NEW EMPLOYEE PACKET FOR NON-TEACHING POSITIONS

Before completing your paper work, be sure you have completed the fingerprinting process. If you have not, please revisit step one of the New Hire Process listed under I want to... > Complete Hiring Process on the main page of the district website www.escambiaschools.org . Once you have completed your background screening, please print the following documents and complete to the best of your ability PRIOR to attending your new hire appointment. We have provided the documents in order to shorten the time spent in your appointment with us in the Human Resource Services Department located at the Dr. Vernon McDaniel Building located at 75 North Pace Boulevard, Pensacola, Florida 32505.

- ☐ Personnel Data Sheet (Page 2)
- ☐ EEO Data Collection Form (Page 3)
- ☐ Florida Retirement System Certification Form (Page 4-5)
- ☐ School Board Policy, Chapter 2.37 Drug-Free Workplace, ~~Chapter 2.47 Tobacco/Cotinine/Nicotine-Free Hiring Policy~~ (*This is being provided for informational purposes and is not required to be returned.)* (Page 6-12) SUSPENDED FROM JULY 1, 2022 – JANUARY 1, 2026
- ☐ Acknowledgment of Receipt of the Drug~~/Tobacco/Cotinine/Nicotine~~-Free Workplace Policy (Page 13)
- ☐ Statement on the Collection of Social Security Numbers Form (Page 14-15)
- ☐ W-4 Form (Page 16-19)
- ☐ Direct Deposit Authorization Form (A*ttach a voided check for the account you plan to have your paycheck deposited, or have your financial institution complete the form.)* (Page 20)
- ☐ Medical History Questionnaire (Page 21-25)

Friendly reminders for the day of your new hire appointment:

- Please plan to bring documents to prove eligibility to work.
- Your appointment will take from an hour and a half to three hours.
- You will be required to travel directly to the drug testing facility immediately upon completion of your paper work.
- It is the labs policy that you may not bring children under 12 years of age with you.

Escambia County School District

Personnel Data Sheet

Name:

_____ _____

(Last, First and Middle) (Maiden)

Residence Address:

_____

(Street/Apartment Number, City, State and Zip)

Mailing address (if different than above):

_____

(Street/Apartment Number, City, State and Zip)

Primary Number: _____ Secondary Number: _____

Alternate Phone Number: _____

**Primary numbers are used for auto call systems.*

Email Address: _____

Emergency Contact: _____ Phone: _____

Relationship to Employee: _____ Alt. Phone: _____

Have you ever worked for the Escambia County School District: ☐ Yes ☐ No

If Yes, Please list position and employment dates:

_____

Escambia County School District
EEO Data Collection Form

Name: _____ _____
(Last, First and Middle) (Maiden)

Date of Birth (MM/DD/YYYY): _____

1. What is your gender?
   - ☐ Female
   - ☐ Male

2. What is your marital status?
   - ☐ Single
   - ☐ Married
   - ☐ Divorced
   - ☐ Widowed

3. What is your race/ethnicity? (Please mark all that apply. At least one option must be selected.)
   - ☐ **Hispanic or Latino** - A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin regardless of race.
   - ☐ **White (Not of Hispanic origin)** - All persons having origins in any of the original peoples of Europe, North Africa or the Middle East.
   - ☐ **Black or African American (Not Hispanic or Latino)** - A person having origins in any of the black racial groups of Africa.
   - ☐ **Asian (Not Hispanic or Latino)** - A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian Subcontinent, including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.
   - ☐ **Native Hawaiian or Other Pacific Islander (Not Hispanic or Latino)** - A person having origins in any of the peoples of Hawaii, Guam, Samoa, or other Pacific Islands.
   - ☐ **American Indian or Alaska Native (Not Hispanic or Latino)** - A person having origins in any of the original peoples of North and South America (including Central America), and who maintain tribal affiliation or community attachment.
   - ☐ **I do not wish to disclose** – If you choose not to self-identify your race/ethnicity at this time the federal government requires this employer to determine this information by visual survey and/or other available information.

☐ STAFF DESIGNATION: _____ STAFF INITIALS: _____

Signature: _____ Date: _____

The School District is subject to certain governmental recordkeeping and reporting requirements for the administration of civil rights laws and regulations. In order to comply with these laws, the employer invites employees to voluntarily self-identify their race or ethnicity. Submission of this information is voluntary and refusal to provide it will not subject you to any adverse treatment. The information obtained will be kept confidential and may only be used in accordance with the provisions of applicable laws, executive orders, and regulations, including those that require the information to be summarized and reported to the federal government for civil rights enforcement. When reported, data will not identify any specific individual.

Florida Retirement System

FRS Employment Certification Form

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

1 Enter Your Info

PLEASE PRINT

NAME _____ SOCIAL SECURITY NUMBER _____

CURRENT AGENCY NAME _____ PREVIOUS AGENCY NAME _____

2 Confirm Prior Membership

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

☐ **No, I have <u>never</u> been a member of a State of Florida-administered retirement plan.**
If No, skip to section 4.

☐ **Yes, I have been a member of a State of Florida-administered retirement plan.**
If Yes, indicate which plan(s) you are or were a member of, then proceed to section 3.

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

If you answered YES above but have never made a retirement plan election (including default) between the FRS Pension Plan and the FRS Investment Plan, you will have a choice period established for you with a designated deadline. See page 2 for additional information on making a choice.

3 Confirm Retiree Status

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

- You have received any benefits (other than a withdrawal of your employee contributions) under the FRS Pension Plan, including DROP.
- You have taken any distribution (including a rollover) from the FRS Investment Plan, or other state-administered retirement programs offered by state universities (SUSORP), state community colleges (SCCSORP), state government for senior managers (SMSOAP), or local governments for senior managers.

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

☐ **Yes, I am retired from a State of Florida-administered plan, and I understand I must satisfy any termination requirement prior to returning to FRS employment.**
If Yes, enter your FRS Pension Plan retirement effective date, DROP termination date, or date you received your first distribution from the FRS Investment Plan, SUSORP, SCCSORP, SMSOAP, or other plan.

DATE _____

4 Sign Here

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

SIGNATURE _____ DATE _____

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

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

Review the Following Important Information Carefully

Section 2 – Confirm prior membership

If you answered NO - Not Previously Enrolled in the FRS

A New Hire Kit will be mailed to your address on file with your employer within 30 to 60 days after your hire date.

- You are responsible for ensuring your retirement plan election is received by the Plan Choice Administrator on or before 4:00 p.m. ET on the last business day of the 8th month following your month of hire.
- If you do not submit an election choice, the Investment Plan will be considered your initial election by default. Exception: If you are enrolled in the Special Risk Class, the Pension Plan will be considered your initial default election.

If you answered YES - Previously Enrolled in the FRS

- If you were previously enrolled in the FRS, made an active election or defaulted into the FRS Pension Plan or FRS Investment Plan, and separated employment without retiring you will not receive a new choice window. You will continue to participate in the plan you were enrolled in at the time of separation and continue to accrue service credit under that plan.

- If you were previously enrolled in the FRS and did not make an election between the FRS Pension Plan and FRS Investment Plan during your previous enrollment in the FRS, you will receive a choice window with a designated choice deadline. This would include those who have never had an opportunity to make a retirement plan election, members with Pension Plan service prior to July 1, 2002, and who return to FRS employment today, and new hires on or after July 1, 2002 who had an election period established previously but separated employment before making an election or defaulting.
    - You are responsible for ensuring your election is received by the Plan Choice Administrator on or before 4:00 p.m. ET on the last business day of the 8th month following your month of hire.
    - If you do not submit an election, the Investment Plan will be considered your initial election by default. Exception: If you are enrolled in the Special Risk Class, the Pension Plan will be considered your initial default election.
    - If you elect or default to the Investment Plan, any accrued value you may have in the Pension Plan will be transferred to your Investment Plan account as your opening account balance and is subject to the vesting requirements of the Pension Plan. The initial transfer amount is an estimate, and your account will be reconciled within 60 days of the transfer using your actual FRS membership record pursuant to Florida law. You direct that all future employer and employee contributions be deposited in your Investment Plan account.

Section 3 – Confirm Retiree Status

If you are a Pension Plan retiree, you understand:

- If you are reemployed within six calendar months of retirement in any type of position with an FRS employer, your retirement and DROP status (if applicable) may be voided. If voided, all retirement and DROP benefits you received must be repaid, and you must reapply for retirement to receive future benefits.

If you are an Investment Plan, SUSORP, SCCSORP, or SMSOAP retiree, you understand:

- If you are reemployed within the first six calendar months of retirement in **any type of position** with an FRS employer, any benefits you received must be repaid, or you must terminate employment.

- **Any type of position** includes, **but is not limited to**, regularly established, full-time, part-time, OPS, temporary, seasonal, substitute teachers, adjunct professors, etc. Also, any paid or unpaid positions with an FRS employer, service arrangements with an FRS employer, employment by or through a third-party providing service to an FRS employer, or positions pre-arranged before retirement to provide services after retirement to any FRS employer, are prohibited.
- Florida law requires a return of all overpaid Pension Plan benefit payments or Investment Plan distributions received by a member who has violated the FRS termination or reemployment provisions. Similar provisions apply to overpaid SUSORP, SCCSORP, or other state-administered plan distributions – contact that plan's administrator for details.
- Retirees may provide volunteer services with an FRS employer without violating the termination requirements or reemployment limitations (must comply with Section 121.091(15), Florida Statutes).
- Effective July 1, 2017, retirees of the Investment Plan, SUSORP, SMSOAP, SCCSORP are eligible for renewed membership in the Investment Plan, SUSORP, SMSOAP, SCCSORP. You must be employed in an FRS-covered position on or after July 1, 2017 in order to have renewed membership. Renewed members may not use a second election to change to the Pension Plan.

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

2.37 DRUG-FREE WORKPLACE

(1) Personnel shall not manufacture, distribute, dispense, possess, be under the influence of, or use alcohol and/or a controlled or harmful substance (as defined in Chapters 893 and 877.111, F.S.) on or in the workplace. This includes but is not limited to any alcoholic substance, any intoxicating or auditory, visual or mental altering chemical or substance or narcotic drug, hallucinogenic drug, amphetamine, barbiturate, marijuana, or any other controlled or harmful chemical substance, as defined by federal or state laws or rules, or any counterfeit of such drugs or substances all being collectively referred to as drugs.

(2) Workplace is defined as the site for the performance of work done in connection with employment. That includes, but is not limited to, any school building or any school premises, any vehicle used to transport students to and from school and school activities off Board property during any school-sponsored or school-approved activity, event, or function, such as a field trip or athletic event, where students are under the jurisdiction of the Board.

(3) As a condition of employment, each employee shall notify his or her supervisor of his or her conviction of any criminal drug or harmful chemical substance statute no later than five (5) days after such conviction. (Also see 2.43, S.B.R., Self-Reporting of Arrests and Convictions by Employees) An employee who violates the terms of this policy may be non-renewed or his or her employment may be suspended or terminated. However, at the discretion of the Board, such employee may be allowed to satisfactorily participate in and complete a substance abuse assistance or rehabilitation program approved by the Board in lieu of a non- renewal, suspension, or termination. Sanctions and discipline against personnel, including non-renewal, suspension, and termination, shall be in accordance with prescribed Board procedures and shall be commenced within thirty (30) days of receiving notice of an employee's conviction. Within ten (10) days of receiving notice of an employee's conviction in violation of this rule, the Superintendent shall notify the State Department of Education when applicable.

(4) Pursuant to Section 440.102, F.S., a drug-free awareness program is hereby established and is to be implemented by the Superintendent to inform personnel of the dangers of drug abuse in the workplace, of the Board's policy on maintaining a drug-free workplace, of available drug counseling, rehabilitation, and assistance programs; and of the penalties to be imposed up to termination, for drug abuse violations. As a part of this program, all personnel and applicants for employment shall be given notice of the Board's policy regarding the maintenance of a drug-free workplace in the following form:

NOTICE TO EMPLOYEES REGARDING DRUG-FREE WORKPLACE PROGRAM

YOU ARE HEREBY NOTIFIED that it is a condition of employment that you refrain from the use of illegal drugs or the abuse of legal drugs or harmful chemical substances on or off the job. As part of the Drug-Free Workplace Program the Board has instituted a drug-testing program. It is a violation of the policy of the Board for any employee to manufacture, distribute, dispense, possess, or use illegal drugs, whether in the workplace or away from the workplace including non-working hours. It is also a violation of the policy of the Board of being under the influence of, or use of alcohol and/or a controlled and/or harmful substance (as defined in Chapters 893 or 877.111, F.S.) on or in the workplace. This includes but is not limited to any alcoholic substance, any intoxicating or auditory, visual, or mental altering chemical or substance, or narcotic drug, hallucinogenic drug, amphetamine, barbiturate, marijuana, or any other controlled substance, as defined by federal or state laws or rules, or any counterfeit of such drugs or substances all being collectively referred to as drugs or harmful chemical substances. Lawful consumption of alcohol during non-working hours and away from the workplace that does not adversely impact the employee's work performance or fitness for duty is not a violation of the Board's Drug-Free Workplace Program. All employees are subject to drug/alcohol testing. Refusal to submit to a drug/alcohol test may subject the employee to termination and, where on-the-job injury is at issue, loss of workers' compensation medical and indemnity benefits. The Drug-Free Workplace Program adopted by the Board authorizes the following types of drug tests:

A. Pre-Employment Screening. An employer must require a candidate for employment to submit to a drug test. The employer may use a refusal to submit to a drug test or a confirmed positive drug test as a basis for denial of employment.

B. Reasonable Suspicion. An employer must require an employee to submit to reasonable suspicion drug testing.

C. Routine Fitness For Duty. An employer must require an employee to submit to a drug test if the test is conducted as part of a routinely scheduled employee fitness-for-duty medical examination that is part of the employer's established policy or that is scheduled routinely for all members of an employment classification or group.

D. Follow-up. If the employee in the course of employment enters an employee assistance program for drug-related problems or an alcohol and drug rehabilitation program, the employer must require the employee to submit to a drug test as a follow-up to such programs and on a quarterly, semiannual, or annual basis for up to two (2) years thereafter.

E. On-the-job Injury. If the employee is injured in the course of employment the employee shall be required to submit to a drug test. Necessary medical care will not be denied pending completion of, or submission to, a drug test.

F. Post-accident. If an employee operating a District vehicle is involved in an at- fault traffic accident satisfying the parameters defined in the Transportation Department

SOP entitled, "Post-Accident Drug/Alcohol Testing," which requirements are incorporated herein by reference, the employee shall be required to submit to a drug/alcohol test. Necessary medical care will not be denied pending completing of, or submission to, a drug test.

All information, interviews, reports, statements, memoranda and drug test results, written or otherwise, received or produced as a result of a drug testing program are confidential communications, but may be used or received in evidence, obtained in discovery or disclosed in any public or private proceedings, as authorized by law.

Employees may confidentially report the use of prescription or non-prescription medications, both before and after being tested. The reports of the use of prescription drugs should include a copy of the medical prescription. Reports may be made to the employee's supervisor, principal or director. Reports must be in writing identifying the use of prescription or nonprescription medications. Attached to this notice is a list of the most common drugs or medications by brand name or common name, as applicable as well as by chemical name, which may alter or affect a drug test. (See Attachment "A")

The Board has instituted an employee assistance program providing alcohol and drug rehabilitation. Employees seeking information or assistance through the program should contact the Director of Risk Management for further information.

Pursuant to Section 440.102(3)(a)8, F.S., an employee or job applicant who receives a positive confirmed drug test may contest or explain the result to the medical review officer (MRO) within five (5) working days after written notification of the positive test. If an employee or job applicant's explanation or challenge is unsatisfactory to the MRO, the MRO shall report a positive test result back to the employer. A person may contest the drug test result pursuant to law or to rules adopted by the Agency for Health Care Administration. (See Attachment "B")

The employee or job applicant has the right to consult the testing laboratory for technical information regarding prescription or nonprescription medication. A list of drugs for which the employer will test, described by brand names or common names as applicable, as well as by chemical names, is attached to this notice. (See Attachment "C")

In addition to the right of the employee to challenge or contest the results of any drug test, the employee has the right to appeal to the Public Employees Relations Commission or applicable court and may have additional rights under a collective bargaining agreement, if any. Questions regarding the collective bargaining agreement may be directed to the appropriate bargaining unit representative.

The Board is required to report an employee conviction of drug violations occurring in the workplace to the State Department of Education within ten (10) days of receiving such notice, when applicable, and is also required to commence disciplinary action against such employee within thirty (30) days of receipt of the notice of violation.

ATTACHMENT "A"

OVER-THE-COUNTER AND PRESCRIPTION DRUGS WHICH COULD AFFECT THE OUTCOME OF A DRUG TEST:

ALCOHOL - All liquid medications containing ethyl alcohol (ethanol). Please read the label for alcohol content. As an example, Vicks Nyquil is 25% (50 proof) ethyl alcohol, Comtrex is 20% (40 proof), Contact Severe Cold Formula Night Strength is 25% (50 proof) and Listerine is 26.9% (54 proof).

AMPHETAMINES - Obetrol, Biphetamine, Desoxyn, Dexedrine, Didrex

CANNABINOIDS - Marinol (Dronabinol, THC)

COCAINE - Cocaine HCI topical solution (Roxanne)

PHENCYCLIDINE - Not legal by prescription.

METHAQUALONE - Not legal by prescription.

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

BARBITURATES - Phenobarbital, Tuinal, Amytal, Nembutal, Seconal, Lotusate, Fiorinal, Fioricet, Esgic, Butisol, Mebaral, Butabarbital, Butabital, Phreniilin, Triad, etc.

BENZODIAZEPINES - Ativan, Azene, Clonopin, Dalmane, Diazepam, Librium, Xanax, Serax, Tranxene, Valium, Verstran, Halcion, Paxiipam, Restoril, Centrex, etc.

METHADONE - Dolphine, Methadose

PROPOXYPHENE - Darvocet, Darvon N, Dolene, etc.

ATTACHMENT "B"

CHALLENGES TO TEST RESULTS

(1) A requirement of the Drug-Free Workplace Program is that within five (5) working days after receiving notice of a positive confirmed test result, the employee or job applicant must be allowed to submit information to the MRO explaining or contesting the test results. If an employee's or job applicant's explanation or challenge of the positive test result is unsatisfactory to the MRO, within fifteen (15) days of receipt of the explanation or challenge, a written explanation as to why the employee's or job applicant's explanation is unsatisfactory along with the report of positive results, shall be provided by the employer to the employee or job applicant. All such documentation shall be kept confidential by the employer and shall be retained by the employer for at least one (1) year.

(2) An employee or job applicant may undertake an administrative challenge by filing a claim for benefits with a judge of compensation claims pursuant to Chapter 440, F.S. If no workplace injury has occurred, the person must challenge the test result in a court of competent jurisdiction. When an employee or job applicant undertakes a challenge to the results of a test, it shall be the employee's or job applicant's responsibility to notify the laboratory and the sample shall be retained by the laboratory until the case is settled.

ATTACHMENT "C"

DRUGS FOR WHICH THE EMPLOYER WILL TEST

Alcohol

Amphetamines

Cannabinoids

Cocaine

Phencyclidine

Methaqualone

Opiates

Barbiturates

Benzodiazepines

Synthetic Narcotics: Methadone, Propoxyphene

Rulemaking Authority:	Sections 1001.41; 1012.22; 1012.23; 1012.27, F.S.
Laws Implemented:	Sections 435.04; 440.102; 1001.10; 1001.41; 1001.43; 1012.795, F.S.
History:	New 11/27/90. Revised/Amended 10/27/92; 08/27/96; 11/20/01; 06/20/06; 02/15/11; 01/22/13; 11/19/13; 04/18/17.

2.47 TOBACCO/COTININE/NICOTINE-FREE HIRING POLICY

(1) The School District is committed to promoting health, wellness, and disease prevention within the community and to providing a safe, clean, and healthy environment for our employees and citizens. The use of tobacco/cotinine/nicotine products is a known and established hazard to the health and well-being of those who use them as well as those around them. The health problems created by the use of these products contribute to the increase in health care costs and the rise in insurance premiums. Use of tobacco/cotinine/nicotine products has been shown to decrease employee productivity and efficiency, and increase absenteeism. It is in recognition of these factors that the District is taking measures to develop a tobacco/cotinine/nicotine-free workforce. The School Board hereby establishes a tobacco/cotinine/nicotine-free hiring policy for all individuals applying for any position which qualifies for insurance benefits within the District. It is the intent of this policy that employees hired in insurance benefit eligible positions after the effective date of this policy must successfully pass a tobacco/cotinine/nicotine test and remain tobacco/cotinine/nicotine-free for the duration of their employment.

(2) For the purposes of this policy, tobacco/cotinine/nicotine is defined to include any products that may include tobacco/nicotine and are intended or expected for human use or consumption, including but not limited to, any lighted or unlighted cigarette, cigar, pipe, bidi cigarette, clove cigarette, hookah, and any other smoking product; and spit tobacco, also known as smokeless, dip, chew and snuff, twist in any form (i.e. lozenges, strips, patches, pouches, pills, etc.), to also include forms of electronic nicotine delivery system devices such as but not limited to e-cigarettes and vaping.

(3) It is the responsibility of the applicant to recognize the use of tobacco/cotinine/nicotine products and the potential for an unfavorable test result. If an applicant receives an unfavorable test result for tobacco/cotinine/nicotine, the individual is not eligible for permanent employment for six (6) months following the test collection date. After six (6) months has passed, the applicant is eligible to reapply for permanent positions.

Rulemaking Authority: Sections 1001.41; 1001.42, F.S.

Laws Implemented: Sections 1001.42; 1001.43, F.S.

History: New: 06/21/11. Revised/Amended: 01/17/12; 04/23/13; 11/19/13; 04/18/17, 7/19/22.

Notice to:

Applicants, Employees and Volunteer Coaches:

Escambia County Public Schools (ECPS), requires all candidates for employment (full-time, part-time, part-time coach, and/or volunteer coach, upon offer of employment, to submit to a drug test that tests for illegal drugs, alcohol, and certain types of prescription and over-the counter drugs including but not limited to in accordance with F.S 893 or F.S. 877.111 and Escambia County School Board Drug-Free Workplace Board policy (sections 1124, 3124 and 2430.01 para. H.).

Any drug screening that returns as "positive" for the following substances: Alcohol Amphetamines, Marijuana/Cannabinoids/THC (including medical marijuana), Cocaine, Phencyclidine Methaqualone, Opiates, Barbiturates, Benzodiazepines, Synthetic Narcotics: Methadone, and Propoxyphene, will result in the offer of employment or volunteer role (whether permanent, part-time, or as a part-time or volunteer coach), being rescinded and/or ineligibility for future employment or as a volunteer coach with Escambia County Public Schools.

Note: Medical Marijuana and/or Over the Counter (OTC) items (i.e. CBD products) may contain levels of Marijuana/ Cannabinoids/THC. Any test for Marijuana/ Cannabinoids/THC above a screening cut-off level (as determined by a Medical Review Officer) that returns as "positive" for Marijuana/ Cannabinoids/THC will result in the offer of employment, or as a volunteer coach, being rescinded and/or ineligibility for future employment or as a volunteer coach.

I, _____ (print name), hereby affirm and acknowledge that completion of a Drug Screen is a mandatory condition of employment. I further understand that a positive result on the Drug Screen will lead to the immediate withdrawal of the employment offer and render me permanently ineligible for employment by the District.

_____ _____

Signature of Applicant **Date**

THE SCHOOL DISTRICT OF ESCAMBIA COUNTY

75 NORTH PACE BOULEVARD, PENSACOLA, FLORIDA 32505
PHONE (850) 432-6121
www.escambiaschools.org

Statement on the Collection, Use or Release of Social Security Numbers of Employees and Others***

Read the information below, sign and return this document to the person who provided you the form.

The School District of Escambia County is authorized to collect, use or release social security numbers (SSN) of employees and other individuals*** for the following purposes, which are noted as either required or authorized by law to be collected. The collection of social security numbers is either specifically authorized by law or imperative for the performance of the District's duties and responsibilities as prescribed by law [Fla. Stat. §119.071(5)(a) 2 & 3].

1. Employment eligibility, report to IRS, SSA, UC, and FAWI, including for W-4's and I-9's [Required by federal statute and regulation 26 U.S.C. 6051 and 26 C.F.R. 31.6011(b)-2, 26 C.F.R. 301.6109-1 and 31.3402(f)(2)-1, and Fla. Stat. §119.071(5)(a)6]
2. Receipts to employees for wages and Statements required in case of sick pay paid by third parties [Required by federal statute 26 U.S.C. 6051 and Fla. Stat. §119.071(5)(a)6]
3. Verification of an alien's eligibility for employment, including I-9 [Authorized by 8 U.S.C. 1324 a(b) and 8 C.F.R. 274a.2]
4. Income tax withholding (including for annuity and sick leave)/Payroll deductions on Form W-2 [Required by 26 U.S.C. 3402, 26 C.F.R. 31.6051-1 and Fla. Stat. §119.071(5)(a)6]
5. Teacher retirement system benefits and contributions [Authorized by Fla. Stat. §238.01 et seq., including 238.07, and Fla. Stat. §119.071(5)(a)6]
6. Retirement contributions required for enrollment in Florida Retirement System (FRS) Investment Plan, second election retirement plan enrollment, or for participation in and contributions to FRS [Required by Fla. Admin. Code 19-11.010, 19-11.006 and 19-11.007 and Fla. Stat. §119.071(5)(a)2 & 6 or required by Fla. Stat. §121.051 and 121.071 and Fla. Admin. Code 19-13.003 and Fla. Stat. §119.071(5)(a)2 & 6]
7. Reports pertaining to deferred vested retirement programs [Required by 26 C.F.R. 301.6057-1 and Fla. Stat. §119.071(5)(a)6]
8. Payments and plan relating to the retiree prescription drug subsidy under 42 C.F.R. §423.34 and 42 C.F.R. §423.886 [Authorized by 42 C.F.R. 423.884 and Fla. Stat. §119.071(5)(a)6]
9. Educator Certification or licensure application, renewal, or add-on, or non-employee registration for professional development for in-service points or incentive pay [Required by Fla. Stat. §§1012.56, and 119.071(5)(a)6, and/or authorized by Fla. Stat. §§1012.21 and 119.071(5)(a)6]
10. Criminal history, Level 1 and level 2 background checks/Identifiers for processing fingerprints by Department of Law Enforcement, if SSN is available [Required by Fla. Admin. Code 11C-6.003 and Fla. Stat. §119.071(5)(a)6]
11. Registration information regarding sexual predators and sexual offenders [Authorized by Fla. Stat. §943.04351 and required by Fla. Stat. §119.071(5)(a)2 & 6]
12. Reports on staff required to be submitted to Florida Department of Education (DOE), including but not limited to Out-of-County/Out-of-State Verification of Highly Qualified [Authorized and required by Fla. Stat. §119.071(5)(a)2 & 6 and/or EDGAR at 34 CFR 80.40(a) or Fla. Stat. §1008.32]
13. Social security contributions [Required by Fla. Admin. Code 60S-3.010 and Fla. Stat. §119.071(5)(a)2 & 6]
14. State directory of new hires (including for determining support obligations and eligibility for several federal and state programs) [Required by federal law 42 U.S.C. 653a and Fla. Stat. § 409.2576 and Fla. Stat. §119.071(5)(a)]
15. Notice to Payor and Income Deduction notices for child support, or for alimony and child support [Required by Fla. Stat. §61.1301(2)(e) and Fla. Stat. §119.071(5)(a)]
16. Child support enforcement [Required by 45 C.F.R. 307.11 and Fla. Stat. §61.13, 742.10 or 409.256.3 or 742.031]
17. Garnishment payment pursuant to a Notice of Levy [Required by Fla. Admin. Code 12E-1.028m and Fla. Stat. §119.071(5)(a)]
18. Request from depository for support payments [Required by Fla. Stat. §61.181 (3)(b) and Fla. Stat. §119.071(5)(a)]
19. Record of remuneration paid to employees [Required by federal regulation 20 C.F.R. 404.1225, Fla. Admin. Code 60BB-2.032, and Fla. Stat. §119.071(5)(a)6]
20. Unemployment benefits and short term compensation plan [Required by Fla. Stat. Ch. 443, including 443.1116, and Fla. Stat. §119.071(5)(a)6]
21. Unemployment reports from District [Required by Fla. Admin. Code 60BB-2.023 and Fla. Stat. §119.071(5)(a)6]
22. Income information disclosure to HUD [Required by federal regulation 24 C.F.R. 5.214 et seq. and Fla. Stat. §119.071(5)(a)6]

23. Vendors/Consultants that District reasonably believes would receive a 1099 form if a tax identification number is not provided Including for IRS form W-9. [Required by 26 C.F.R. §31.3406-0, 26 C.F.R. §301.6109-1, and Fla. Stat. §119.071(5)(a)2 & 6]
24. Tort claims and tort notices of claim against the School Board [Required by Fla. Stat. §768.28(6), and Fla. Stat. §119.071(5)(a)6]
25. Reporting to and reports of worker's compensation injury or death, including for DWC-1 [Required by Fla. Stat. §440.185 and Fla. Admin. Code 69L-3.003 et seq. and Fla. Stat. §119.071(5)(a)6]
26. Worker's compensation petitions for benefits and responses thereto [Authorized by Fla. Admin. Code 60Q-6.103 and Fla. Stat. §119.071(5)(a)6]
27. The disclosure of the social security number is for the purpose of the administration of health benefits for a District employee or his or her dependents [Required by Fla. Stat. §119.071(5)(a)6]
28. The disclosure of the social security number is for the purpose of the administration of a pension fund administered for the District employee's retirement fund, deferred compensation plan, or defined contribution plan [Required by Fla. Stat. §119.071(5)(a)6]
29. Use of motor vehicle information from the Department of Motor Vehicles for the District to carry out its functions and to verify the accuracy of information submitted by agent or employee to District, including to prevent fraud, in connection with insurance investigations, and to verify a commercial driver's license [Authorized allowed by federal law 18 U.S.C. 2721 et seq. and Fla. Stat. §119.071(5) (a) 6]
30. **Authorization for direct deposit of funds by electronic or other medium to a payee's account [Required by Fla. Admin. Code 6A-1.0012 and Fla. Stat. §119.071(5)(a)6]**
31. Identification of blood donors [Authorized by 42 U.S.C. 405(c)(2)(D)(i)]
32. Employee's and former employee's request for report of exposure to radiation [Authorized by 41 C.F.R. 50-204.33 and .3]
33. Collection and/or disclosure are imperative or necessary for the performance of the District's duties and responsibilities as prescribed by law, including but not limited for password identification to the District's network [Authorized by Fla. Stat. §119.071(5)(a)6 and required by Fla. Stat. §119.071(5)(a)2]
34. The disclosure of the social security number is expressly required by federal or state law or a court order [Required by Fla. Stat. §§1012.56 and 119.071(5) (a)6]
35. The individual expressly consents in writing to the disclosure of his or her social security number [Allowed by Fla. Stat. §119.071(5)(a)6]
36. The disclosure of the social security number is made to prevent and combat terrorism to comply with the USA Patriot Act of 2001, Pub. L. No. 107-56, or Presidential Executive Order 13224 [Required by Fla. Stat. §119.071(5)(a)6]
37. The disclosure of the social security number is made to a commercial entity for the permissible uses set forth in the federal Driver's Privacy Protection Act of 1994, 18 U.S.C. Sec. 2721 et seq.; the Fair Credit Reporting Act, 15 U.S.C. Sec. 1681 et seq.; or the Financial Services Modernization Act of 1999, 15 U.S.C. Sec. 6801 et seq., provided that the authorized commercial entity complies with the requirements of paragraph 5 in Fla. Stat. §119.071 [Allowed by Fla. Stat. §119.071(5)(a)6]
38. The disclosure of the social security number is for the purpose of the administration of the Uniform Commercial Code by the office of the Secretary of State [Required by Fla. Stat. §119.071(5)(a)6]

I hereby acknowledge receipt of this "Statement on the Collection, Use or Release of Social Security Numbers of Employees and Others".

_____
Signature

_____
Date

XXX-XX-_____
(Employee ID #)

_____
Print Name

*** Note that this form states the reasons for collecting, using or releasing the social security numbers only of employees and individuals other than students, parents and volunteers. A separate written statement sets forth the reasons for collecting, using or releasing the social security numbers of students and parents, and a separate written statement exists for collecting, using or releasing the social security numbers of volunteers as part of the volunteer application.

Form **W-4**

Department of the Treasury
Internal Revenue Service

Employee's Withholding Certificate

Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay.
Give Form W-4 to your employer.
Your withholding is subject to review by the IRS.

OMB No. 1545-0074

2026

Step 1: Enter Personal Information

(a) First name and middle initial	Last name	(b) Social security number
Address		**Does your name match the name on your social security card?** If not, to ensure you get credit for your earnings, contact SSA at 800-772-1213 or go to *www.ssa.gov*.
City or town, state, and ZIP code		

(c) ☐ **Single** or **Married filing separately**
☐ **Married filing jointly** or **Qualifying surviving spouse**
☐ **Head of household** (Check only if you're unmarried and pay more than half the costs of keeping up a home for yourself and a qualifying individual.)

Caution: To claim certain credits or deductions on your tax return, you (and/or your spouse if married filing jointly) are required to have a social security number valid for employment. See page 2 for more information.

TIP: Consider using the estimator at *www.irs.gov/W4App* to determine the most accurate withholding for the rest of the year if you: are completing this form after the beginning of the year; expect to work only part of the year; or have changes during the year in your marital status, number of jobs for you (and/or your spouse if married filing jointly), dependents, other income (not from jobs), deductions, or credits. Have your most recent pay stub(s) from this year available when using the estimator. At the beginning of next year, use the estimator again to recheck your withholding.

Complete Steps 2–4 ONLY if they apply to you; otherwise, skip to Step 5. See page 2 for more information on each step, who can claim exemption from withholding, and when to use the estimator at *www.irs.gov/W4App*.

Step 2: Multiple Jobs or Spouse Works

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

Do **only one** of the following.

(a) Use the estimator at *www.irs.gov/W4App* for the most accurate withholding for this step (and Steps 3–4). If you or your spouse have self-employment income, use this option; **or**

(b) Use the Multiple Jobs Worksheet on page 3 and enter the result in Step 4(c) below; **or**

(c) If there are only two jobs total, you may check this box. Do the same on Form W-4 for the other job. This option is generally more accurate than Step 2(b) if pay at the lower paying job is more than half of the pay at the higher paying job. Otherwise, Step 2(b) is more accurate . . . . . ☐

Complete Steps 3–4(b) on Form W-4 for only ONE of these jobs. Leave those steps blank for the other jobs. (Your withholding will be most accurate if you complete Steps 3–4(b) on the Form W-4 for the highest paying job.)

Step 3: Claim Dependent and Other Credits

If your total income will be $200,000 or less ($400,000 or less if married filing jointly):

(a) Multiply the number of qualifying children under age 17 by $2,200 . . . . . **3(a)** $

(b) Multiply the number of other dependents by $500 . . . **3(b)** $

Add the amounts from Steps 3(a) and 3(b), plus the amount for other credits. Enter the total here . . . . . **3** $

Step 4: Other Adjustments

(a) Other income (not from jobs). If you want tax withheld for other income you expect this year that won't have withholding, enter the amount of other income here. This may include interest, dividends, and retirement income . . . . . **4(a)** $

(b) Deductions. Use the Deductions Worksheet on page 4 to determine the amount of deductions you may claim, which will reduce your withholding. (If you skip this line, your withholding will be based on the standard deduction.) Enter the result here . . **4(b)** $

(c) Extra withholding. Enter any additional tax you want withheld each **pay period** . . **4(c)** $

Exempt from withholding

I claim exemption from withholding for 2026, and I certify that I meet **both** of the conditions for exemption for 2026. See *Exemption from withholding* on page 2. I understand I will need to submit a new Form W-4 for 2027 . ☐

Step 5: Sign Here

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

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

Employers Only

Employer's name and address	First date of employment	Employer identification number (EIN)

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Future Developments

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

Purpose of Form

Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay. If too little is withheld, you will generally owe tax when you file your tax return and may owe a penalty. If too much is withheld, you will generally be due a refund. Complete a new Form W-4 when changes to your personal or financial situation would change the entries on the form. For more information on withholding and when you must furnish a new Form W-4, see Pub. 505, Tax Withholding and Estimated Tax.

Exemption from withholding. You may claim exemption from withholding for 2026 if you meet both of the following conditions: you had no federal income tax liability in 2025 **and** you expect to have no federal income tax liability in 2026. You had no federal income tax liability in 2025 if (1) your total tax on line 24 on your 2025 Form 1040 or 1040-SR is zero (or less than the sum of lines 27a, 28, 29, and 30), or (2) you were not required to file a return because your income was below the filing threshold for your correct filing status. If you claim exemption, you will have no income tax withheld from your paycheck and may owe taxes and penalties when you file your 2026 tax return. To claim exemption from withholding, certify that you meet both of the conditions by checking the box in the *Exempt from withholding* section. Then, complete Steps 1(a), 1(b), and 5. Do not complete any other steps. You will need to submit a new Form W-4 by February 16, 2027.

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

When to use the estimator. Consider using the estimator at *www.irs.gov/W4App* if you:

1. Are submitting this form after the beginning of the year;

2. Expect to work only part of the year;

3. Have changes during the year in your marital status, number of jobs for you (and/or your spouse if married filing jointly), or number of dependents, or changes in your deductions or credits;

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

5. Prefer the most accurate withholding for multiple job situations.

TIP: Have your most recent pay stub(s) from this year available when using the estimator to account for federal income tax that has already been withheld this year. At the beginning of next year, use the estimator again to recheck your withholding.

Self-employment. Generally, you will owe both income and self-employment taxes on any self-employment income you receive separate from the wages you receive as an employee. If you want to pay these taxes through withholding from your wages, use the estimator at *www.irs.gov/W4App* to figure the amount to have withheld.

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

Specific Instructions

Step 1(c). Check your anticipated filing status. This will determine the standard deduction and tax rates used to compute your withholding.

Step 2. Use this step if you (1) have more than one job at the same time, or (2) are married filing jointly and you and your spouse both work. Submit a separate Form W-4 for each job.

Option **(a)** most accurately calculates the additional tax you need to have withheld, while option **(b)** does so with a little less accuracy.

Instead, if you (and your spouse) have a total of only two jobs, you may check the box in option **(c)**. The box must also be checked on the Form W-4 for the other job. If the box is checked, the standard deduction and tax brackets will be cut in half for each job to calculate withholding. This option is accurate for jobs with similar pay; otherwise, more tax than necessary may be withheld, and this extra amount of tax withheld will be larger the greater the difference in pay is between the two jobs.

CAUTION ***Multiple jobs.*** *Complete Steps 3 through 4(b) on only one Form W-4. Withholding will be most accurate if you do this on the Form W-4 for the highest paying job.*

Step 3. This step provides instructions for determining the amount of the child tax credit and the credit for other dependents that you may be able to claim when you file your tax return. To qualify for the child tax credit, the child must be under age 17 as of December 31, must be your dependent who generally lives with you for more than half the year, and must have the required social security number. You (and/or your spouse if married filing jointly) must have the required social security number to claim certain credits. You may be able to claim a credit for other dependents for whom a child tax credit can't be claimed, such as an older child or a qualifying relative. For additional eligibility requirements for these credits, see Pub. 501, Dependents, Standard Deduction, and Filing Information. You can also include **other tax credits** for which you are eligible in this step, such as the foreign tax credit and the education tax credits. To do so, add an estimate of the amount for the year to your credits for dependents and enter the total amount in Step 3. Including these credits will increase your paycheck and reduce the amount of any refund you may receive when you file your tax return.

Step 4.

Step 4(a). Enter in this step the total of your other estimated income for the year, if any. You shouldn't include income from any jobs or self-employment. If you complete Step 4(a), you likely won't have to make estimated tax payments for that income. If you prefer to pay estimated tax rather than having tax on other income withheld from your paycheck, see Form 1040-ES, Estimated Tax for Individuals.

Step 4(b). Enter in this step the amount from the Deductions Worksheet, line 15, if you expect to claim deductions other than the basic standard deduction on your 2026 tax return and want to reduce your withholding to account for these deductions. This includes both itemized deductions and other deductions such as for qualified tips, overtime compensation, and passenger vehicle loan interest; student loan interest; IRAs; and seniors. You (and/or your spouse if married filing jointly) must have the required social security number to claim certain deductions. For additional eligibility requirements, see Pub. 501.

Step 4(c). Enter in this step any additional tax you want withheld from your pay **each pay period**, including any amounts from the Multiple Jobs Worksheet, line 4. Entering an amount here will reduce your paycheck and will either increase your refund or reduce any amount of tax that you owe when you file your tax return.

Step 2(b)—Multiple Jobs Worksheet *(Keep for your records.)*

If you choose the option in Step 2(b) on Form W-4, complete this worksheet (which calculates the total extra tax for all jobs) on **only ONE** Form W-4. Withholding will be most accurate if you complete the worksheet and enter the result on the Form W-4 for the highest paying job. To be accurate, submit a new Form W-4 for all other jobs if you have not updated your withholding since 2019.

Note: If more than one job has annual wages of more than $120,000 or there are more than three jobs, see Pub. 505 for additional tables; or, you can use the online withholding estimator at *www.irs.gov/W4App*.

1 **Two jobs.** If you have two jobs or you're married filing jointly and you and your spouse each have one job, find the amount from the appropriate table on page 5. Using the "Higher Paying Job" row and the "Lower Paying Job" column, find the value at the intersection of the two household salaries and enter that value on line 1. Then, **skip** to line 3 . . . . . **1** $ _____

2 **Three jobs.** If you and/or your spouse have three jobs at the same time, complete lines 2a, 2b, and 2c below. Otherwise, skip to line 3.

a Find the amount from the appropriate table on page 5 using the annual wages from the highest paying job in the "Higher Paying Job" row and the annual wages for your next highest paying job in the "Lower Paying Job" column. Find the value at the intersection of the two household salaries and enter that value on line 2a . . . . . **2a** $ _____

b Add the annual wages of the two highest paying jobs from line 2a together and use the total as the wages in the "Higher Paying Job" row and use the annual wages for your third job in the "Lower Paying Job" column to find the amount from the appropriate table on page 5 and enter this amount on line 2b . . . . . **2b** $ _____

c Add the amounts from lines 2a and 2b and enter the result on line 2c . . . . . **2c** $ _____

3 Enter the number of pay periods per year for the highest paying job. For example, if that job pays weekly, enter 52; if it pays every other week, enter 26; if it pays monthly, enter 12, etc. . . . . **3** _____

4 **Divide** the annual amount on line 1 or line 2c by the number of pay periods on line 3. Enter this amount here and in **Step 4(c)** of Form W-4 for the highest paying job (plus any other additional amount you want withheld) . . . . . **4** $ _____

Step 4(b)—Deductions Worksheet *(Keep for your records.)*

See the Instructions for Schedule 1-A (Form 1040) for more information about whether you qualify for the deductions on lines 1a, 1b, 1c, 3a, and 3b.

1 Deductions for qualified tips, overtime compensation, and passenger vehicle loan interest.

- **a** **Qualified tips.** If your total income is less than $150,000 ($300,000 if married filing jointly), enter an estimate of your qualified tips up to $25,000 . . . **1a** $
- **b** **Qualified overtime compensation.** If your total income is less than $150,000 ($300,000 if married filing jointly), enter an estimate of your qualified overtime compensation up to $12,500 ($25,000 if married filing jointly) of the "and-a-half" portion of time-and-a-half compensation . . . **1b** $
- **c** **Qualified passenger vehicle loan interest.** If your total income is less than $100,000 ($200,000 if married filing jointly), enter an estimate of your qualified passenger vehicle loan interest up to $10,000 **1c** $

2 Add lines 1a, 1b, and 1c. Enter the result here . . . **2** $

3 **Seniors age 65 or older.** If your total income is less than $75,000 ($150,000 if married filing jointly):

- **a** Enter $6,000 if you are age 65 or older before the end of the year . . . **3a** $
- **b** Enter $6,000 if your spouse is age 65 or older before the end of the year and has a social security number valid for employment . . . **3b** $

4 Add lines 3a and 3b. Enter the result here . . . **4** $

5 Enter an estimate of your student loan interest, deductible IRA contributions, educator expenses, alimony paid, and certain other adjustments from Schedule 1 (Form 1040), Part II. See Pub. 505 for more information . . . **5** $

6 **Itemized deductions.** Enter an estimate of your 2026 itemized deductions from Schedule A (Form 1040). Such deductions may include qualifying:

- **a** **Medical and dental expenses.** Enter expenses in excess of 7.5% (0.075) of your total income . **6a** $
- **b** **State and local taxes.** If your total income is less than $505,000 ($252,500 if married filing separately), enter state and local taxes paid up to $40,400 ($20,200 if married filing separately) . **6b** $
- **c** **Home mortgage interest.** If your home acquisition debt is less than $750,000 ($375,000 if married filing separately), enter your home mortgage interest expense (including mortgage insurance premiums) . . . **6c** $
- **d** **Gifts to charities.** Enter contributions in excess of 0.5% (0.005) of your total income . . . **6d** $
- **e** **Other itemized deductions.** Enter the amount for other itemized deductions . . . **6e** $

7 Add lines 6a, 6b, 6c, 6d, and 6e. Enter the result here . . . **7** $

8 **Limitation on itemized deductions.**

- **a** Enter your total income . . . **8a** $
- **b** Subtract line 4 from line 8a. If line 4 is greater than line 8a, enter -0- here and on line 10. Skip line 9 **8b** $

9 Enter:
- $768,700 if you're married filing jointly or a qualifying surviving spouse
- $640,600 if you're single or head of household
- $384,350 if you're married filing separately

. . . **9** $

10 If line 9 is greater than line 8b, enter the amount from line 7. Otherwise, multiply line 7 by 94% (0.94) and enter the result here . . . **10** $

11 **Standard deduction.**

Enter:
- $32,200 if you're married filing jointly or a qualifying surviving spouse
- $24,150 if you're head of household
- $16,100 if you're single or married filing separately

. . . **11** $

12 **Cash gifts to charities.** If you take the standard deduction, enter cash contributions up to $1,000 ($2,000 if married filing jointly) . . . **12** $

13 Add lines 11 and 12. Enter the result here . . . **13** $

14 If line 10 is greater than line 13, subtract line 11 from line 10 and enter the result here. If line 13 is greater than line 10, enter the amount from line 12 . . . **14** $

15 Add lines 2, 4, 5, and 14. Enter the result here and in Step 4(b) of Form W-4 . . . **15** $

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

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

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

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

Married Filing Jointly or Qualifying Surviving Spouse

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	$0 - 9,999	$10,000 - 19,999	$20,000 - 29,999	$30,000 - 39,999	$40,000 - 49,999	$50,000 - 59,999	$60,000 - 69,999	$70,000 - 79,999	$80,000 - 89,999	$90,000 - 99,999	$100,000 - 109,999	$110,000 - 120,000
$0 - 9,999	$0	$0	$480	$850	$850	$1,020	$1,020	$1,020	$1,020	$1,020	$1,020	$1,020
$10,000 - 19,999	0	480	1,480	1,850	2,050	2,220	2,220	2,220	2,220	2,220	2,220	2,620
$20,000 - 29,999	480	1,480	2,480	3,050	3,250	3,420	3,420	3,420	3,420	3,420	3,820	4,820
$30,000 - 39,999	850	1,850	3,050	3,620	3,820	3,990	3,990	3,990	3,990	4,390	5,390	6,390
$40,000 - 49,999	850	2,050	3,250	3,820	4,020	4,190	4,190	4,190	4,590	5,590	6,590	7,590
$50,000 - 59,999	1,020	2,220	3,420	3,990	4,190	4,360	4,360	4,760	5,760	6,760	7,760	8,760
$60,000 - 69,999	1,020	2,220	3,420	3,990	4,190	4,360	4,760	5,760	6,760	7,760	8,760	9,760
$70,000 - 79,999	1,020	2,220	3,420	3,990	4,190	4,760	5,760	6,760	7,760	8,760	9,760	10,760
$80,000 - 99,999	1,020	2,220	3,420	4,240	5,440	6,610	7,610	8,610	9,610	10,610	11,610	12,610
$100,000 - 149,999	1,870	4,070	6,270	7,840	9,040	10,210	11,210	12,210	13,210	14,210	15,360	16,560
$150,000 - 239,999	1,870	4,100	6,500	8,270	9,670	11,040	12,240	13,440	14,640	15,840	17,040	18,240
$240,000 - 319,999	2,040	4,440	6,840	8,610	10,010	11,380	12,580	13,780	14,980	16,180	17,380	18,580
$320,000 - 364,999	2,040	4,440	6,840	8,610	10,010	11,380	12,580	13,860	15,860	17,860	19,860	21,860
$365,000 - 524,999	2,720	5,920	9,390	12,260	14,760	17,230	19,530	21,830	24,130	26,430	28,730	31,030
$525,000 and over	3,140	6,840	10,540	13,610	16,310	18,980	21,480	23,980	26,480	28,980	31,480	33,990

Single or Married Filing Separately

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	$0 - 9,999	$10,000 - 19,999	$20,000 - 29,999	$30,000 - 39,999	$40,000 - 49,999	$50,000 - 59,999	$60,000 - 69,999	$70,000 - 79,999	$80,000 - 89,999	$90,000 - 99,999	$100,000 - 109,999	$110,000 - 120,000
$0 - 9,999	$90	$850	$1,020	$1,020	$1,020	$1,070	$1,870	$1,870	$1,870	$1,870	$1,870	$1,970
$10,000 - 19,999	850	1,780	1,980	1,980	2,030	3,030	3,830	3,830	3,830	3,830	3,930	4,130
$20,000 - 29,999	1,020	1,980	2,180	2,230	3,230	4,230	5,030	5,030	5,030	5,130	5,330	5,530
$30,000 - 39,999	1,020	1,980	2,230	3,230	4,230	5,230	6,030	6,030	6,130	6,330	6,530	6,730
$40,000 - 59,999	1,020	2,880	4,080	5,080	6,080	7,080	7,950	8,150	8,350	8,550	8,750	8,950
$60,000 - 79,999	1,870	3,830	5,030	6,030	7,100	8,300	9,300	9,500	9,700	9,900	10,100	10,300
$80,000 - 99,999	1,870	3,830	5,100	6,300	7,500	8,700	9,700	9,900	10,100	10,300	10,500	10,700
$100,000 - 124,999	2,030	4,190	5,590	6,790	7,990	9,190	10,190	10,390	10,590	10,940	11,940	12,940
$125,000 - 149,999	2,040	4,200	5,600	6,800	8,000	9,200	10,200	10,950	11,950	12,950	13,950	14,950
$150,000 - 174,999	2,040	4,200	5,600	6,800	8,150	10,150	11,950	12,950	13,950	14,950	16,170	17,470
$175,000 - 199,999	2,040	4,200	6,150	8,150	10,150	12,150	13,950	15,020	16,320	17,620	18,920	20,220
$200,000 - 249,999	2,720	5,680	7,880	10,140	12,440	14,740	16,840	18,140	19,440	20,740	22,040	23,340
$250,000 - 449,999	2,970	6,230	8,730	11,030	13,330	15,630	17,730	19,030	20,330	21,630	22,930	24,240
$450,000 and over	3,140	6,600	9,300	11,800	14,300	16,800	19,100	20,600	22,100	23,600	25,100	26,610

Head of Household

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	$0 - 9,999	$10,000 - 19,999	$20,000 - 29,999	$30,000 - 39,999	$40,000 - 49,999	$50,000 - 59,999	$60,000 - 69,999	$70,000 - 79,999	$80,000 - 89,999	$90,000 - 99,999	$100,000 - 109,999	$110,000 - 120,000
$0 - 9,999	$0	$280	$850	$950	$1,020	$1,020	$1,020	$1,020	$1,560	$1,870	$1,870	$1,870
$10,000 - 19,999	280	1,280	1,950	2,150	2,220	2,220	2,220	2,760	3,760	4,070	4,070	4,210
$20,000 - 29,999	850	1,950	2,720	2,920	2,980	2,980	3,520	4,520	5,520	5,830	5,980	6,180
$30,000 - 39,999	950	2,150	2,920	3,120	3,180	3,720	4,720	5,720	6,720	7,180	7,380	7,580
$40,000 - 59,999	1,020	2,220	2,980	3,570	4,640	5,640	6,640	7,750	8,950	9,460	9,660	9,860
$60,000 - 79,999	1,020	2,610	4,370	5,570	6,640	7,750	8,950	10,150	11,350	11,860	12,060	12,260
$80,000 - 99,999	1,870	4,070	5,830	7,150	8,410	9,610	10,810	12,010	13,210	13,720	13,920	14,120
$100,000 - 124,999	1,870	4,270	6,230	7,630	8,900	10,100	11,300	12,500	13,700	14,210	14,720	15,720
$125,000 - 149,999	2,040	4,440	6,400	7,800	9,070	10,270	11,470	12,670	14,580	15,890	16,890	17,890
$150,000 - 174,999	2,040	4,440	6,400	7,800	9,070	10,580	12,580	14,580	16,580	17,890	18,890	20,170
$175,000 - 199,999	2,040	4,440	6,400	8,510	10,580	12,580	14,580	16,580	18,710	20,320	21,620	22,920
$200,000 - 249,999	2,720	5,920	8,680	10,900	13,270	15,570	17,870	20,170	22,470	24,080	25,380	26,680
$250,000 - 449,999	2,970	6,470	9,540	12,040	14,410	16,710	19,010	21,310	23,610	25,220	26,520	27,820
$450,000 and over	3,140	6,840	10,110	12,810	15,380	17,880	20,380	22,880	25,380	27,190	28,690	30,190

THE SCHOOL DISTRICT OF ESCAMBIA COUNTY

Payroll Department - 75 North Pace Blvd - Pensacola, Florida 32505

Direct Deposit Authorization Form

Return Completed Direct Deposit Form to the Payroll Department. If you have questions please call (850) 469-6199. The fax number for the Payroll Department is (850) 469-6353.

Your Work Location: _____

Check one: ☐ **Inst/Admin/Prof** ☐ **Ed Support** ☐ **Sub-ESP** ☐ **Sub-INSTR** ☐ **Coach Not Tch** ☐ **Other**

*** Verify with your financial institution(s) on your pay date that your direct deposit is correct.**
*** Allow up to 10 days for processing this request.**
*** Only 2 accounts are allowed for direct deposit.**

Check one of the following: ☐ **START** ☐ **CHANGE** ☐ **STOP**

Name (Last, First, Middle Initial)	**Last 4 of Social Security #**

District Email Address (REQUIRED)

@ecsdfl.us

Account Information

The last item must be for the remaining amount owed to you. Make sure to indicate what kind of account, along with amount to be deposited, if less than your total net paycheck.

#1 Bank Name/City, State

Transit Routing Number (must be 9 numbers)	**Account Number**

Checking ☐ *Savings* ☐ *I wish to deposit $*_____ ***OR*** ☐ *Entire Net Pay*

NO PERCENTAGES!

**Payroll Debit Card* ☐ **Have you previously been issued a Rapid Pay Card from the ECSD and if so, do you still have the card?* *YES* ☐ *NO* ☐

#2 Bank Name/City, State

Transit Routing Number (must be 9 numbers)	**Account Number**

Checking ☐ *Savings* ☐ **Payroll Debit Card* ☐ *I wish to deposit $*_____ ***OR*** ☐ *Entire Net Pay*

NO PERCENTAGES!

I authorize the School District of Escambia County, Florida to direct deposit funds to my account(s) in the financial institution(s) listed above. If funds to which I am not entitled are deposited to my account, I authorize the School District of Escambia County to initiate a debit entry. If any of the above information changes, I will promptly complete a new authorization form. This authority is to remain in full force and effect until 10 days after the School District has received written notification of cancellation of this direct deposit. Changes updated in Skyward must be verified for accuracy by the employee or their pay may be delayed for up to 10 business days.

Date:	Employee Signature	Daytime Phone Number

If you select to have your payment sent to your Checking or Savings Account:

Tape a voided check, a copy of a check, or your banking institution authorization form to the bottom of this form.

Do Not Attach Deposit Slip to Direct Deposit!

Any Old Bank
For _____

Routing No. → 263281695

Account No. → 40068603

Do not include the check number → 1234

Revised: March 10, 2023

THE SCHOOL DISTRICT OF ESCAMBIA COUNTY
Risk Management Department
75 North Pace Boulevard
Pensacola, FL 32505 Phone: (850) 469-6160

MEDICAL HISTORY QUESTIONNAIRE

INSTRUCTIONS: Please complete all information and return to the Risk Management Department.

EMPLOYEE NAME: (Last, First and Middle)	SOCIAL SECURITY NUMBER XXX-XX-

ADDRESS (Street Address/Apartment Number, City, State and ZIP Code

MAILING ADDRESS, if different from above (Street Address/Apartment Number, City, State and ZIP Code

HOME PHONE NUMBER	GENDER (Check One): Male Female	DATE OF BIRTH	WORK STATUS ACTIVE	WORK LOCATION	EMPLOYMENT DATE

RETIREMENT/TERMINATION DATE	MARITAL STATUS (Check One): Single Married Divorced Widowed	DATE OF MARRIAGE	DATE OF DIVORCE (If Applicable)

If you have other medical insurance coverage, please provide the insurance company name, policy number, effective date of policy and address in the spaces below.

NAME	POLICY NUMBER	EFFECTIVE DATE OF COVERAGE

ADDRESS, CITY, STATE AND ZIP CODE

Complete the section below only if your spouse and/or children are covered under your other medical plan listed above.

Last Name	First Name	Relationship	Date of Birth	Social Security Number
				XXX-XX-
				XXX-XX-
				XXX-XX-
				XXX-XX-
				XXX-XX-
				XXX-XX-
				XXX-XX-
				XXX-XX-

Do your dependents live with you at your primary residence? _____ YES _____ NO

If you answered NO to the above question, please provide below, name and address of individual where dependent(s) reside.

NAME	ADDRESS
NAME	ADDRESS
NAME	ADDRESS
NAME	ADDRESS

EMPLOYEE SIGNATURE	DATE

MEDICAL HISTORY QUESTIONNAIRE

I hereby affirm that the School District has made me an offer of employment, conditioned on the satisfactory completion of this questionnaire and, if necessary, within the sole discretion of the School District, a medical examination. The purpose of this inquiry is to determine whether I currently have the physical or mental qualifications necessary to perform the job that has been offered, whether and what accommodations may be necessary, and whether I can perform the job without posing a direct threat to the health or safety of myself or others and for the purposed and reasons as stated on the attached questionnaire.

This information will be kept confidential in a separate medical file, apart from my personnel file. I hereby affirm that the questions as found in the attached medical questionnaire have not been asked of me by anyone with School District until after I have signed this statement and been offered a job.

I declare that the answers given by me to the foregoing questions and statements are true and correct without pertinent omissions. I agree that the Board shall not be held liable if my employment is terminated because of the falsity of statements, answers or omissions made by me in this application. I also authorize all former employers, schools, and the persons named above to give any information regarding my employment, together with any information they may have regarding me. I hereby release said employees, schools, or persons from all liability for issuing this information.

Name:_____

Social Security Number: XXX-XX-_____

Date of Birth:_____

Signature:_____

Date:_____

_____
Witness

_____
Witness

PERMANENT EMPLOYMENT POST JOB OFFER MEDICAL HISTORY QUESTIONNAIRE

NAME: _____

NOTICE TO APPLICANTS: In compliance with the Americans with Disabilities Act of 1990 (ADA), you have received a **conditional** offer of employment. At this point, all applicants are required to provide the answers to all questions below and our job offer is conditional upon the results of your statements. If the results reveal that you cannot satisfy the employment criteria for the position you are being considered for, the employment offer may be withdrawn. Use (Page 5) of this questionnaire to explain fully all questions answered **YES**. Include diagnosis, treatment, results, dates, durations and names and addresses of all doctors and hospitals where you have been treated. **ANSWER EVERY ITEM, PLEASE!**

1. Have you ever had or been treated for any of the following conditions or diseases?

	Yes	No		Yes	No		Yes	No
Epilepsy (fits, convulsions)			Tuberculosis			Wrist trouble/injury		
Diabetes			Allergies (chemical or other)			Back trouble/injury		
Cardiac disease (heart trouble)			Hay Fever or Asthma			Elbow trouble/injury		
Residual disability from Polio			Skin trouble			Foot trouble/injury		
Total loss of sight of one or both eyes or a partial loss of corrected vision of more than 75% bilaterally			Reaction to serum or drug			Hand trouble/injury		
Cerebral Palsy			Kidney or bladder trouble			Shoulder trouble/injury		
Multiple Sclerosis			Ulcers			Neck trouble/injury		
Parkinson's Disease			Cancer			Spinal/Disc trouble/injury		
Hemophilia			Dizziness or fainting spells			Headaches or head injury		
Chronic Osteomyelitis (bone infection)			Arthritis or Rheumatism			Operation/Surgery		
Hyperinsulinism (low blood sugar)			Obesity (30% above average for height and age)			Serious illness/injury		
Muscular Dystrophy			Alcoholism addiction or treatment			Any disabilities?		
Total deafness			Drug addiction or treatment			Ever been injured on the job?		
Thrombophlebitis (inflammation of a vein with a blood clot formed in the vein)			Severe headaches			Ever filed a workers' compensation claim?		
Heat Stroke			Chronic cough			Ever denied a workers' compensation claim?		
Hernia			Shortness of breath			Lost time from work due to serious illness or injury?		
Tobacco use			Mental illness, psychiatric treatment or professional counseling			Ever had an impairment rating?		
Mental handicap			Ruptured Cruciate Ligament			Ever changed employment because of your health?		
Meniscectomy (knee)			Surgical or Spontaneous Fusion of a major weight bearing joint			One or more back injuries or diseased process of the back resulting in disability over a total of 90 or more days?		
Patellectomy			Arm Injury			Any permanent physical condition which constitutes impairment of a member or of the body as a whole?		
Rheumatic Fever			Hip trouble/injury			Advised to have or contemplate having surgery?		
High Blood Pressure			Joint trouble/injury			Is there any type of work you cannot do for health reasons?		
Varicose veins or leg ulcer			Knee trouble/injury			Refused employment or life insurance because of your health?		
Chest pain			Leg trouble/injury			Any other illness, injury, treatment not listed on this form?		

2. Please list any medical condition for which you have been treated in the past 3 years. If no treatment has been provided, state "none."

_____

_____

3. Have you ever been hospitalized? If so, for what condition? If you have not been hospitalized, state "none."

_____

_____

4. Have you ever been treated by a psychiatrist or psychologist? If so, for what condition? If no such treatment has been received, state "none."

5. Have you ever been treated for any mental condition? If so, please explain. If no such treatment has been received, state "none."

6. Is there any health-related reason, you may not be able to perform the job for which you are applying? If yes, please explain.

7. Have you had a major illness in the last 5 years? If none, state "none."

8. How many days were you absent from work because of illness last year? If none, state "none."

9. Do you have any physical defects which preclude you from performing certain kinds of work? If yes, describe such defects and specific work limitations. If none, state "none."

10. Do you have any disabilities or impairments which may affect your performance in the position for which you are applying?

11. Are you taking any prescription drugs? If yes, state the medication and the reason for taking it. If no medications are being taken, state "none."

12. Have you ever been treated for drug addiction or alcoholism? If yes, identify the medical care provider and dates of treatment. If no treatment has been provided, state "none."

13. Have you ever had a job related injury and/or filed a workers' compensation claim? If yes, please explain and include permanent impairment rating assigned, if any. Have you had any treatment in the last 10 years?

NOTE: ALL QUESTIONS ANSWERED "YES" MUST BE FULLY EXPLAINED. Include date, diagnosis, treatment, result and doctor/hospital on the fourth page of this questionnaire.

SPACE TO ANSWER QUESTIONS ANSWERED "YES": (Give the number you are explaining) Continue on reverse if needed.

If I have an on-the-job injury, or if Escambia County School District (hereinafter ECSD) needs to obtain medical details identified by me on the second, third and fourth pages of this questionnaire, I authorize any physician, medical practitioner, hospital, clinic or other health facility, or employer, to release any and all medical information in its possession about me to ECSD, or its legal representatives, as long as I am employed by ECSD. Medical information means all information in the possession of or derived from providers of health care regarding the medical history, mental or physical condition, or treatment of me. I understand that I may request a copy of this authorization form. I affirm that all the facts and information given on this form are true and complete. I understand that any false, incomplete or misleading information given by me on this form, regardless of when it is discovered, is sufficient cause for rejection of my application or termination of my employment with ECSD. I understand and agree that any change in my medical history, as reported on this form, affecting my ability to perform any part of my assignment will be reported in writing to ECSD immediately upon occurrence of such change.

YOUR SIGNATURE **DATE** **WITNESS**