GIBRALTAR

FIRE & RESCUE

New Member Packet

P.O. Box 610 Fish Creek, Wi 54212 920-868-3820 chief@gibraltarfirerescue.com

Town of Gibraltar Fire & Rescue
Firefighter / First Responder Application
And Information Sheet

*Name (including middle initial) _____

*Social Security number _____

*NWTC student ID # _____

*DOB _____

*Driver's License number _____

*What state issue the Driver's License _____

*Mailing address _____

*Physical address _____

*Work address _____

Your Place of employment _____

Employers contact information _____

Past employer _____

Your Telephone number (Day) _____

Your Telephone number (Night) _____

*Your Cell phone _____

*Your E-Mail _____

Emergency contact (and relationship) _____

Emergency Contact Number _____

Previous Fire Fighting Experience _____

Previous Fire Fighting Classes _____

Past Fire Fighting references and contact numbers _____

_____

WI EMS License number _____

EMS License level _____

Previous First Responder Experience _____

Previous First Responder classes _____

*High School Name, Location and year graduated: _____

_____

Post-Secondary (Collage or Tech School) _____

_____

Significant Medical History (Heart Attack, Stroke, Respiratory Problems) _____

_____

_____

Previous employment terminations - Employer, contact, reason and explanation _____

_____

_____

Previous criminal convictions _____

_____

_____

Pending criminal conviction _____

_____

_____

Past or pending Civil litigations _____

_____

_____

Three non-family references – name, contact information and relationship:

1.) _____
2.) _____
3.) _____

With my signature I acknowledge I have been provided the Fire Fighter and / or First Responder job description and I have reviewed and understand this document. I also understand if I have any questions or concerns regarding this document I should address them with the Fire Chief or Assistant Fire Chief.

I understand that as an employee of the Town of Gibraltar I am an at will employee, and as such I may be suspended or terminated at the discretion of the Fire Chief, Town Board, or their designee. I also understand that in signing this document I give the Fire Department and/or the Town Board permission to conduct background and reference checks and / or perform random drug testing at their discretion.

Signature _____ Date _____

* = required information for enrolment at NWTC and/or our insurance carrier

GIBRALTAR
FIRE & RESCUE

I understand that it is the intent of Gibraltar Fire and Rescue Department (GFD) to safeguard and protect the privacy and security of its applicants, employees' and patients' "protected health information" as defined by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

I understand that "protected health information" includes individually identifiable information, maintained or transmitted through any medium, relating to an individual's past, present, or future physical or mental health or healthcare. Health information is considered individually identifiable if it either identifies a person by name or creates a reasonable basis to believe the individual could be identified (through identifiers such as address, Social Security number, dates of service, telephone number, email address or vehicle identification number). In the course of my tenure with GFD, I understand that I may come into contact with protected health information of applicants, employees, and patients. In consideration for my application with the GFD, I hereby agree that I will not at any time (either during my assigned time with GFD, or any time thereafter) access, use, or disclose to any person or entity, any protected health information of the GFD's applicants, employees, or patients.

I further understand it is the policy of GFD to ensure the confidentiality, integrity, and availability of protected health information entrusted to GFD by its applicants, employees, and patients by protecting those assets from unauthorized access, alteration, deletion, or unauthorized transmission and to ensure their physical security. In consideration for my application with GFD. I further agree that I will not make any unauthorized transmission, alteration, deletion, or unauthorized access of protected health information.

I understand that these privacy and security obligations apply, regardless of the manner in which I acquired the protected health information, whether it was communicated verbally, in writing, electronically, or in any format, and regardless of whether it was communicated directly to me or intended for my access. I understand that this obligation survives the completion of my application period with GFD no matter the circumstances whereby my experience is completed. I understand that the unauthorized access, use, disclosure, alteration, deletion, or unauthorized transmission of protected health information in violation of this policy may subject me to immediate removal from all GFD facilities or apparatus. I also understand that violating the privacy and security rights of individuals protected health information under HIPAA may also result in the imposition of civil/and criminal penalties and other sanctions provided by federal and state laws.

By printing, signing, and including today's date below, I acknowledge that I have read and understand my obligations as an applicant of GFD to protect the privacy and security of protected health information relating to any applicant, employee, or patient.

APPLICANTS PRINTED NAME:_____

APPLICANTS'S
SIGNATURE:_____DATE_____

P.O. Box 610 Fish Creek, Wi 54212 920-868-3820 chief@gibraltarfirerescue.com

Town Of Gibraltar Fire Department

4097 Hwy 42 PO Box 850

Fish Creek, WI 54212

920-868-1714 Fax 920-868-9425

Authorization for release of information

I am an applicant for a position with the Town of Gibraltar Fire Department. The department needs to investigate my background to evaluate my qualifications to hold the position of a member. This release is signed so that any relevant information concerning my personal and employment history is disclosed to the Gibraltar Fire Department.

I hereby release and hold harmless any individual, institution or agency, including its officers, employees or other related personnel both individual and collectively, from any and all liability for damages of whatever kind, which may result to me or any person related or associated to me. I agree to hold the Town of Gibraltar and its agents and employees harmless from any and all claims and liability associated with my application for employment.

I hereby waive any rights to inspect, review or obtain the contents of the background investigation conducted by the authorized agent of the Town of Gibraltar. I further waive any other rights I may have to inspect or view or have produced to me the contents of this background investigation as provided for in any applicable document or statute both State and Federal, any labor contracts or employment agreements.

Print name of applicant_____
Address _____
Phone number_____
Date of birth _____

Notarization of this authorization is mandatory:
Signature of Applicant_____
Date authorization signed_____

Subscribed and sworn to before me this _____day of_____, 20___

Notary Public_____(Signature)
My commission expires_____

APPLICATION FOR EMPLOYMENT

We consider applications for all positions without regard to race, color, religion, creed, sex, national origin, disability, sexual orientation, citizenship status or any other legally protected status.

(PLEASE PRINT)

Position(s) Applied For | Date of Application

How Did You Learn About Us?

☐ Advertisement ☐ Relative ☐ Inquiry
☐ Employment Agency ☐ Friend ☐ Other _____

Last Name | First Name | Middle Name

Address *Number* *Street* *City* *State* *Zip Code*

Telephone Number(s) | Social Security Number (Voluntary)

Best time to contact you at home is: ..... ____:_____ AM PM

If you are under 18 years of age, can you provide required proof of your eligibility to work? ..... ☐ Yes ☐ No

Have you ever filed an application with us before? ..... ☐ Yes ☐ No

..... If Yes, give date _____

Have you ever been employed with us before? ..... ☐ Yes ☐ No

If Yes, give date _____

Do any of your friends or relatives, other than spouse, work here? ..... ☐ Yes ☐ No

Are you currently employed? ..... ☐ Yes ☐ No

May we contact your present employer? ..... ☐ Yes ☐ No

Are you prevented from lawfully becoming employed in this country because of Visa or Immigration Status
Proof of citizenship or immigration status will be required upon employment. ..... ☐ Yes ☐ No

Date available for work ____/____/____ What is your desired salary range? _____

Are you available to work: ☐ Full-Time (please indicate 1 2 3 shift)
☐ Part-Time (please indicate Mornings Afternoon Evenings)
☐ Temporary (please indicate dates available ___/___/___ - ___/___/___)

Are you currently on "lay-off" status and subject to recall? ..... ☐ Yes ☐ No

Can you travel if a job requires it? ..... ☐ Yes ☐ No

WE ARE AN EQUAL OPPORTUNITY EMPLOYER

Employment Experience

Start with your present or last job. Include any job-related military service assignments and volunteer activities. You may exclude organizations which indicate race, color, religion, gender, national origin, disabilities or other protected status.

1.

Employer		Dates Employed From	Dates Employed To	Work Performed
Address				
Telephone Number(s)		Hourly Rate/Salary Starting	Hourly Rate/Salary Final	
Job Title	Supervisor			
Reason for Leaving				

2.

Employer		Dates Employed From	Dates Employed To	Work Performed
Address				
Telephone Number(s)		Hourly Rate/Salary Starting	Hourly Rate/Salary Final	
Job Title	Supervisor			
Reason for Leaving				

3.

Employer		Dates Employed From	Dates Employed To	Work Performed
Address				
Telephone Number(s)		Hourly Rate/Salary Starting	Hourly Rate/Salary Final	
Job Title	Supervisor			
Reason for Leaving				

4.

Employer		Dates Employed From	Dates Employed To	Work Performed
Address				
Telephone Number(s)		Hourly Rate/Salary Starting	Hourly Rate/Salary Final	
Job Title	Supervisor			
Reason for Leaving				

If you need additional space, please continue on a separate sheet of paper.

List professional, trade, business or civic activities and offices held.
You may exclude membership which would reveal gender, race, religion, national origin, age, ancestry, disability or other protected status:

EDUCATION

	Name and Address of School	Course of Study	Number of Years Completed	Diploma Degree
Elementary School				
High School				
Undergraduate College				
Graduate Professional				
Other (Specify)				

Describe any specialized training, apprenticeship, skills and extra-curricular activities.

Describe any job-related training received in the United States military.

Additional Information

Other Qualifications

Summarize special job-related skills and qualifications acquired from employment or other experience.

Specialized Skills (Check Skills/Equipment Operated)

☐ Terminal	☐ Spreadsheet	Production/Mobile Machinery (list)	Other (list)
☐ PC/MAC	☐ Word Processing		
☐ Typewriter	☐ Shorthand		
WPM ☐	WPM ☐		

State any additional information you feel may be helpful to us in considering your application.

Note to Applicants: DO NOT ANSWER THIS QUESTION UNLESS YOU HAVE BEEN INFORMED ABOUT THE REQUIREMENTS OF THE JOB FOR WHICH YOU ARE APPLYING.

Can you perform the essential functions of the job, for which you are applying, either with or without a reasonable accommodation? ___YES ___NO

References

1. _____ (_____) _____
   (Name) Phone #
   _____
   (Address)
2. _____ (_____) _____
   (Name) Phone #
   _____
   (Address)
3. _____ (_____) _____
   (Name) Phone #
   _____
   (Address)

APPLICANT'S STATEMENT

I certify that answers given herein are true and complete.

I authorize investigation of all statements contained in this application for employment as may be necessary in arriving at an employment decision.

This application for employment shall be considered active for a period of time not to exceed 45 days. Any applicant wishing to be considered for employment beyond this time period should inquire as to whether or not applications are being accepted at that time.

I hereby understand and acknowledge that, unless otherwise defined by applicable law, any employment relationship with this organization is of an *"at will"* nature, which means that the Employee may resign at any time and the Employer may discharge Employee at any time with or without cause. It is further understood that this *"at will"* employment relationship may not be changed by any written document or by conduct unless such change is specifically acknowledged in writing by an authorized executive of this organization.

In the event of employment, I understand that false or misleading information given in my application or interview(s) may result in discharge. I understand, also, that I am required to abide by all rules and regulations of the employer.

_____ _____

Signature of Applicant Date

FOR PERSONNEL DEPARTMENT USE ONLY

Arrange Interview ☐ Yes ☐ No

Remarks _____

_____ _____

INTERVIEWER DATE

Employed ☐ Yes ☐ No Date of Employment _____

Job Title _____ Hourly Rate/ Salary _____ Department _____

By _____

NAME AND TITLE DATE

This Application For Employment is sold for general use throughout the United States. Amsterdam Printing and Litho assumes no responsibility for the use of said form or any questions which, when asked by the employer of the job applicant, may violate State and/or Federal Law.

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Toll Free 1-866-466-1438 or online www.amsterdamprintingforms.com

Amsterdam

FOR PERSONNEL DEPARTMENT USE ONLY

Position(s) Applied For Is Open: ☐ Yes ☐ No

Position(s) Considered For: _____

_____

Date _____

NAME: _____ POSITION: _____ DATE: ___/___/___

Form W-4 (2016)

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

Exemption from withholding. If you are exempt, complete **only** lines 1, 2, 3, 4, and 7 and sign the form to validate it. Your exemption for 2016 expires February 15, 2017. See Pub. 505, Tax Withholding and Estimated Tax.

Note: If another person can claim you as a dependent on his or her tax return, you cannot claim exemption from withholding if your income exceeds $1,050 and includes more than $350 of unearned income (for example, interest and dividends).

Exceptions. An employee may be able to claim exemption from withholding even if the employee is a dependent, if the employee:

- Is age 65 or older,
- Is blind, or
- Will claim adjustments to income; tax credits; or itemized deductions, on his or her tax return.

The exceptions do not apply to supplemental wages greater than $1,000,000.

Basic instructions. If you are not exempt, complete the **Personal Allowances Worksheet** below. The worksheets on page 2 further adjust your withholding allowances based on itemized deductions, certain credits, adjustments to income, or two-earners/multiple jobs situations.

Complete all worksheets that apply. However, you may claim fewer (or zero) allowances. For regular wages, withholding must be based on allowances you claimed and may not be a flat amount or percentage of wages.

Head of household. Generally, you can claim head of household filing status on your tax return only if you are unmarried and pay more than 50% of the costs of keeping up a home for yourself and your dependent(s) or other qualifying individuals. See Pub. 501, Exemptions, Standard Deduction, and Filing Information, for information.

Tax credits. You can take projected tax credits into account in figuring your allowable number of withholding allowances. Credits for child or dependent care expenses and the child tax credit may be claimed using the **Personal Allowances Worksheet** below. See Pub. 505 for information on converting your other credits into withholding allowances.

Nonwage income. If you have a large amount of nonwage income, such as interest or dividends, consider making estimated tax payments using Form 1040-ES, Estimated Tax for Individuals. Otherwise, you may owe additional tax. If you have pension or annuity income, see Pub. 505 to find out if you should adjust your withholding on Form W-4 or W-4P.

Two earners or multiple jobs. If you have a working spouse or more than one job, figure the total number of allowances you are entitled to claim on all jobs using worksheets from only one Form W-4. Your withholding usually will be most accurate when all allowances are claimed on the Form W-4 for the highest paying job and zero allowances are claimed on the others. See Pub. 505 for details.

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

Check your withholding. After your Form W-4 takes effect, use Pub. 505 to see how the amount you are having withheld compares to your projected total tax for 2016. See Pub. 505, especially if your earnings exceed $130,000 (Single) or $180,000 (Married).

Future developments. Information about any future developments affecting Form W-4 (such as legislation enacted after we release it) will be posted at *www.irs.gov/w4*.

Personal Allowances Worksheet (Keep for your records.)

A	Enter "1" for **yourself** if no one else can claim you as a dependent	A ____
B	Enter "1" if: • You are single and have only one job; or • You are married, have only one job, and your spouse does not work; or • Your wages from a second job or your spouse's wages (or the total of both) are $1,500 or less. . . .	B ____
C	Enter "1" for your **spouse.** But, you may choose to enter "-0-" if you are married and have either a working spouse or more than one job. (Entering "-0-" may help you avoid having too little tax withheld.)	C ____
D	Enter number of **dependents** (other than your spouse or yourself) you will claim on your tax return	D ____
E	Enter "1" if you will file as **head of household** on your tax return (see conditions under **Head of household** above) . .	E ____
F	Enter "1" if you have at least $2,000 of **child or dependent care expenses** for which you plan to claim a credit . . . (**Note:** Do **not** include child support payments. See Pub. 503, Child and Dependent Care Expenses, for details.)	F ____
G	**Child Tax Credit** (including additional child tax credit). See Pub. 972, Child Tax Credit, for more information. • If your total income will be less than $70,000 ($100,000 if married), enter "2" for each eligible child; then **less** "1" if you have two to four eligible children or **less** "2" if you have five or more eligible children. • If your total income will be between $70,000 and $84,000 ($100,000 and $119,000 if married), enter "1" for each eligible child . .	G ____
H	Add lines A through G and enter total here. (**Note:** This may be different from the number of exemptions you claim on your tax return.) ▶	H ____

For accuracy, complete all worksheets that apply.

- If you plan to **itemize** or **claim adjustments to income** and want to reduce your withholding, see the **Deductions and Adjustments Worksheet** on page 2.
- If you are **single and have more than one job** or are **married and you and your spouse both work** and the combined earnings from all jobs exceed $50,000 ($20,000 if married), see the **Two-Earners/Multiple Jobs Worksheet** on page 2 to avoid having too little tax withheld.
- If **neither** of the above situations applies, **stop here** and enter the number from line H on line 5 of Form W-4 below.

Separate here and give Form W-4 to your employer. Keep the top part for your records.

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

Employee's Withholding Allowance Certificate

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

OMB No. 1545-0074

2016

1 Your first name and middle initial	Last name	2 **Your social security number**
Home address (number and street or rural route)	3 ☐ Single ☐ Married ☐ Married, but withhold at higher Single rate. **Note:** If married, but legally separated, or spouse is a nonresident alien, check the "Single" box.	
City or town, state, and ZIP code	4 **If your last name differs from that shown on your social security card, check here. You must call 1-800-772-1213 for a replacement card.** ▶ ☐	
5 Total number of allowances you are claiming (from line **H** above **or** from the applicable worksheet on page 2)		5
6 Additional amount, if any, you want withheld from each paycheck		6 $
7 I claim exemption from withholding for 2016, and I certify that I meet **both** of the following conditions for exemption. • Last year I had a right to a refund of **all** federal income tax withheld because I had **no** tax liability, **and** • This year I expect a refund of **all** federal income tax withheld because I expect to have **no** tax liability. If you meet both conditions, write "Exempt" here . . . . . ▶		7

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

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

8 Employer's name and address (Employer: Complete lines 8 and 10 only if sending to the IRS.)	9 Office code (optional)	10 Employer identification number (EIN)

Deductions and Adjustments Worksheet

Note: Use this worksheet *only* if you plan to itemize deductions or claim certain credits or adjustments to income.

1 Enter an estimate of your 2016 itemized deductions. These include qualifying home mortgage interest, charitable contributions, state and local taxes, medical expenses in excess of 10% (7.5% if either you or your spouse was born before January 2, 1952) of your income, and miscellaneous deductions. For 2016, you may have to reduce your itemized deductions if your income is over $311,300 and you are married filing jointly or are a qualifying widow(er); $285,350 if you are head of household; $259,400 if you are single and not head of household or a qualifying widow(er); or $155,650 if you are married filing separately. See Pub. 505 for details . . . **1** $ _____

2 Enter: { $12,600 if married filing jointly or qualifying widow(er); $9,300 if head of household; $6,300 if single or married filing separately } . . . . . **2** $ _____

3 **Subtract** line 2 from line 1. If zero or less, enter "-0-" . . . . . **3** $ _____

4 Enter an estimate of your 2016 adjustments to income and any additional standard deduction (see Pub. 505) **4** $ _____

5 **Add** lines 3 and 4 and enter the total. (Include any amount for credits from the *Converting Credits to Withholding Allowances for 2016 Form W-4* worksheet in Pub. 505.) . . . . . **5** $ _____

6 Enter an estimate of your 2016 nonwage income (such as dividends or interest) . . . . . **6** $ _____

7 **Subtract** line 6 from line 5. If zero or less, enter "-0-" . . . . . **7** $ _____

8 **Divide** the amount on line 7 by $4,050 and enter the result here. Drop any fraction . . . . . **8** _____

9 Enter the number from the **Personal Allowances Worksheet,** line H, page 1 . . . . . **9** _____

10 **Add** lines 8 and 9 and enter the total here. If you plan to use the **Two-Earners/Multiple Jobs Worksheet,** also enter this total on line 1 below. Otherwise, **stop here** and enter this total on Form W-4, line 5, page 1 **10**

Two-Earners/Multiple Jobs Worksheet (See *Two earners or multiple jobs* on page 1.)

Note: Use this worksheet *only* if the instructions under line H on page 1 direct you here.

1 Enter the number from line H, page 1 (or from line 10 above if you used the **Deductions and Adjustments Worksheet**) **1** _____

2 Find the number in **Table 1** below that applies to the **LOWEST** paying job and enter it here. **However,** if you are married filing jointly and wages from the highest paying job are $65,000 or less, do not enter more than "3" . . . . . **2** _____

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

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

4 Enter the number from line 2 of this worksheet . . . . . **4** _____

5 Enter the number from line 1 of this worksheet . . . . . **5** _____

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

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

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

9 Divide line 8 by the number of pay periods remaining in 2016. For example, divide by 25 if you are paid every two weeks and you complete this form on a date in January when there are 25 pay periods remaining in 2016. 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 - $6,000	0	$0 - $9,000	0
6,001 - 14,000	1	9,001 - 17,000	1
14,001 - 25,000	2	17,001 - 26,000	2
25,001 - 27,000	3	26,001 - 34,000	3
27,001 - 35,000	4	34,001 - 44,000	4
35,001 - 44,000	5	44,001 - 75,000	5
44,001 - 55,000	6	75,001 - 85,000	6
55,001 - 65,000	7	85,001 - 110,000	7
65,001 - 75,000	8	110,001 - 125,000	8
75,001 - 80,000	9	125,001 - 140,000	9
80,001 - 100,000	10	140,001 and over	10
100,001 - 115,000	11		
115,001 - 130,000	12		
130,001 - 140,000	13		
140,001 - 150,000	14		
150,001 and over	15		

Table 2

Married Filing Jointly		All Others	
If wages from **HIGHEST** paying job are—	Enter on line 7 above	If wages from **HIGHEST** paying job are—	Enter on line 7 above
$0 - $75,000	$610	$0 - $38,000	$610
75,001 - 135,000	1,010	38,001 - 85,000	1,010
135,001 - 205,000	1,130	85,001 - 185,000	1,130
205,001 - 360,000	1,340	185,001 - 400,000	1,340
360,001 - 405,000	1,420	400,001 and over	1,600
405,001 and over	1,600		

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

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

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

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

Employee's Wisconsin Withholding Exemption Certificate/New Hire Reporting WT-4

Employee's Section (Print clearly)

Employee's legal name *(last, first, middle initial)*			Social security number	☐ Single ☐ Married ☐ Married, but withhold at higher Single rate. Note: If married, but legally separated, check the Single box.
Employee's address *(number and street)*			Date of birth	
City	State	Zip code	Date of hire	

FIGURE YOUR TOTAL WITHHOLDING EXEMPTIONS BELOW

Complete Lines 1 through 3 only if your Wisconsin exemptions are different than your federal allowances.

1. (a) Exemption for yourself – enter 1 ..... _____
   (b) Exemption for your spouse – enter 1 ..... _____
   (c) Exemption(s) for dependent(s) – you are entitled to claim an exemption for each dependent ..... _____
   (d) Total – add lines (a) through (c) ..... _____
2. Additional amount per pay period you want deducted (if your employer agrees) ..... _____
3. I claim complete exemption from withholding (see instructions). Enter "Exempt" ..... _____

I CERTIFY that the number of withholding exemptions claimed on this certificate does not exceed the number to which I am entitled. If claiming complete exemption from withholding, I certify that I incurred no liability for Wisconsin income tax for last year and that I anticipate that I will incur no liability for Wisconsin income tax for this year.

Signature _____ Date Signed _____

EMPLOYEE INSTRUCTIONS:

- **WHO MUST FILE:**
  Every Employee is required to file a completed Form WT-4 with each of his or her employers unless the Employee claims the same number of withholding exemptions for Wisconsin withholding tax purpose as for federal withholding tax purpose. Form WT-4 (or federal Form W-4 if a Form WT-4 is not filed) will be used by your employer to determine the amount of Wisconsin income tax to be withheld from your paychecks. If you have more than one employer, you should claim a smaller number or no exemptions on each Form WT-4 filed with employers other than your principal employer so that the total amount withheld will be closer to your actual income tax liability.

  Your employer may also require you to complete this form to report your hiring to the Department of Workforce Development.

  You may file a new Form WT-4 any time you wish to change the amount of withholding from your paychecks, providing the number of exemptions you claim does not exceed the number you are entitled to claim.

- **UNDER WITHHOLDING:**
  If sufficient tax is not withheld from your wages, you may incur additional interest charges under the tax laws. In general, 90% of the net tax shown on your income tax return should be withheld.

- **OVER WITHHOLDING:**
  If you are using Form WT-4 to claim the maximum number of exemptions to which you are entitled and your withholding exceeds your expected income tax liability, you may use Form WT-4A to minimize the over withholding.

- **WHEN TO FILE IF YOUR EXEMPTIONS CHANGE:**
  You must file a new certificate within 10 days if the number of exemptions previously claimed by you DECREASES.

  You may file a new certificate at any time if the number of your exemptions INCREASES.

WT-4 Instructions – Provide your information in the employee section.

- **LINE 1:**
  (a)-(c) Number of exemptions – Do not claim more than the correct number of exemptions. If you expect to owe more income tax for the year than will be withheld if you claim every exemption to which you are entitled, you may increase your withholding by claiming a smaller number of exemptions on lines 1(a)-(c) or you may enter into an agreement with your employer to have additional amounts withheld (see instruction for line 2).

  (c) Dependents – Those persons who qualify as your dependents for federal income tax purposes may also be claimed as dependents for Wisconsin purposes. The term "dependents" does not include you or your spouse. Indicate the number of dependents that you are claiming in the space provided.

- **LINE 2:**
  Additional withholding – If you have claimed "zero" exemptions on line 1, but still expect to have a balance due on your tax return for the year, you may wish to request your employer to withhold an additional amount of tax for each pay period. If your employer agrees to this additional withholding, enter the additional amount you want deducted from each of your paychecks on line 2.

- **LINE 3:**
  Exemption from withholding – You may claim exemption from withholding of Wisconsin income tax if you had no liability for income tax for last year, and you expect to incur no liability for income tax for this year. You may not claim exemption if your return shows tax liability before the allowance of any credit for income tax withheld. If you are exempt, your employer will not withhold Wisconsin income tax from your wages.

  You must revoke this exemption (1) within 10 days from the time you expect to incur income tax liability for the year or (2) on or before December 1 if you expect to incur Wisconsin income tax liabilities for the next year. If you want to stop or are required to revoke this exemption, you must file a new Form WT-4 with your employer showing the number of withholding exemptions you are entitled to claim. This certificate for exemption from withholding will expire on April 30 of next year unless a new Form WT-4 is filed before that date.

Employer's Section

Employer's name				Federal Employer ID Number
Employer's payroll address *(number and street)*		City	State	Zip code
Completed by	Title	Phone number ( )	Email	

EMPLOYER INSTRUCTIONS for Department of Revenue:

- If you do not have a Federal Employer Identification Number (FEIN), contact the Internal Revenue Service to obtain a FEIN.
- If the Employee has claimed more than 10 exemptions OR has claimed complete exemption from withholding and earns more than $200.00 a week or is believed to have claimed more exemptions than he or she is entitled to, mail a copy of this certificate to: Wisconsin Department of Revenue, Audit Bureau, PO Box 8906, Madison WI 53708 or fax (608) 267-0834.
- Keep a copy of this certificate with your records. If you have questions about the Department of Revenue requirements, call (608) 266-8646 or (608) 266-2776.

EMPLOYER INSTRUCTIONS for New Hire Reporting:

- This report contains the required information for reporting a New Hire to Wisconsin. If you are reporting new hires electronically, you do not need to forward a copy of this report to the Department of Workforce Development. Visit http://dwd.wisconsin.gov/uinh to report new hires.
- If you do not report new hires electronically, mail the original form to the Department of Workforce Development, New Hire Reporting, PO Box 14431, Madison WI 53708-0431 or fax toll free to 1-800-277-8075.
- If you have questions about New Hire requirements, call toll free (888) 300-HIRE (888-300-4473). Visit dwd.wisconsin.gov/uinh for more information.

Employment Eligibility Verification

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

USCIS
Form I-9
OMB No. 1615-0047
Expires 03/31/2016

►**START HERE.** **Read instructions carefully before completing this form. The instructions must be available during completion of this form.**
ANTI-DISCRIMINATION NOTICE: It is illegal to discriminate against work-authorized individuals. Employers **CANNOT** specify which document(s) they will accept from an employee. The refusal to hire 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 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	E-mail Address	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):

☐ A citizen of the United States

☐ A noncitizen national of the United States *(See instructions)*

☐ A lawful permanent resident (Alien Registration Number/USCIS Number): _____

☐ An alien authorized to work until (expiration date, if applicable, mm/dd/yyyy) _____. Some aliens may write "N/A" in this field. *(See instructions)*

*For aliens authorized to work, provide your Alien Registration Number/USCIS Number **OR** Form I-94 Admission Number:*

1. Alien Registration Number/USCIS Number: _____

OR

2. Form I-94 Admission Number: _____

If you obtained your admission number from CBP in connection with your arrival in the United States, include the following:

Foreign Passport Number: _____

Country of Issuance: _____

Some aliens may write "N/A" on the Foreign Passport Number and Country of Issuance fields. *(See instructions)*

3-D Barcode
Do Not Write in This Space

Signature of Employee:	Date *(mm/dd/yyyy):*

Preparer and/or Translator Certification *(To be completed and signed if Section 1 is prepared by a person other than the employee.)*

I attest, under penalty of perjury, that I have assisted in the completion of this form and that to the best of my knowledge the information is true and correct.

Signature of Preparer or Translator:			Date *(mm/dd/yyyy):*
Last Name *(Family Name)*	First Name *(Given Name)*		
Address *(Street Number and Name)*	City or Town	State	Zip Code

STOP ***Employer Completes Next Page*** STOP

Section 2. Employer or Authorized Representative Review and Verification

(Employers or their authorized representative must complete and sign Section 2 within 3 business days of the employee's first day of employment. You must physically examine one document from List A OR examine a combination of one document from List B and one document from List C as listed on the "Lists of Acceptable Documents" on the next page of this form. For each document you review, record the following information: document title, issuing authority, document number, and expiration date, if any.)

Employee Last Name, First Name and Middle Initial from Section 1:

List A Identity and Employment Authorization	**OR**	**List B** Identity	**AND**	**List C** Employment Authorization
Document Title:		Document Title:		Document Title:
Issuing Authority:		Issuing Authority:		Issuing Authority:
Document Number:		Document Number:		Document Number:
Expiration Date *(if any)(mm/dd/yyyy)*:		Expiration Date *(if any)(mm/dd/yyyy)*:		Expiration Date *(if any)(mm/dd/yyyy)*:
Document Title:				
Issuing Authority:				
Document Number:				
Expiration Date *(if any)(mm/dd/yyyy)*:				
Document Title:				
Issuing Authority:				
Document Number:				
Expiration Date *(if any)(mm/dd/yyyy)*:				

3-D Barcode Do Not Write in This Space

Certification

I attest, under penalty of perjury, that (1) I have examined the document(s) presented by the above-named employee, (2) the above-listed document(s) appear to be genuine and to relate to the employee named, and (3) to the best of my knowledge the employee is authorized to work in the United States.

The employee's first day of employment *(mm/dd/yyyy)*: _____ *(See instructions for exemptions.)*

Signature of Employer or Authorized Representative	Date *(mm/dd/yyyy)*	Title of Employer or Authorized Representative
Last Name *(Family Name)* First Name *(Given Name)*		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)* Last Name *(Family Name)* First Name *(Given Name)* Middle Initial	B. Date of Rehire *(if applicable) (mm/dd/yyyy)*:

C. If employee's previous grant of employment authorization has expired, provide the information for the document from List A or List C the employee presented that establishes current 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:	Date *(mm/dd/yyyy)*:	Print Name of Employer or Authorized Representative:

LISTS OF ACCEPTABLE DOCUMENTS
All documents must be UNEXPIRED

Employees may present one selection from List A
or a combination of one selection from List B and one selection from List C.

LIST A Documents that Establish Both Identity and Employment Authorization	OR	LIST B Documents that Establish Identity	AND	LIST C Documents that Establish Employment Authorization
1. U.S. Passport or U.S. Passport Card		1. Driver's license or ID card issued by a State or outlying possession of the United States provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		1. A Social Security Account Number card, unless the card includes one of the following restrictions: (1) NOT VALID FOR EMPLOYMENT (2) VALID FOR WORK ONLY WITH INS AUTHORIZATION (3) VALID FOR WORK ONLY WITH DHS AUTHORIZATION
2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551)		2. ID card issued by federal, state or local government agencies or entities, provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		2. Certification of Birth Abroad issued by the Department of State (Form FS-545)
3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa		3. School ID card with a photograph		3. Certification of Report of Birth issued by the Department of State (Form DS-1350)
4. Employment Authorization Document that contains a photograph (Form I-766)		4. Voter's registration card		4. Original or certified copy of birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal
5. For a nonimmigrant alien authorized to work for a specific employer because of his or her status: a. Foreign passport; and b. Form I-94 or Form I-94A that has the following: (1) The same name as the passport; and (2) An endorsement of the alien's nonimmigrant status as long as that period of endorsement has not yet expired and the proposed employment is not in conflict with any restrictions or limitations identified on the form.		5. U.S. Military card or draft record		5. Native American tribal document
		6. Military dependent's ID card		6. U.S. Citizen ID Card (Form I-197)
		7. U.S. Coast Guard Merchant Mariner Card		7. Identification Card for Use of Resident Citizen in the United States (Form I-179)
6. Passport from the Federated States of Micronesia (FSM) or the Republic of the Marshall Islands (RMI) with Form I-94 or Form I-94A indicating nonimmigrant admission under the Compact of Free Association Between the United States and the FSM or RMI		8. Native American tribal document		8. Employment authorization document issued by the Department of Homeland Security
		9. Driver's license issued by a Canadian government authority		
		For persons under age 18 who are unable to present a document listed above:		
		10. School record or report card		
		11. Clinic, doctor, or hospital record		
		12. Day-care or nursery school record		

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

Refer to Section 2 of the instructions, titled "Employer or Authorized Representative Review and Verification," for more information about acceptable receipts.

MINISTRY
Door County Medical Center

OSHA RESPIRATOR MEDICAL EVALUATION QUESTIONNAIRE (PART A)

(Mandatory - page 1 of 2)

TO THE EMPLOYER: ***Answers to questions in Section I and to question 9 in Section 2 of Part A do not require a medical examination.***

Employee Name:_____ Date of Birth:_____

Employee #:_____ Company/Employer: _____

TO THE EMPLOYEE: Can you read? ☐ YES ☐ NO

Your employer must allow you to answer this questionnaire during normal working hours or at a time and place that is convenient to you. To maintain your confidentiality your employer or supervisor must not look at or review your answers, and your employer must tell you how to deliver or send this questionnaire to the health care professional who will review it.

PART A. Section 1 (Mandatory)
The following information must be provided by every employee who has been selected to use any type of respirator.
(Please Print)

1. Today's date: _____
2. Your name: _____
3. Your age (to nearest year): _____
4. Sex: ☐ Male ☐ Female
5. Your height: _____ ft. _____ in.
6. Your weight: _____ lbs.
7. Your job title: _____
8. A phone number where you can be reached by the health care professional who reviews this questionnaire (include area code):____
9. The best time to phone you at this number: _____
10. Has your employer told you how to contact the health care professional who will review this questionnaire? ☐ YES ☐ NO
11. Check the type of respirator you will use (you can check more than one category):
    a. ☐ N, R, or P disposable respirator (filter-mask, non-cartridge type only)
    b. ☐ Other type (for example, half or full face piece type, powered-air purifying, supplied-air, self-contained breathing apparatus)
12. Have you worn a respirator? ☐ YES ☐ NO
    If "yes", what type:_____

PART A. Section 2 (Mandatory)

Questions 1 - 9 below must be answered by every employee who has been selected to use <u>any</u> type of respirator. (Please check "YES" or "NO".)

1. Do you ***<u>currently</u>*** smoke tobacco, or have you smoked tobacco in the last month:
   YES ☐ NO
2. Have you *ever* had any of the following conditions:
   a. Seizures (*fits*): ☐ YES ☐ NO
3. Have you ***<u>ever</u>*** had any of the following pulmonary or lung problems?
   a. Asbestosis: ☐ YES ☐ NO
   b. Asthma: ☐ YES ☐ NO
   c. Chronic bronchitis: ☐ YES ☐ NO
   d. Emphysema: ☐ YES ☐ NO
   e. Pneumonia: ☐ YES ☐ NO
   f. Tuberculosis: ☐ YES ☐ NO
   g. Silicosis: ☐ YES ☐ NO
   h. Pneumothorax (*collapsed lung*): ☐ YES ☐ NO
   i. Lung cancer: ☐ YES ☐ NO
   j. Broken ribs: ☐ YES ☐ NO
   k. Any chest injuries or surgeries: ☐ YES ☐ NO
   l. Any other lung problem that you've been told about: ☐ YES ☐ NO
4. Do you ***<u>currently</u>*** have any of the following symptoms of pulmonary or lung illness:
   a. Shortness of breath: ☐ YES ☐ NO
   b. Shortness of breath when walking fast on level ground or walking up a slight hill or incline: ☐ YES ☐ NO
   c. Shortness of breath when walking with other people at an ordinary pace on level ground: ☐ YES ☐ NO
   d. Have to stop for breath when walking at your own pace on level ground:
      YES ☐ NO
   e. Shortness of breath when washing or dressing yourself: ☐ YES ☐ NO
   f. Shortness of breath that interferes with your job: ☐ YES ☐ NO
   g. Coughing that produces phlegm (*thick mucous*): ☐ YES ☐ NO
   h. Coughing that wakes you early in the morning: ☐ YES ☐ NO
   i. Coughing that occurs mostly when you are lying down: ☐ YES ☐ NO
   j. Coughing up blood in the last month: ☐ YES ☐ NO
   k. Wheezing: ☐ YES ☐ NO
   l. Wheezing that interferes with your job:
      YES ☐ NO
   m. Chest pain when you breathe deeply: ☐ YES ☐ NO
   n. Any other symptoms that you think may be related to lung problems: ☐ YES ☐ NO

MINISTRY
Door County Medical Center

disease): ☐ YES ☐ NO

s that interfere with your breathing: ☐ YES ☐ NO

d. Claustrophobia (*fear of closed-in places*): ☐ YES ☐ NO

e. Trouble smelling odors: ☐ YES ☐ NO

OSHA RESPIRATOR MEDICAL EVALUATION QUESTIONNAIRE (PART A)

(Mandatory - page 2 of 2)

Employee Name: _____ Date of Birth: _____

5. Have you ***ever*** had any of the following cardiovascular or heart problems?
   a. Heart attack: ☐ YES ☐ NO
   b. Stroke: ☐ YES ☐ NO
   c. Angina ☐ YES ☐ NO
   d. Heart failure: ☐ YES ☐ NO
   e. Swelling in your legs or feet (*not caused by walking*): ☐ YES ☐ NO
   f. Heart arrhythmia (*heart beating irregularly*): ☐ YES ☐ NO
   g. High blood pressure: ☐ YES ☐ NO
   h. Any other heart problems you've been told about ☐ YES ☐ NO

6. Have you ***ever*** had any of the following cardiovascular or heart symptoms?
   a. Frequent pain or tightness in your chest: ☐ YES ☐ NO
   b. Pain or tightness in your chest during physical activity: ☐ YES ☐ NO
   f. Pain or tightness in your chest that interferes with your job: ☐ YES ☐ NO
   d. In the past two years have you noticed your heart skipping or missing a beat: ☐ YES ☐ NO
   e. Heartburn or indigestion that is not related to eating: ☐ YES ☐ NO
   f. Any other symptoms that you think may be related to heart or circulation problems: ☐ YES ☐ NO

7. Do you ***currently*** take medication for any of the following problems:
   a. Breathing or lung problems: ☐ YES ☐ NO
   b. Heart trouble: ☐ YES ☐ NO
   c. Blood pressure: ☐ YES ☐ NO
   d. Seizures (fits): ☐ YES ☐ NO

8. If you've used a respirator have you ***ever*** had any of the following problems. (*If you've never used a respirator, check the following space and go to question 9*) _____.
   a. Eye irritation: ☐ YES ☐ NO
   b. Skin allergies or rashes: ☐ YES ☐ NO

Questions 10-15 below must be answered by every employee who has been selected to use either a full-face piece respirator or a self-contained breathing apparatus (SCBA). For employees who have been selected to use other types of respirators answering these questions is voluntary.

10. Have you ***ever*** lost vision in either eye (*temporarily or permanently):* ☐ YES ☐ NO
11. Do you ***currently*** have any of the following vision problems?
    a. Wear contact lenses: ☐ YES ☐ NO
    b. Wear glasses: ☐ YES ☐ NO
    c. Color blind: ☐ YES ☐ NO
    d. Any other eye or vision problems: ☐ YES ☐ NO
12. Have you ***ever*** had an injury to your ears including a broken ear drum: ☐ YES ☐ NO
13. Do you ***currently*** have any of the following hearing problems?
    a. Difficulty hearing: ☐ YES ☐ NO
    b. Wear a hearing aid: ☐ YES ☐ NO
    c. Any other hearing or ear problems: ☐ YES ☐ NO
14. Have you ***ever*** had a back injury: ☐ YES ☐ NO
15. Do you ***currently*** have any of the following musculoskeletal problems:
    a. Weakness in any of your arms and legs: ☐ YES ☐ NO
    b. Back pain: ☐ YES ☐ NO
    c. Difficulty fully moving your arms and legs: ☐ YES ☐ NO
    d. Pain or stiffness when you lean forward or backward at the waist: ☐ YES ☐ NO
    e. Difficulty fully moving you head up or down: ☐ YES ☐ NO
    f. Difficulty fully moving your head side to side: ☐ YES ☐ NO
    g. Difficulty bending at your knees: ☐ YES ☐ NO
    h. Difficulty squatting to the ground: ☐ YES ☐ NO
    i. Climbing a flight of stairs or ladder carrying more than 25 lbs.: ☐ YES ☐ NO
    j. Any other muscle or skeletal problem that interferes with ☐ ☐

c. Anxiety: ☐ YES ☐ NO d. General weakness or fatigue: ☐ YES ☐ NO e. Any other problems that interferes with your use of a respirator: ☐ YES ☐ NO 9. Would you like to talk to the health care professional who will review this questionnaire about your answers to this questionnaire: ☐ YES ☐ NO	using a respirator: YES NO

Employee Signature: _____ **Date**: _____

Ministry Occupational Health and Wellness Clinic
133 S. 16th Place
Sturgeon Bay, WI 54235
P: 920-746-0726 f: 920-746-0597

MID DOOR COUNTY
SERVICE AWARD PROGRAM
BENEFICIARY DESIGNATION FORM

Please read all instructions carefully before completing this form to ensure proper designation of your beneficiaries.

This form is intended for naming or changing your beneficiary. Any death benefit from the Service Award Program will be made payable in accordance with the designation provided below. This information will be relied upon to contact the individual(s) in the event that a death benefit is payable. Please keep a copy of this form for your records and complete a new form if any of the information needs to be updated or changed. Please consult with an attorney before naming a minor or your estate as a beneficiary; typically, death benefits cannot be paid directly to a minor. Please complete this form and return it to the sponsoring municipality or volunteer organization.

PARTICIPANT INFORMATION

Full Name (First, MI, Last) _____ Social Security No. _____ Date of Birth _____ Phone Number / E-mail _____

Mailing Address _____ City _____ State _____ Zip _____ Company _____

BENEFICIARY DESIGNATION

Death benefits are paid in entirety to the surviving primary beneficiaries. Benefits are paid to contingent beneficiaries only when there are no surviving primary beneficiaries. Unless percentages are indicated, death benefits will be made payable in equal amounts. If a beneficiary listed is deceased, the corresponding benefit will be made payable to the remaining beneficiaries within that designation, proportional to the original percentages allocated. If more space is needed, please attach an additional form and label it "Addendum."

PRIMARY

Share (%)	Full Name	Relation	Social Security No.	Date of Birth	Mailing Address
____%					
____%					
____%					

CONTINGENT

Share (%)	Full Name	Relation	Social Security No.	Date of Birth	Mailing Address
____%					
____%					
____%					

PARTICIPANT AND WITNESS SIGNATURES

I hereby name the individuals above as my beneficiaries and declare that this designation supersedes all previous designations.

_____ _____
Participant Signature Date

_____ _____
Witness Signature Date

Witness must be a Notary, or an Official of the Town or Department

Accident & Health Beneficiary Designation Form

Please complete this form and return it to your organization's Secretary who should maintain this form with your emergency service organization's records. Please do not return this form to Provident. If necessary, please photocopy this page or print additional copies at www.providentbenefits.com. Please PRINT or TYPE.

Policyholder Name (Emergency Service Organization) _____ Policy # _____

Insured Person's Last Name _____ First _____ Initial _____ Date of Birth _____

Insured Person's Street Address _____

Insured Person's City _____ State _____ Zip Code _____ Social Security # _____

Primary Beneficiary ~ If the benefit is to be paid to more than one person, please list the names, dates of birth, and Social Security #'s, and indicate the relationship to the Insured Person, as well as the percentage each primary beneficiary should receive. If percentage shares are not given, they will be equal. Total percentage for all primary beneficiaries must equal 100%.

Name	Date of Birth	Social Security #	Relationship	% Share

Contingent Beneficiary ~ The contingent beneficiary(ies) will only receive benefits if all named primary beneficiaries predecease the Insured Person. If the benefit is to be paid to more than one contingent beneficiary, please list the names, dates of birth, and Social Security #'s, and indicate the relationship to the Insured Person, as well as the percentage each contingent beneficiary should receive. If percentage shares are not given, they will be equal. Total percentage for all contingent beneficiaries must equal 100%.

Name	Date of Birth	Social Security #	Relationship	% Share

Insured Person's Signature _____ Date Signed _____

PROVIDENT

PAI-AH-BENE 07/2006

Please return this form to your organization's secretary where it should be maintained with your emergency service organization's records.

Provided by: Provident Agency, Inc.
Toll Free 800.447.0360

Offered by:

PROVIDENT

Beneficiary Designation Form

Group Accidental Death & Dismemberment Insurance

Unum Life Insurance Company of America

For the members of:

NVFC NATIONAL VOLUNTEER FIRE COUNCIL FIRE • EMS • RESCUE

Instructions: As a member of the National Volunteer Fire Council, you are eligible for benefits under the group Accidental Death & Dismemberment policy offered by Provident Agency, Inc. You have the right to name a beneficiary. If you choose **not** to name a beneficiary, or if all named beneficiaries die with or before you, the death benefits may be payable in the order listed below:

a. spouse;
b. child or children, equally, if living, otherwise to their descendants per stirpes;
c. parents, equally or to the survivor;
d. sisters or brothers, equally or to the survivor or survivors;
e. your estate.

If you would like to identify a specific beneficiary(ies), then you need to complete this form. If you do not submit a completed beneficiary designation form to Provident Agency, Inc. at 272 Alpha Drive, Pittsburgh, PA 15238 or fax to 412-963-0415, then any death benefits payable may be made in the order listed above.

For inquiries related to this policy, contact Provident Agency, Inc. at 800-447-0360.
For inquiries related to NVFC membership status, call 888-275-6832.

Important Information About Designation of Beneficiaries

Beneficiary Information

- **Primary Beneficiary(ies)** means the person(s) you choose to receive your life insurance benefits. Please specify the percentage of the benefit you want to be paid to each primary beneficiary; these percentages should total 100%. If any primary beneficiary is disqualified or dies before you, his/her percentage of the benefit will be paid to the remaining primary beneficiary(ies).

- **Contingent Beneficiary(ies)** means the person(s) you choose to receive your life insurance benefits only if **all** primary beneficiaries are disqualified or die before you. Please specify the percentage of the benefit you want to be paid to each contingent beneficiary; these percentages should total 100%. If any contingent beneficiary is disqualified or dies before you, his/her percentage of the benefit will be paid to the remaining contingent beneficiary(ies).

- **Minor Beneficiary(ies)** - When you designate minors as beneficiaries, it is important to understand that insurance benefits may not be released to a minor child. They may, however, be paid to a court appointed guardian of the child's estate. The regulations governing minor beneficiaries vary by state.

- **Trust** - You may designate a valid trust as a beneficiary.

Type of Coverage

- **AD&D** is Accidental Death & Dismemberment coverage.

General Information

- **Updates to Your Beneficiary Designation** - You can change your beneficiary designation at any time. You may wish to review your designation periodically.

- **Consult an Attorney** - This information is not intended to be relied on as legal advice. You may wish to get the assistance of an attorney to help ensure your beneficiary designation correctly reflects your intentions.

Offered by:

PROVIDENT

Beneficiary Designation Form

Group Accidental Death & Dismemberment Insurance

Unum Life Insurance Company of America

For the members of:

NVFC NATIONAL VOLUNTEER FIRE COUNCIL FIRE • EMS • RESCUE

Instructions: Please complete, sign and date this form to designate your beneficiary(ies) or to change your existing beneficiary(ies). This form cancels all prior designations. If more than one beneficiary is named and no percentages are indicated, payment will be made to them in equal shares. If there are more than three (3) primary and/or contingent beneficiaries, please attach a separate sheet of paper. **Return the completed form to Provident Agency, Inc. by fax to 412-963-0415 or by mail to 272 Alpha Drive, Pittsburgh, PA 15238.**

Section 1: Member Information

Name (Last Name, Suffix, First Name, MI)	Phone #	Date of Birth

Address, City, State, Zip	Social Security Number

Section 2: Primary Beneficiary(ies)

I choose the person(s) named below to be the primary beneficiary(ies) of the Life Insurance benefits that may be payable at the time of my death. If any primary beneficiary(ies) is disqualified or dies before me, his/her percentage of this benefit will be paid to the remaining primary beneficiary(ies).

Name & Address	Relationship	Social Security Number	Date of Birth	Percentage

Total Must Equal 100%

Section 3: Contingent Beneficiary(ies)

If **all** primary beneficiaries are disqualified or die before me, I choose the person(s) named below to be my contingent beneficiary(ies) of the Life Insurance benefits that may be payable at the time of my death.

Name & Address	Relationship	Social Security Number	Date of Birth	Percentage

Total Must Equal 100%

Section 4: Signature

X _____

Member Signature

_____

Date

PAI-400-1006 (03.2013)

Gibraltar Fire Training Survey

In an effort to optimize our department's training nights we ask you to please answer the following questions based on your personal feelings.

1. Rate each training topic's importance to you personally by circling the number.

(1= not important 5= very important)

•Interior fire attack- 1 2 3 4 5

(Hose advancement, forcible entry, SCBA)

•Truck operations- 1 2 3 4 5

(Venting, ladders, search& rescue)

•Pumping- 1 2 3 4 5

(Drafting, discharging water, CAFS)

•Auto extrication- 1 2 3 4 5

(Cribbing, hydraulic tools, air bags)

• Wild land firefighting- 1 2 3 4 5

(Progressive hose packs, brush units, indian packs)

•Boat operations- 1 2 3 4 5

(Water rescue, driver training, loading& unloading boat)

•Ice water rescue- 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐

(Mustang suits, line tendering, MARSARS, Fortuna)

•High angle rescue- 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐

(Raising and lowering systems, patient packing, ropes& knots)

•Miscellaneous equipment use- 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐

(Gas tools, hand tools, ladders, drop tanks)

2. Rate your satisfaction with the current training you are receiving.

(Bad) 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ (Good)

3. Do you feel that working with other departments' equipment and personnel Is beneficial to you?

Yes ☐ **No** ☐

4. Rate your interest in doing off meeting night specialty training- 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐

(RIT, high angle rescue, extrication)

5. What was your favorite training night? _____

6. What training night do you think failed and why?

_____

_____

7. Please write any training activities that you feel are not being looked at enough or are being ignored.

_____

_____

TOWN OF GIBRALTAR
EMPLOYEE POLICIES /PRACTICES
DECEMBER 1 5, 2017

- Educational Reimbursement Program
- Educational Reimbursement Program Repayment Agreement
- Mileage and Meal Reimbursement Practices
- Meal Periods, Time and Attendance Practices
- Vehicle/Equipment Policy
- Drug Free Workplace Policy
- Harassment Policy

_____

Employee Signature Date

(Signature indicates you have received and read these policies and practices. It does not necessarily imply agreement with the policy and/or practice.)

_____

Supervisor Signature Date

Educational Reimbursement Program

The Town of Gibraltar encourages employees to take advantage of opportunities that will assist them in the development of their job related skills. In order to facilitate such skill development, the Town provides an educational reimbursement program to eligible employees enrolled in job-related or career development coursework. The Town reserves the right to modify or terminate the Education Reimbursement Program at any time and for any reason.

A. Eligibility

The Educational Reimbursement Program provides eligible employee's with reimbursement of tuition and textbooks for approved course work. All full-time employees are eligible to participate in the Education Reimbursement Program, except that the following employees are not eligible to participate: (1) employees covered by a collective bargaining agreement; and (2) "highly compensated employees," as that term is defined in Section 414(q)(1) of the Internal Revenue Code. Employees may begin participating as soon as they are eligible, provided no disciplinary action has been taken within the preceding 12 months of the request.

B. Courses Reimbursed

All courses require prior written approval from the Town with a signed purchase order. Eligible courses are not limited to an accredited college, university or technical/trade school. The Town reserves the right to approve or disapprove any college, university, school or other board approved venue.

All courses taken under this program must be directly related to the employee's current job or career development. The Town reserves the right to determine, in its sole discretion, whether a course is related to the employee's current job or career development and will not exceed budget limitations. Education involving sports, games, or hobbies is not eligible for reimbursement unless such education is required as part of a degree program.

C. Reimbursement Maximum

Eligible employees may be reimbursed for a maximum of $5,250 per calendar year for tuition and textbooks under the Educational Reimbursement Program. This is an IRS-imposed limit under Internal Revenue Code Section 127. Any amount above the maximum must be approved by the Town and the reimbursement sought must be job-related and either (1) taken to maintain or improve job skills or (2) required by the Town or by law. Under no circumstances may an employee be reimbursed for more than $5,250 in a calendar year for expenses incurred in connection with education that is needed to meet the minimum educational requirements of an employee's current job or to qualify the employee for a new trade or business.

If an eligible employee is also reimbursed through the GI bill, scholarship, grant or other source, the Town will pay the appropriate amount less the amount reimbursed by other sources.

D. Application for Reimbursement

Employees must have all coursework preapproved using the *Employee Education Reimbursement Request Form* provided by the Town. Requests should be submitted a minimum of 4 weeks prior to the start of the course for consideration. The Town reviews the form for final approval or disapproval.

E. Grade Requirement

The approved courses must be successfully completed with a "C" or better in a course where a grade is provided or official documentation from the institution that the course was "Passed" or "Satisfactory" for coursework where a final grade is unavailable. An "Incomplete" is unreimbursable until a final grade is issued.

F. Reimbursement Process

Within 60 days of completing the course(s), employees are required to send all of the following to the Town:

- Institutional documentation (a grade report or unofficial transcript) of successful completion stating a "C" grade of better, "Pass" or "Satisfactory";
- Proof of the tuition payment (copy of receipt/paid bill); and
- The *Employee Educational Reimbursement Request Form* with the Town approval signature for final processing.

Reimbursement payments will be based upon receipt of all the required documentation. Employees will receive reimbursement within 4 weeks from the date the Town receives all required documentation.

G. Other Programs/Classes

In addition to the above, this policy covers job-related trainings, classes, programs, conferences, and seminars offered by professional organizations or other third-parties which are approved in advance by the Town, in its sole discretion, and further an employee's professional development. Employees must obtain advanced approval from their manager/supervisor to receive the benefits described in this paragraph. The Town may pay the fees for approved programs directly. Employees will be reimbursed for reasonable meal and lodging expenses incurred in connection with the approved program consistent with the Town's existing guidelines on the reimbursement of expenses. The Town may require an employee to use the Town vehicle for travel from and to an approved program. If no Town vehicle is available for use, the Town will reimburse the employee for mileage at the applicable IRS rate. Employees shall provide documentation of expenses and other documentation requested by the Town, including but not limited to verification of attendance at, or completion of, an approved program. Notwithstanding the language to the contrary in the "Eligibility" section above, highly compensated employees are eligible for the benefits described in this paragraph. All other requirements listed in the "Eligibility" section above apply.

H. Repayment Requirements

Amounts reimbursed or paid by the Town under this Educational Reimbursement Program are subject to the following repayment conditions.

Employee Voluntarily Terminates Employment	Employee Repayment Requirement
Within 12 months of any payment made by the Town under this policy	100% of the amount reimbursed/paid by the Town
After 12 months but within 18 months of any payment made by the Town under this policy	75% of the amount reimbursed/paid by the Town
After 18 months but within 24 months of any payment made by the Town under this policy	50% of the amount reimbursed/paid by the Town
After 24 months of any payment made by the Town under this policy	0% of the amount reimbursed/paid by the Town

EDUCATIONAL REIMBURSEMENT PROGRAM
PAYBACK AGREEMENT

This Agreement is between the Town of Gibraltar (the "Town") and _____ (the "Employee"). The purpose of this Agreement is to establish the repayment obligations of employees participating in the Educational Reimbursement Program ("the Program").

If Employee voluntarily terminates his/her employment with the Town, Employee shall be liable for repayment of any expenditure by the Company under the Program as follows:

- If separation occurs within twelve (12) months of any payment made under the Program, Employee shall be liable for repayment of 100% of the expenditures made by the Town under the Program.

- If separation occurs after twelve (12) months, but within eighteen (18) months of any payment made under the Program, Employee shall be liable for repayment of 75% of the expenditures made by the Town under the Program.

- If separation occurs after eighteen (18) months, but within twenty-four (24) months of any payment made under the Program, Employee shall be liable for repayment of 50% of the expenditures made by the Town under the Program.

- If separation occurs after twenty-four (24) months of any payment made under the Program, no repayment is required.

Should Employee be required to repay the Town pursuant to this Agreement, any repayment made by Employee will be applied first to the balance of payments made by the Town that were excludable from Employee's income, if any, and any additional repayment applied to the balance of payments made by the Town that were includable in the Employee's income.

By signing this Agreement, Employee agrees to the above terms.

Employee Signature: _____

Printed Name: _____

Date: _____

Employee Educational Reimbursement Request Form

Name:
Email:

Coursework and School Information:

Institution Name:
Institution Location:

Level of Course(s) Requested: (Check One):

☐ Technical College ☐ Undergraduate ☐ Graduate

☐ Other

Type of Degree Sought: (Check One):

☐ Associate ☐ BA/BS ☐ MA/MS ☐ Ph.D/Ed.D.
☐ Other:

☐ Check here if courses are not part of a degree program

Eligibility of Courses: Coursework must be directly related to your current position or position of advancement with the Town of Gibraltar. Coursework must be approved prior to reimbursement.

The coursework I am requesting is related to: (Check One)

☐ My current job ☐ Future career advancement ☐ Both

Please describe how this course(s) relate(s) to your current job or future career advancement with the Town of Gibraltar:

_____

_____

_____

Course(s) Information:

Term and Year (Sprint/Summer/ Fall/Winter)	Course Title	Course Number	Start Date of Course	Last Date of Course	# of Credits	Amount Requested
						$
						$
						$
				FEE TOTAL		$
				TOTAL REQUESTED		$

Employee Educational Reimbursement Request Form

Section [illegible]: Agreement and Signature

- I have read the Town of Gibraltar's policies related to educational reimbursement.
- I understand I am required to receive prior approval of all coursework for any consideration of reimbursement.
- I understand that I must submit the required documentation within 60 days of completing the course.
- I understand I must be actively working and in a benefits-eligible status on the date my reimbursement request is submitted. A leave of absence with pay is considered to be actively working.
- By requesting reimbursement, I certify that I am not eligible to have these same expenses paid from any other source (e.g., student grants or scholarships).
- I agree to immediately repay any amount not used for its intended purpose or which exceeds my actual educational expense.
- I understand and agree that if I voluntarily terminate employment: (1) within 12 months of receiving a reimbursement, I shall repay 100% of the amount reimbursed; (2) after 12 months but within 18 months of receiving a reimbursement, I shall repay 75% of the amount reimbursed; (3) after 18 months but within 24 months of receiving a reimbursement, I shall repay 50% of the amount reimbursed.
- I understand that successful completion requires the achievement of a "C" or better in the course where a grade is provided, or official documentation from the institution of "Passed" or "Satisfactory" for coursework where a final grade is unavailable. An "Incomplete" is not reimbursable until a final grade is issued.
- Intended Tax Treatment (select all that apply)
- I understand the requisition approval process and budget restraints.

☐ Tax Free Under Code Section 127. In order to check this box, all of the following statements must be true:
- Total reimbursements under Code Section 127 do not exceed $5,250 in any calendar year;
- The employee is not a highly compensated employee ($120,000 of compensation in calendar year 2017).

☐ Tax Free Under Code Section 132. In order to check this box, the reimbursement must be associated with a course that relates to your current job and the course may not: (1) qualify you for a new trade or business; or (2) fulfill the minimum education requirements for your job.

☐ Taxable Benefits. Check this box unless either or both of the preceding boxes,

If more than one box is checked, please note the amount intended to be allocated to each category:

Code Section 132: $_____
Code Section 127: $_____
Taxable Benefits: $_____

_____ _____
Employee Signature **Date**

Employee Educational Reimbursement Request Form

Section III: FOR THE TOWN ONLY

Town Approval:

I certify the above course is directly related to the employee's current work assignment or future career development at the Town of Gibraltar. There have been no disciplinary actions in relation to this employee during the preceding 12-month period that would prohibit eligibility for reimbursement. *(Note—Please exclude any disciplinary actions related to performance that this course is intended to address and if the course is during work time, I have given my approval for the employee to attend the course.)*

Town Representative (please print): _____ Date: _____

☐ Approved ☐ Not Approved

☐ Reimbursement Directly to Employee

Documentation Provided:

☐ Fee/Bill ☐ Grade Report/Unofficial Transcript

Date Documentation Provided:

Intended Tax Treatment (check all that apply)

☐ Tax Free Under Code Section 132(d). In order to check this box, each of the following statements must be true:

- Each course is job-related for the employee;
- No course is needed to meet the minimum educational requirement for the employee's current job;
- No course is needed to qualify the employee for a new trade or business.

☐ Tax Free Under Code Section 127. In order to check this box, each of the following statements must be true:

- Total reimbursements do not exceed $5,250 in any calendar year;
- The employee is not a highly compensated employee ($120,000 of compensation in calendar year 2017).

REIMBURSEMENT
TOWN OF GIBRALTAR

On June 6, 2001 it was approved that mileage reimbursement be at the current IRS rate (presently $0.325 per mile) and reimbursement for breakfast at $6.00, lunch at $12.00, and dinner at $24.00, with receipts being received within 30 days after the event.

One November 5, 2008, it was approved that mileage reimbursement be at the IRS rate at the prevailing rate at the time of the event and all associated expenses be submitted to the Town Board within 30 days after the event.

Meal Periods (Non exempt Employees Only)

Length of Meal Periods

Employees shall be provided a paid meal period not to exceed 30 minutes plus 5 minutes wash up time. The Town Administrator may allow deviations from the above policy due to unusual working conditions of the employee's assignment.

Meal Periods, General

Employees shall not be required to work more than 6 hours without a meal period. If an employee elects to take a meal period away from his/her work location and if the employee is using a municipal vehicle, the vehicle shall be returned to the assigned municipal parking area and their personal vehicle used. The specific location for municipal vehicle parking will be determined by the Town Administrator.

Time and Attendance (Non exempt employees only)

Employees shall accurately record their time on duty. The use of a time clock will be used for documenting arrival and departure time from work. The employee is the only person authorized to clock in his/her time. Timesheets documenting the employees daily work log shall be turned in on a weekly basis.

Any employee arriving late or leaving early from a regularly assigned workday must notify the Town Administrator. Excessive irregularities in maintaining proper hours will result in disciplinary actions.

No employee shall be on Town property earlier than one half hour before scheduled work time nor later than one half hour after normal work time, without proper authorization.

Vehicle/Equipment Policy

Vehicles and equipment owned by the Town of Gibraltar are not to be used for reasons other than the execution of Town duties. Municipal vehicles and equipment shall be parked/stored on town property outside of working hours. The specific location for municipal vehicle parking will be determined by the Town Administrator. If their use is required beyond the limits of the Town of Gibraltar, authorization by the Town Administrator shall be given in advance. Mileage logs are to be kept for documentation purposes and turned in along with employee timesheets weekly.

July 6, 2016

TOWN OF GIBRALTAR
HARASSMENT POLICY

The Town is committed to providing a work environment in which employees are treated with courtesy, respect and dignity. The most productive and satisfying work environment is one in which work is accomplished in a spirit of mutual trust and respect. Harassment is a form of discrimination that is offensive, impairs morale, undermines the integrity of employment relationships and causes serious harm to the productivity, efficiency and stability of our workplaces.

All employees have a right to work in an environment free from discrimination and harassing conduct, including sexual harassment. Harassment, whether verbal, physical or written, with regard to an employee's race, color, creed, ancestry, national origin, age, disability, sex, arrest or conviction record, marital status, sexual orientation, membership in the military reserve, use or nonuse of lawful products away from work, or any other protected characteristics is expressly prohibited under this policy.

Definitions. In general, harassment means persistent and unwelcome conduct or actions on any of the above bases.

Sexual harassment is one type of harassment and includes unwelcome sexual advances, unwelcome physical contact of a sexual nature or unwelcome verbal, physical or written conduct of a sexual nature. Unwelcome verbal or physical conduct of a sexual nature includes, but is not limited to:

The repeated making of unsolicited, inappropriate gestures or comments; or

The display or transmission of offensive sexually graphic materials not necessary to our work.

Harassment on any basis (race, sex, age, disability, etc.) exists whenever:

Submission to harassing conduct is made, either explicitly or implicitly, a term or condition of an individual's employment; or
Submission to or rejection of such conduct is used as the basis for an employment decision affecting an individual; or
The conduct interferes with an employee's work or creates an intimidating, hostile or offensive work environment.

Recognizing Harassment. Harassment may be subtle, manipulative and is not always blatant. It does *not* refer to occasional compliments or criticisms of a socially acceptable nature. It refers to behavior that is not welcome and is personally offensive. All forms of gender harassment are covered. Men can be sexually harassed; men can harass men; women can harass other women. Offenders can be supervisors, co-workers, and citizens.
Examples of harassment include:

Verbal: Jokes, insults and innuendoes (based on race, sex, age, disability, etc.); degrading sexual remarks; referring to someone as a stud, hottie, hunk or babe; whistling; catcalls; comments on a person's body or sex life; or pressure for sexual favors.

Non-verbal: Gestures; staring; touching; hugging; patting; blocking a person's movement; standing too close; brushing against a person's body; or display of sexually suggestive or degrading pictures; or racist or other derogatory cartoons or drawings.

Complaint. Any employee who believes he or she is being harassed, or any employee who becomes aware of harassment, should promptly notify the Clerk, Deputy Clerk or Town Chairman. Supervisors shall report all

This policy may be promulgated from time to time.

Town of Gibraltar

Drug-Free Workplace Policy

Purpose and Goal

The Town of Gibraltar is committed to protecting the safety, health and well being of all employees and other individuals in our workplace. We recognize that alcohol and/or drug abuse and drug use pose a significant threat to our goals. We have established a drug-free workplace program that balances our respect for individuals with the need to maintain a safe environment.

- This organization encourages employees to voluntarily seek help with drug and alcohol problems.

Covered Workers

Any individual who conducts business for the town, or is applying for a position with the town, is covered by our drug-free workplace policy. Our policy includes, but is not limited to, management, full-time employees, part-time employees and volunteers.

Applicability

Our drug-free workplace policy is intended to apply whenever anyone is representing or conducting business for the town. Therefore, this policy applies during all working hours, whenever conducting business or representing the town and while on call or paid standby.

Prohibited Behavior

It is a violation of our drug-free workplace policy to use, possess, sell, trade, and/or offer for sale any illegal drugs, or to be impaired under the influence of alcohol.

Notification of Convictions

Any employee who is convicted of a criminal drug violation in the workplace must notify the town in writing within five calendar days of the conviction. The town will take appropriate action within 30 days of notification. Federal contracting agencies will be notified when appropriate.

Searches

Entering in or upon town property, including land, buildings and vehicles, constitutes consent to searches and inspections. If an individual is reasonably suspected of violating the drug-free workplace policy, he or she may be asked to submit to a search or inspection at any time. Searches can be conducted of lockers, desks and work stations and town vehicles and equipment.

Consequences

One of the goals of our drug-free workplace program is to encourage employees to voluntarily seek help with alcohol and/or drug problems. If, however, an individual violates the policy, the consequences are serious.

It is the supervisor's responsibility to:

- Inform employees of the drug-free workplace policy.
- Observe employee performance.
- Investigate reports of dangerous practices.
- Document negative changes and problems in performance.
- Counsel employees as to expected performance improvement.

Communication

Communicating our drug-free workplace policy to both supervisors and employees is critical to our success. To ensure all employees are aware of their role in supporting our drug-free workplace program:

- All employees will receive a written copy of the policy.
- The policy will be reviewed in orientation sessions with new employees.
- The policy and assistance programs will be reviewed at safety meetings.
- Brochures will be available to all covered workers.
- Employee education about the dangers of alcohol and drug use and the availability of help will be provided to all employees.

FACTS ABOUT

Substance Abuse in Your Workplace

This Facts Sheet is intended to provide answers to questions about our workplace. Please read it carefully and keep it in a safe place for future reference. If you have further questions, contact your immediate supervisor or human resources department.

Substance abuse and the American workplace

Chances are, someone in your workplace may have a substance-abuse problem. A recent study indicates that 16.4 million illicit drug users and 15 million heavy alcohol users are employed full time. In this same study, 1 in 2 full time U.S. workers admitted to using illicit drugs in the past month.

According to the U.S. Department of Labor, substance abuse in the workplace is on the rise, and the chance that your company employs a substance abuser is greater today than it has been in the past several years. Small businesses are especially at risk for substance-abuse problems. One government survey shows that 82% of workers using illegal drugs are employed at businesses with fewer than 500 employees.

Research indicates that workers with substance-abuse problems are more likely to have extended absences from work, show up late, be involved in workplace accidents, perform less productively than coworkers, and file workers' compensation claims. Alcohol abuse alone was a factor in 40% of industrial fatalities and was found to be a contributing factor in almost half of all industrial injuries. Substance abuse on the job has been estimated to cost American businesses more than $100 billion a year.

Understanding the serious nature of this problem, becoming familiar with applicable laws and regulations, and following the simple steps detailed below, under "Your Responsibility as an employee," can help you and your employer combat this workplace problem.

Your employer's role: addressing substance abuse in the workplace

To provide the safest possible workplace for their employees, many employers today have written policies prohibiting the use in the workplace of illegal drugs and alcohol. Employers also can prohibit employees from coming to work under the influence of drugs and/or alcohol. Depending on the policies the particular employer has in place, employees may be subject to discipline or even termination for the use, possession or distribution of drugs in the workplace. These policies are intended to make the workplace safer for all employees, reduce workers' compensation costs, and provide a more productive work environment.

Your company may have its own policy regarding drug testing and drugs in the workplace. Under this policy, you may be subject to drug testing both as a condition of hiring and during your employment. Check your employee handbook or ask your employer for information regarding the policy.

Your responsibility as an employee

Substance abuse in the workplace poses a danger to you, to your fellow workers, and to customers and clients. If you use drugs or alcohol on the job or come to work in an impaired condition, you could endanger yourself as well as those around you. At the very least, you could risk losing your job. Follow these easy steps to avoid problems:

1. Do not report to work in an impaired condition due to illegal drug use, abuse of prescription medications, or alcohol consumption.
2. Report any such activity on the part of coworkers to your supervisor or another responsible party. Follow your company's reporting procedure, if it has a policy for reporting situations involving illegal drug use or alcohol consumption on the job.
3. If you have a problem or suspect you may have a problem with drug abuse or alcoholism, take advantage of any counseling or treatment offered by your employer. If treatment or counseling programs are not offered, seek help elsewhere, such as through Alcoholics Anonymous or Narcotics Anonymous.

Drug testing

Drug testing is the most reliable means your employer has to determine illegal drug use among employees. Testing is at the discretion of an employer, subject only to the federal and state laws controlling such a process. These include:

Federal laws

Department of Transportation

The U.S. Department of Transportation (DOT) requires that certain transportation industry employees be tested by their employers for drug use. DOT regulations provide for:

- Pre-employment testing for drugs and alcohol
- Random testing equal to 50% of the total number of covered employees each year
- Post-accident drug testing, and/or
- Reasonable cause testing

Defense Contractors

Similarly, the U.S. Department of Defense (DOD) has developed guidelines that require drug testing of employees of businesses holding DOD contracts. Primarily, these drug-free workplace clauses are included in contracts involving work dealing with classified information or national security interests.

Other Federal Contractors and Grant Recipients

The Drug-Free Workplace Act of 1988 requires recipients of federal grants and most federal contractors holding government contracts worth $100,000 or more to comply with the requirements of the Act. Those employers covered by the Act must:

1. Establish and publish a drug-free workplace policy that prohibits using, making, selling, possessing and/or distributing drugs in the workplace
2. Establish a drug-free awareness program that:
   - Informs employees of their employer's drug-free workplace policy
   - Informs employees of the adverse effects of using drugs
   - Outlines penalties that will be imposed for violation of the policy, and
   - Provides any information concerning the availability of drug counseling, rehabilitation or other assistance programs (the Drug-Free Workplace Act does not require that your employer furnish any such programs)

Under the Drug-Free Workplace Act, drug testing is optional, not mandatory. Your employer is free to elect whether to use drug testing in your workplace.

Americans with Disabilities Act

The Americans with Disabilities Act (ADA) does not prohibit, require or encourage drug testing. Employers are free to conduct tests for the presence of unlawful drugs upon applicants or current employees without violating the ADA.

Under the ADA, illegal drugs are defined as controlled substances not being taken under the supervision of a licensed healthcare professional or otherwise in accordance with federal law. Note that the ADA does not protect current illegal drug users. Current drug users may be fired, or an employer may refuse to hire an applicant for testing positive. The ADA does, however, protect:

- Former drug users who have successfully completed a substance-abuse treatment program
- Former drug users currently in a substance-abuse treatment program, and
- Disabled persons who are legally using prescription drugs as prescribed

Alcoholism is treated differently from illegal drug use under the ADA. Because alcoholism is regarded as a disability under the ADA, tests for the presence of alcohol in an employee's system can be given only when job-related and consistent with business necessity. In the case of job applicants, alcohol testing may be administered only after the employer extends a conditional offer of employment. Even though alcoholism is a protected disability under the ADA, and testing for alcohol is limited to certain situations, employers may require that alcoholics meet the same qualifications and performance standards as are applied to other employees. The EEOC's technical guidance on the ADA specifically notes that unsatisfactory behavior such as excessive absenteeism, tardiness, poor job performance or accidents caused by alcohol abuse need not be accepted nor accommodated by employers.

State law

In addition to the federal laws outlined above, some states have passed laws regulating the use of drug testing in the workplace. Your employer will be required to comply with state law in implementing any drug-screening program.

Conclusion

Both employers and employees have an obligation to make sure that substance abuse does not enter the workplace, bringing with it all the negative consequences discussed above. By adhering to your employer's policies and the law, you, your employer, your coworkers, and those you interact with on the job benefit from a safer, healthier, and more productive work environment.

Employee Receipt

I certify that I have received a copy of this Facts Sheet and have read its contents.

_____ ____/____/____

Employee Signature Date

GIBRALTAR FIRE & RESCUE

Designation of Beneficiaries Form
for U.S. Department of Justice Public Safety Officers' Benefits (PSOB) Program

PURPOSE OF THIS FORM

WHO RECEIVES PSOB BENEFITS IF A CLAIM IS APPROVED?

Benefits are paid to survivors according to the following criteria:

1. If there is a spouse and no child* or children, all to the spouse.
2. If there is a spouse and child or children, one-half to the spouse and one-half to the child or children in equal shares.
3. If no spouse, and children only, all to the child or children in equal shares.
4. **If no spouse or children, then to the individual(s) designated by the officer in the most recently executed designation of (PSOB) beneficiary on file with the officer's agency at the time of the officer's death. If no PSOB designation, then to the individual(s) designated by the officer on the most recently executed life insurance policy on file with the officer's agency at the time of death.**
5. If no spouse, children, PSOB designation, or life insurance beneficiary, then to the officer's surviving parents in equal shares.
6. If none of the above, then to the officer's children who would receive the benefit but for age (i.e., adult children.)

**"Child" is defined as any natural, illegitimate, adopted or posthumous child or stepchild of a deceased public safety officer who, at the time of the officer's death, is 18 years old or under; 19-22 and a full-time student; or 19 and older, and incapable of self-support due to a physical or mental disability.*

This form is for use in declaring a beneficiary for any PSOB benefits that your survivors may be eligible for in the event of your death. The circumstances in which the beneficiaries identified here might be eligible for the PSOB benefit identified in Step 4 above and would not apply if there is an eligible surviving spouse and/or children. Should you wish to complete this form, it **must be retained with official department records.**

I, _____ (print full name), as a member of _____ (print agency name), hereby designate the following beneficiary(s) for an PSOB benefits that may be paid in the event of my death:

Name	Percent (must total 100)	Address	Relationship

Public Safety Officer signature: _____ Date: ___/___/___

Witness signature: _____ Date: ___/___/___

P.O. Box 610 • Fish Creek, Wisconsin 54212 • 920-868-3820 • email: gibfire@dcwis.com

Gibraltar Fire & Rescue
Line of Duty Death Information Packet

The information you provide below is confidential and will be used only in the event of your death in the line of duty. Please fill out the form as accurately as possible. This document may be used by the Fire Dept. and the Human Resources Dept. to assist your survivors. Providing this information in advance will be of extreme comfort to your family. ***(Wording in italics for department use only)***

PLEASE PRINT:

Name: _____

Address: _____ Phone: _____

City: _____ State: _____ Zip: _____

FAMILY INFORMATION:

Spouse's full name: _____ Maiden name: _____ DOB: _____

Spouse's place of employment: _____ Shift: 1 2 3

Dependents Names/Dates of Birth (residing with you)

_____ DOB___-___-____

_____ DOB___-___-____

_____ DOB___-___-____

_____ DOB___-___-____

_____ DOB___-___-____

Additional dependents listed on back

Are there surviving children elsewhere? Y☐ N☐

(Include adult children not residing with you)
Name/Date of Birth

_____ Address: _____ Guardian: _____

Name/Date of Birth

_____Address:_____Guardian:_____

Name/Date of Birth

_____Address:_____Guardian:_____

Name/Date of Birth

_____Address:_____Guardian:_____

NOTIFICATION TO BE GIVEN TO

Whom do you want us to notify of your death:

Primary:

Name:_____Address:_____Phone:_____

Relationship to you: s☐se re☐ve (brother/sister/parent) Other_____

Notified by _____ ***Unable to reach for notification (contact alternate)***

Alternate #1:

Name:_____Address:_____Phone:_____

Relationship to you: s☐se re☐e (brother/sister/parent) Other_____

Notified by _____

Alternate #2:

Name:_____Address:_____Phone:_____

Relationship to you: sp☐e r☐ive (brother/sister/parent) Other_____

Notified by _____

If you are divorced, would you like your ex-spouse notified: ☐ YES ☐ NO (do not list name)

Name_____Address:_____Phone:_____

Notified by _____

NOTIFICATION GIVEN BY:
In the event of your death, whom would you prefer notifies your family? Please indicate members of Fire Department and in order of preference. Keep in mind that should your first choice be unavailable we will contact your alternates in the order listed.

Primary Fire Department:
Name:_____ Address:_____ Phone:_____
Contacted by _____ ***Available*** ***Unavailable (proceed to 1st alternate)***

Alternate Fire Department #1:
Name:_____ Address:_____ Phone:_____
Contacted by _____ ***Available*** ***Unavailable (proceed to 2nd alternate)***

Alternate Fire Department #2:
Name:_____ Address:_____ Phone:_____
Contacted by _____ ***Available*** ***Unavailable (Contact Department Liaison)***

Is there anyone you would like to accompany the Fire Department representative when your family is notified? (Pastor, Relative, Friend)

Name:_____ Phone: (H)_____(C)_____
Address:_____
Relationship to you: relative (brother/sister/parent) Other_____
Contacted by _____

Are there any known medical conditions or other items of concern about your family that we should be aware of prior to notification (small children at home, heart condition, etc.) Y ☐ ☐

Do you wish to donate your organs? ☐ YES ☐ NO
Have you signed the uniform donor card on your license? ☐ YES ☐ NO
Hospital/Coroner notified as applicable. _____

Public Safety Officer's Benefits Program (888)-744-6513
See Attorney Generals Guide to the Hometown Heroes Survivor's Benefits Act
www.ojp.usdoj.gov/BJA/grant/psob/psob_heroes.html

Who would you like to be the Fire Department liaison to your family? This individual will assist in personal matters.
Primary:
Name:

Secondary:
Name:

List any fire department, religious, military or community organizations that may provide assistance to your survivors that we may notify:

Name:_____ Contact:_____

Address: _____

Name:_____ Contact:_____

Address: _____

Name:_____ Contact:_____

Address: _____

Name:_____ Contact:_____

Address: _____

Do you have a Will? Y ☐ - ☐

If yes, where is it located or who should be contacted about it?_____

List all life insurance policies you have: Is all information current? (Beneficiary names, contact info, etc. This information may determine who gets Federal benefits.)

Company	Policy Number	Location of Policy

List any Special requests here:

_____

_____

_____

_____

_____

This form should be reviewed annually and updated as necessary. The contents of this form are confidential and solely for the use of assisting your survivors should you die in the line of duty. The information you have given will be very important and comforting to your survivors.

_____ _____ _____

Signature Unit Date

Town of Gibraltar Fire & Rescue
Funeral Information Guide

The following information is confidential and provided by you voluntarily in the event of your line of duty death (LODD). Funerals can vary depending on family wishes, weather, space, and other logistics. The purpose of this form is to serve as a ***guide*** in arranging for, and conducting, a subsequent fire department funeral. Many issues and questions must be addressed by family, funeral home, and church and will take priority as applicable. For each question, circle your answer that is in **BOLD** or fill in the blanks as they apply.

Name _____ Date completed _____

Dates Reviewed _____

1. Choose one of the following regarding what type of funeral you desire. Keep in mind that this information will be shared with your family and the funeral director and that your family's wishes will be paramount while using this form as a general guide.

   ☐ I *do not* wish for a formal fire department funeral and have made separate arrangements. Please complete #2 below and disregard the remainder.

   ☐ I *do not* wish for a formal fire department funeral but welcome fire department presence and participation. Please complete #2 below as well as any other questions as applicable.

   ☐ I *would* like a formal fire department funeral. Please complete all of the questions below.

2. I would like the following officer(s) to act as liaison to my family and the Department:
   (remember whoever you pick will not be a part of Honor Guard or any other part of the funeral, they are with your family for the entire process)

   _____ Alternate: _____

3. Many factors come into play, but ***in general***, if the LODD occurs along with another officer(s), I likely **WOULD** **WOULD NOT** wish to have services conducted jointly.

4. Funeral home and city _____

   Church name (or other) and city _____

   Presiding clergy member name (or other) and city _____

5. I prefer: ☐ **CREMATION** ☐ **CASKET BURIAL** ☐ **CASKET VIEWING FOLLOWED BY CREMATION**

6. I ☐ **WOULD** ☐ **WOULD NOT** like a Visitation/viewing *prior to* the day of the service.
   If so, where? _____

7. I ☐ **WOULD** ☐ **WOULD NOT** like a short Visitation/viewing *before and on the day of* the service.

8. I ☐ **DO** ☐ **DO NOT** wish to be in uniform. If so, describe which uniform _____

9. I would like the National flag to be:

   DRAPED AS APPROPRIATE ☐ **DISPLAYED FOLDED** ☐ **NOT PRESENT** ☐

10. I would like a Memorial Fund in the name of _____ to be donated to _____.

11. Any special wishes (photo displays, music, mementos, etc) or other issues regarding Visitations/viewing? _____

_____

_____

_____

_____

_____

12. I would like the Service to occur at: _____
(location)

13. List a fire department member you wish to participate for a eulogy if any:

_____ Alternate: _____

14. Please list as it applies:

PALLBEARERS	**OR**	URN ESCORT
_____		Urn Bearer _____
_____		Escort _____
_____		Escort _____
_____		Alternate _____
_____		Alternate _____
_____		Alternate _____
Alternate _____		Alternate _____
Alternate _____		Alternate _____

Check if you wish to have any of the following as pallbearers/escorts:

☐ Door County Sworn Honor Guard ☐ Pallbearers ☐ Escort

☐ Other Agency Honor Guard _____ ☐ Pallbearers ☐ Escort
(Agency)

15. As applicable, I ☐ **OULD** ☐ **WOULD NOT** wish for a formal law enforcement procession.

16. I would like to have fire department presence at the Committal/Graveside: ☐ **YES** ☐ **NO**

a. If YES, I would like the traditional Committal Rites to be conducted (National Flag formally folded, Firing Detail, Taps/Pipes, etc). ☐ **YES** ☐ **NO**

b. I am a US Veteran and prefer the Committal Rites be conducted by:

☐ **MILITARY** ☐ **FIRE DEPARTMENT** ☐ **MILITARY & F.D./L.E. WORKING TOGETHER**

Branch: _____ Rank: _____ **Active** ☐ **Retired** ☐ (circle one)

Current military memberships: _____

c. I would like the folded flag to be presented by _____

and presented to _____.

17. I would like a second National pre-folded flag: ☐ **YES** ☐ **NO**

To be carried by _____ and presented to

_____.

18. Check one:

_____ I would like the SBFD Honor Guard to formally organize the details listed above and other issues regarding the funeral (casket posting, color guards, flag folding, hearse escort, etc.)

_____ I do not wish for the SBFD Honor Guard's formal assistance, but would rather have the following person(s) assist with arrangements: _____.

19. Are there any special department mementos (i.e. your helmet, etc.) you would like to be presented to someone or have donated to the department? **YES** ☐ **NO** ☐

Item	Person/Donated
_____	_____
_____	_____
_____	_____

20. Please list any special instructions or wishes that are not included above:

_____

_____

_____

_____

_____

_____

FIREFIGHTER / EMPLOYEE INFORMATION FOR ON-DUTY INJURIES & MEDICAL EMERGENCIES

This information is confidential and will be used ONLY in the event the officer/employee is injured on duty OR suffers from a medical emergency while on duty AND is unable to give specific instructions him/herself. This information will be kept sealed, but available to an "on-duty" officer for use in emergency situations only. The "on-duty" officer will make every effort to adhere to the wishes of the employee when making a notification. ***The "on-duty" officer will, however, need to consider ALL the circumstances of the situation when making the notification decision. Of primary concern will be the urgency of the situation and the necessity of getting a family member to the hospital quickly.***

Employee: _____

Hospital preference: _____
Primary physician: _____

Known medical conditions: _____
_____
_____

Medications: _____
_____
_____

Allergies: _____
_____

Primary person to be contacted: _____

Relationship: _____

Contact number: _____

Contact address: _____

Secondary contact: _____

Relationship: _____

Contact number: _____

Contact address: _____

Person(s) you would like to do the notification: _____
_____

Do you have advanced medical directives: ____ YES ____ NO (State of Wisconsin recognizes living will or durable power of attorney for healthcare)

Signature _____ Date _____