GEORGIA DEPARTMENT OF CORRECTIONS

Non- Sworn Employee Hiring Package Checklist

EMPLOYEE INFORMATION	
Name:	

HIRING PACKAGE FORMS		
☐	Employee Hiring Package Form -1	
☐	Employment Eligibility Verification (I-9) - 2	Directions included - 1
☐	Direct Deposit Notification Form - 1	
☐	Authorization for Release of Information - 1	
☐	Loyalty Oath/State Security Questionnaire -2	
☐	Criminal/Driver History Consent Form - 1	
☐	Employee's Withholding Allowance Certificate (G-4) – 1	Directions included - 1
☐	Employee's Withholding Allowance Certificate (W-4) - 2	
☐	Selective Service Verification - 1	
☐	Request for Identification Card – 1	
☐	MAPEP	

Please print and sign this form. Include this form with your hiring package documents.

I certify that I have read and completed the forms above for the hiring package.

Print Name		Date	

Signature: _____

Georgia Department of Corrections Employee Hiring Package Form

Please type in your personal information following the instructions that you printed. Your personal information will be printed in each applicable field on all forms that you will print when you click the print button at the bottom of this form.

Field Name/Description	Applicant/Employee Data					
First Name						
Middle Name			Initial:			
Maiden Name						
Last Name						
Home Address						
Home Apartment Number						
Home City						
Home State						
Home Zip Code						
County of Residence						
Home Phone						
Work Phone						
Social Security Number						
Date of Birth	Month:		Day:		Year:	
Place of Birth						
Employee ID (If Applicable)						
Race						
Gender						
Height	Feet:		Inches:			
Weight						
Eye Color						
Hair Color						
Job Title						

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 OR **List B** AND **List C**		
Identity and Employment Authorization	**Identity**	**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)
		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:		
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		**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.

ERSGA
Employees' Retirement System of Georgia
Serving those who serve Georgia

PSR Peach State Reserves GaBreeze Direct, Easy Access to Your Benefits

GSEPS Automatic Enrollment Acknowledgement Form

I, _____, do hereby acknowledge that as a Georgia State Employees' Pension & Savings Plan (GSEPS) member of the Employees' Retirement System of Georgia, I have been automatically enrolled in the Peach State Reserves 401(k) Plan at a contribution rate of 5% of my eligible before-tax salary. This contribution will be deducted each pay period. I understand that I may elect to change my contribution rate or opt out of the plan at any time by contacting GaBreeze.

I have also received the GSEPS Enrollment Information Notice as part of my new hire informational material from my Human Resources official.

_____
(Please print name)

_____ _____
Employee Signature Date

EMPLOYEES' RETIREMENT SYSTEM OF GEORGIA

G 1 $ E R S

Membership Election Form for Vested Members of the Employees' Retirement System or Teachers Retirement System

Member Name_____ _____
(Please Print) **Social Security Number**

Dept./School_____ **Dept./School ID**_____

O.C.G.A 47-2-181(c)(1-4) and O.C.G.A 47-3-81(b)(1-5) state that any vested member (10 or more years of creditable service excluding forfeited leave) of the Employees' Retirement System (ERS) or the Teachers Retirement System (TRS) who becomes an employee in an agency covered by the other System may elect to remain a member of their vested System. *This election must be made in writing to the Boards of Trustees not later than 60 days of first becoming employed in a position covered by the other System and is* ***irrevocable****.*

To the Boards of Trustees of the ERS and TRS:

☐ Being vested, I elect to *remain* a member of the (check one):

- ☐ Employees' Retirement System
- ☐ Teachers Retirement System

Member Signature:_____ Date:_____/_____/_____

OR

☐ I elect to *become* a member of the (check one):

- ☐ Employees' Retirement System
- ☐ Teachers Retirement System

Member Signature:_____ Date:_____/_____/_____

MEMBER: Upon completion, file a copy of this form with your Human Resources or Payroll office.

EMPLOYER: Send a copy of the completed, signed form to the Employees' Retirement System *and* Teachers Retirement System **within 60 days of hire**.

State Accounting Office of Georgia
Fiscal Leadership for Georgia

Direct Deposit Notification Form

(To be signed by all new hires and rehires on and after May 1, 2010)

In accordance with the Mandatory Direct Deposit policy issued May 1, 2010, as a condition of employment, a person hired or rehired to a position in a State organization on or after May 1, 2010, and who is paid by the PeopleSoft HCM central payroll system (system) administered by the State Accounting Office (SAO), is required to accept all payroll related payments by direct deposit. The complete policy, and related documents, can be found on SAO's website at the following location: State Accounting Office Accounting Policy Manual.

I understand that as a condition of employment, because I am a new hire or rehire applicant, I must comply with the policy and enroll in direct deposit using the Employee Self Service (ESS) feature of the system within 30 days of being hired or rehired and remain enrolled in direct deposit during the tenure of my employment. I understand that I can apply for an exemption from this requirement as provided by the policy. I understand that if I am not granted an exemption, I may be subject to dismissal.

Employee Name (Please Print) _____

Employee Signature: _____ Date: _____

To be completed by employing organization:

Employee ID Number: _____ Position Title: _____

Hiring Organization Name: _____

Hiring Supervisor or HR Official: _____

Copy 1 - Organization Human Resources Office
Copy 2 - Employee

GEORGIA DEPARTMENT OF CORRECTIONS

Name of Applicant

/ /

Date of Birth

AUTHORIZATION FOR RELEASE OF INFORMATION FOR EMPLOYMENT PURPOSES

I hereby request and authorize THE GEORGIA DEPARTMENT OF CORRECTIONS

Address of Local Hiring Authority

to obtain from: Any Law Enforcement Agency, Former Employee or Personal Reference

Name of Person or Agency Holding the Information

The following type(s) of information from my records (and any specific portion thereof):

Criminal background check, character information from personal reference, and Work record from former employers.

for the purpose of completing a Departmental Background Investigation for employment.

All information I hereby authorize to be obtained from this person or agency will be held strictly confidential and cannot be released again without my written consent.

Date

Signature of **Applicant**

Signature of **Witness**

Title or Relationship to Applicant

USE THIS SPACE IF APPLICANT WITHDRAWS CONSENT

Date this consent is revoked by applicant

Signature of Applicant

Revised 1/11

Original

STATE OF GEORGIA
LOYALTY OATH
STATE SECURITY QUESTIONNAIRE

NOTICE TO APPLICANTS/EMPLOYEES: The Sedition and Subversive Activities Act of 1953 (Ga. Laws, 1953), as amended, requires each applicant/employee to complete and sign, prior to his/her employment in State government, a questionnaire which is designed to establish that there are no reasonable grounds to believe that he/she is a subversive person. A subversive person is defined as one who commits acts, advocates, or teaches the overthrow of the government of the United States or government of the State of Georgia by force or violence, or who is a knowing member of a subversive organization. Georgia Code 45-3-11 requires all employees of State government to take an oath that they will support the Constitution of the United States and the Constitution of the State of Georgia.

INSTRUCTIONS: All items must be completed on a typewriter or printed in ink. If more space is needed for any item, or explanation, continue under item 10. This questionnaire and loyalty oath will be filed in the employee's personnel file in the employing agency. The employee may request that a copy be executed for his/her personal files.

FULL NAME, INCLUDING MAIDEN NAME, NAMES OF FORMER MARRIAGES, FORMER NAMES CHANGED LEGALLY OR OTHERWISE, ALIASES AND NICKNAMES AND THE DATES USED.

1.	LAST NAME	FIRST NAME	MIDDLE NAME	PHONE NO.

MAIDEN NAME	DATES USED	NICKNAMES	DATES USED
OTHER NAMES, INCLUDING ALIASES &FORMER MARRIAGES	DATES USED	NICKNAMES	DATES USED
	DATES USED	NICKNAMES	DATES USED

2.	ADDRESS	APT. NO.	CITY	STATE	COUNTY	ZIP

3.	DATE OF BIRTH / /	U.S. CITIZEN _____ Yes _____ No (Nationality _____)	RACE	SEX

4. Are you now or have you been in the last ten (10) years a member of any organization which to *your* knowledge at the time of membership advocates or has as one of its objects, the overthrow of the government of the United States or the government of the State of Georgia by force or violence?

☐ Yes ☐ No

If "Yes", state the name of the organization and your past and present membership status including any offices held therein.

NOTE: If the answer to the above question is "Yes" and the employing authority deems further inquiry necessary, you will be notified of such determination. No action adverse to your application will be taken because of an affirmative answer until after such an inquiry, with notice to you and an opportunity for you to present evidence, and only if the results of such inquiry brings your application within the prohibition within the Sedition and Subversive Activities Act of 1953.

5. LIST CHRONOLOGICALLY ALL OF YOUR PREVIOUS RESIDENCES FOR THE PAST TEN YEARS:

DATES		STREET	CITY	STATE
From	To			

6. LIST NAMES AND ADDRESSES OF THE FOLLOWING:

SPOUSE (MAIDEN NAME)	ADDRESS
FATHER	ADDRESS
MOTHER	ADDRESS

7.	MILITARY SERVICE: (Past or Present)						
	SERIAL NUMBER	BRANCH	ACTIVE SERVICE From	ACTIVE SERVICE To	ACTIVE OR INACTIVE From	ACTIVE OR INACTIVE To	DISCHARGED Honorably ☐ Dishonorably ☐ Other ☐ If Discharge other than Honorable, explain in item 10.

8.	Have you ever been convicted by Federal, State, or other law-enforcement authorities, for any violation of any Federal law, State law, county or municipal law, regulation, or ordinance? (Do not include anything that happened before your sixteenth birthday. Do not include minor traffic violations for which a fine of $35.00 or less was imposed.) ☐ YES ☐ NO If answer is yes, provide the following information		
	CHARGE ON WHICH CONVICTED	DATE CONVICTED	NAME OF COURT & PLACE WHERE CONVICTED

Are you a former inmate, former parolee, or former probationer? ☐ YES ☐ NO If answer is yes, provide dates and details.

9.	Are there any charges now pending against you by Federal, State, or other law enforcement authorities for any violations of any Federal law, State law, county or municipal law, regulation, or ordinance? (Do not include anything that happened before your sixteenth birthday.) Do not include minor violations for which a fine of $35.00 or less would likely be imposed.) ☐ Yes ☐ No If answer yes, provide dates and details.		
	VIOLATION CHARGED	NAME OF GOVERNMENT	NAME OF COURT & LOCATION WHERE PENDING

Are you currently a parolee or probationer? ☐ YES ☐ NO If answer is yes, provide dates and details.

10.	SPACE FOR CONTINUING ANSWERS OR EXPLANATIONS: (Show item numbers to which answers or explanation apply. Attach a separate sheet if more space is needed.)

NOTE: Before signing this form, check all answers and explanations to see that you have answered all questions fully and correctly. This form is to be executed under oath subject to the penalties of false swearing as prescribed in Code Section 16-10-71 of the Criminal Code of Georgia.

LOYALTY OATH

I, _____ , a citizen of United States of America And being

An employee of Georgia Department of Corrections And the recipient of public funds for services rendered as such employee, do hereby solemnly swear and affirm that I will support the Constitution of the United States and the Constitution of the State of Georgia.

AFFIDAVIT OF VERIFICATION

Georgia County

Personally appeared before the undersigned officer, duly authorized to administer _____

_____ ,who, after being duly sworn, deposes and says and declares under penalties of false swearing that he is the person who executed the foregoing instrument; that he has read and completed the same and knows and understands the contents thereof; that the matters stated therein and the answers and information furnished by him in the foregoing questionnaire, and loyalty oath, including any attachments thereto, are true and correct.

_____

SWORN TO AND SUBSCRIBED BEFORE ME: (SIGNATURE OF AFFIANT)

This _____ Day of _____ , 20 ____

_____

(Notary Public)

GEORGIA DEPARTMENT OF CORRECTIONS
CRIMINAL/DRIVER HISTORY CONSENT FORM

PLEASE PRINT

I hereby authorize the Georgia Department of Corrections to receive all criminal history information pertaining to me **anytime** during the course of my employment with the Department. I understand that convictions revealed from these background investigations may impact by certification with P.O. S.T. and my employment with the Department.
Reason (Check one below)
☐ Criminal Justice Employment – Civilian Personnel OR ☐ Criminal Justice Employment POST Certified Employee OR ☐ POST Investigator
Supervisor(if current employee):
Signature:
Position Applied For:

Please Enter Your Personal Information below

Last Name		First Name	
Middle Name		Suffix	
Social Security #		Re-enter SSN#	
Date of Birth	/ /	Weight	
Sex		Race	
Eye Color		Hair Color	
Height		Place of Birth	
Country of Citizenship		D.L. State & #	

Address Information

Address		Address 2	
City		Apt	
County		Zip	
Address State		Email	
Phone #			

****************************PLEASE CHECK ONE OF THE BOXES BELOW************************************

One of the following must be checked:

☐ This authorization is valid for 90/180/___ (circle one) days from date of signature.

☐ I, _____ give consent to the above named to perform periodic criminal history background checks for the duration of my employment with this agency.

REGISTRATION DATE: _____ REGISTRATION ID _____

Retention Schedule: Retain for two years in hiring/selection packet; if hired, retain permanently in local official personnel file.

INSTRUCTIONS FOR COMPLETING FORM G-4

Enter your full name, address and social security number in boxes 1a through 2b.

Line 3: Write the number of allowances you are claiming in the brackets beside your marital status.

A. Single - enter 1 if you are claiming yourself
B. Married Filing Joint, both spouses working - enter 1 if you claim yourself or 2 if you claim yourself and your spouse
C. Married Filing Joint, one spouse working - enter 1 if you claim yourself or 2 if you claim yourself and your spouse
D. Married Filing Separate - enter 1 if you claim yourself or 2 if you claim yourself and your spouse
E. Head of Household - enter 1 if you claim yourself but the individual(s) for whom you maintain a home does not qualify as a dependent; or 2 if you claim yourself and a qualified dependent for whom you maintain a home
Do not claim a deduction on Line 4 for a dependent used to qualify you as head of household

Line 4: Enter the number of dependent allowances you are entitled to claim.

Line 5: Complete the worksheet on Form G-4 if you claim additional allowances. Enter the number from Line H here.
Failure to complete and submit the worksheet will result in automatic denial of your claim.

Line 6: Enter a specific dollar amount that you authorize your employer to withhold in addition to the tax withheld based on your marital status and number of allowances.

Line 7: Enter the letter of your marital status from Line 3. Enter total of the numbers on Lines 3 - 5.

Line 8: Check the box if you qualify to claim exempt from withholding. You can claim exempt if you filed a Georgia income tax return last year and the amount on Line 4 of Form 500EZ or Line 16 of Form 500 was zero, **and** you expect to file a Georgia tax return this year and will not have a tax liability. You can not claim exempt if you did not file a Georgia income tax return for the previous tax year. **Receiving a refund for the previous tax year does not qualify you to claim exempt.**
Do not complete Lines 3 - 7 if claiming exempt.

EXAMPLES: Your employer withheld $500 of Georgia income tax from your wages. The amount on Line 4 of Form 500EZ or Line 16 of Form 500 was $100. Your tax liability is the amount on Line 4 or Line 16; therefore, **you do not qualify** to claim exempt.

Your employer withheld $500 of Georgia income tax from your wages. The amount on Line 4 of Form 500EZ or Line 16 of Form 500 was $0 (zero) and you filed a prior year income tax return. Your tax liability is the amount on Line 4 or Line 16; therefore, **you qualify** to claim exempt.

NOTE: Effective January 1, 2003, the deduction allowed for the dependent is increased from $2,700 to $3,000. This does not apply to the deduction allowed for you or your spouse.

O.C.G.A. § 48-7-102 requires you to complete and submit Form G-4 to your employer in order to have tax withheld from your wages. By correctly completing this form, you can adjust the amount of tax withheld to meet your tax liability. Failure to submit a properly completed Form G-4 will result in your employer withholding tax as though you are single with zero allowances.

Employers are required to mail any Form G-4 claiming more than 14 allowances or exempt from withholding to the Georgia Department of Revenue for approval. Employers will honor the properly completed form as submitted pending notification from the Withholding Tax Unit. Upon approval, such forms remain in effect until changed or until February 15 of the following year. Employers who know that a G-4 is erroneous should not honor the form and should withhold as if the employee is single claiming zero allowances until a corrected form has been received.

DO NOT SUBMIT THIS PAGE
FOR INFORMATION ONLY

Form G-4 (Rev. 10/06)

STATE OF GEORGIA

EMPLOYEE'S WITHHOLDING ALLOWANCE CERTIFICATE

1a. YOUR FULL NAME	1b. YOUR SOCIAL SECURITY NUMBER
2a. HOME ADDRESS (Number, Street, or Rural Route)	2b. CITY, STATE AND ZIP CODE

READ INSTRUCTIONS ON REVERSE SIDE BEFORE COMPLETING THIS FORM

3. MARITAL STATUS (If you do not wish to claim an allowance, enter "0" in the brackets beside your marital status.)

A. Single: enter 0 or 1 ..... [ ]

B. Married Filing Joint, both spouses working: enter 0 or 1 or 2 ..... [ ]

C. Married Filing Joint, one spouse working: enter 0 or 1 or 2 ..... [ ]

D. Married Filing Separate: enter 0 or 1 or 2 ..... [ ]

E. Head of Household: enter 0 or 1 or 2 ..... [ ]

4. DEPENDENT ALLOWANCES [ ]

5. ADDITIONAL ALLOWANCES [ ]
(complete worksheet below)

6. ADDITIONAL WITHHOLDING $ _____

WORKSHEET FOR CALCULATING ADDITIONAL ALLOWANCES

This worksheet must be completed if Line 5 is greater than zero.

1. COMPLETE THIS LINE ONLY IF USING STANDARD DEDUCTION:
   Yourself: ☐ Age 65 or over ☐ Blind
   Spouse: ☐ Age 65 or over ☐ Blind Number of boxes checked _____ x 1300 = $ _____
2. ADDITIONAL ALLOWANCES FOR DEDUCTIONS:
   A. Estimated Federal Itemized Deductions ..... $ _____
   B. Georgia Standard Deduction (enter one): Single/Head of Household $2,300
      Each Spouse $1,500 $ _____
   C. Subtract Line B from Line A ..... $ _____
   D. Allowable Deductions to Federal Adjusted Gross Income ..... $ _____
   E. Add the Amounts on Lines 1, 2C, and 2D ..... $ _____
   F. Estimate of Taxable Income not Subject to Withholding ..... $ _____
   G. Subtract Line F from Line E (if zero or less, stop here) ..... $ _____
   H. Divide the Amount on Line G by $3,000. Enter total here and on Line 5 above ..... _____
      This is the maximum number of additional allowances you can claim. If the remainder is over $1,500 round up.

7. LETTER USED (Marital Status A, B, C, D, or E) _____ **TOTAL ALLOWANCES** (Total of Lines 3 - 5) _____
(Employer: The letter indicates the tax tables in the Employer's Tax Guide)

8. EXEMPT: Skip this line if you entered information on Lines 3 - 7. Read the instructions for Line 8 on page 2.

I claim exemption from withholding because I incurred no Georgia income tax liability last year and I do not expect to have a Georgia income tax liability this year. **Check here** [ ]

I certify under penalty of perjury that I am entitled to the number of withholding allowances or the exemption from withholding status claimed on this Form G-4. Also, I authorize my employer to deduct per pay period the additional amount listed above.

Employee's Signature _____ Date _____

Employer: Complete Line 9 and mail entire form only if the employee claims over 14 allowances or exempt from withholding.
If necessary, mail form to: Georgia Department of Revenue, Withholding Tax Unit, P. O. Box 49432, Atlanta, GA 30359.

9. EMPLOYER'S NAME AND ADDRESS:

EMPLOYER'S FEIN: _____

EMPLOYER'S WH#: _____

Do not accept forms claiming additional allowances unless the worksheet has been completed. Do not accept forms claiming exempt if numbers are written on Lines 3 - 7.

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.

SELECTIVE SERVICE VERIFICATION

State Law requires all selected male applicants between the ages of 18 and 26 to present proof of having registered with the Selective Service System or to present proof of being exempt from registration prior to beginning State employment.

In accordance with State Law, I have verified that _____
[Name of Applicant]

[check one]

☐ Has registered with the Selective Service System (attach copy of the registration card or screen print from the Selective Service System Internet web site: www.sss.gov)

OR

☐ Is exempt from registration with the Selective Service System (attach verifying documentation)

_____ _____
[Name of Official – please print] [Title]

_____ _____
[Signature of Official] [Date]

Published 11/1/00

GEORGIA DEPARTMENT OF CORRECTIONS
REQUEST FOR IDENTIFICATION CARD

COMPLETE TOP PORTION ONLY			
Full Name		Social Security #	
Employee ID or Scribe ID		Job Title	
Facility/Unit		Division	
Contractor/ Organization Representing			

TYPE OF IDENTIFICATION CARD Check applicable lines *(For Police Powers Card, please use Police Powers Request Form)*					
☐	Employee ID	☐		Employee Locator	
☐	Employee Retiree				
☐	Volunteer ID	☐		Volunteer Locator	
☐	Contractor ID	☐		Contractor Locator	
Contrctr Pstn		Contractor Title			

REPLACEMENT			
Do you have an ID card to turn in?		☐ No	☐ Yes
	Was your Id Lost or Stolen?	☐ No	☐ Yes – Complete a **Report for Missing Identification Card** form and an **Incident Report**

APPOINTING AUTHORITY SIGNATURE (Identification Card will not be issued if Employee/Scribe ID number is missing and Appointing Authority Approval signature is omitted, *unless this is for SOSTC employee*)			
Appointing Authority's Approval			
Print Name		Date	
Title		Facility/Unit	

ID CARD ISSUANCE - For Human Resource Office Use Only – Circle all types issued			
EMPLOYEE/RETIREE	LOCATOR	CONTRACTOR	VOLUNTEER

Expiration Date:		Signature	
Imaging Site			

ID RECIPIENT SIGNATURE Card holder acknowledges receipt of			
☐ Empl/Retiree ID	☐ Volunteer ID	☐ Contractor ID	☐ Locator Card

Signature		Date	

Retention Schedule: Retain permanently in local personnel file (official personnel file if made in CHRM); copy retained for two (2) years at imaging site for any employee from a non-imaging site.

GEORGIA
DEPARTMENT OF CORRECTIONS

State of Georgia
Manual for Medical and Physical Examination Program (MAPEP)
SPECIALIZED MEDICAL GUIDELINES- Category 5 Positions

Candidates for "Category 5" positions must meet the requirements set forth in the General Medical Guidelines plus the following specific physical standards.

A. General: Height and weight should not be such as to interfere with specific job activities.

B. Vision: 1) Distant vision -- minimum vision of 20/40 in each eye, corrected (with glasses or contact lenses) and at least 20/100 in each eye uncorrected (without glasses or contacts). **2) Near vision --** minimum of 20/40, corrected or uncorrected in each eye. **3)** Adequate depth perception and the ability to distinguish colors. **4) Peripheral vision --** at least 70 degrees in each eye.
All Category 5 positions are subject to the guidelines above for 2) Near Vision, 3) Depth perception and the ability to distinguish colors, and 4) Peripheral Vision. The following are position specific exceptions to the 1) Distant Vision guidelines only.

- **For GBI: Special Investigation Agent series only: 1) Distant vision --** minimum vision of 20/20 in one eye and 20/40 in the other eye, corrected (with glasses or contact lenses), and minimum of 20/200 in each eye, uncorrected (without glasses or contacts).
- **For Trooper/ GSP series only: 1) Distant vision** -- minimum vision of 20/40 in each eye, corrected (with glasses or contact lenses), and minimum of 20/60 in each eye, uncorrected (without glasses or contacts).
- **For Correctional Officer series, Firefighting & Fire Prevention Specialist series, Probation Officer series, and Parole Officer series: 1) Distant vision** -- minimum vision of 20/40 in each eye, corrected or uncorrected (with or without glasses or contact lenses).

C. Hearing: Hearing loss no greater than 24dB (decibels) for the average of frequencies 500Hz, 1000Hz, 2000Hz, and 3000Hz in the better ear, unaided (without a hearing aid) or aided (with a hearing aid).
"Normal hearing" is a hearing loss no greater than 24 dB at 250Hz, 500Hz, 1000Hz, 2000Hz, 3000Hz, 4000Hz, 6000Hz, 8000Hz in both the right and left ears, unaided.

- An Otoscopic examination is required prior to the air conduction audiogram.
- A complete pure tone or warble tone air conduction audiogram is required, and results recorded for all candidates. **The audiogram must be completed at all frequencies listed on Form MS 10-56 on both the right and left ears.** The pure tone air conduction audiogram is to be used as the baseline audiogram.
    - If the testing indicates air conduction thresholds to be within the stated hearing guidelines for employment, no further hearing testing is necessary. However, if any

single air conduction threshold is obtained outside the normal, 0-24dB range; i.e., if hearing is not within "normal limits", the results of the test are explained to the candidate and the recommendation is made to obtain a complete audiological evaluation at the individual's expense for his/her own hearing healthcare benefit.

- If the testing indicates air conduction thresholds to be outside the stated hearing guidelines for employment, the results of the test are explained to the candidate and a complete audiological evaluation is recommended, at the individual's expense for his/her own hearing healthcare benefit.

- In addition to the pure tone air conduction testing, warble sound field testing is required and results must be recorded for all candidates who wear a hearing aid and do not meet the guidelines on the air conduction test, to verify if an individual meets the guideline for employment with the use of a hearing aid. If the site does not have the personnel or equipment to satisfy this requirement, then a referral is indicated.

- A qualified individual should administer the audiometric testing and perform the otoscopic examination. Qualified individuals include licensed audiologists, otolaryngologists, physicians trained in hearing conservation, technicians who are certified by the Council for Accreditation of Occupational Hearing Conservation, or technicians trained by such a physician. A technician who performs audiometric tests must be responsible to an audiologist, otolaryngologist, or physician.

- All tests should be performed in an acoustic environment to meet the current ANSI standards.

- All audiometric equipment should be calibrated annually to meet current ANSI standards.

D. ENT: There should be adequately free nasal breathing. The mouth should be free from deformities or conditions that interfere significantly with distinct speech.

E. Cardiovascular: Rheumatic and congenital heart disease should be thoroughly evaluated by the examining physician and commented on in the examination report. Atherosclerotic (arteriosclerotic) heart disease, myocardial infarction, coronary insufficiency, angina pectoris, and hypertension above 140/90 must be evaluated on an individual basis and must not be of sufficient severity to interfere with the performance of all duties.

F. Respiratory: Free of infectious diseases or other pulmonary processes that would interfere with the physical demands of the position.

G. Gastrointestinal: Must be free of any major pathological conditions that will interfere with the performance of physical requirements of the position.

H. Rectum and Anus: Major hemorrhoidal conditions and symptomatic pilonidal cysts must not be of sufficient severity to interfere with the job.

I. Hernia: Hernia (E) which might interfere with the performance of duty would require surgical repair with clearance from operating surgeon, prior to employment.

J. Genital/Urinary: Large varicocele or hydrocele, which might interfere with the performance of duties, should be repaired with clearance from operating surgeon prior to employment.

K. Back and Neck: History of significant injury, deformity, surgical procedure, or other spinal pathology should be thoroughly evaluated by the examining physician and commented on the examination report.

L. Extremities: *If a prosthesis or orthosis is used, such prosthesis or orthosis must not interfere with the performance of duty. 1) Upper Extremities -- both hands must have at least the index, middle, and one other finger and must not interfere with the performance of duty; both thumbs must be functional; or see (*) above. 2) Lower Extremities -- both lower extremities must be free from limitation of any joint motion which would interfere with the performance of duties; both great toes must be functionally normal; or see (*) above.

M. Nervous System: Central and peripheral nervous system disorders must be evaluated by the medical examiner. Applicants with seizures must be thoroughly evaluated by the examining physician and all findings included in the examination report. Special attention must be given to any history of seizure activity.

N. Emotional Stability: Any history of significant emotional instability or mental illness should be thoroughly evaluated by the examining physician and commented on in the examination report.

O. Laboratory Analysis: Items 1 through 4 are not required unless medical history or physical examination results indicate that such tests are needed to adequately assess the applicant's physical status. Item 5 is required for Correctional Officers (including Juvenile Correctional Officers) only.

1. Urinalysis (Multi-Test Stick): Abnormalities in the sugar and albumin tests must be evaluated further. If Glycosuria is significant, must have Glucose Tolerance Test and if albuminuria, must have the cause identified.
2. Hemoglobin or Hematocrit.
3. Chest x-ray.
4. Resting Electrocardiogram.
5. Tuberculin Skin Test. (**For Correctional Officer Series Only**) If there is a positive reaction of 10mm or greater, a chest x-ray is required to document the absence of tuberculosis.

MS Form 10-56

GEORGIA
DEPARTMENT OF CORRECTIONS

ADDITIONAL TEST(S) REQUESTED
Urinalysis
Pulmonary Function
Tuberculin Skin Test (TST)
EKG/Resting
EKG/Stress
Hemoglobin/Hematocrit
Chest X-Ray
Back X-Ray
Other Tests

STATE OF GEORGIA

MEDICAL AND PHYSICAL
EXAMINATION PROGRAM

Medical Findings

NOTE TO EXAMINING PHYSICIAN
The person you are about to examine is being evaluated for the position described at the bottom of the third page of this form. In conducting your exam and reporting your findings and conclusions, take the job duty data into consideration.

ALL FIELDS IN THIS FORM MUST BE FILLED IN OR THE REVIEWING PHYSICIAN WILL RETURN THE FORM TO YOU.

1. Examinee's Name	2. SSN	3. Height (Feet, Inches)	4. Weight (pounds)

5. Vision Evaluation

Depth Perception	Within Normal Limits Yes ☐ No ☐	Peripheral Vision Right Eye _____ Left Eye _____
	Distant Vision	Near Vision
a. Without Glasses ☐	Right 20/ _____ Left 20/ _____	b. Without Glasses ☐ Right 20/ _____ Left 20/ _____
c. With Glasses ☐	Right 20/ _____ Left 20/ _____	d. With Glasses ☐ Right 20/ _____ Left 20/ _____
e. Is color vision normal when Ishihara or other color plate test is used? ☐ Yes ☐ No		f. If the answer is "No", can applicant pass lantern or other compatible? ☐ Yes ☐ No

6. Hearing Evaluation

a. OTOSCOPIC EXAMINATION: Right Ear _____ Left Ear _____

b. PURE TONE AIR CONDUCTION TEST RESULTS: (This section is to be used for all pre employment air conduction hearing testing.)

Right Ear								Left Ear							
250	500	1000	2000	3000	4000	6000	8000	250	500	1000	2000	3000	4000	6000	8000

c. SOUND FIELD PURE TONE/WARBLE TONE TEST RESULTS: (This section is to be used in conjunction with the pure tone air conduction testing section for all individuals with hearing aids who do not meet the guidelines on the air conduction test.)

	250	500	1000	2000	3000	4000	6000	8000
Sound Field Test								

If individual meets the stated hearing guideline, no further hearing testing is necessary for the purpose of employment. *However, if any single air conduction threshold is obtained outside the normal, 0-24dB range, the results of the test must be explained to the candidate and the recommendation made to obtain a complete audiological evaluation at the individual's expense.*

d. AUDIOMETER SERIAL #: _____ e. DATE OF CALIBRATION: _____

f. **MEETS HEARING GUIDELINES:** ☐ Yes ☐ No

RESTRICTED/MEDICAL

7. Blood Pressure/Pulse		
a. Systolic/diastolic	b. Two additional Readings if elevated	c. Pulse

8. Physical Examination

Clinical Evaluation	Normal	Abnormal	Remarks
a. Head, face, neck, and scalp			
b. Nose			
c. Mouth and Throat			
d. Ears			
e. Eyes			
f. Ophthalmoscopic			
g. Ocular motility			
h. Lungs and Chest (Breast, if indicated)			
I Heart			
j. Vascular system (Varicosities, etc.)			
k. Abdomen			
l. Anus and rectum (If indicated)			
m. Endocrine system			
n. Hernia (Any type)			
o. Upper extremities			
p. Feet			
q. Lower extremities			
r. Spine			
s. Identifying body marks, scars			
t. Skin, lymphatics			
u. Neurological			
v. Mental status			

9. Allergies

1.	3.
2.	4.

10. Surgery

Type of Surgery	Date (Mo/Yr)
1.	
2.	
3.	
4	

11. Comments/Implications for Fitness for Duty

12. Physician Signature and Address

a. Physician's Name (Type or Print)	b. Physician Telephone	c. Address
d. Signature	e. Date	

13. Employer Name and Address

IMPORTANT: Examining Physician -- Return all materials supplied by the prospective employee to the employer address provided.	Return to:

In order to comply with "The Genetic Information Nondiscrimination Act of 2008 (GINA), we ask that you NOT provide any genetic information when responding to this request for medical information. This includes family medical history, results of genetic tests, information regarding genetic services, and genetic information about an individual's or family members' fetus or embryo.

DESCRIPTION OF WHAT A CORRECTIONAL OFFICER IS REQUIRED TO DO:
Position requires employee to supervise and maintain control and custody of offenders at correctional facilities and work sites; observe and monitor offenders for improper conduct and escape attempts; use physical force to restrain offenders; respond quickly to emergency situations (e.g., escapes, riots); utilize and operate security and/or manual labor work detail equipment (including motor vehicles in some classes); stand for extended periods of time; and engage in correctional officer training of a physical nature. The physical requirements for training are: Male: 16 push-ups in one minute, 25 sit-ups in one minute and a 13-minute mile. Female: 8 push-ups in one minute, 16 sit-ups in one minute and a 13-minute mile.

GEORGIA
DEPARTMENT OF CORRECTIONS

MEDICAL AND PHYSICAL EXAMINATION PROGRAM (MAPEP)

Inquiry Authority/Use Statement

The collection of this information is authorized by O.C.G.A. 45-2-40. This information will be used to determine fitness for duty and to provide protection to employees from potential harmful effects associated with this employment. Unless otherwise stated, this information may be disclosed to the hiring agency, State agencies responsible for State benefits and workers' compensation programs, and, where pertinent, to an appropriate law enforcement agency for investigation for prosecutive purposes or in a legal proceeding to which the hiring agency is a party. As provided by the Americans with disabilities Act of 1990 (Public Law 101-336), this information is to be filed separately from other personnel records and is to be used only for legitimate, non-discriminatory hiring and placement purposes with reasonable accommodation, where appropriate. Completion of this form is voluntary; however, if this information is not provided, the individual may not receive the requested benefits or employment.

A: Completed by Employee

1. Employee Name: _____ (Last / First / Middle) 2. _____-_____-_____ (Social Security Number)

3. Race _____ 4. Sex: ☐ Female ☐ Male 5. _____ (Date of Birth) 6. _____ (Daytime Telephone Number)

7. Address: _____

_____

_____

8. Position Title: _____

9. Position Number: _____

10. Location of Position: _____

11. Direct Contact for Position Information

a. Name: _____

b. Title: _____

c. Phone: _____

d. E-Mail: _____

e. Fax: _____

f.. Dept.: _____

g. Unit: _____

h. Address: _____

_____

_____

_____

12. Have you been provided detailed information on the duties of this position? □ Yes □ No

13. Do you understand the functional requirements and environmental factors of this position? □ Yes □ No

14. Are you capable of performing the duties and responsibilities of this position (with reasonable accommodations, if necessary, as described in Section A, Item #17)? □ Yes □ No

For the following questions, explain a "Yes" answer in the space provided below

15. Have you ever been employed by the State of Georgia? □ Yes □ No

16. Have you had a physical examination for employment with the State of Georgia within the past twelve month period? □ Yes □ No

17. Is there anything in your past medical history, of which you have knowledge that would prevent your being able to perform the duties of this position? □ Yes □ No

Explanation of items 15-17 checked "Yes." Enter item number before each comment.

_____

_____

_____

I certify that all information given by me in connection with this medical assessment is true to the best of my knowledge and belief. I agree and understand that any misstatements of material facts may cause forfeiture on my part of all right to employment in the service of the State of Georgia; may result in dismissal after appointment; or may result in loss of entitlement to disability retirement benefits. My signature also indicates that I understand all of the questions on this form.

20. _____ 8. _____
Signature of Employee Date

B: Completed by Employer

1. Indicate type of job information used for medical review (check all that apply):
   - □ Job description
   - □ Performance standards
   - □ Functional requirements analysis
   - □ Environmental factors analysis
   - □ Other (please specify) _____

2. Check job category:
   - □ Category 1 Sedentary
   - □ Category 2 Active
   - □ Category 3 Food Handling
   - □ Category 4 Health-related
   - □ Category 5 Law Enforcement

3. Describe any notable or unusual job requirements or working conditions: (continue on separate page, if needed)

4. Were any "reasonable accommodations" needed? If "Yes," describe: ☐ Yes ☐ No

(Type or Print Official Contact's Name)

6. _____ 20. _____
Signature of Official Contact Date

GEORGIA
DEPARTMENT OF CORRECTIONS

MEDICAL AND PHYSICAL EXAMINATION PROGRAM (MAPEP)

Health Information Checklist

This checklist contains questions regarding your medical history and health. The primary use of this information will be to alert the employer and applicant of conditions that could negatively impact the health of customers or co-workers. This information may be used to determine fitness to perform job duties. This information will be handled in a confidential manner. It is essential that you answer all questions truthfully and completely. False or incomplete information may result in disqualification or termination if hired.

Completed by Applicant/Employee

(Type or Print in Ink)

Section I

Date: _____

Employee Name: _____ Social Security Number _____-_____-_____

Last, First Middle

Employing Agency: _____ Date Employed: _____

Section II

Have you now, or ever had the following?	Yes	No
1. Loss of sight of both eyes. Loss of uncorrected (without glasses or contact lens) vision of more than 75% bilaterally (vision of 20/160 or J* or worse using both eyes).		
2. Diabetes		
3. Tuberculosis		
4. Epilepsy (convulsions, seizures or fits)		
5. Ankylosis (immobility) of major weight bearing joints (ankles, knee, hip)		
6. Any permanent condition which causes 20% (or more) impairment of a foot, leg, hand, arm, back, or the body as a whole		
7. Arthritis which is a hindrance to employment		
9. Amputated (loss of) foot, leg, arm, or hand		
10. Parkinson's disease (Paralysis Agitans)		
11. Cerebral palsy		
12. Multiple sclerosis		
13. Mental retardation (intelligence quotient within the lowest two percent of the general population)		

	Yes	No
14. Psychoneurotic disability following confinement for treatment in a recognized medical or mental hospital for a period in excess of six months.		
15. Hemophilia		
16. Sickle cell anemia		
17. Cardiovascular (heart or blood vessel) disease		
18. Total occupational loss of hearing (loss of over half of hearing in each ear)		
19. Compressed air sequelae (damage to lungs, ruptured ear drum, etc e to air concussion, blasting, explosion, etc.)		
20. Muscular dystrophy		
21 Hyperinsulinism (hypoglycemia)		
22. Residual disability from poliomyelitis (Disability due to polio)		
23. Ruptured intervertebral (back) disc		
23. Chronic osteomyelitis (bone infection)		
24. Hepatitis		

REMARKS:_____

_____

_____

_____ _____

Signature of Employee Date

(MS Form 10-52)

GEORGIA
DEPARTMENT OF CORRECTIONS

STATE OF GEORGIA Name_____ Soc. Sec. No. _____-_____-_____

MEDICAL AND PHYSICAL Job Title _____ Department _____

EXAMINATION PROGRAM

MEDICAL HISTORY REPORT Job Category (circle one) 1 2 3 4 5

The purpose of these questions is to gather information concerning your health and physical condition, both now and in the past. This information will be used only to determine whether you can safely perform the duties of the job for which you are being considered. Please answer all of the following questions as fully and completely as you can. If you don't understand a question, or are unsure of how to answer it, leave it blank and request assistance.

I certify under penalty of perjury, that the information given by me is true to the best of my knowledge and belief. I agree and understand that any misstatements of material facts may cause forfeiture on my part of all right to employment in the service of the State of Georgia, may result in dismissal after appointment; or may result in loss of entitlement to disability retirement benefits. My signature also indicates that I understand all of the questions on this medical history form.

EMPLOYEES' SIGNATURE: _____ DATE: _____

Individual History – To Be Completed By Applicant/Employee (Use Ink)

A. MEDICAL CONDITIONS. Check every item. Do you have or have you ever had any of the following: (If "Yes," give date of most recent occurrence and explain on page 3.)

Health Condition	*Yes*	*Year*	*No*
HEAD, NOSE, MOUTH AND THROAT			
1. Persistent or severe headaches			
2. Frequent nose bleeds			
3. Frequent nasal congestion			
4. Persistent or severe sinus condition			
5. Bleeding gums			
6. Persistent or severe dental condition			
7. Hoarse when don't have cold			
8. Difficulty swallowing			
9. Persistent sore throat			
10. Loss of taste or smell			
11. Head injury			
12. Other head, nose, mouth or throat conditions:			
EARS AND HEARING			
13. Hearing difficulties			
14. Use hearing aid			
15. Ringing in ears (tinnitus)			
16. Perforated ear drum			
17. Persistent or severe ear infection			
18. Other ear or hearing conditions			
EYES AND VISION			
19. Glaucoma			
20. Cataract			
21. Eye irritations (itching or burning)			
22. Eye infection			
23. Defective vision			
24. Color blindness			
25. Injury to eye			
26. Eye surgery			
27. Double vision			

Health Condition	*Yes*	*Year*	*N o*
28. Glasses			
29. Contact lenses			
RESPIRATORY SYSTEM (lungs & breathing)			
30. Persistent or severe colds			
31. Persistent or severe cough			
32. Coughing blood			
33. Asthma or breathing difficulty			
34. Emphysema			
35. Pneumonia			
36. Tuberculosis			
37. Other lung or breathing condition:			
CARDIOVASCULAR SYSTEM (heart & blood vessels)			
38. Heart attack			
39. Hardening of the arteries (Arteriosclerosis)			
40 High or low blood pressure			
41. Heart murmur			
42. Palpitations or irregular heart beat			
43. Episodes of chest pains, tightness, discomfort			
44. Shortness of breath			
45. Varicose veins			
46. Swelling of ankles, feet or legs (edema)			
47. Leg pains, cramps			
48. Other cardiac conditions:			
GASTROINTESTINAL SYSTEM (stomach & intestines)			
49. Persistent or severe nausea or indigestion			
50. Persistent or severe stomach pain			
51. Vomiting blood			
52. Persistent or severe vomiting			
53. Hernia (rupture)			
54. Stomach or duodenal ulcer			

Health Condition	Yes	Year	No		Health Condition	Yes	Year	No
55. Colitis					99. Trick or locked knee			
56. Hemorrhoids or piles					100. Knee surgery			
57. Change in bowel habits					101. Foot problems			
58. Black stool or blood in stool					102. Bone infection			
59. Persistent or severe constipation					103. Broken or fractured bone			
60. Persistent or severe diarrhea					104. Persistent or severe muscle aches or pains			
61. Pancreatitis					105. Other Musculoskeletal conditions:			
62. Appendicitis					ENDOCRINE/METABOLIC SYSTEM			
63. Other conditions of stomach or intestines					106. Diabetes			
LIVER, SPLEEN & GALLBLADDER					107. Thyroid condition or disease			
64. Cirrhosis					108. Hypoglycemia			
65. Hepatitis					109. Unexplained weight gain or loss			
66. Yellow jaundice					110. Unusual loss or growth of body hair			
67. Gallstones					111. Gout			
68. Other conditions of liver, spleen or gallbladder					112. Osteoporosis or other bone disease			
KIDNEYS & URINARY TRACT					SKIN			
69. Kidney stones					113. Rash			
70. Kidney infection					114. Hives			
71. Blood or pus in urine					115. Moles that bleed or get larger			
72. Pain or burning when urinating					116. Change in color of skin (other than suntan)			
73. Frequent urination					117. Frequent boils/abscesses			
74. Albumen or protein in urine					118. Trouble with fingernails			
75. Prostate condition					119. Small itching blisters on the side of fingers or palms			
76. Burning discharge from penis					120. Sores that do not heal			
77. Other conditions of kidneys or urinary tract					121. Other skin conditions:			
REPRODUCTIVE SYSTEM (FEMALES ONLY)					BLOOD/LYMPH (hematologic) SYSTEMS			
78. Pregnant at present					122. Anemia			
NEUROLOGICAL (Nervous) SYSTEM					123. Bleeding disorder			
79. Epilepsy, convulsions, seizures					124 Sickle cell disease or trait			
80. Periods of blackouts/loss of consciousness					125. Phlebitis/blood clot			
81. Fainting spells					126. Blood transfusion			
82. Dizzy spells (vertigo)					127. Chills, fever, night sweats			
83. Memory difficulty					128. Lymph node or glandular swelling that persists			
84. Tremor of the hands or head					129. Other conditions of blood or lymph:			
85. Paralysis of any type					CANCER			
86. Stroke					130. Surgery			
87. Severe numbness, tingling or weakness					131. Radiation therapy			
88. Dyslexia/learning difficulty					132. Chemotherapy			
89. Other conditions of neurological (nervous) system:					133. Immunotherapy			
MUSCULOSKELETAL SYSTEM					134. Hormone therapy			
90. Arthritis					135. Breast			
91. Bursitis/tendonitis					136. Bone			
92. Swollen or painful joints					137. Skin			
93. Dislocations					138. Other			
94. Painful or trick shoulder					PSYCHOLOGICAL/MOOD			
95. Elbow problems					139. mental problem requiring hospitalization			
96. Wrist or hand problems					140. Suicidal/attempted suicide			
97. Back pain					141. Active psychosis			
98. Back surgery					142. Drug, narcotic or alcohol			

Health Condition	*Yes*	*Year*	*No*		*Health Condition*	*Yes*	*Year*	*No*
143. Persistent or severe depression/worry					ALLERGIES (caused by)			
144. Other psychological conditions:					152. Medication			
INFECTIOUS OR CHILDHOOD DISEASES					147. Rheumatic fever			
145. Meningitis/encephalitis					153. Food			
146. Polio					154. Soaps or detergents			
148. Mumps					155. Pollen			
149. Measles					156. Insect bites/scales			
150. Venereal Disease					157. Other:			
151. Other:								

Explanation of items checked "Yes." Enter item number (1-157) before each comment.

_____

_____

_____

_____

_

B. CURRENT MEDICATIONS: _____

_____

C. SURGICAL HISTORY

Have you ever had surgery? ☐ **Yes** ☐ **No**

[If "Yes, complete the following information about each surgery]

TYPE OF SURGERY DATE (Mo/Yr)

1. _____ _____

2. _____ _____

D. HOSPITALIZATION HISTORY

Have you ever been hospitalized? ☐ **Yes** ☐ **No**

[If "Yes," complete the following information about each hospitalization.]

REASON FOR HOSPITALIZATION DATE (Mo/Yr)

1. _____ _____

2. _____ _____

3. _____ _____

Georgia Peace Officer Standards & Training Council

Physician's Affidavit

Physician's Affidavit – PAGE 1 of 2

Candidate's Name			SS#
HEIGHT	WEIGHT lbs	SEX/GENDER	Date of Birth *(mm/dd/yyyy)*

PHYSICIAN'S INSTRUCTIONS: Please complete this form & answer all questions related to your medical examination of this candidate. Do the following steps:

- **Review the candidate's job duties/responsibilities.** This candidate is applying to become a certified officer and will be required to meet the relevant job demands and working conditions of an officer in GA.
- **Complete the patient information and then conduct your physical exam.**
- **Review the patient's Medical and Physical History.**
- **Answer all questions.** Check the appropriate block for each question & provide any necessary comments.
- **SIGN & DATE** on the appropriate page of this form and provide your address & phone #.
- **Give all forms to the candidate** for return to the hiring agency**.**

Questions:

1.) In your opinion, does the candidate have, or is the candidate likely to develop, any physical symptoms or limitations that could impair performance in this position?

☐ No - Proceed to question next question.
☐ Indeterminate - Describe additional tests or information required prior to making final determination.

☐ Yes - Describe the impact of these limitations including the following criteria: Job functions affected, Nature & degree of severity, Duration of impairment (if intermittent or temporary), & Likelihood(s) associated with this impact.

2.) In your opinion, could the candidate's performance in this position result in a risk to the health and safety of the candidate or others?

☐ No - Proceed to next question.
☐ Indeterminate - Describe additional tests or information required prior to making final determination.

☐ Yes - Describe the impact of these limitations including the following criteria: specific job duties/functions and/or working conditions that precipitate the risk, nature & severity of potential harm, ipact of harm on self and/or others, likelihood(s) associated with this risk, and imminence and duration of the threat;

3.) Please describe any means, devices or work restrictions that could reduce or eliminate any identified risks to a level not significantly greater than that posed by the average candidate. Include the manner in which the accommodation needs to be implemented, maintained, and monitored; any side effects or risks associated with the accommodation; and a revised estimate of the candidate's viability in this position if it is implemented.

Georgia Peace Officer Standards & Training Council

Physician's Affidavit

Physician's Affidavit – PAGE 2 of 2

Candidate's Name:

4.) In summary, my overall evaluation of the ability of the above named candidate to safely perform the duties of this position? (*choose one below*)

☐ This candidate has ***no*** **physical, emotional, or mental** conditions that might adversely affect his/her ability to perform the duties of a peace officer or take part in training programs relative to law enforcement. **Comments**:

☐ This candidate has **no physical conditions** that might adversely affect his/her ability, **but** there are some concerns that should be addressed regarding **one or more emotional or mental conditions** that could adversely affect their ability. (Please state recommendations on how to address here.) **Comments**:

☐ This candidate has **no emotional or mental conditions** that could adversely affect their ability, **but** there are some concerns that should addressed regarding **one or more physical conditions** that could adversely affect their ability. (Please state recommendations on how to address here.) **Comments**:

☐ This candidate has **one or more physical** , **emotional, or mental conditions** that could adversely affect their ability that need to be addressed. (Please state recommendations on how to address here.) **Comments**:

(Please note that this exam ***must be conducted by a licensed physician or osteopath***, and the form **signed** by a licensed physician or osteopath only. ***Forms signed by other personnel such as nurses, nurse practitioners, physician's assistant, or other staff WILL BE REJECTED.***

EXAMINING PHYSICIAN'S NAME (printed)	**SIGNATURE OF LICENSED EXAMINING PHYSICIAN (*required*)**	**DATE** (m/d/yyyy)
Last First		

ADDRESS OF LICENSED EXAMINING PHYSICIAN'S PRACTICE	**Phone: Area Code+Number ( )**
Street City, State, Zip	

SECTION 2: HIRING AUTHORITY'S ASSESSMENT (TO BE COMPLETED BY HIRING AUTHORITY)

Based on the information provided by the physician and the candidate, it is my belief that the candidate meets the state standards for this position and can safely perform the essential job demands of the position for which they are being hired. If a reasonable accommodation is necessary for this individual and the state standards are still met, I have attached a letter explaining the necessary accommodations.

AGENCY HEAD *(OR DESIGNEE)* ***Signature*** *(required)*	DATE

☐ Accommodation Noted:. Check here if a letter from agency head giving details of accommodation is attached (***required***). This letter indicates that the candidate needs a reasonable accommodation which can be implemented without undue hardship to the agency & still meets state standards.