

**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#\_\_\_\_\_

**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.

**2023****Step 1:  
Enter  
Personal  
Information**

(a) First name and middle initial	Last name	(b) Social security number
Address		Does your name match the name on your social security card? If not, to ensure you get credit for your earnings, contact SSA at 800-772-1213 or go to <a href="http://www.ssa.gov">www.ssa.gov</a> .
City or town, state, and ZIP code		
(c) <input type="checkbox"/> Single or Married filing separately <input type="checkbox"/> Married filing jointly or Qualifying surviving spouse <input type="checkbox"/> 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, other details, and privacy.

**Step 2:  
Multiple Jobs  
or Spouse  
Works**

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

Do **only one** of the following.

- (a) Reserved for future use.
- (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 ☐

**TIP:** If you have self-employment income, see page 2.

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.)

<b>Step 3: Claim Dependent and Other Credits</b>	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 . . . . .	<b>3</b>	\$
<b>Step 4 (optional): Other Adjustments</b>	(a) <b>Other income (not from jobs).</b> 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 . . . . .	<b>4(a)</b>	\$
	(b) <b>Deductions.</b> 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 . . . . .	<b>4(b)</b>	\$
	(c) <b>Extra withholding.</b> Enter any additional tax you want withheld each pay period . . . . .	<b>4(c)</b>	\$

**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)
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Florida Retirement System

## FRS Employment Certification Form

This form is not an offer of employment and completion of this form does not constitute enrollment in a retirement program under the Florida Retirement System (FRS). If you are hired, information about your retirement plan options may be mailed to your address on file.

**1**

### Enter Your Info

PLEASE PRINT

NAME \_\_\_\_\_

SOCIAL SECURITY NUMBER \_\_\_\_\_

CURRENT AGENCY NAME \_\_\_\_\_

PREVIOUS AGENCY NAME \_\_\_\_\_

**2**

### Confirm Prior Membership

Have you ever been a member of a State of Florida-administered retirement plan?

☐

No, I have never been a member of a State of Florida-administered retirement plan.

If No, skip to section 4.

☐

Yes, I have been a member of a State of Florida-administered retirement plan.

If Yes, indicate which plan(s) you are or were a member of, then proceed to section 3.

☐ FRS Pension Plan (including DROP)

☐ FRS Investment Plan

☐ Senior Management Service Optional Annuity Program (SMSOAP)

☐ State Community College System Optional Retirement Program (SCCSORP)

☐ State University System Optional Retirement Program (SUSORP)

☐ Other \_\_\_\_\_

**3**

### Confirm Retiree Status

Are you retired from a State of Florida-administered plan? You are considered retired if:

- You have received any benefits (other than a withdrawal of your employee contributions) under the FRS Pension Plan, including DROP.
- 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.

☐

No, I am not retired from a State of Florida-administered plan. I understand that if it is later determined I am retired, both my employer and I might be liable for repaying retirement benefits I have received if I am reemployed by or provide services to an FRS-covered employer through any paid or unpaid arrangement as described below. Refer to Page 2 for additional information.

☐

Yes, I am retired from a State of Florida-administered plan, and I understand I must satisfy any termination requirement prior to returning to FRS employment.

If Yes, enter your FRS Pension Plan retirement effective date, DROP termination date, or date you received your first distribution from the FRS Investment Plan, SUSORP, SCCSORP, SMSOAP, or other plan.

DATE \_\_\_\_\_

**4**

### Sign Here

By signing below, I acknowledge that I have read and understand the information on pages 1 and 2 of this form, and I certify all supplied information to be true and correct.

SIGNATURE \_\_\_\_\_

DATE \_\_\_\_\_

**Questions?** Call the MyFRS Financial Guidance Line at 1-866-446-9377, Option 2 (TRS 711) or visit MyFRS.com.

This completed form, including page 2, should be retained in the employee's personnel file. Do not send this form to the FRS, unless requested.



**Employment Eligibility Verification**  
**Department of Homeland Security**  
**U.S. Citizenship and Immigration Services**

**USCIS**  
**Form I-9**  
OMB No. 1615-0047  
Expires 10/31/2022

► **START HERE:** Read instructions carefully before completing this form. The instructions must be available, either in paper or electronically, during completion of this form. Employers are liable for errors in the completion of this form.

**ANTI-DISCRIMINATION NOTICE:** It is illegal to discriminate against work-authorized individuals. Employers **CANNOT** specify which document(s) an employee may present to establish employment authorization and identity. The refusal to hire or continue to employ an individual because the documentation presented has a future expiration date may also constitute illegal discrimination.

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):

<input type="checkbox"/> 1. A citizen of the United States	<div>QR Code - Section 1 Do Not Write in This Space</div>
<input type="checkbox"/> 2. A noncitizen national of the United States (See instructions)	
<input type="checkbox"/> 3. A lawful permanent resident (Alien Registration Number/USCIS Number): _____	
<input type="checkbox"/> 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: _____ <b>OR</b> 2. Form I-94 Admission Number: _____ <b>OR</b> 3. Foreign Passport Number: _____ Country of Issuance: _____	

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



**Employment Eligibility Verification**  
**Department of Homeland Security**  
**U.S. Citizenship and Immigration Services**

**USCIS**  
**Form I-9**  
OMB No. 1615-0047  
Expires 10/31/2022

<b>Employee Info from Section 1</b>	Last Name (Family Name)	First Name (Given Name)	M.I.	Citizenship/Immigration Status
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<b>List A</b> Identity and Employment Authorization	<b>OR</b>	<b>List B</b> Identity	<b>AND</b>	<b>List C</b> 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		<div>Additional Information</div> <div>QR Code - Sections 2 &amp; 3 Do Not Write In This Space</div>		
Issuing Authority				
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

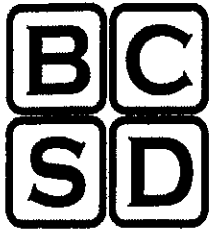
<b>A. New Name (if applicable)</b>			<b>B. Date of Release (if applicable)</b>	
Last Name (Family Name)	First Name (Given Name)	Middle Initial	Date (mm/dd/yyyy)	

**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)
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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
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# BRADFORD COUNTY SCHOOL DISTRICT

## *Human Resources Department*

501 W. WASHINGTON STREET • STARKE, FL 32091 • 904.966.6031

### HEALTH AND LIFE INSURANCE POLICIES

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 Office's Human Resources Department. If the new employee desires to purchase additional life insurance and/or health benefits, he/she has thirty (30) days from the initial hire date with BCSD to secure insurance. After the thirty (30) day period expires, the employee must wait until the next open enrollment period to add insurance.

New employees should contact the Insurance Administrator in the HR Department to activate BCSD provided life insurance and/or add additional life or health insurance coverage. Please make a note of this stipulation and contact the Insurance Administrator before the thirty (30) days are expired.

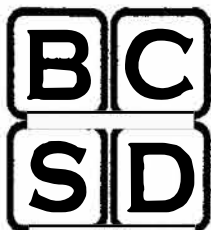
My signature verifies that I have been informed of this policy by Human Resources.

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
HR Representative Signature

\_\_\_\_\_  
Date



# BRADFORD COUNTY SCHOOL DISTRICT

## *Human Resources Department*

501 W. WASHINGTON STREET • STARKE, FL 32091 • 904.966.6031

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### *OATH OF LOYALTY*

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STATE OF FLORIDA  
COUNTY

BRADFORD

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Employee Name

As 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.

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Employee

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Date

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Superintendent or Designee

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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 31<sup>st</sup> 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.



**BRADFORD COUNTY SCHOOL DISTRICT  
EMPLOYEE HEALTH INFORMATION RECORD**

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

NAME: \_\_\_\_\_ DOB: \_\_\_\_\_  
                    Last                      First                      Middle

ADDRESS: \_\_\_\_\_

Military Service: \_\_\_\_ YES \_\_\_\_ NO    Medical Discharge: \_\_\_\_ YES \_\_\_\_ NO    S.S.#: \_\_\_\_\_

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**WORKERS' COMPENSATION  
SPECIAL DISABILITY TRUST FUND 440.49 F.S.**

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 operation? \_\_\_\_ Yes \_\_\_\_ No  
If yes, what \_\_\_\_\_ and year \_\_\_\_\_.
2. Have you ever received Workers' Compensation benefits for an injury? \_\_\_\_ Yes \_\_\_\_ No  
If yes, please provide date \_\_\_\_\_.
3. Do you now have or have you ever had any disability rating for an injury, either temporary or permanent, assigned to you by an 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 the physical reasons? \_\_\_\_ Yes \_\_\_\_ No  
If yes, explain \_\_\_\_\_.
7. Have you every 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

**Have you ever had any of the following conditions list in the 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 correction vision of more than 75% bilaterally		
F. Residual disability from poliomyelitis		
G. Cerebral Palsy		
H. Multiple Sclerosis		
I. Parkinson's Disease		
J. Meniscectomy		
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 intervertebral disk		
T. Surgical removal of an intervertebral disc		
U. One or more back injuries or a disease process of the back resulting in a 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/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 Body Pressure Study		

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

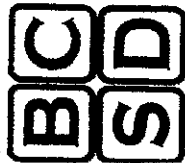
***I hereby certify that the above answers are complete and true to the best of my information, knowledge and belief.***

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Superintendent's Designee

\_\_\_\_\_  
Date



## BRADFORD COUNTY SCHOOL DISTRICT

### Pre-Employment Drug Screening Policy DRUG FREE WORKPLACE

#### Purpose:

In an effort to meet its 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 hires 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 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.

#### 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 applicant's 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, malt beverage or intoxicating liquor).

##### **AMPHETAMINES:**

(Obetrol, Bephetamine, Desoxyn, Dexedrine, Didrex, Ionamine, and Fastin).

##### **CANNABINOID:**

(Marijuana, THC).

##### **COCAINE**

##### **PHENCYCLIDINE:**

(PCP)

##### **METHAQUALONE**

##### **OPIATES:**

(Paregoric, Parepectolin, Donnagel PG, Morphine, Tylenol with Codeine, Empirin with Codeine, APAP with Codeine, Aspirin with Codeine, Robitussin AC, Guaiatus 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, Floricet, Esigic, Butisol, Mebaral, Butabarbital, Butalinol, Phreninlin, Triad, etc.).

##### **BENZODIAZEPINES:**

(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 results, the employee or applicant may contest or explain the results to a Medical Review Officer (MRO). If the explanation or challenge of the positive test results is unsatisfactory to the MRO, the MRO 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 MRO, 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 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**



**BRADFORD COUNTY SCHOOL DISTRICT**

501 W. Washington Street  
Starke, FL 32091  
904.966.6031

***BradfordSchools.org***

**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 the **BRADFORD COUNTY SCHOOL DISTRICT** to submit a set of my fingerprints to the FL Department of Law Enforcement (FDLE) for the purpose of accessing and reviewing FL 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 subsequent arrest notifications, upon request you may provide me a copy of the criminal history record report, if any, that you receive on me and that I am entitled to challenge the accuracy and completeness of any information contained in such reports. I am aware that procedures for obtaining a change, correction, or updating of the FDLE or FBI criminal history are set forth in FS 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 \_\_\_\_\_

City/St/Zip \_\_\_\_\_

.....  
(Original must be retained by a non-criminal justice agency.)

## PUBLIC OFFICERS AND EMPLOYEES COVERED BY EXEMPTIONS

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Personal information concerning the following public officers and employees may, under certain circumstances, be exempted from disclosure pursuant to Section 119.071(4)(d) and 119.071(5)(i) and (k), *Florida Statutes*. This list is not intended to be exhaustive and there may be additional criteria within the following listed exemptions which could affect the application of said exemption. Please consult the Human Resources Department with any additional questions or concerns you may have regarding this list and/or the applicability of these exemptions.

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1. Abuse investigators for Department of Children and Families and Department of Health;
2. Child advocacy personnel and child protection team members;
3. Code enforcement officers;
4. County addiction facility personnel;
5. County tax collectors;
6. Domestic violence and other specified crime victims;
7. Emergency medical technicians or paramedics;
8. Firefighters;
9. Guardians ad litem;
10. Hospital employees;
11. Human resource managers (local governments);
12. Impaired practitioner consultants;
13. Inspectors general and internal auditors performing specified duties;
14. Investigators and inspectors of the Department of Business and Professional Regulation;
15. Investigators of the Department of Financial Services and Office of Financial Regulation with specified duties;
16. Judges, magistrates and hearing officers (state);
17. Law enforcement and correctional personnel;
18. Personnel of the Department of Health with specified duties;
19. Prosecutors and judges (federal);
20. Prosecutors (state);
21. Public defenders and other specified counsel;
22. Public guardians;
23. Revenue collection and enforcement or child support enforcement; and
24. U.S. military service members.

BRADFORD COUNTY SCHOOL DISTRICT

REQUEST FOR EXEMPTION FROM DISCLOSURE OF PERSONAL INFORMATION  
PURSUANT TO CHAPTER 119, *FLORIDA STATUTES*

Florida has a very broad public records law which allows for the disclosure to requesting parties of certain personal information concerning public officers and employees – including employees of the Bradford County School District. See Chapter 119, *Florida Statutes*. Among the information that is subject to disclosure are home addresses, telephone number(s) and dates of birth.

Some personal information, including the home addresses and telephone numbers, for certain public officers and employees – and their family members – has been specifically exempted from disclosure. A list of public officers and employees whose personal information may be exempted from disclosure pursuant to Section 119.071(4)(d) and 119.071(5)(i) and (k), *Florida Statutes*, is on the back of this page.

Employees of the Bradford County School District who believe that their home address, telephone numbers, date of birth and other personal information should be exempt from disclosure pursuant to Section 119.071(4)(d) and 119.071(5)(i) and (k), *Florida Statutes*, should complete the following and return this form to the Human Resources Department.

Employees MUST provide a justification below for their inclusion in an exempted class (as listed on the back of this page); and/or their relationship to an individual who is included in an exempted class. Employees may also be required to submit written documentation in support of their request for exemption.

NAME: \_\_\_\_\_

EMPLOYEE NUMBER: \_\_\_\_\_

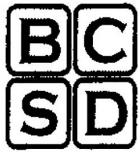
BASIS FOR EXEMPTION: \_\_\_\_\_

I, \_\_\_\_\_, an employee of the Bradford County School District, hereby certify that I believe my home address, telephone number(s), date of birth and other personal information to be exempt from disclosure pursuant to Section 119.071(4)(d) and 119.071(5)(i) and (k), *Florida Statutes*, based upon the basis for exemption that I have identified herein; and that the information provided herein is true and correct to the best of my knowledge.

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

FOR HUMAN RESOURCES DEPARTMENT USE ONLY

APPROVED: \_\_\_\_\_ DATE: \_\_\_\_\_



# BRADFORD COUNTY SCHOOL DISTRICT

## *Human Resources*

501 W. WASHINGTON STREET • STARKE, FL 32091 • 904.966.6031

### **EMPLOYEE FERPA AGREEMENT**

(Family Education Rights and Privacy Act)

I understand that by virtue of my employment with Bradford County School District, I may have access to records that contain individually identifiable information about a student, the disclosure of which is prohibited by the Family Education Rights and Privacy Act of 1974 (FERPA).

Student records are highly confidential and all employees are expected to abide by FERPA as well as general confidentiality practices. In order to ensure that student record information is protected, you are asked to review the following and sign below:

- Access to student information is limited to employees with approved security access. Requests from others for a student's phone number, address, or other protected information should be directed to a supervisor.
- Social security numbers are to be protected at all times. At no time should you provide someone with his/her social security number or the document with that number printed on it unless a valid photo ID is provided.
- All documents with any personal identification information must be destroyed properly (shredding bin or shredder).
- Access to student information is for the purpose of conducting the business of the Schools and District. Information on a student may not be accessed for any other reason nor shared with anyone for any other purpose.
- No student information may be altered without using standard procedures (completing forms, having a staff member enter the information in the system).
- No employee shall knowingly include or cause to be included in any student record or report a false, inaccurate or misleading entry.
- At no time should confidential student information be given out over the phone or faxed.
- Please ensure that confidential information is not left out in the open with view of students.

While your supervisor can assist you in understanding these laws and BCSD's policies, you should become familiar with them, particularly those regarding required consent to release information, the list of information which can be released for currently enrolled students without consent, and how information is designated when the student has indicated that it cannot be released.

When a student has chosen to indicate information about them it is not to be released, the requestor should be advised "that we are unable to release any information" and be given no indication of whether or not you may have any information on the person. You are advised to refer any questions or requests for information that you are unsure of to your supervisor.

I acknowledge that I fully understand that the intentional disclosure by me of this information to any unauthorized person violates federal law, state law and BCSD's policy and could constitute just cause for disciplinary action including termination of my employment regardless of whether criminal or civil penalties are imposed.

\_\_\_\_\_  
Last Name, First Name (Please Print or Type)

\_\_\_\_\_  
Last 4 digits of SSN

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Date



**This Organization  
Participates in E-Verify**

**Esta Organización  
Participa en E-Verify**

**E-Verify**



This employer 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.

If E-Verify cannot confirm that you are authorized to work, this employer is required to give you written instructions and an opportunity to contact Department of Homeland Security (DHS) or Social Security Administration (SSA) so you can begin to resolve the issue before the employer can take any action against you, including terminating your employment.

Employers can only use E-Verify once you have accepted a job offer and completed the Form I-9.

### **E-Verify Works for Everyone**

For more information on E-Verify, or if you believe that your employer has violated its E-Verify responsibilities, please contact DHS.

Este empleador participa en E-Verify y proporcionará al gobierno federal la información de su Formulario I-9 para confirmar que usted está autorizado para trabajar en los EE.UU..

Si E-Verify no puede confirmar que usted está autorizado para trabajar, este empleador está requerido a darle instrucciones por escrito y una oportunidad de contactar al Departamento de Seguridad Nacional (DHS) o a la Administración del Seguro Social (SSA) para que pueda empezar a resolver el problema antes de que el empleador pueda tomar cualquier acción en su contra, incluyendo la terminación de su empleo.

Los empleadores sólo pueden utilizar E-Verify una vez que usted haya aceptado una oferta de trabajo y completado el Formulario I-9.

### **E-Verify Funciona Para Todos**

Para más información sobre E-Verify, o si usted cree que su empleador ha violado sus responsabilidades de E-Verify, por favor contacte a DHS.

**888-897-7781**  
**dhs.gov/e-verify**



**E-VERIFY IS A SERVICE OF DHS AND SSA**

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# New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved  
OMB No. 1210-0149  
(expires 6-30-2023)

## 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.

### 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.<sup>1</sup>

**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?

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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<sup>1</sup> 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 at this job?			
11. Phone number (if different from above)		12. Email address	

You are not eligible for health insurance coverage through this employer. You and your family may be able to obtain health coverage through the Marketplace, with a new kind of tax credit that lowers your monthly premiums and with assistance for out-of-pocket costs.

UD  
ms

Please complete the employment verification form for the designated employee. **List each year separately**. If part-time, list the number of hours taught per day. Do not list substitute teaching of any kind. Clearly mark any leave of absence. This form may be duplicated as needed to list all years taught. **All columns must be completed**. Thank you for your cooperation!

Employee		XXX - XX		SS #				
SCHOOL	SCHOOL YEAR	DAYS IN YEAR	DAYS WORKED	FT/PT	HOURS PER DAY	SUBJECT TAUGHT	GRADE	SATISFACTORY EVALUATION
								Yes <input type="checkbox"/> No <input type="checkbox"/>
								Yes <input type="checkbox"/> No <input type="checkbox"/>
								Yes <input type="checkbox"/> No <input type="checkbox"/>
								Yes <input type="checkbox"/> No <input type="checkbox"/>
								Yes <input type="checkbox"/> No <input type="checkbox"/>
								Yes <input type="checkbox"/> No <input type="checkbox"/>
								Yes <input type="checkbox"/> No <input type="checkbox"/>
								Yes <input type="checkbox"/> No <input type="checkbox"/>
								Yes <input type="checkbox"/> No <input type="checkbox"/>

Did the employee hold a valid teaching certificate?	
Public or private institution?	
If Public, in what state?	
If Private, in what state?	

District accreditation agency?	
Accreditation agency?	

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

Signature of School/District representative	Title	Email
Printed name of School/District representative	Telephone	Date
Address	City, State Zip	

**Please return this form to:**

**Bradford County School District**

**904.966.6017 Fax**

**904.966.6031**

**Kidd.michael@mybradford.us**

Hurst.dana@mybradford.us

**AFFIX OFFICIAL SEAL HERE**

**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		Duties
	From	To	

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