AC, Guiatuss AC, Novahistine DH, Novahistine Expectorant, Dilaudid (Hydromophone), M-S Contin and Roxanol (morphine sulfate), Percodan, Vicodin, Tuss-Organidin, etc.).

BARBITURATES: (Phenobarbital, Tuinal, Amytal, Nembutal, Seconal, Lotusate, Fiorinal, Fioricet, Esgic, Butisol, Mebaral, Butabarbital, Butabital, Phreninlin, Triad, etc.).

BENZODIAZEPHINES: (Ativan, Azene, Clonopin, Dalmane, Diazepam, Librium, Xanax, Serax, Tranxene, Valium, Halcion, Paxipam, Restoril, Centrax).

METHADONE

PROPOXYPHENE: (Darvocet, Darvon N, Dolene, etc.).

METABOLITE of any of the substances listed above.

Rules of Conduct

The School Board of Bradford County strictly prohibits its employees from being on duty and possessing, using, distributing or being under the influence of alcohol, marijuana or any drug not prescribed for the employee. Further, the School Board of Bradford County prohibits its employees from misusing alcohol or possessing, using or distributing drugs off the job to the extent that any off-duty possession, use or distribution impacts upon the effectiveness and ability to perform their employment effectiveness and ability to perform their employment duties, or adversely affects the interests of the Board.

Challenges to Test Results

A. Within five (5) working days after receiving written notice of a positive confirmed test result, the employee or applicant may contest or explain the results to a Medical review Officer. If the explanation or challenge of the positive test result is unsatisfactory to the Medical Review Officer, the Medical Review Officer shall report a positive test result back to the School Board of Bradford County.

B. Within five (5) working days after receipt of a positive confirmed test from the Medical Review Officer, the School Board of Bradford County will inform the job applicant in writing of such positive test results, the consequences of such results, and the options available to the job applicant. Within five (5) working days after receiving notice of a positive confirmed test result, the applicant may submit information to the School Board of Bradford County explaining or contesting the test result, and explaining why the result does

not constitute a violation of the School Board of Bradford County's Drug Pre-Employment Drug Screening Policy. If a job applicant's explanation or challenge of the test result is unsatisfactory to the School Board of Bradford County, then within fifteen (15) days of receipt of the explanation or challenge, a written explanation as to why the job applicant's explanation is unsatisfactory, along with the report of positive results, will be provided to the applicant. All such documentation will be kept confidential by the School Board of Bradford County.

C. An applicant with a positive drug screen may reapply for employment after ninety days, provided the initial drug screening did not test positive for: Amphetamines, Cannabinoid, Cocaine, Phencyclidine, Methaqualone, Barbiturates, and Methadone.

D. An applicant testing positive a second time, for any of the drugs listed in the Pre-Employment Drug Screening Policy, will not be considered for any future job position within the Bradford County School System.

Confidentiality/Employee Safeguards

A. All information, interviews, reports, statements memoranda, and drug test results, written or otherwise, received by the School Board of Bradford County through the Pre-Employment Drug Screening Policy shall be treated in a confidential manner. Unless otherwise required by Florida law.

B. The School Board of Bradford County, any collection sites, laboratories, drug and alcohol rehabilitation programs, and their agents who receive or have access to information concerning drug test results shall keep all information confidential, unless otherwise required by Florida law.

Workforce Regarding Substance Abuse

The School Board of Bradford County believes that education and understanding can be powerful weapons in the fight against drugs. Employees armed with knowledge are better prepared to resist substance abuse and intervene when necessary. As such, the School Board of Bradford County maintains a current resource file or providers of employee assistance including alcohol and drug abuse programs, mental health providers, and various other persons, entities or organizations designed to assist employees with personal and behavioral problems including, but not limited to those referenced in the "Florida Comprehensive Directory, Substance Abuse and Mental Services," published by the Department of Health and Rehabilitative Services. Further, the School Board of Bradford County will provide an annual education course to help employees identify the signs of personal and emotional problems brought on by substance abuse. This course will include a presentation of the legal, social, physical and emotional consequences of the misuse of alcohol and drugs.

Employee Assistance Plan

Lists containing a sampling of the names, addresses, and telephone numbers of providers of assistance programs and local alcohol and drug rehabilitation programs available in our community are located in the HRMD office and the Risk Manager's office.

The Risk Manager has been designated as the School Board official responsible for providing information and answering any questions concerning this Policy.

- -

My signature will acknowledge that I have been given employee information regarding the Board's Drug Screening Policy. I have read, understand, and have had an opportunity to ask any questions regarding this policy.

______________________________ Printed Name of Applicant

______________________________ Signature of Applicant

__________________ Date

The School Board of Bradford County
Sexual Harassment Training

The District will provide training in Sexual Harassment including the definition of, types of conduct that may constitute Sexual Harassment, District Bradford Policy of Discrimination, Including Sexual and Other Forms of Harassment, and prohibited retaliation of reporting such.

My signature below acknowledges my participation in the District sponsored training of Sexual Harassment.

______________________________ ____________________
Name of Employee (Last, First, MI) Date

______________________________ ____________________
Signature of Employee Date

______________________________ ____________________
Trainer Name Date

BRADFORD COUNTY SCHOOL DISTRICT
Notice of Use of Social Security Numbers
Employees/Applicants/Vendors/Students

COLLECTION

A. Social Security numbers shall be collected only when allowed by law or when necessary for the performance of the school system's duties.

B. The district shall collect the Social Security Number of each **applicant and employee** for the following purposes:
   1. Verification of citizenship or immigration status, as required by the US Department of Homeland Security or other governmental agencies.
   2. Employee benefit processing, including membership in the Florida Retirement System, health insurance, prescription, insurance, or other benefits offered to employees by the district.
   3. Compliance with reporting requirements of the IRS, US Social Security Administration, Florida Agency for Work Force Innovation, and such other official reporting responsibilities imposed by law.
   4. Processing pre-employment and post-employment criminal background checks required by law.
   5. For such other purposes as may be directed by the employee, such as direct deposit of wages or salary, etc.

C. Social Security Numbers or federal employer identification numbers shall be collected from all **vendors** to facilitate vendor recordkeeping by the School Board and to permit compliance with income reporting requirements of the US Internal Revenue Code, including but not necessarily limited to issuance of US Internal Revenue Form 1099.

D. Social Security numbers may be collected from **STUDENTS**:
   1. As required by 1008.386, Florida Statutes.
   2. To facilitate proper processing of student scholarship applications.
   3. As otherwise consented to by the student or the student's parent.
   4. State student assessments.
   5. To determine Medicaid eligibility for services possibly provided by ESE Department.

NOTIFICATION

A. **Applicants for employment and employees** shall be notified of the requirement for providing their social security number prior to the time of the completion and the submission of the application for employment, the submission of their recommendation for employment to the School Board and the purposes for which an **applicant/employee's** number will be used.

REVIEW

A. The Superintendent shall review the collection of Social Security Numbers to ensure that the reasons for collection and the process for collection and maintenance are consistent with Florida Statutes. The Superintendent shall report his/her findings as required by law.

CONFIDENTIALITY

A. A Social Security Number shall be considered confidential and exempt from public inspection in accordance with Florida Statutes. Social Security Numbers may be disclosed to another agency or governmental entity if it is necessary for the receiving entity to perform its responsibilities.

RELEASE TO COMMERCIAL ENTITIES

A. **Non-student Social Security Numbers** may be released to a commercial entity as permitted by law. The commercial entity must state the reason for requesting the Social Security numbers.
   1. Commercial entity is any corporation, partnership, limited partnership, proprietorship, sole proprietorship, firm, enterprise, franchise, or association that performs a commercial activity in this state.
   2. Release of Social Security Numbers shall be processed as required by 119.071(5), Florida Statutes.

B. The School Board shall annually report to the Executive Office of the Governor, the President of the Senate, and the Speaker of the House of Representatives, the identity of all commercial entities that have requested Social Security Numbers during the preceding year and the reasons for the requests. If no requests have been received during the preceding year, the report shall so state. The report shall be filed by January 31st of each year.

Sign below, if you are an employee, applicant, vendor, or parent of a student who is registering for the school year.

PLEASE PRINT, FOR FILING ______________________ ______________________
LAST NAME **FIRST NAME**

______________________________ ______________
Signature Date

PLEASE PRINT -
Child's name, if signing for student registration: ______________________ School ____________

Your signature above verifies that you have read and understand the Notice of Use of Social Security Numbers.

CUR00025

BRADFORD COUNTY SCHOOL DISTRICT – Verification of Professional Experience

Employee Name____

EXPERIENCE INFORMATION

Please complete the employment verification form for the designated employee. *List each year separately*. When indicating part-time experience, please list the number of hours taught per day. Do not list substitute teaching, including long term substitute teaching. *Leaves of absences need to be clearly identified*. You may duplicate this form as needed. **ALL COLUMNS MUST BE COMPLETED TO GRANT EXPERIENCE**. The employee will not be granted credit for any year for which he/she did not receive a satisfactory performance evaluation. The final column is very important. Thank you in advance for your cooperation.

School	Dates of Service		Total Days in School Year	Actual Days Paid	Status Full Time/Part Time	Hours Per Day	Held State Certificate? Yes/No	Subject(s) taught: Math, Science, ELA, S.S.	Grade Level	Public or Private**	Satisfactory Evaluation Received (Yes/No)
	Beginning Mo/Day/Yr -	Ending Mo/Day/Yr									

**If this experience was earned at a private school, was the school accredited? Yes________ No________

Date(s) of Accreditation:______________________________ Accrediting Agency:______________________________

**If this experience was earned at a college or university, 1) Was the employee a student while teaching? Yes_______ No_______
2) Was the employee an adjunct? Yes_______ No_______

FOR FLORIDA EXPERIENCE ONLY: Did this teacher hold continuing contract or professional service contract? Yes_______ No_______

AFFIX BOARD SEAL HERE

DATE______________________

I certify that all information listed above is complete and correct according to the official records on file in the school system/institution providing verification.

______________________ Signature of Superintendent or Authorized Official

______________________ Typed or Printed Name

______________________ Title

______________________ Date

______________________ Street Address/City/State/Zip Code

______________________ Telephone Number including Area Code

RETURN COMPLETED FORM TO: BRADFORD COUNTY SCHOOL DISTRICT, HUMAN RESOURCES, ATTN: Christal Wilsey, 501 W. WASHINGTON STREET, STARKE, FL 32091 **Revised 11/7/18**

Form W-4 (2019)

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

Purpose. Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay. Consider completing a new Form W-4 each year and when your personal or financial situation changes.

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

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

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

General Instructions

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

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

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

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

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

Nonresident alien. If you're a nonresident alien, see Notice 1392, Supplemental Form W-4 Instructions for Nonresident Aliens, before completing this form.

Specific Instructions

Personal Allowances Worksheet

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

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

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

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

---

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

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

Employee's Withholding Allowance Certificate

► **Whether you're entitled to claim a certain number of allowances or exemption from withholding is subject to review by the IRS. Your employer may be required to send a copy of this form to the IRS.**

OMB No. 1545-0074

2019

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

Home address (number and street or rural route)	3 ☐ Single ☐ Married ☐ Married, but withhold at higher Single rate. **Note:** If married filing separately, check "Married, but withhold at higher Single rate."
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 800-772-1213 for a replacement card.** ► ☐

5 Total number of allowances you're claiming (from the applicable worksheet on the following pages) **5**

6 Additional amount, if any, you want withheld from each paycheck . . . . **6** $

7 I claim exemption from withholding for 2019, and I certify that I meet **both** of the following conditions for exemption.

- Last year I had a right to a refund of **all** federal income tax withheld because I had **no** tax liability, **and**
- This year I expect a refund of **all** federal income tax withheld because I expect to have **no** tax liability.

If you meet both conditions, write "Exempt" here . . . . ► **7**

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

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

8 Employer's name and address (**Employer:** Complete boxes 8 and 10 if sending to IRS and complete boxes 8, 9, and 10 if sending to State Directory of New Hires.)	9 First date of employment	10 Employer identification number (EIN)

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

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

Deductions, Adjustments, and Additional Income Worksheet

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

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

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

Two-Earners/Multiple Jobs Worksheet

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

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

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

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

Instructions for Employer

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

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

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

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

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

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

Personal Allowances Worksheet (Keep for your records.)

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

For accuracy, **complete all worksheets that apply.**

- If you plan to **itemize** or **claim adjustments to income** and want to reduce your withholding, or if you have a large amount of nonwage income not subject to withholding and want to increase your withholding, see the **Deductions, Adjustments, and Additional Income Worksheet** below.
- If you **have more than one job at a time** or are **married filing jointly and you and your spouse both work,** and the combined earnings from all jobs exceed $53,000 ($24,450 if married filing jointly), see the **Two-Earners/Multiple Jobs Worksheet** on page 4 to avoid having too little tax withheld.
- If **neither** of the above situations applies, **stop here** and enter the number from line H on line 5 of Form W-4 above.

Deductions, Adjustments, and Additional Income Worksheet

Note: Use this worksheet *only* if you plan to itemize deductions, claim certain adjustments to income, or have a large amount of nonwage income not subject to withholding.

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

Two-Earners/Multiple Jobs Worksheet

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

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

2 Find the number in **Table 1** below that applies to the **LOWEST** paying job and enter it here. **However,** if you're married filing jointly and wages from the highest paying job are $75,000 or less and the combined wages for you and your spouse are $107,000 or less, don't enter more than "3" . . . . 2 ______

3 If line 1 is **more than or equal to** line 2, subtract line 2 from line 1. Enter the result here (if zero, enter "-0-") and on Form W-4, line 5, page 1. **Do not** use the rest of this worksheet . . . . 3 ______

Note: If line 1 is **less than** line 2, enter "-0-" on Form W-4, line 5, page 1. Complete lines 4 through 9 below to figure the additional withholding amount necessary to avoid a year-end tax bill.

4 Enter the number from line 2 of this worksheet . . . . 4 ______

5 Enter the number from line 1 of this worksheet . . . . 5 ______

6 **Subtract** line 5 from line 4 . . . . 6 ______

7 Find the amount in **Table 2** below that applies to the **HIGHEST** paying job and enter it here . . . . 7 $ ______

8 **Multiply** line 7 by line 6 and enter the result here. This is the additional annual withholding needed . . . 8 $ ______

9 **Divide** line 8 by the number of pay periods remaining in 2019. For example, divide by 18 if you're paid every 2 weeks and you complete this form on a date in late April when there are 18 pay periods remaining in 2019. Enter the result here and on Form W-4, line 6, page 1. This is the additional amount to be withheld from each paycheck . . . . 9 $ ______

Table 1

Married Filing Jointly		All Others	
If wages from **LOWEST** paying job are—	Enter on line 2 above	If wages from **LOWEST** paying job are—	Enter on line 2 above
$0 - $5,000	0	$0 - $7,000	0
5,001 - 9,500	1	7,001 - 13,000	1
9,501 - 19,500	2	13,001 - 27,500	2
19,501 - 35,000	3	27,501 - 32,000	3
35,001 - 40,000	4	32,001 - 40,000	4
40,001 - 46,000	5	40,001 - 60,000	5
46,001 - 55,000	6	60,001 - 75,000	6
55,001 - 60,000	7	75,001 - 85,000	7
60,001 - 70,000	8	85,001 - 95,000	8
70,001 - 75,000	9	95,001 - 100,000	9
75,001 - 85,000	10	100,001 - 110,000	10
85,001 - 95,000	11	110,001 - 115,000	11
95,001 - 125,000	12	115,001 - 125,000	12
125,001 - 155,000	13	125,001 - 135,000	13
155,001 - 165,000	14	135,001 - 145,000	14
165,001 - 175,000	15	145,001 - 160,000	15
175,001 - 180,000	16	160,001 - 180,000	16
180,001 - 195,000	17	180,001 and over	17
195,001 - 205,000	18		
205,001 and over	19		

Table 2

Married Filing Jointly		All Others	
If wages from **HIGHEST** paying job are—	Enter on line 7 above	If wages from **HIGHEST** paying job are—	Enter on line 7 above
$0 - $24,900	$420	$0 - $7,200	$420
24,901 - 84,450	500	7,201 - 36,975	500
84,451 - 173,900	910	36,976 - 81,700	910
173,901 - 326,950	1,000	81,701 - 158,225	1,000
326,951 - 413,700	1,330	158,226 - 201,600	1,330
413,701 - 617,850	1,450	201,601 - 507,800	1,450
617,851 and over	1,540	507,801 and over	1,540

Privacy Act and Paperwork Reduction Act Notice. We ask for the information on this form to carry out the Internal Revenue laws of the United States. Internal Revenue Code sections 3402(f)(2) and 6109 and their regulations require you to provide this information; your employer uses it to determine your federal income tax withholding. Failure to provide a properly completed form will result in your being treated as a single person who claims no withholding allowances; providing fraudulent information may subject you to penalties. Routine uses of this information include giving it to the Department of Justice for civil and criminal litigation; to cities, states, the District of Columbia, and U.S. commonwealths and possessions for use in administering their tax laws; and to the Department of Health and Human Services for use in the National Directory of New Hires. We may also disclose this information to other countries under a tax treaty, to federal and state agencies to enforce federal nontax criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism.

You aren't required to provide the information requested on a form that's subject to the Paperwork Reduction Act unless the form displays a valid OMB control number. Books or records relating to a form or its instructions must be retained as long as their contents may become material in the administration of any Internal Revenue law. Generally, tax returns and return information are confidential, as required by Code section 6103.

The average time and expenses required to complete and file this form will vary depending on individual circumstances. For estimated averages, see the instructions for your income tax return.

If you have suggestions for making this form simpler, we would be happy to hear from you. See the instructions for your income tax return.

SCHOOL BOARD OF BRADFORD COUNTY, FLORIDA
HEALTH INFORMATION RECORD

NOTE: Failure to provide accurate information could result in loss of Workers Compensation benefits and/or employment.

Name ______________________________________ Social Security # ______________
Last First Middle

Address ______________________________ City/St./Zip: ______________________

Date of Birth ____________________ Military Service ______ Yes ______ No

Medical Discharge _____ Yes _____ No

WORKERS' COMPENSATION
SPECIAL DISABILITY TRUST FUND 440.49 F. S.
EMPLOYEE INFORMATION

Chapter 440, Florida Statutes provides for recovery from the Special Disability Trust Fund when an injury merges with a pre-existing permanent physical impairment to cause a greater disability than would have resulted from the injury alone. However, in order to recover from the Special Disability Trust Fund it is required that the employer have knowledge of this impairment prior to the occurrence of the compensable injury. In addition to a general category of impairments, there are certain specific impairments outlined by the above statutes. Therefore, the following questions are to be answered by each employee.

1. Have you ever had a serious illness, injury, or operations? ___ Yes ___ No If yes, please indicate what ______________________ and year ________________.

2. Have you ever received Workers Compensation benefits for an injury? ____ Yes ____ No If yes, please give year ________.

3. Do you now have or have you ever had any disability rating for an injury, either temporary or permanent, assigned to you by and insurance company or governmental agency, either Federal, State, County, or City? _____ Yes ___ No. If yes, please give %__ and from whom __________

4. Have you ever had or do you now have back trouble or complaints? ____ Yes ____ No

5. Have you ever changed employment for reasons of health? ___ Yes ___ No If yes, explain ____.

6. Is there any type of work you cannot do for physical reasons? ___ Yes ___ No If yes, explain ____.

7. Have you ever been refused employment or life insurance for physical reasons? __ Yes __ No
If yes, explain ____

8. Have you ever been hospitalized in the past 5 years? ___ Yes ___ No If yes, give dates and reasons
____

-over-

Have you ever had any of the following conditions listed in Florida Statute Section 440.49 F.S.?

	YES	NO
A) Epilepsy	( )	( )
B) Diabetes	( )	( )
C) Cardiac Disease	( )	( )
D) Amputation of foot, leg, arm, or hand.	( )	( )
E) Total loss of sight of one or both eyes or a partial loss of corrected vision of more than 75% bilaterally	( )	( )
F) Residual disability from poliomyelitis	( )	( )
G) Cerebral Palsy	( )	( )
H) Multiple Sclerosis	( )	( )
I) Parkinson's disease	( )	( )
J) Menisectomy	( )	( )
K) Patellectomy	( )	( )
L) Ruptured cruciate ligament	( )	( )
M) Hemophilia	( )	( )
N) Chronic osteomyelitis	( )	( )
O) Surgical or spontaneous fusion of a major weight-bearing joint	( )	( )
P) Hyperinsulinism	( )	( )
Q) Muscular dystrophy	( )	( )
R) Thrombophlebitis	( )	( )
S) Herniated intervertabral disk	( )	( )
T) Surgical removal of an intervertabral disk	( )	( )
U) One or more back injuries or a disease process of the back resulting in disability over a total of 120 days or more days, if substantiated by a doctor's opinion that there was a preexisting impairment to the claimant's back	( )	( )
V) Total deafness	( )	( )
W) Mental retardation, provided the employee's intelligence quotient is such that she or he falls within the lowest 2 percentile of the general population. However, it shall not be necessary for the employer to know the employee's actual intelligence quotient or actual relative ranking in relation to the intelligence quotient of the general population	( )	( )
X) Any permanent physical condition which, prior to the industrial accident or occupational disease, constitutes a 20% impairment of a member or of the body as a whole	( )	( )
Y) Obesity, provided the employee is 30% or more over the average weight designated for her or his height and age in the Table of Average Weight of Americans by Height and Age prepared by the Society of Actuaries using data from the 1979 Build and Blood Pressure Study	( )	( )

Please state for each yes answer given above, whether or not the condition has resulted in a permanent physical impairment. ______________________________

____

I hereby certify that the above answers are complete and true to the best of my information, knowledge and belief.

______________________________ ______________________________

Employee signature Date Superintendent's designee Date