

Thank you for your interest in the Plantation Volunteer Fire Department.

Copies of the following items must be included with your application.

Your application will not be accepted without the proper documentation.

- **Drivers License** (Three color copies, enlarged 200% each)
- **Social Security Card** (Two color copies, enlarged 200% each)
- **High School Diploma/G.E.D./College Diploma**
- **Proof of Residency** (FPL or water bill OR lease or mortgage agreement in your name**.)

(We cannot accept cable or phone bills, or any other mail with your address on it.)

- ****If any of these items are in your spouse's or parent's name and their last name is the same as yours**, you may bring a copy of their bill or agreement.
- ****If you do not have any of these items in your name because you live with or rent a room from someone, you must complete an AFFIDAVIT** as part of the application process and include a copy of the person's FPL or water bill. (An AFFIDAVIT form is available at the front desk of Fire Administration.)

- **Training Certificates*** (Must be current. Each certificate copy must be on a separate piece of paper.)
 - *Examples: Fire Cert (minimum standard Fire 1), CPR, EMT/PM, ICS-100, 700, 200, EVOC

Beneficiary Information

Certain forms in the application will ask for a principal and contingent beneficiary.

- Select 2 people to be your beneficiaries. (You must use the same 2 people throughout your application.)
- Please provide their name, address, date of birth and social security number

If you have any questions regarding the documents/information required to complete your application, please contact Plantation Fire Administration: 954-797-2150.

NAME: _____

CHECK-OFF (Date)	ITEMS	# OF COPIES	NOTES
	BACKGROUND SENT TO HR		
	RECEIVED FDLE BACKGROUND CHECK		
	DRIVER'S LICENSE (Color Copies Enlarged 200% with top margin)	3	
	SOCIAL SECURITY CARD (Color Copies Enlarged 200% with top margin)	2	
	PROOF OF RESIDENCY (FPL / Water Bill or Lease)	1	
	HIGH SCHOOL DIPLOMA OR EQUIVALENT	1	
	PVFA APPLICATION		
	EMERGENCY MEDICAL TREATMENT AUTHO.		
	WORKERS COMP AUTHORIZATIONS (2 Forms)		
	HARTFORD INS BENEFICIARY FORM		
	VOL FIREFIGHTER'S RETIREMENT BENEFICIARY FORM		
	FORM W/4 (Employee's Withholding Allowance)		
	DRUG FREE WORKPLACE FORMS (2)		
	FORM W9 (Request for Taxpayer)		
	SOCIAL SECURITY DISCLOSURE FORM		
	CHIEF'S LETTER		
	SIGNED PVFA REQUIREMENTS & GUIDELINES		
	PHYSICAL EXAM - SCHEDULED & NOTIFIED BY LTR		
	PHYSICAL EXAM - DATE		
	RECEIVED PHYSICAL EXAM RESULTS		
	ASSOCIATION DUES - REC'D.		
	ASSOC. MTG / FIRST READING - ATTENDED		
	COPIED APPLICATION, ETC & SENT TO PERSONNEL		
	BUILD RECORDS		

Paperwork to each applicant

	CHIEF'S LETTER
	WORKERS COMP Q&A TO APPLICANT
	DRUG FREE WORKPLACE POLICY (3)
	SIGNED PVFA REQUIREMENTS & GUIDELINES (one to applicant)

PLANTATION VOLUNTEER FIRE ASSOCIATION, INC.
APPLICATION FOR MEMBERSHIP
PLEASE PRINT CLEARLY & ANSWER ALL QUESTIONS

YOUR FULL NAME: _____
(Last) (First) (Middle) (Suffix: Jr., I, II, III, IV)

ANY ALIAS/
MAIDEN NAME: _____ **NICKNAME:** _____
(Name you want to be called.)

STREET ADDRESS: _____

CITY: _____ **ZIP CODE:** _____ **DATE OF BIRTH:** _____

PHONE #'s: _____ Home # _____ Cell # _____ Office/Work # _____

_____ **HAVE YOU EVER APPLIED WITH US BEFORE?** Y N
Email Address

SOCIAL SECURITY #: _____

DRIVER'S LICENSE # _____ **EXP. DATE** _____

EMPLOYED BY: _____ **OCCUPATION:** _____

EMPLOYER'S ADDRESS: _____ **CITY, STATE ZIP** _____

ARE YOU CURRENTLY ENROLLED IN SCHOOL? Y N

IF SO, WHAT PROGRAM OF STUDY? _____

(If you have any firefighting or medical training certificates, please **attach them to application** & complete the following.)

FIRE CERTIFICATION #: _____ **EMS CERT #:** _____ **EXP. DATE** _____ **NATL. REG.** Y N

YOUR MARITAL STATUS (circle one): S M D W **SPOUSE'S NAME** _____

DO YOU HAVE CHILDREN? HOW MANY? _____

_____ **(Primary Beneficiary's Name)** _____ **(Relationship)** _____ **(DOB)** _____

_____ **(Contingent Beneficiary's Name)** _____ **(Relationship)** _____ **(DOB)** _____

In case of emergency, notify: _____
(Name) (Relationship)

Emergency Contact Phone #(s): _____

WHEN ARE YOU AVAILABLE FOR FIRE CALLS? (Check all that apply.) _____ **DAYS** _____ **NIGHTS** _____ **WEEKENDS** _____

ARE YOU, OR HAVE YOU EVER BEEN AN ACTIVE MEMBER OF ANY CIVIC ORGANIZATION (S)?

YES _____ **NO** _____ If yes, list organization(s) & dates of membership: _____

SIGNATURE OF APPLICANT: _____ **DATE:** _____

(Do not write below this line.)

APPLICANT HAS PASSED MEDICAL EXAMINATION: YES _____ NO _____ **DATE:** _____

APPLICANT HAS PASSED CRIMINAL HISTORY BACKGROUND SURVEY: YES _____ NO _____

FIRST READING DATE: _____



WORKER'S COMPENSATION

MEDICAL TREATMENT AUTHORIZATION

ALL on-the-job work related injuries MUST be reported to your supervisor regardless of the severity of the injury and as soon as possible after the injury. A Notice of Injury Form and Supervisor's Report of Accident Form MUST be completed for EVERY injury.

The Human Resources Department authorizes medical treatment for all injuries that occur between 8:00 a.m. and 4:30 p.m., Monday through Friday. ANY follow-up medical treatment must also be authorized by the Human Resources Department.

Supervisors may authorize treatment at the Urgent Care Center. If the injury occurs after 4:30 p.m. and before 8:00 a.m., Monday through Friday, or on a weekend or if an employee is injured to the extent that emergency medical treatment is required, supervisors may authorize treatment at Westside Regional Medical Center or Plantation General Hospital. (NOTE: A City-issued Identification Card must be furnished to the facility/provider to identify the employee as being employed by the City of Plantation.)

Employees who have received injuries which did not need medical attention at the time of injury, but who require medical attention at a later date MUST contact the Human Resources Department to receive authorization and an appointment for said medical treatment.

REMEMBER: ALL MEDICAL TREATMENT MUST BE AUTHORIZED BY THE HUMAN RESOURCES DEPARTMENT OR A SUPERVISOR, DEPENDING UPON THE DAY AND TIME THE INJURY OCCURS.

FAILURE TO OBTAIN THE NECESSARY AUTHORIZATION FROM THE PROPER INDIVIDUAL CAUSES ANY AND ALL CHARGES INCURRED TO BECOME YOUR RESPONSIBILITY! THESE CHARGES WILL NOT BE PAID BY YOUR HEALTH INSURANCE. WORKER'S COMPENSATION LAW STATES THAT ALL CHARGES INCURRED IN THE COURSE OF AND AS A RESULT OF UNAUTHORIZED TREATMENT BECOMES THE RESPONSIBILITY OF THE EMPLOYEE.

I have read the above information regarding authorization for medical treatment and understand that all charges incurred for treatment by an unauthorized physician, facility, etc., becomes my personal responsibility.

VOLUNTEER'S NAME

VOLUNTEER'S SIGNATURE

DEPARTMENT REPRESENTATIVE

DATE



**CITY OF PLANTATION
WORKERS' COMPENSATION BENEFITS
MANAGED CARE ARRANGEMENT
EMPLOYEE ACKNOWLEDGEMENT**

The City of Plantation provides you with workers' compensation benefits administered through Preferred Governmental Claims Solutions (PGCS). Collectively, we are committed to promoting a safe and healthy work environment. However, work related illness, as well as accidents do occur.

In order to provide you with the best possible medical care should a work related illness or accident occur, the City of Plantation has implemented a Managed Care Arrangement.

The Preferred Provider Network offers many benefits including the following:

- Doctors and hospitals are located near your work site
- Has providers who have been reviewed and have met stringent PPN standards and credentialing criteria
- Providers are experienced in treating on-the-job injuries and want to aid in your return to work when medically appropriate

Except in emergency situations and/or specific circumstances, ***YOU MUST OBTAIN MEDICAL CARE FROM A PPN PROVIDER*** in order to receive full workers' compensation benefits. The City of Plantation, administered through PGCS is prepared to assist you in accessing and selecting a provider.

The Managed Care Arrangement promotes a team approach to treating workers' compensation injuries. The team includes you, the PPN Provider and the City of Plantation administered through PGCS. This approach ensures that timely, appropriate and cost efficient medical treatment is provided to you. This will ensure that you are able to return to work as soon as possible. Everyone benefits from this partnership.

Since we anticipate that you will have numerous questions regarding the Managed Care Arrangement, we have prepared the attached list. Please review the attached questions and answers and if you need additional information, please contact the Human Resources Department at 954-797-2240.

I have read and I understand the Managed Care Program. This form will be retained in my Personnel file.

VOLUNTEER'S NAME

VOLUNTEER'S SIGNATURE

DEPARTMENT REPRESENTATIVE

DATE



QUESTIONS AND ANSWERS

WHAT DO I DO IF I AM INJURED AND NEED EMERGENCY TREATMENT?

You will be provided with treatment at the nearest hospital or appropriate facility. This treatment will be authorized and the bill will be paid. When your condition no longer requires emergency treatment, you will be sent to a PPN provider for continuing treatment.

IF I AM INJURED, AND IT IS NOT AN EMERGENCY SITUATION, WHERE DO I GO FOR MEDICAL TREATMENT?

You will need to advise your employer, who will assist you in finding a primary care physician in your immediate area.

WHAT DO I DO WHEN I NEED TO SEE A DOCTOR BUT I AM WORKING FOR MY EMPLOYER OUTSIDE MY AREA?

In an emergency, seek treatment at the nearest facility. If not contact the Human Resources Department and you will be assisted in finding a PPN near you.

HOW CAN I FIND OUT WHO THE AUTHORIZED PHYSICIANS ARE IN MY AREA?

Your employer has a list of all approved PPN's, specialists, hospitals and other medical providers.

WHO CAN BE A PRIMARY CARE PROVIDER?

A primary care provider may be a family practitioner, general practitioner or internist. In some cases the primary provider may also be an occupational medical provider, podiatrist, optometrist or dentist.

WHAT IS MEANT BY A MEDICAL CARE COORDINATOR?

A Medical Care Coordinator is another term for the primary care physician or provider.

WHAT IS THE ROLE OF A MEDICAL CARE COORDINATOR OR PRIMARY CARE PROVIDER?

The primary care provider is responsible for managing the Medical Care and determines other health care providers and other facilities in conjunction with your Nurse, to which an injured employee may need to be referred for evaluation or treatment.

WHAT SHOULD I DO IF I AM NOT HAPPY WITH MY PRIMARY CARE PROVIDER?

You will be allowed to select another primary care provider, but you must contact the Human Resources Department at 954-797-2240. You are not allowed to change physicians within the network without prior authorization.

WHAT IF THE PRIMARY CARE PROVIDER DECIDES THAT I NEED TO SEE A SPECIALIST SUCH AS A NEUROLOGIST?

You will be provided with a Neurologist from the Preferred Provider Network and the primary care provider will refer you to that physician upon authorization from the Nurse.

IF I DECIDE THAT I WOULD RATHER SEE A SPECIALIST, CAN I REQUEST AND/OR SELECT ONE OF MY OWN?

No. All referrals to a specialist have to be made and recommended by your primary care provider and reviewed by your Nurse. If your PCP does not believe a referral is necessary, you can call the City of Plantation Human Resources Department at 954-797-2240 to discuss your treatment plan.

WHAT CAN I DO IF I AM NOT HAPPY WITH THE SPECIALIST WHO HAS BEEN PROVIDED?

You need to request another specialist from your PCP and another one will be provided from your PPN. You are entitled to one change in Specialty. Simply call the Human Resources Department at 954-797-2240.

AFTER HAVING A CHANGE IN EITHER MY PRIMARY CARE PROVIDER OR ANY SPECIALIST, WHAT SHOULD I DO IF I AM STILL DISSATISFIED?

You should immediately call the Human Resources Department at 954-797-2240 and express your concerns and/or dissatisfaction. You will be referred to the managed care grievance coordinator if you want to file a grievance and explain the procedure to you.

WHAT CONSTITUTES A GRIEVANCE OR DISPUTE?

Some disputes could involve the following:

- Dissatisfaction with the treating physician and/or medical care treatment
- Unable to obtain a referral to a Specialist
- Failure to note improvement under current treatment plan

HOW DOES THE GRIEVANCE RESOLUTION WORK?

You will contact the Nurse and she will advise the Grievance Coordinator to ask for a review and resolution. If necessary, the Grievance Coordinator will contact an MCC. If the MCC advisor is unable to resolve the dispute to your satisfaction within 30 days, the matter will automatically be referred to the Medical Director.

The Medical Director will issue a decision in 30 days unless further information is required, in which case an additional 30 days will be allowed. If an agreement is not reached and you are not satisfied with the decision of the Medical Director, you may file a request for grievance reconsideration to the Division of Worker's Compensation at 2728 Centerview Drive, 220 Forest Building, Tallahassee, FL 32399-0685, or call 1-800-342-1741. Of course, you can contact the Division of Worker's Compensation and file a request for grievance validation while the grievance is in process.

Grievance level process can be obtained by contacting the Human Resources Department at 954-797-2240.

IF I AM DISSATISFIED WITH ANYTHING OTHER THAN MEDICAL CARE, WHOM DO I CONTACT?

The Grievance Coordinator only becomes involved in disputes regarding medical treatment. All other concerns or questions should be addressed to the Human Resources Department at 954-797-2240.

CO-PAY

Employees who have reached Maximum Medical Improvement will be responsible for a \$10.00 co-payment for every office visit after that date, except for emergencies.

CHIROPRACTIC TREATMENT

Chiropractic treatment is limited to 18 visits or 8 weeks, whichever comes first.



Plantation
the grass is greener

**HARTFORD ACCIDENT AND INDEMNITY COMPANY
HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY**

**BENEFICIARY DESIGNATION
(FIRE DEPARTMENT- EMT & PARAMEDICS)**

Policy No. 21VP480091

Insured Person's Name

Employee #

Policyholder

CITY OF PLANTATION

Death Benefits to be paid to beneficiary(ies) named below. State relationship.

Primary Beneficiary Name

Primary Beneficiary Street Address

City

State

Zip Code

Social Security No.

Date of Birth

Relationship

Contingent Beneficiary Name

Contingent Beneficiary Street Address

City

State

Zip Code

Social Security No.

Date of Birth

Relationship

And the right to change the beneficiary(ies) without the consent of said beneficiary(ies) is reserved.

Signature of Insured Person

Date

Witness of Signature

Date

NAMING THE BENEFICIARY

It is important that your beneficiary designation be clear, so that there will be no question as to your meaning. If you need assistance, contact your Company Representative.

The following are the most common designations:

Mary J. Doe, Wife (NOT Mrs. John J. Doe).

Mary J. Doe, Wife, if living, otherwise to Joseph W. Doe, Son.

Mary J. Doe, Wife, if living, otherwise to Jane Doe, Daughter, and Joseph W. Doe, Son, in equal shares or to the survivor. Estate of Insured Person.

If you name more than one beneficiary with unequal shares, please show the amount of insurance to be paid to each beneficiary in fractional parts; for example "1/3 to Mary Jones, mother, and 2/3 to Edith Jones, wife."

Please state age and relationship of each beneficiary. If the beneficiary is not related to you either by blood or marriage, insert the words "Not related," and state address of beneficiary.

The signature must be in ink. Do not erase. If corrections are necessary, line out the error and initial the correction.

STATE OF FLORIDA

COUNTY OF BROWARD

The foregoing instrument was acknowledged before me this _____ day of, _____ 2011, by _____ who is personally known to me or who has produced D.L. # _____ as identification and who did take an oath.

Signature

SEAL



CITY OF PLANTATION
VOLUNTEER FIREFIGHTERS' RETIREMENT SYSTEM
BENEFICIARY DESIGNATION CERTIFICATE

Print Name: _____

TO: Board of Trustees: I hereby make the following beneficiary designation for any benefits due under the above Retirement System in the event of my death:

PRINCIPAL:

Form fields for Principal beneficiary: Name of Beneficiary, Relationship, Street Address + Apt #, City, State, Zip, Phone #, Date of Birth, Social Security #

CONTINGENT:

Form fields for Contingent beneficiary: Name of Beneficiary, Relationship, Street Address + Apt #, City, State, Zip, Phone #, Date of Birth, Social Security #

If any designated beneficiary shall predecease me, the rights and interests of such beneficiary shall thereupon automatically terminate. If at my death there be no designated principal or contingent beneficiary as to my benefit, then any such benefit shall be payable to my estate; provided, however, the Board of Trustees, at its option, may pay such benefit to my spouse, child or children, or to a legal Guardian of any minor or incompetent heirs, and payment in that manner shall completely discharge the liability with respect to the benefit so paid.

I reserve the right to change the designated beneficiaries at any time upon filing a new written request with the Board which request, when received by the Board of Trustees shall revoke any prior selection or designation of beneficiary. The consent of a beneficiary shall not be required to effectuate any change.

Form fields for Member's Signature, Date, Street Address + Apt #, City, State, Zip

Department Representative/Witness Date

Please see the Social Security Number Collection Disclosure Form

Form W-4 (2014)

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 2014 expires February 17, 2015. 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 \$1,000 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 2014. 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: <ul style="list-style-type: none"> • 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. <ul style="list-style-type: none"> • If your total income will be less than \$65,000 (\$95,000 if married), enter "2" for each eligible child; then less "1" if you have three to six eligible children or less "2" if you have seven or more eligible children. • If your total income will be between \$65,000 and \$84,000 (\$95,000 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 _____
<p>For accuracy, complete all worksheets that apply.</p> <ul style="list-style-type: none"> • 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	<h2 style="margin: 0;">Employee's Withholding Allowance Certificate</h2> <p style="margin: 0;">▶ 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.</p>	OMB No. 1545-0074 2014
1 Your first name and middle initial _____ Last name _____		2 Your social security number _____
Home address (number and street or rural route) _____		3 <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Married, but withheld 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. ▶ <input type="checkbox"/>
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 2014, and I certify that I meet both of the following conditions for exemption. <ul style="list-style-type: none"> • 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 2014 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, 1950) of your income, and miscellaneous deductions. For 2014, you may have to reduce your itemized deductions if your income is over \$305,050 and you are married filing jointly or are a qualifying widow(er); \$279,650 if you are head of household; \$254,200 if you are single and not head of household or a qualifying widow(er); or \$152,525 if you are married filing separately. See Pub. 505 for details 1 \$ _____
- 2 Enter: $\left\{ \begin{array}{l} \$12,400 \text{ if married filing jointly or qualifying widow(er)} \\ \$9,100 \text{ if head of household} \\ \$6,200 \text{ if single or married filing separately} \end{array} \right\}$ 2 \$ _____
- 3 **Subtract** line 2 from line 1. If zero or less, enter "-0-" 3 \$ _____
- 4 Enter an estimate of your 2014 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 2014 Form W-4* worksheet in Pub. 505.) 5 \$ _____
- 6 Enter an estimate of your 2014 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 \$3,950 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 2014. 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 2014. 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

Table 2

Married Filing Jointly		All Others		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	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 - \$6,000	0	\$0 - \$6,000	0	\$0 - \$74,000	\$590	\$0 - \$37,000	\$590
6,001 - 13,000	1	6,001 - 16,000	1	74,001 - 130,000	990	37,001 - 80,000	990
13,001 - 24,000	2	16,001 - 25,000	2	130,001 - 200,000	1,110	80,001 - 175,000	1,110
24,001 - 26,000	3	25,001 - 34,000	3	200,001 - 355,000	1,300	175,001 - 385,000	1,300
26,001 - 33,000	4	34,001 - 43,000	4	355,001 - 400,000	1,380	385,001 and over	1,560
33,001 - 43,000	5	43,001 - 70,000	5	400,001 and over	1,560		
43,001 - 49,000	6	70,001 - 85,000	6				
49,001 - 60,000	7	85,001 - 110,000	7				
60,001 - 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						

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.



SUMMARY OF THE CITY OF PLANTATION'S
DRUG-FREE WORKPLACE POLICY

EMPLOYEES ARE HEREBY NOTIFIED THAT IT IS A CONDITION OF EMPLOYMENT FOR EACH EMPLOYEE TO REFRAIN FROM REPORTING TO WORK OR WORKING WITH THE PRESENCE OF DRUGS OR ALCOHOL IN HIS OR HER BODY. IF AN EMPLOYEE TESTS CONFIRMED POSITIVE OR REFUSES TO SUBMIT TO A TEST FOR DRUGS OR ALCOHOL, THE EMPLOYEE IS SUBJECT TO DISCIPLINARY ACTION, INCLUDING DISCHARGE, AND MAY FORFEIT ELIGIBILITY FOR MEDICAL AND INDEMNITY BENEFITS.

I WHAT IS THE DRUG-FREE WORKPLACE POLICY?

- A. In accordance with Florida's Drug Free Workplace law, Section 440.101 et seq., the City of Plantation (the "City") prohibits the illegal use, possession, sale, manufacture, or distribution, of drugs, alcohol, or other controlled substances on its property. For purposes of this policy alcohol is considered to be a drug.
- B. It is also against City policy for employees to report to work or to work under the influence of drugs. This includes prescription drugs which induce an unsafe mental or physical state. Any employee who is taking any prescription drug which might impair safety, performance, or any motor functions should advise his or her supervisor before commencing work under such medication.
- C. For the purpose of this policy, an individual is presumed to be under the influence of drugs if a confirmed drug test is positive.
- D. The use, sale, purchase, possession, distribution, or dispensing of drugs on duty or on City property is cause for discharge.
- E. The City may suspend employees without pay under this policy pending the results of a drug test or investigation.
- F. The City has contracted with a Medical Review Officer (MRO) who is a licensed physician with knowledge of substance abuse disorders, laboratory testing procedures, chain of custody collection procedures, the medical use of prescription drugs and the pharmacology and toxicology of illicit drugs. The purpose of the MRO is to ensure to the maximum extent possible that all test results are accurate. Applicants or employees can discuss any technical questions regarding testing with the MRO prior to or after the test.

II WHO IS TESTED?

The City tests all applicants and employees as described below:

A. Applicants:

1. Applicants who are considered final candidates for a position will be tested for the presence of drugs as part of the application process. The City may elect to test for only certain job classifications.
2. Applicants will be asked to sign a Pre-employment Drug Testing Agreement, consenting to the drug test. If an applicant refuses, he or she will not be considered for employment and the employment application process will be terminated.
3. If an applicant's test is confirmed positive, the applicant will not be considered for employment at that time and will be informed that he or she has failed to meet employment standards.

B. Employees:

1. Reasonable-Suspicion Testing: Employees will be tested when there is a reasonable suspicion that an employee is or has used, possessed, sold, solicited, or transferred drugs while on the City's premises or while operating its vehicles, machines, equipment or when there is evidence that an employee has tampered with a drug test during his employment. Reasonable suspicion drug testing means drug testing based on a belief that an employee is using or has used drugs in violation of this Policy drawn from specific objective and articulable facts and reasonable inferences drawn from those facts in light of experience. Among other things, such facts and inferences may be based upon:
 - (a) Observable phenomena while at work, such as direct observation of drug use or of the physical symptoms or manifestations of being under the influence of a drug;
 - (b) Abnormal conduct or erratic behavior while at work or a significant deterioration of work performance;
 - (c) A report of drug use, provided by a reliable and credible source, which has been independently corroborated;
 - (d) Evidence that an individual has tampered with a drug test during his or her employment with the City;
 - (e) Information that an employee has caused, contributed to, or been involved in an accident while at work; or
 - (f) Evidence that an employee has used, possessed, sold, solicited, or transferred drugs while working or while on the City's premises or while operating a vehicle, machinery, or equipment of the City.
2. Post On-the-Job Accident or Injury Testing: Employees who sustain an on-the-job injury which requires medical treatment, or who have caused, contributed to or have been involved in an accident while at work will be tested at the time medical treatment is administered, or as soon as possible. Employees involved in an accident must not use alcohol for eight (8) hours following an accident or until a post-accident test is conducted, whichever comes first.

3. Routine Fitness-for-Duty Testing: Employees will be drug tested as part of any routinely scheduled employee fitness-for-duty medical examination.
4. Follow-up and Return to Duty Testing: Employees who have failed a test and who are permitted by the City to return to work after completing treatment for alcohol or drug abuse will be tested prior to returning to work and will be subject to unannounced follow-up tests for a period of two (2) years.
5. Random: Employees may be required to undergo random drug testing if required by law, collective bargaining agreement, or because the employee's position is a "safety-sensitive" or "special-risk" position.

II WHAT IF AN APPLICANT OR EMPLOYEE REFUSES TO BE TESTED?

- A. Any applicant who refuses to submit to the pre-employment drug test will be ineligible for hire.
- B. Any employee who refuses to submit to a drug test may be terminated from employment or otherwise disciplined. An employee involved in a workers' compensation accident/incident who refuses to submit to a drug test, or who has a confirmed positive test result, in addition to any disciplinary action, may forfeit his or her eligibility for workers' compensation medical and indemnity benefits.
- C. Any urine and/or blood and/or hair specimen submitted by an employee for drug testing that is found by the MRO or testing laboratory to have been adulterated or tampered with will be considered a refusal to test resulting in disciplinary action or discharge and denial of unemployment benefits and workers' compensation claims.

III WHAT IF SOMEONE TESTS POSITIVE?

- A. An employee who tests positive on a confirmation test will be subject to discipline, up to and including termination.
- B. Tests will be conducted only by laboratories licensed and approved by the proper state and/or federal agencies. Test specimens will be collected, tested, and stored pursuant to the requirements of Florida law. No physician-patient relationship is created between an employee or job applicant and the City or any person performing or evaluating a drug test.
- C. The City's Medical Review Officer (MRO) will initially receive and verify that test results were properly analyzed and handled by the laboratory testing. The MRO will then contact the job applicant or employee to give the person an opportunity to explain or challenge a positive test result to determine whether prescription or other legitimately taken drugs could have caused the positive test result. If the MRO decides that the applicant or employee's explanation is unsatisfactory, the MRO will report a positive test to the City. The City will notify the job applicant or employee of confirmed positive test results within five (5) working days after receipt of the result from the MRO.
- D. A job applicant or employee who receives a positive confirmed drug test result may contest or explain the result to the MRO or the City within five (5) days after written notification of the positive test result. If the explanation or challenge is unsatisfactory, a written explanation will be given to the applicant or employee. If the applicant's or employee's challenge is unsatisfactory to the MRO or the City, the applicant or employee may have the right to contest the test results pursuant to rules adopted by the Florida Division of Workers' Compensation or in a court of competent jurisdiction.

- E. Employees who are covered under a collective bargaining agreement between the City and any certified labor organization may have the right to file a grievance regarding discipline imposed by the City as a result of a violation of this policy if said grievance is permitted to be filed pursuant to the collective bargaining agreement.
- F. The testing laboratory will preserve specimens of confirmed positive test results for at least two hundred ten (210) days after the result was mailed to the MRO. A job applicant or employee has the responsibility of notifying the drug testing laboratory of any administrative or civil action brought pursuant to Chapter 440, Florida Statutes. If timely notified, the testing laboratory will maintain the sample until the case or administrative appeal is settled.
- G. Any applicant or employee who elects to have a portion of his or her specimen retested at another licensed testing laboratory (at his or her expense) must notify the testing laboratory and make a request to the City within one hundred eighty (180) days after written notification of a positive test result.
- H. A list of names, addresses, and telephone numbers of employee assistance programs and local drug rehabilitation programs are on file with the City. This information will be provided to any person upon request. Information about local assistance programs and/or rehabilitation programs may also be obtained at:

Switchboard of Miami
(305) 358-4357

Crisis Information Line
(954) 537-0211

IV WHAT IF AN APPLICANT OR EMPLOYEE HAS QUESTIONS ABOUT LEGITIMATE PRESCRIPTION DRUG OR OTHER TECHNICAL INFORMATION ABOUT THE TESTS?

- A. Job applicants and employees have the right to confidentially consult the Medical Review Officer (MRO) for technical information regarding prescription and non-prescription medication and may contest or explain the test result to the MRO both before and after being tested.
- B. Prior to testing, the job applicant or employee will be given a list of the most common medications by brand name or common name and chemical name which may alter or affect a drug test. This information is also provided on the Drug Testing Chain-of-Custody Form.
- C. A Drug Use Information form, which is a confidential report, may be filled out by job applicants and employees before or after being drug tested. This form permits individuals to provide to the MRO a list of all prescription and non-prescription drugs they are currently using or have used in the last month, as well as any other information they consider relevant to the test.
- D. All information, interviews, reports, statements, memoranda and drug test results, written or otherwise, received by the City as part of this drug testing program are confidential communications. Unless authorized by state laws, rules or regulations, the City will not release such information without a written consent form signed voluntarily by the person tested. The City or its legal counsel may disclose such information in the event that a challenge or other form of civil, disciplinary or administrative litigation is commenced by a job applicant or employee.

V WHAT TYPE OF DRUGS ARE TESTED?

The following is a list of drugs (described by brand name, common name and/or chemical name) for which the City may test. Also listed and identified are those most common medications which may alter or affect a drug test:

Alcohol (booze, drink, distilled spirits, wine, malt beverages, beer, intoxicating liquors, alcoholic beverages, etc.)

Amphetamines (Binhetamine, Desoxyn, Dexedrine)

Cannabinoids (marijuana, hashish, hash, hash oil, pot, joint, roach, spleaf, grass, weed, reefer)

Cocaine (coke, blow, nose candy, snow, flake, crack)

Phencyclidine (PCP, angel dust, hog)

Methaqualone

Opiates (opium, dover's powder, paregoric, parepectolin)

Barbiturates (Phenobarbital Tuinal, Amytal)

Benzodiazophines (Ativan, Azene, Klonopin, Dalmane, Diazepam, Halcion, Librium, Poxipam, Restoril, Serax, Tranxene, Valium, Vertron, Xanax)

Methadone (Dolophine, Methadose)

Propoxyphene (Darvocet, Darvon N, Dolene)

Metabolites of any substances listed above.

VI WHAT ELSE SHOULD I KNOW ABOUT THE POLICY?

- A. Details of this policy may be obtained during regular business hours from the Human Resources Department.
- B. The contents of this policy constitute statements of the City's current policy and may be changed and updated by the City at any time. Nothing in this policy is intended to create a contract between the City and any employee. Nothing in these guidelines binds the City to a specific or definite period of employment or to any specific policies, procedures, actions, rules, or terms and conditions of employment.
- C. As a condition of employment and continued employment, all employees are required to abide by this policy.



CITY OF PLANTATION
DRUG-FREE WORKPLACE

**EMPLOYEE ACKNOWLEDGMENT OF RECEIPT
OF SUMMARY OF DRUG-FREE WORKPLACE POLICY**

I _____, hereby acknowledge that I have received a copy of the City of Plantation's Summary of Drug-Free Workplace Policy, consisting of this page and the five (5) preceding typewritten pages on the date indicated below. I understand that on the effective date of the policy, it will be a condition of my employment to refrain from reporting to work or working with the presence of drugs or alcohol in my body.

EMPLOYEE'S SIGNATURE

DATE

WITNESS SIGNATURE

DATE



**CITY OF PLANTATION
CERTIFICATE OF AGREEMENT AND RELEASE FOR DRUG TESTING**

I, _____, hereby certify that I have received and read the “Summary of the City of Plantation’s Drug-Free Workplace Policy” regarding substance abuse.

I hereby consent to submit to drug and alcohol testing of my urine and/or blood and/or hair at any time requested by the City pursuant to the City’s Drug-Free Workplace Policy and Work Rules. I hereby authorize and give full permission to have the City’s contracted medical provider, their staff, and/or their associates send a specimen of my urine and/or blood and/or hair to a laboratory for screening tests for the presence of drugs and/or alcohol. I authorize the release of the results of such tests, positive or negative, to a Medical Review Officer selected by the City and to the Human Resources Department.

I understand that failure to comply with a request to submit to a drug and/or alcohol test by an authorized City representative, or that a positive confirmed result from a drug and/or alcohol test may lead to termination of my employment.

Name

Signature

Date

Witness Signature

Date

Request for Taxpayer Identification Number and Certification

**Give Form to the
 requester. Do not
 send to the IRS.**

Print or type See Specific Instructions on page 2.	Name (as shown on your income tax return)	
	Business name/disregarded entity name, if different from above	
	Check appropriate box for federal tax classification: <input type="checkbox"/> Individual/sole proprietor <input type="checkbox"/> C Corporation <input type="checkbox"/> S Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Trust/estate <input type="checkbox"/> Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=partnership) ▶ _____ <input type="checkbox"/> Other (see instructions) ▶ _____	Exemptions (see instructions): Exempt payee code (if any) _____ Exemption from FATCA reporting code (if any) _____
	Address (number, street, and apt. or suite no.)	Requester's name and address (optional)
	City, state, and ZIP code	
List account number(s) here (optional)		

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on the "Name" line to avoid backup withholding. For individuals, this is your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 3. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN* on page 3.

Social security number	
	-
	-

Note. If the account is in more than one name, see the chart on page 4 for guidelines on whose number to enter.

Employer identification number	
	-

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding, and
3. I am a U.S. citizen or other U.S. person (defined below), and
4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions on page 3.

Sign Here	Signature of U.S. person ▶	Date ▶
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General Instructions

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

Future developments. The IRS has created a page on IRS.gov for information about Form W-9, at www.irs.gov/w9. Information about any future developments affecting Form W-9 (such as legislation enacted after we release it) will be posted on that page.

Purpose of Form

A person who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) to report, for example, income paid to you, payments made to you in settlement of payment card and third party network transactions, real estate transactions, mortgage interest you paid, acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA.

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN to the person requesting it (the requester) and, when applicable, to:

1. Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),
2. Certify that you are not subject to backup withholding, or
3. Claim exemption from backup withholding if you are a U.S. exempt payee. If applicable, you are also certifying that as a U.S. person, your allocable share of any partnership income from a U.S. trade or business is not subject to the

withholding tax on foreign partners' share of effectively connected income, and

4. Certify that FATCA code(s) entered on this form (if any) indicating that you are exempt from the FATCA reporting, is correct.

Note. If you are a U.S. person and a requester gives you a form other than Form W-9 to request your TIN, you must use the requester's form if it is substantially similar to this Form W-9.

Definition of a U.S. person. For federal tax purposes, you are considered a U.S. person if you are:

- An individual who is a U.S. citizen or U.S. resident alien,
- A partnership, corporation, company, or association created or organized in the United States or under the laws of the United States,
- An estate (other than a foreign estate), or
- A domestic trust (as defined in Regulations section 301.7701-7).

Special rules for partnerships. Partnerships that conduct a trade or business in the United States are generally required to pay a withholding tax under section 1446 on any foreign partners' share of effectively connected taxable income from such business. Further, in certain cases where a Form W-9 has not been received, the rules under section 1446 require a partnership to presume that a partner is a foreign person, and pay the section 1446 withholding tax. Therefore, if you are a U.S. person that is a partner in a partnership conducting a trade or business in the United States, provide Form W-9 to the partnership to establish your U.S. status and avoid section 1446 withholding on your share of partnership income.

In the cases below, the following person must give Form W-9 to the partnership for purposes of establishing its U.S. status and avoiding withholding on its allocable share of net income from the partnership conducting a trade or business in the United States:

- In the case of a disregarded entity with a U.S. owner, the U.S. owner of the disregarded entity and not the entity,
- In the case of a grantor trust with a U.S. grantor or other U.S. owner, generally, the U.S. grantor or other U.S. owner of the grantor trust and not the trust, and
- In the case of a U.S. trust (other than a grantor trust), the U.S. trust (other than a grantor trust) and not the beneficiaries of the trust.

Foreign person. If you are a foreign person or the U.S. branch of a foreign bank that has elected to be treated as a U.S. person, do not use Form W-9. Instead, use the appropriate Form W-8 or Form 8233 (see Publication 515, Withholding of Tax on Nonresident Aliens and Foreign Entities).

Nonresident alien who becomes a resident alien. Generally, only a nonresident alien individual may use the terms of a tax treaty to reduce or eliminate U.S. tax on certain types of income. However, most tax treaties contain a provision known as a "saving clause." Exceptions specified in the saving clause may permit an exemption from tax to continue for certain types of income even after the payee has otherwise become a U.S. resident alien for tax purposes.

If you are a U.S. resident alien who is relying on an exception contained in the saving clause of a tax treaty to claim an exemption from U.S. tax on certain types of income, you must attach a statement to Form W-9 that specifies the following five items:

1. The treaty country. Generally, this must be the same treaty under which you claimed exemption from tax as a nonresident alien.
2. The treaty article addressing the income.
3. The article number (or location) in the tax treaty that contains the saving clause and its exceptions.
4. The type and amount of income that qualifies for the exemption from tax.
5. Sufficient facts to justify the exemption from tax under the terms of the treaty article.

Example. Article 20 of the U.S.-China income tax treaty allows an exemption from tax for scholarship income received by a Chinese student temporarily present in the United States. Under U.S. law, this student will become a resident alien for tax purposes if his or her stay in the United States exceeds 5 calendar years. However, paragraph 2 of the first Protocol to the U.S.-China treaty (dated April 30, 1984) allows the provisions of Article 20 to continue to apply even after the Chinese student becomes a resident alien of the United States. A Chinese student who qualifies for this exception (under paragraph 2 of the first protocol) and is relying on this exception to claim an exemption from tax on his or her scholarship or fellowship income would attach to Form W-9 a statement that includes the information described above to support that exemption.

If you are a nonresident alien or a foreign entity, give the requester the appropriate completed Form W-8 or Form 8233.

What is backup withholding? Persons making certain payments to you must under certain conditions withhold and pay to the IRS a percentage of such payments. This is called "backup withholding." Payments that may be subject to backup withholding include interest, tax-exempt interest, dividends, broker and barter exchange transactions, rents, royalties, nonemployee pay, payments made in settlement of payment card and third party network transactions, and certain payments from fishing boat operators. Real estate transactions are not subject to backup withholding.

You will not be subject to backup withholding on payments you receive if you give the requester your correct TIN, make the proper certifications, and report all your taxable interest and dividends on your tax return.

Payments you receive will be subject to backup withholding if:

1. You do not furnish your TIN to the requester,
2. You do not certify your TIN when required (see the Part II instructions on page 3 for details),
3. The IRS tells the requester that you furnished an incorrect TIN,
4. The IRS tells you that you are subject to backup withholding because you did not report all your interest and dividends on your tax return (for reportable interest and dividends only), or
5. You do not certify to the requester that you are not subject to backup withholding under 4 above (for reportable interest and dividend accounts opened after 1983 only).

Certain payees and payments are exempt from backup withholding. See *Exempt payee code* on page 3 and the separate instructions for the Requester of Form W-9 for more information.

Also see *Special rules for partnerships* on page 1.

What is FATCA reporting? The Foreign Account Tax Compliance Act (FATCA) requires a participating foreign financial institution to report all United States account holders that are specified United States persons. Certain payees are exempt from FATCA reporting. See *Exemption from FATCA reporting code* on page 3 and the instructions for the Requester of Form W-9 for more information.

Updating Your Information

You must provide updated information to any person to whom you claimed to be an exempt payee if you are no longer an exempt payee and anticipate receiving reportable payments in the future from this person. For example, you may need to provide updated information if you are a C corporation that elects to be an S corporation, or if you no longer are tax exempt. In addition, you must furnish a new Form W-9 if the name or TIN changes for the account, for example, if the grantor of a grantor trust dies.

Penalties

Failure to furnish TIN. If you fail to furnish your correct TIN to a requester, you are subject to a penalty of \$50 for each such failure unless your failure is due to reasonable cause and not to willful neglect.

Civil penalty for false information with respect to withholding. If you make a false statement with no reasonable basis that results in no backup withholding, you are subject to a \$500 penalty.

Criminal penalty for falsifying information. Willfully falsifying certifications or affirmations may subject you to criminal penalties including fines and/or imprisonment.

Misuse of TINs. If the requester discloses or uses TINs in violation of federal law, the requester may be subject to civil and criminal penalties.

Specific Instructions

Name

If you are an individual, you must generally enter the name shown on your income tax return. However, if you have changed your last name, for instance, due to marriage without informing the Social Security Administration of the name change, enter your first name, the last name shown on your social security card, and your new last name.

If the account is in joint names, list first, and then circle, the name of the person or entity whose number you entered in Part I of the form.

Sole proprietor. Enter your individual name as shown on your income tax return on the "Name" line. You may enter your business, trade, or "doing business as (DBA)" name on the "Business name/disregarded entity name" line.

Partnership, C Corporation, or S Corporation. Enter the entity's name on the "Name" line and any business, trade, or "doing business as (DBA) name" on the "Business name/disregarded entity name" line.

Disregarded entity. For U.S. federal tax purposes, an entity that is disregarded as an entity separate from its owner is treated as a "disregarded entity." See Regulation section 301.7701-2(c)(2)(iii). Enter the owner's name on the "Name" line. The name of the entity entered on the "Name" line should never be a disregarded entity. The name on the "Name" line must be the name shown on the income tax return on which the income should be reported. For example, if a foreign LLC that is treated as a disregarded entity for U.S. federal tax purposes has a single owner that is a U.S. person, the U.S. owner's name is required to be provided on the "Name" line. If the direct owner of the entity is also a disregarded entity, enter the first owner that is not disregarded for federal tax purposes. Enter the disregarded entity's name on the "Business name/disregarded entity name" line. If the owner of the disregarded entity is a foreign person, the owner must complete an appropriate Form W-8 instead of a Form W-9. This is the case even if the foreign person has a U.S. TIN.

Note. Check the appropriate box for the U.S. federal tax classification of the person whose name is entered on the "Name" line (individual/sole proprietor, Partnership, C Corporation, S Corporation, Trust/estate).

Limited Liability Company (LLC). If the person identified on the "Name" line is an LLC, check the "Limited liability company" box only and enter the appropriate code for the U.S. federal tax classification in the space provided. If you are an LLC that is treated as a partnership for U.S. federal tax purposes, enter "P" for partnership. If you are an LLC that has filed a Form 8832 or a Form 2553 to be taxed as a corporation, enter "C" for C corporation or "S" for S corporation, as appropriate. If you are an LLC that is disregarded as an entity separate from its owner under Regulation section 301.7701-3 (except for employment and excise tax), do not check the LLC box unless the owner of the LLC (required to be identified on the "Name" line) is another LLC that is not disregarded for U.S. federal tax purposes. If the LLC is disregarded as an entity separate from its owner, enter the appropriate tax classification of the owner identified on the "Name" line.

Other entities. Enter your business name as shown on required U.S. federal tax documents on the "Name" line. This name should match the name shown on the charter or other legal document creating the entity. You may enter any business, trade, or DBA name on the "Business name/disregarded entity name" line.

Exemptions

If you are exempt from backup withholding and/or FATCA reporting, enter in the *Exemptions* box, any code(s) that may apply to you. See *Exempt payee code* and *Exemption from FATCA reporting code* on page 3.

OFFICE OF THE MAYOR

Diane Veltri Bendekovic,
Mayor

FIRE DEPARTMENT

E. Laney Stearns, III
Fire Chief



CITY COUNCIL

Dr. Robert A. Levy, Council President
Lynn Stoner, President Pro Tem
Jerry Fadgen
Ron Jacobs
Chris P. Zimmerman, AIA

SOCIAL SECURITY NUMBER COLLECTION DISCLOSURE

The City of Plantation collects your Social Security Number for the following purposes: Classification of Accounts; Identification and Verification; Credit Worthiness; Billing and Payments; Data Collection, Reconciliation, Tracking, Benefit Processing, Tax Reporting, and to initiate and process applicant or employee background checks to include consumer reports, educational institutions, government agencies, companies, corporations, and credit reporting agencies in compliance with the Fair Credit Reporting Act; and for Drug Screening Identification.

Printed name of Individual

ACKNOWLEDGEMENT

Signature

Date

Revised 1/08

OFFICE OF THE MAYOR

Diane Veltri Bendekovic,
Mayor

FIRE DEPARTMENT

E. Laney Stearns, III
Fire Chief



CITY COUNCIL

Dr. Robert A. Levy, Council President
Lynn Stoner, President Pro Tem
Jerry Fadgen
Ron Jacobs
Chris P. Zimmerman, AIA

To: Prospective Volunteer

From: Fire Chief Laney Stearns

Initial:

RE: Special Considerations for Joining the Fire Department

The Plantation Fire Department is a **VOLUNTEER** Fire Department. We feel that we are an elite organization with goals, policies, performance and a philosophy, which is a cut above other organizations that you may consider volunteering with.

We request that you closely evaluate your commitment to our organization to ensure it is one of dedication and performance **before** seeking acceptance into the Fire Department. Consider:

- Are you joining for the "fun" of it or is this just a "whim"?
- Do you just need "something to do"?
- Are you joining just to be near your friends?
- Are you here to keep one certificate active while working on another?
- Do you have an agenda other than serving your community?

IF you answered yes to any of the questions above, you should give more thought to your decision before you fill out the application.

This Fire Department has rules, regulations, policies and procedures, which you must follow. We are not a social club. When the alarm rings, you must be thoroughly committed to performing the tasks assigned and required - our citizens deserve nothing less.

You cannot expect to perform properly and safely if you have not attended the training sessions. Firefighting is not a game. It requires your dedication to save lives, protect property, and to ensure each one of us goes home at the end of an incident.

To be a member of our department you must follow the rules, attend meetings and training sessions, participate in department functions and projects, and, most importantly, respond to emergency calls.

You will need to attend our Basic Training Classes, at no cost to you, before you can respond to emergency incidents. Additional training is required during your entire membership; we train continuously.

We wish for you to join the Plantation Fire Department, but we will require your dedication. If you feel you are ready and willing to accomplish these requirements, **WELCOME!** If you feel you cannot, no problem, please do not submit the application for membership.

We guarantee that you will feel a special sense of pride and accomplishment that comes from helping your neighbors during their time of need. We will provide training, motivation, leadership, protective equipment, and a rewarding experience of a lifetime. You provide your personal commitment and time!

OFFICE OF THE MAYOR

Diane Veltri Bendekovic,
Mayor

FIRE DEPARTMENT

E. Laney Stearns, III
Fire Chief



CITY COUNCIL

Dr. Robert A. Levy, Council President
Lynn Stoner, President Pro Tem
Jerry Fadgen
Ron Jacobs
Chris P. Zimmerman, AIA

To: Prospective Volunteer

From: Fire Chief Laney Stearns

Initial:

RE: Special Considerations for Joining the Fire Department

The Plantation Fire Department is a **VOLUNTEER** Fire Department. We feel that we are an elite organization with goals, policies, performance and a philosophy, which is a cut above other organizations that you may consider volunteering with.

We request that you closely evaluate your commitment to our organization to ensure it is one of dedication and performance **before** seeking acceptance into the Fire Department. Consider:

- Are you joining for the "fun" of it or is this just a "whim"?
- Do you just need "something to do"?
- Are you joining just to be near your friends?
- Are you here to keep one certificate active while working on another?
- Do you have an agenda other than serving your community?

IF you answered yes to any of the questions above, you should give more thought to your decision before you fill out the application.

This Fire Department has rules, regulations, policies and procedures, which you must follow. We are not a social club. When the alarm rings, you must be thoroughly committed to performing the tasks assigned and required - our citizens deserve nothing less.

You cannot expect to perform properly and safely if you have not attended the training sessions. Firefighting is not a game. It requires your dedication to save lives, protect property, and to ensure each one of us goes home at the end of an incident.

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**PLANTATION VOLUNTEER FIRE ASSOCIATION
REQUIREMENTS AND GUIDELINES FOR ALL APPLICANTS**

On behalf of the membership of the Plantation Volunteer Fire Association, we would like to express our appreciation for your interest in becoming a volunteer firefighter in the City of Plantation. As requested by the Fire Chief and the Membership committee, you **MUST READ AND UNDERSTAND** the following information.

ALL COMPLETED APPLICATIONS AND SUPPORTING DOCUMENTS CAN BE SCANNED AND EMAILED TO FIREMEMBERSHIP@PSD.PLANTATION.ORG. APPLICATIONS CAN ALSO BE SUBMITTED IN PERSON TO THE DESIGNATED REPRESENTATIVE OF THE PLANTATION VOLUNTEER FIRE ASSOCIATION, LOCATED IN THE ADMINISTRATION OFFICES OF THE FIRE DEPARTMENT, LOCATED AT 550 NW 65 AVE. Application are accepted Monday- Friday 8:00 a.m. to 4:00 p.m. If you have any questions you can call 954-797-2150. When you come in, please bring copies of all supporting documents with you including your Florida Driver's License, Proof of Residency (FPL or Water Bill, or a Lease Agreement with your name on it.) your High School Diploma, and any Training Certificates you may possess relating to Firefighter or Medical Rescue.

APPLICANTS MUST MEET THE FOLLOWING REQUIREMENTS as set forth by Florida Statute 633.34 and the Plantation Volunteer Fire Association.

1. Minimum age of 18 years.
2. Posses a High School diploma or the equivalent. (Copy of diploma or GED Certificate is needed by applicant.)
3. Be a resident of the City of Plantation, or reside not more than 2.5 miles and 5 minutes from nearest fire station.
4. Never have been convicted of a felony or other crime, which would indicate a lack of good moral character.
5. Have good moral character as determined through investigation by the Membership Committee.
6. Any offer of membership into the Plantation Volunteer Fire Association is conditional upon the applicant undergoing a medical examination and test for the illegal use of drugs.
7. Applicant must possess and maintain possession of a State of Florida Driver's License.

New applicants will be contacted prior to their acceptance into the Association to schedule their **PHYSICAL EXAMINATION** and **MANDATORY ORIENTATION**.

PRIOR TO ACCEPTANCE IN THE ASSOCIATION, YOU WILL HAVE PAID ASSOCIATION DUES OF \$50.00. THIS IS A MANDATORY PREREQUISITE TO YOUR ACCEPTANCE. THERE WILL BE NO EXCEPTIONS.

Membership: Applicants will be presented to the Association for membership at the Association Meeting held on the 3rd Tuesday of the month (**APPLICANTS MUST BE PRESENT.**)

FIREFIGHTER BASIC TRAINING CLASS will begin the first Thursday following your acceptance to the Association. (Approx. 7 months Mon. & Thurs., 7:00 p.m. – 10:30 p.m. and typically two (2) Saturdays per month).

PROBATIONARY PERIOD: The probationary period for all new members is six (6) months after completion of Firefighter I and/or Partners II. This period is used to closely monitor a member's work to secure the most efficient adjustment of the new member to the position, and to evaluate the new member's performance. The probationary member may be dismissed at anytime during probation.

I have received a copy of this document, and hereby state that I have a read and understand this information. By my signature, I also agree to become familiar with and abide by the By Laws of this Association.

DATE

SIGNATURE

**PLANTATION VOLUNTEER FIRE ASSOCIATION
REQUIREMENTS AND GUIDELINES FOR ALL APPLICANTS**

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DATE

SIGNATURE

CITY OF PLANTATION
FIRE DEPARTMENT

MEMBERSHIP INQUIRY RELEASE

I understand that as a condition of membership, statements I have made either verbally or in writing in the course of my seeking membership with the City of Plantation Fire Dept., as a volunteer, will be verified through various sources including but not limited to a Criminal History Records search, Driver's License History, former and current employers and personal references. I hereby authorize the City of Plantation to obtain any information in files pertaining to my employment records including, but not limited to achievement, attendance, personal history and disciplinary records. I hereby direct you to release such information upon request of the bearer. This release is executed with full knowledge and understanding that the information is only for the official use only of the City of Plantation. Consent is further granted for the City of Plantation to furnish such information as is described above, to third parties in the course of fulfilling its official responsibilities.

I hereby release you, as the custodian of such records, including its officers, employees, or related personnel, both individually and collectively, from any and all liability for damages of whatever kind, sort, or description, which may at any time result to me, my heirs, family, or associates because of compliance with this authorization and request to release information, or any attempt to comply with it. Should there be any questions as to the validity of this release, you may contact me as indicated below.

Full Name: _____

Current Address: _____

Telephone Number(s): _____

Social Security Number: _____

Driver's License Number: _____ State: _____

Other Prior Names/Aliases: _____

Applicant's Signature: _____ Date: _____

**NOTICE TO APPLICANT OF
INTENT TO OBTAIN A CONSUMER REPORT**

Dear Applicant:

In connection with your application for volunteer membership, we would like to procure certain background information concerning you, which is contained in a consumer report. A consumer report may contain information regarding your: creditworthiness, credit standing, credit capacity, character, general reputation, personal characteristics, mode of living, driver's license history and/or criminal background.

Before we may procure a consumer report, you must authorize such procurement in writing. You have the right to decline authorization for us to procure a consumer report. However, we will not consider you further for membership if you so decline.

On the back of this form you will find a release, which will allow us to obtain a consumer report. Please read the release carefully before signing it and indicating your choice regarding disclosure.

RELEASE TO PROCURE A CONSUMER REPORT

I have read the "Notice to Applicant of Intent to Obtain Consumer Report" letter on the back of this form.

I understand that I have the right to decline authorization for the City of Plantation to procure a consumer report concerning me.

I understand that the consumer report may contain information concerning my: credit-worthiness, credit standing, general reputation, personal characteristics, mode of living, driver's license history and /or criminal background.

Understanding these rights,

_____ I authorize City of Plantation to procure a consumer report concerning me.

_____ I do not authorize City of Plantation to procure a consumer report concerning me.

PLEASE PRINT ALL REQUESTED INFORMATION

Full Name _____

Other names used _____

Current Address _____

Telephone(s) _____

City, State, Zip _____

Previous Address _____

City, State, Zip _____

Driver's License Number _____ State _____ Exp. Date _____

Social Security Number _____ Date of Birth* _____

Applicant's Signature _____ Date _____

Prospective Dept. CITY OF PLANTATION FIRE DEPARTMENT

*Date of Birth is being requested in order to obtain accurate retrieval of records.