

GEORGIA DEPARTMENT OF CORRECTIONS



Sworn Full and Part Time Hiring Package Checklist

EMPLOYEE INFORMATION

Name:	
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HIRING PACKAGE FORMS – SEND TO CHRM OFFICE

<input type="checkbox"/>	Employee Hiring Package Form -1	
<input type="checkbox"/>	Personal Information Form -1	
<input type="checkbox"/>	Employment Eligibility Verification (I-9) – 2 (Attach two forms of identification)	Directions included - 1
<input type="checkbox"/>	GSEPS Automatic Enrollment Acknowledgement Form - 1	
<input type="checkbox"/>	GSEPS Opt-Out Form – 1 (PT will automatically be enrolled in GDCP until retired or rehired. If TRS, contact local HR)	
<input type="checkbox"/>	Loyalty Oath -2	
<input type="checkbox"/>	Criminal/Driver History Consent Form – 1 (Attach Live Scan Results)	
<input type="checkbox"/>	Employee's Withholding Allowance Certificate (W-4) - 2	
<input type="checkbox"/>	Employee's Withholding Allowance Certificate (G-4) – 1	Directions included - 1

FORMS – SEND TO REGIONAL OFFICE WITH ORIENTATION FORMS

<input type="checkbox"/>	MAPEP for Correctional Officers – 3	Directions included - 2
<input type="checkbox"/>	MAPEP – Inquiry Authority Use Statement & Health Information Checklist – 6	
<input type="checkbox"/>	Georgia Peace Officer Standards & Training Council – Physician's Affidavit - 2	
<input type="checkbox"/>	Georgia Peace Officer Standards & Training Council – Application for Certification - 1	
<input type="checkbox"/>	POST Supporting Documentation - Photograph - 1	
<input type="checkbox"/>	POST Supporting Documentation – GCIC/NCIC FP Results - 1	
<input type="checkbox"/>	POST Supporting Documentation – Certified Copy of School Records - 1	
<input type="checkbox"/>	POST Supporting Documentation – Primary Citizenship Proof - 1	
<input type="checkbox"/>	POST Supporting Documentation – Driver's History - 1	
<input type="checkbox"/>	POST Supporting Documentation – Entrance Exam Proof – 1 (Certified copy with seal on envelope from school)	
<input type="checkbox"/>	POST Supporting Documentation – Physician's Affidavit - 1	
<input type="checkbox"/>	POST Supporting Documentation – Personal History Release - 1	

<input type="checkbox"/>	POST Supporting Documentation – Court Disposition - 1	
<input type="checkbox"/>	POST Supporting Documentation – EE Statement - 1	
<input type="checkbox"/>	Selective Service Verification	
<input type="checkbox"/>	Authorization for Release of Information for Employment Purposes - 1	
<input type="checkbox"/>	<i>Instructions on how to Register as a New User on the Georgia POST website-7</i>	<i>For employee use only</i>

ADDITIONAL DOCUMENTS – SEND TO CHRM WITH HIRING PACKET (COPY RETAINED AT LOCAL FACILITY)

<input type="checkbox"/>	Personnel/Position Action - 1	
<input type="checkbox"/>	Two Forms of Identification	
<input type="checkbox"/>	Live Scan Fingerprint Results	
<input type="checkbox"/>	State Application/Resume	

New Employee Onboarding

We'd Like to Hear from You!

Getting Started

Contact your local Human Resources office with new hire-related questions and concerns.

Facility HR Office Phone: _____

General questions: WelcomeToGDC@gdc.ga.gov

Central Human Resource Management (CHRM) Phone: 478-992-5211

Benefits Eligibility, Enrollment & Programs

Have a benefits question?

Contact the Benefits Office Benefit.Hub@gdc.ga.gov

Georgia Department of Corrections Employee Hiring Package Form

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

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

Personal Information Form Education, Language and Military

PRINT NAME: _____

EMPLID: _____

Highest Education Level (Check only 1 box)			
	<input checked="" type="checkbox"/>		<input checked="" type="checkbox"/>
B- Less Than HS Graduate	<input type="checkbox"/>	H- Some Graduate School	<input type="checkbox"/>
C- HS Graduate or Equivalent	<input type="checkbox"/>	I- Master's Level Degree	<input type="checkbox"/>
D- Some College	<input type="checkbox"/>	J- Doctorate (Academic)	<input type="checkbox"/>
E- Technical School	<input type="checkbox"/>	K- Doctorate (Professional)	<input type="checkbox"/>
F- 2-Year College Degree	<input type="checkbox"/>	L- Post-Doctorate	<input type="checkbox"/>
G- Bachelor's Level Degree	<input type="checkbox"/>		<input type="checkbox"/>

Language Code (Check only if fluent in a language OTHER than English. Check only 1)			
	<input checked="" type="checkbox"/>		<input checked="" type="checkbox"/>
Can French	<input type="checkbox"/>	Japanese	<input type="checkbox"/>
Danish	<input type="checkbox"/>	Korean	<input type="checkbox"/>
Dutch	<input type="checkbox"/>	Portuguese	<input type="checkbox"/>
French	<input type="checkbox"/>	SChinese	<input type="checkbox"/>
German	<input type="checkbox"/>	Spanish	<input type="checkbox"/>
Greek	<input type="checkbox"/>	Swedish	<input type="checkbox"/>
Intl Eng	<input type="checkbox"/>	TChinese	<input type="checkbox"/>
Italian	<input type="checkbox"/>	Thai	<input type="checkbox"/>

Military (Check only 1 –Most recent status recommended.)			
	<input checked="" type="checkbox"/>		<input checked="" type="checkbox"/>
Active Reserve	<input type="checkbox"/>	Pre-Vietnam-Era Veteran	<input type="checkbox"/>
Inactive Reserve	<input type="checkbox"/>	Retired Military	<input type="checkbox"/>
Not a Veteran	<input type="checkbox"/>	Vietnam-Era Veteran	<input type="checkbox"/>
Post-Vietnam-Era Veteran	<input type="checkbox"/>		<input type="checkbox"/>

Any questions should be directed to your local Human Resources Representative.

Signature/Date



Employment Eligibility Verification

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

USCIS
Form I-9

OMB No.1615-0047

Expires 05/31/2027

START HERE: Employers must ensure the form instructions are available to employees when completing this form. Employers are liable for failing to comply with the requirements for completing this form. See below and the [Instructions](#).

ANTI-DISCRIMINATION NOTICE: All employees can choose which acceptable documentation to present for Form I-9. Employers cannot ask employees for documentation to verify information in **Section 1**, or specify which acceptable documentation employees must present for **Section 2** or Supplement B, Reverification and Rehire. Treating employees differently based on their citizenship, immigration status, or national origin may be illegal.

Section 1. Employee Information and Attestation: Employees must complete and sign Section 1 of Form I-9 no later than the **first day of employment**, but not before accepting a job offer.

Last Name (Family Name)		First Name (Given Name)		Middle Initial (if any)	Other Last Names Used (if any)	
Address (Street Number and Name)			Apt. Number (if any)	City or Town		State ZIP Code
Date of Birth (mm/dd/yyyy)	U.S. Social Security Number <div></div>		Employee's Email Address			Employee's Telephone Number
I am aware that federal law provides for imprisonment and/or fines for false statements, or the use of false documents, in connection with the completion of this form. I attest, under penalty of perjury, that this information, including my selection of the box attesting to my citizenship or immigration status, is true and correct.		Check one of the following boxes to attest to your citizenship or immigration status (See page 2 and 3 of the instructions.):				
		<input type="checkbox"/> 1. A citizen of the United States				
		<input type="checkbox"/> 2. A noncitizen national of the United States (See Instructions.)				
		<input type="checkbox"/> 3. A lawful permanent resident (Enter USCIS or A-Number.)				
		<input type="checkbox"/> 4. An alien authorized to work until (exp. date, if any)				
		If you check Item Number 4. , enter one of these:				
		USCIS A-Number	OR	Form I-94 Admission Number	OR	Foreign Passport Number and Country of Issuance
Signature of Employee					Today's Date (mm/dd/yyyy)	

If a preparer and/or translator assisted you in completing Section 1, that person **MUST** complete the [Preparer and/or Translator Certification](#) on Page 3.

Section 2. Employer Review and Verification: Employers or their authorized representative must complete and sign **Section 2** within three business days after the employee's first day of employment, and must physically examine, or examine consistent with an alternative procedure authorized by the Secretary of DHS, documentation from List A OR a combination of documentation from List B and List C. Enter any additional documentation in the Additional Information box; see Instructions.

List A		OR	List B	AND	List C
Document Title 1					
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					
Document Title 2 (if any)		Additional Information			
Issuing Authority		Check here if you used an alternative procedure authorized by DHS to examine documents.			
Document Number (if any)					
Expiration Date (if any)					
Document Title 3 (if any)					
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					
Certification: I attest, under penalty of perjury, that (1) I have examined the documentation presented by the above-named employee, (2) the above-listed documentation appears to be genuine and to relate to the employee named, and (3) to the best of my knowledge, the employee is authorized to work in the United States.			First Day of Employment (mm/dd/yyyy):		
Last Name, First Name and Title of Employer or Authorized Representative			Signature of Employer or Authorized Representative		Today's Date (mm/dd/yyyy)
Employer's Business or Organization Name		Employer's Business or Organization Address, City or Town, State, ZIP Code			

For reverification or rehire, complete [Supplement B, Reverification and Rehire](#) on Page 4.

LISTS OF ACCEPTABLE DOCUMENTS

All documents containing an expiration date must be unexpired.

* Documents extended by the issuing authority are considered unexpired.

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

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

LIST A		LIST B	LIST C
Documents that Establish Both Identity and Employment Authorization	OR	Documents that Establish Identity	AND Documents that Establish Employment Authorization
1. U.S. Passport or U.S. Passport Card		1. Driver's license or ID card issued by a State or outlying possession of the United States provided it contains a photograph or information such as name, date of birth, sex, height, eye color, and address	1. A Social Security Account Number card, unless the card includes one of the following restrictions: (1) NOT VALID FOR EMPLOYMENT (2) VALID FOR WORK ONLY WITH INS AUTHORIZATION (3) VALID FOR WORK ONLY WITH DHS AUTHORIZATION 2. Certification of report of birth issued by the Department of State (Forms DS-1350, FS-545, FS-240) 3. Original or certified copy of birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal 4. Native American tribal document 5. U.S. Citizen ID Card (Form I-197) 6. Identification Card for Use of Resident Citizen in the United States (Form I-179) 7. Employment authorization document issued by the Department of Homeland Security For examples, see Section 7 and Section 13 of the M-274 on uscis.gov/i-9-central . The Form I-766, Employment Authorization Document, is a List A, Item Number 4. document, not a List C document.
2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551)		2. ID card issued by federal, state or local government agencies or entities, provided it contains a photograph or information such as name, date of birth, sex, height, eye color, and address	
3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa		3. School ID card with a photograph	
4. Employment Authorization Document that contains a photograph (Form I-766)		4. Voter's registration card	
5. For an individual temporarily authorized to work for a specific employer because of his or her status or parole: a. Foreign passport; and b. Form I-94 or Form I-94A that has the following: (1) The same name as the passport; and (2) An endorsement of the individual's status or parole as long as that period of endorsement has not yet expired and the proposed employment is not in conflict with any restrictions or limitations identified on the form.		5. U.S. Military card or draft record	
		6. Military dependent's ID card	
		7. U.S. Coast Guard Merchant Mariner Card	
		8. Native American tribal document	
		9. Driver's license issued by a Canadian government authority	
		For persons under age 18 who are unable to present a document listed above:	
		10. School record or report card	
		11. Clinic, doctor, or hospital record	
		12. Day-care or nursery school record	
Acceptable Receipts May be presented in lieu of a document listed above for a temporary period. For receipt validity dates, see the M-274.			
<ul style="list-style-type: none">Receipt for a replacement of a lost, stolen, or damaged List A document.Form I-94 issued to a lawful permanent resident that contains an I-551 stamp and a photograph of the individual.Form I-94 with "RE" notation or refugee stamp issued to a refugee.	OR	Receipt for a replacement of a lost, stolen, or damaged List B document.	Receipt for a replacement of a lost, stolen, or damaged List C document.

*Refer to the Employment Authorization Extensions page on [I-9 Central](#) for more information.



Supplement A, Preparer and/or Translator Certification for Section 1

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

USCIS
Form I-9
Supplement A
OMB No. 1615-0047
Expires 05/31/2027

Last Name (Family Name) from Section 1 .	First Name (Given Name) from Section 1 .	Middle initial (if any) from Section 1 .
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Instructions: This supplement must be completed by any preparer and/or translator who assists an employee in completing Section 1 of Form I-9. The preparer and/or translator must enter the employee's name in the spaces provided above. Each preparer or translator must complete, sign, and date a separate certification area. Employers must retain completed supplement sheets with the employee's completed Form I-9.

I attest, under penalty of perjury, that I have assisted in the completion of Section 1 of this form and that to the best of my knowledge the information is true and correct.

Signature of Preparer or Translator		Date (mm/dd/yyyy)	
Last Name (Family Name)	First Name (Given Name)	Middle Initial (if any)	
Address (Street Number and Name)	City or Town	State	ZIP Code

I attest, under penalty of perjury, that I have assisted in the completion of Section 1 of this form and that to the best of my knowledge the information is true and correct.

Signature of Preparer or Translator		Date (mm/dd/yyyy)	
Last Name (Family Name)	First Name (Given Name)	Middle Initial (if any)	
Address (Street Number and Name)	City or Town	State	ZIP Code

I attest, under penalty of perjury, that I have assisted in the completion of Section 1 of this form and that to the best of my knowledge the information is true and correct.

Signature of Preparer or Translator		Date (mm/dd/yyyy)	
Last Name (Family Name)	First Name (Given Name)	Middle Initial (if any)	
Address (Street Number and Name)	City or Town	State	ZIP Code

I attest, under penalty of perjury, that I have assisted in the completion of Section 1 of this form and that to the best of my knowledge the information is true and correct.

Signature of Preparer or Translator		Date (mm/dd/yyyy)	
Last Name (Family Name)	First Name (Given Name)	Middle Initial (if any)	
Address (Street Number and Name)	City or Town	State	ZIP Code



Supplement B,
Reverification and Rehire (formerly Section 3)

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

USCIS
Form I-9
Supplement B
OMB No. 1615-0047
Expires 05/31/2027

Last Name (Family Name) from Section 1.	First Name (Given Name) from Section 1.	Middle initial (if any) from Section 1.
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Instructions: This supplement replaces Section 3 on the previous version of Form I-9. Only use this page if your employee requires reverification, is rehired within three years of the date the original Form I-9 was completed, or provides proof of a legal name change. Enter the employee's name in the fields above. Use a new section for each reverification or rehire. Review the Form I-9 instructions before completing this page. Keep this page as part of the employee's Form I-9 record. Additional guidance can be found in the [Handbook for Employers: Guidance for Completing Form I-9 \(M-274\)](#)

Date of Rehire (if applicable)	New Name (if applicable)		
Date (mm/dd/yyyy)	Last Name (Family Name)	First Name (Given Name)	Middle Initial
Reverification: If the employee requires reverification, your employee can choose to present any acceptable List A or List C documentation to show continued employment authorization. Enter the document information in the spaces below.			
Document Title	Document Number (if any)	Expiration Date (if any) (mm/dd/yyyy)	
I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented documentation, the documentation I examined appears to be genuine and to relate to the individual who presented it.			
Name of Employer or Authorized Representative	Signature of Employer or Authorized Representative	Today's Date (mm/dd/yyyy)	
Additional Information (Initial and date each notation.)		Check here if you used an alternative procedure authorized by DHS to examine documents.	

Date of Rehire (if applicable)	New Name (if applicable)		
Date (mm/dd/yyyy)	Last Name (Family Name)	First Name (Given Name)	Middle Initial
Reverification: If the employee requires reverification, your employee can choose to present any acceptable List A or List C documentation to show continued employment authorization. Enter the document information in the spaces below.			
Document Title	Document Number (if any)	Expiration Date (if any) (mm/dd/yyyy)	
I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented documentation, the documentation I examined appears to be genuine and to relate to the individual who presented it.			
Name of Employer or Authorized Representative	Signature of Employer or Authorized Representative	Today's Date (mm/dd/yyyy)	
Additional Information (Initial and date each notation.)		Check here if you used an alternative procedure authorized by DHS to examine documents.	

Date of Rehire (if applicable)	New Name (if applicable)		
Date (mm/dd/yyyy)	Last Name (Family Name)	First Name (Given Name)	Middle Initial
Reverification: If the employee requires reverification, your employee can choose to present any acceptable List A or List C documentation to show continued employment authorization. Enter the document information in the spaces below.			
Document Title	Document Number (if any)	Expiration Date (if any) (mm/dd/yyyy)	
I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented documentation, the documentation I examined appears to be genuine and to relate to the individual who presented it.			
Name of Employer or Authorized Representative	Signature of Employer or Authorized Representative	Today's Date (mm/dd/yyyy)	
Additional Information (Initial and date each notation.)		Check here if you used an alternative procedure authorized by DHS to examine documents.	

GSEPS Automatic Enrollment Acknowledgement Form

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

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

(Please print name)

Employee Signature

Date



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

Member Name _____
(Please Print) Social Security Number _____

Dept./School _____ Dept./School ID _____

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

To the Boards of Trustees of the ERS and TRS:

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

☐ Employees' Retirement System

☐ Teachers Retirement System

Member Signature: _____ Date: ____/____/____

OR

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

☐ Employees' Retirement System

☐ Teachers Retirement System

Member Signature: _____ Date: ____/____/____

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

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

STATE OF GEORGIA LOYALTY OATH STATE SECURITY QUESTIONNAIRE

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

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

FULL NAME, INCLUDING MAIDEN NAME, NAMES OF FORMER MARRIAGES, FORMER NAMES CHANGED LEGALLY OR OTHERWISE, ALIASES AND NICKNAMES AND THE DATES USED.				
1.	LAST NAME	FIRST NAME	MIDDLE NAME	PHONE NO.
	MAIDEN NAME	DATES USED	NICKNAMES	DATES USED
	OTHER NAMES, INCLUDING ALIASES & FORMER MARRIAGES	DATES USED	NICKNAMES	DATES USED
		DATES USED	NICKNAMES	DATES USED
2.	ADDRESS	APT. NO.	CITY	STATE COUNTY ZIP
3.	DATE OF BIRTH	U.S. CITIZEN _____ Yes _____ No (Nationality _____)		RACE SEX
4.	<p>Are you now or have you been in the last ten (10) years a member of any organization which to <i>your</i> knowledge at the time of membership advocates or has as one of its objects, the overthrow of the government of the United States or the government of the State of Georgia by force or violence?</p> <p style="text-align: center;"> <input type="checkbox"/> Yes <input type="checkbox"/> No </p> <p>If "Yes", state the name of the organization and your past and present membership status including any offices held therein.</p> <p>NOTE: If the answer to the above question is "Yes" and the employing authority deems further inquiry necessary, you will be notified of such determination. No action adverse to your application will be taken because of an affirmative answer until after such an inquiry, with notice to you and an opportunity for you to present evidence, and only if the results of such inquiry brings your application within the prohibition within the Sedition and Subversive Activities Act of 1953.</p>			
5.	LIST CHRONOLOGICALLY ALL OF YOUR PREVIOUS RESIDENCES FOR THE PAST TEN YEARS:			
	DATES		STREET	CITY STATE
	From	To		
6.	LIST NAMES AND ADDRESSES OF THE FOLLOWING:			
	SPOUSE (MAIDEN NAME)		ADDRESS	
	FATHER		ADDRESS	
	MOTHER		ADDRESS	

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

8. Have you ever been convicted by Federal, State, or other law-enforcement authorities, for any violation of any Federal law, State law, county or municipal law, regulation, or ordinance? (Do not include anything that happened before your sixteenth birthday. Do not include minor traffic violations for which a fine of \$35.00 or less was imposed.) ____YES ____NO If answer is yes, provide the following information

CHARGE ON WHICH CONVICTED	DATE CONVICTED	NAME OF COURT & PLACE WHERE CONVICTED

Are you a former inmate, former parolee, or former probationer? ____YES ____NO If answer is yes, provide dates and details.

9. Are there any charges now pending against you by Federal, State, or other law enforcement authorities for any violations of any Federal law, State law, county or municipal law, regulation, or ordinance? (Do not include anything that happened before your sixteenth birthday.) Do not include minor violations for which a fine of \$35.00 or less would likely be imposed.) ____Yes ____No If answer yes, provide dates and details.

VIOLATION CHARGED	NAME OF GOVERNMENT	NAME OF COURT & LOCATION WHERE PENDING

Are you currently a parolee or probationer? ____YES ____NO If answer is yes, provide dates and details.

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

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

LOYALTY OATH

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

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

AFFIDAVIT OF VERIFICATION

Georgia _____ County

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

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

SWORN TO AND SUBSCRIBED BEFORE ME:

(SIGNA

TURE OF AFFIANT)

This _____ Day of _____, 20 _____

(Notary Public)

Employee's Withholding Certificate

OMB No. 1545-0074

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.****2025****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) <input type="checkbox"/> Single or Married filing separately <input type="checkbox"/> Married filing jointly or Qualifying surviving spouse <input type="checkbox"/> Head of household (Check only if you're unmarried and pay more than half the costs of keeping up a home for yourself and a qualifying individual.)		

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 (b) if pay at the lower paying job is more than half of the pay at the higher paying job. Otherwise, (b) is more accurate ☐

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):

Multiply the number of qualifying children under age 17 by \$2,000 \$ _____

Multiply the number of other dependents by \$500 \$ _____

Add the amounts above for qualifying children and other dependents. You may add to this the amount of any other credits. Enter the total here

3 \$**Step 4**
(optional):
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.** If you expect to claim deductions other than the standard deduction and want to reduce your withholding, use the Deductions Worksheet on page 3 and enter the result here

4(b) \$

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

4(c) \$**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 2025 if you meet both of the following conditions: you had no federal income tax liability in 2024 **and** you expect to have no federal income tax liability in 2025. You had no federal income tax liability in 2024 if (1) your total tax on line 24 on your 2024 Form 1040 or 1040-SR is zero (or less than the sum of lines 27, 28, and 29), 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 2025 tax return. To claim exemption from withholding, certify that you meet both of the conditions above by writing "Exempt" on Form W-4 in the space below Step 4(c). 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 17, 2026.

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 will be larger the greater the difference in pay is between the two jobs.



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 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 (optional).

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 5, if you expect to claim deductions other than the basic standard deduction on your 2025 tax return and want to reduce your withholding to account for these deductions. This includes both itemized deductions and other deductions such as for student loan interest and IRAs.

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.

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 4. 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 4 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 4 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 (along with any other additional amount you want withheld) **4** \$ _____

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

- 1** Enter an estimate of your 2025 itemized deductions (from Schedule A (Form 1040)). Such deductions may include qualifying home mortgage interest, charitable contributions, state and local taxes (up to \$10,000), and medical expenses in excess of 7.5% of your income **1** \$ _____
- 2** Enter:

{	• \$30,000 if you're married filing jointly or a qualifying surviving spouse	}	2	\$ _____
	• \$22,500 if you're head of household				
	• \$15,000 if you're single or married filing separately				

- 3** If line 1 is greater than line 2, subtract line 2 from line 1 and enter the result here. If line 2 is greater than line 1, enter "-0-" **3** \$ _____
- 4** Enter an estimate of your student loan interest, deductible IRA contributions, and certain other adjustments (from Part II of Schedule 1 (Form 1040)). See Pub. 505 for more information **4** \$ _____
- 5 Add** lines 3 and 4. Enter the result here and in **Step 4(b)** of Form W-4 **5** \$ _____

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	\$700	\$850	\$910	\$1,020	\$1,020	\$1,020	\$1,020	\$1,020	\$1,020	\$1,020
\$10,000 - 19,999	0	700	1,700	1,910	2,110	2,220	2,220	2,220	2,220	2,220	2,220	3,220
\$20,000 - 29,999	700	1,700	2,760	3,110	3,310	3,420	3,420	3,420	3,420	3,420	4,420	5,420
\$30,000 - 39,999	850	1,910	3,110	3,460	3,660	3,770	3,770	3,770	3,770	4,770	5,770	6,770
\$40,000 - 49,999	910	2,110	3,310	3,660	3,860	3,970	3,970	3,970	4,970	5,970	6,970	7,970
\$50,000 - 59,999	1,020	2,220	3,420	3,770	3,970	4,080	4,080	5,080	6,080	7,080	8,080	9,080
\$60,000 - 69,999	1,020	2,220	3,420	3,770	3,970	4,080	5,080	6,080	7,080	8,080	9,080	10,080
\$70,000 - 79,999	1,020	2,220	3,420	3,770	3,970	5,080	6,080	7,080	8,080	9,080	10,080	11,080
\$80,000 - 99,999	1,020	2,220	3,420	4,620	5,820	6,930	7,930	8,930	9,930	10,930	11,930	12,930
\$100,000 - 149,999	1,870	4,070	6,270	7,620	8,820	9,930	10,930	11,930	12,930	14,010	15,210	16,410
\$150,000 - 239,999	1,870	4,240	6,640	8,190	9,590	10,890	12,090	13,290	14,490	15,690	16,890	18,090
\$240,000 - 259,999	2,040	4,440	6,840	8,390	9,790	11,100	12,300	13,500	14,700	15,900	17,100	18,300
\$260,000 - 279,999	2,040	4,440	6,840	8,390	9,790	11,100	12,300	13,500	14,700	15,900	17,100	18,300
\$280,000 - 299,999	2,040	4,440	6,840	8,390	9,790	11,100	12,300	13,500	14,700	15,900	17,100	18,300
\$300,000 - 319,999	2,040	4,440	6,840	8,390	9,790	11,100	12,300	13,500	14,700	15,900	17,170	19,170
\$320,000 - 364,999	2,040	4,440	6,840	8,390	9,790	11,100	12,470	14,470	16,470	18,470	20,470	22,470
\$365,000 - 524,999	2,790	6,290	9,790	12,440	14,940	17,350	19,650	21,950	24,250	26,550	28,850	31,150
\$525,000 and over	3,140	6,840	10,540	13,390	16,090	18,700	21,200	23,700	26,200	28,700	31,200	33,700

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	\$200	\$850	\$1,020	\$1,020	\$1,020	\$1,370	\$1,870	\$1,870	\$1,870	\$1,870	\$1,870	\$2,040
\$10,000 - 19,999	850	1,700	1,870	1,870	2,220	3,220	3,720	3,720	3,720	3,720	3,890	4,090
\$20,000 - 29,999	1,020	1,870	2,040	2,390	3,390	4,390	4,890	4,890	4,890	5,060	5,260	5,460
\$30,000 - 39,999	1,020	1,870	2,390	3,390	4,390	5,390	5,890	5,890	6,060	6,260	6,460	6,660
\$40,000 - 59,999	1,220	3,070	4,240	5,240	6,240	7,240	7,880	8,080	8,280	8,480	8,680	8,880
\$60,000 - 79,999	1,870	3,720	4,890	5,890	7,030	8,230	8,930	9,130	9,330	9,530	9,730	9,930
\$80,000 - 99,999	1,870	3,720	5,030	6,230	7,430	8,630	9,330	9,530	9,730	9,930	10,130	10,580
\$100,000 - 124,999	2,040	4,090	5,460	6,660	7,860	9,060	9,760	9,960	10,160	10,950	11,950	12,950
\$125,000 - 149,999	2,040	4,090	5,460	6,660	7,860	9,060	9,950	10,950	11,950	12,950	13,950	14,950
\$150,000 - 174,999	2,040	4,090	5,460	6,660	8,450	10,450	11,950	12,950	13,950	15,080	16,380	17,680
\$175,000 - 199,999	2,040	4,290	6,450	8,450	10,450	12,450	13,950	15,230	16,530	17,830	19,130	20,430
\$200,000 - 249,999	2,720	5,570	7,900	10,200	12,500	14,800	16,600	17,900	19,200	20,500	21,800	23,100
\$250,000 - 399,999	2,970	6,120	8,590	10,890	13,190	15,490	17,290	18,590	19,890	21,190	22,490	23,790
\$400,000 - 449,999	2,970	6,120	8,590	10,890	13,190	15,490	17,290	18,590	19,890	21,190	22,490	23,790
\$450,000 and over	3,140	6,490	9,160	11,660	14,160	16,660	18,660	20,160	21,660	23,160	24,660	26,160

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	\$450	\$850	\$1,000	\$1,020	\$1,020	\$1,020	\$1,020	\$1,870	\$1,870	\$1,870	\$1,890
\$10,000 - 19,999	450	1,450	2,000	2,200	2,220	2,220	2,220	3,180	4,070	4,070	4,090	4,290
\$20,000 - 29,999	850	2,000	2,600	2,800	2,820	2,820	3,780	4,780	5,670	5,690	5,890	6,090
\$30,000 - 39,999	1,000	2,200	2,800	3,000	3,020	3,980	4,980	5,980	6,890	7,090	7,290	7,490
\$40,000 - 59,999	1,020	2,220	2,820	3,830	4,850	5,850	6,850	8,050	9,130	9,330	9,530	9,730
\$60,000 - 79,999	1,020	3,030	4,630	5,830	6,850	8,050	9,250	10,450	11,530	11,730	11,930	12,130
\$80,000 - 99,999	1,870	4,070	5,670	7,060	8,280	9,480	10,680	11,880	12,970	13,170	13,370	13,570
\$100,000 - 124,999	1,950	4,350	6,150	7,550	8,770	9,970	11,170	12,370	13,450	13,650	14,650	15,650
\$125,000 - 149,999	2,040	4,440	6,240	7,640	8,860	10,060	11,260	12,860	14,740	15,740	16,740	17,740
\$150,000 - 174,999	2,040	4,440	6,240	7,640	8,860	10,860	12,860	14,860	16,740	17,740	18,940	20,240
\$175,000 - 199,999	2,040	4,440	6,640	8,840	10,860	12,860	14,860	16,910	19,090	20,390	21,690	22,990
\$200,000 - 249,999	2,720	5,920	8,520	10,960	13,280	15,580	17,880	20,180	22,360	23,660	24,960	26,260
\$250,000 - 449,999	2,970	6,470	9,370	11,870	14,190	16,490	18,790	21,090	23,280	24,580	25,880	27,180
\$450,000 and over	3,140	6,840	9,940	12,640	15,160	17,660	20,160	22,660	25,050	26,550	28,050	29,550

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.

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 4. 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 4 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 4 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 (along with any other additional amount you want withheld) **4** \$ _____

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

- 1** Enter an estimate of your 2021 itemized deductions (from Schedule A (Form 1040)). Such deductions may include qualifying home mortgage interest, charitable contributions, state and local taxes (up to \$10,000), and medical expenses in excess of 10% of your income **1** \$ _____
- 2** Enter: $\left\{ \begin{array}{l} \bullet \$25,100 \text{ if you're married filing jointly or qualifying widow(er)} \\ \bullet \$18,800 \text{ if you're head of household} \\ \bullet \$12,550 \text{ if you're single or married filing separately} \end{array} \right\}$ **2** \$ _____
- 3** If line 1 is greater than line 2, subtract line 2 from line 1 and enter the result here. If line 2 is greater than line 1, enter "-0-" **3** \$ _____
- 4** Enter an estimate of your student loan interest, deductible IRA contributions, and certain other adjustments (from Part II of Schedule 1 (Form 1040)). See Pub. 505 for more information **4** \$ _____
- 5 Add** lines 3 and 4. Enter the result here and in **Step 4(b)** of Form W-4 **5** \$ _____

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 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 return.

**DO NOT SUBMIT THIS PAGE
FOR INFORMATION ONLY**



2511004015

STATE OF GEORGIA EMPLOYEE'S WITHHOLDING ALLOWANCE CERTIFICATE

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

PLEASE READ INSTRUCTIONS ON REVERSE SIDE BEFORE COMPLETING LINES 3 – 8

3. MARITAL STATUS

Enter letter below on Line 7.

4. DEPENDENT ALLOWANCES []

- A. Single
 B. Married Filing Separate or Married Filing Joint, both spouses working
 C. Married Filing Joint, one spouse working
 D. Head of Household

5. GEORGIA ADJUSTMENTS ALLOWANCE []
 (See instructions for details. Worksheet below must be completed)

6. ADDITIONAL WITHHOLDING \$ _____

WORKSHEET FOR CALCULATING ADDITIONAL ALLOWANCES

(Must be completed for step 5)

A. Federal Estimated Itemized Deductions (If Itemizing Deductions).....\$ _____

B. Georgia Standard Deduction (enter one): \$ _____

Single/Head of Household\$12,000

Married Filing Joint\$24,000

Married Filing Separate\$12,000

C. Subtract Line B from Line A (If zero or less, enter zero)\$ _____

D. Allowable Georgia Adjustments to Federal Adjusted Gross Income\$ _____

E. Add the Amounts on Lines C and D\$ _____

F. Estimate of Taxable Income not Subject to Withholding\$ _____

G. Subtract Line F from Line E (if zero or less, stop here).....\$ _____

H. Divide the Amount on Line G by \$4,000. Enter total here and on Line 5 above\$ _____

(This is the number of Georgia Adjustments Allowances you can claim. If the remainder is over \$1,500 round up)

7. LETTER USED (Marital Status A, B, C or D) _____ TOTAL ALLOWANCES (Total of Lines 4 - 5) _____
 (Employer: The letter indicates the tax tables in Employer's Tax Guide)

8. EXEMPT: (Do not complete Lines 4 - 7 if claiming exempt) Read the Line 8 instructions on page 2 before completing this section.

- a) I claim exemption from withholding because I incurred no Georgia income tax liability last year and I do not expect to have a Georgia income tax liability this year. **Check here** ☐
- b) I certify that I am not subject to Georgia withholding because I meet the conditions set forth under the Servicemembers Civil Relief Act as provided on page 2. My state of residence is _____. My spouse's (servicemember) state of residence is _____. The states of residence must be the same to be exempt. **Check here** ☐

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

Employee's Signature _____ Date _____

Employer: Complete Line 9 and mail entire form only if the employee claims over 14 allowances or exempt from withholding. If necessary, mail form to: Georgia Department of Revenue, Taxpayer Services Division, P.O. Box 105685, Atlanta, GA 30348-5685

9. EMPLOYER'S NAME AND ADDRESS: EMPLOYER'S FEIN: _____

EMPLOYER'S WH#: _____

Do not accept forms claiming additional allowances unless the worksheet has been completed. Do not accept forms claiming exempt if numbers are written on Lines 4 - 7.

INSTRUCTIONS FOR COMPLETING FORM G-4

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

Line 3: Write the letter on Line 7 according to your marital status.

- A. Single
- B. Married Filing Separate or Married Filing Joint, both spouses working
- C. Married Filing Joint, one spouse working
- D. Head of Household

Line 4: Enter the number of dependent allowances you are entitled to claim. The term "dependent" shall have the same meaning as in the Internal Revenue Code of 1986; provided, however, that any unborn child with a detectable human heartbeat, as such terms are defined in Code Section 1-2-1, shall qualify as a dependent minor.

Line 5: Complete the worksheet on Form G-4 if you claim Georgia adjustments Allowances. Enter the number from Line H here.

Failure to complete and submit the worksheet will result in automatic denial on your claim.

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

Line 7: Enter the letter of your marital status from Line 3. Enter total of the numbers on Lines 4-5.

Line 8:

- a) Check the first box if you qualify to claim exempt from withholding. You can claim exempt if you filed a Georgia income tax return last year and the amount of Line 4 of Form 500EZ or Line 16 of Form 500 was zero, **and** you expect to file a Georgia tax return this year and will not have a tax liability. You cannot claim exempt if you did not file a Georgia income tax return for the previous tax year. **Receiving a refund in the previous tax year does not qualify you to claim exempt.**

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

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

- b) Check the second box if you are not subject to Georgia withholding and meet the conditions set forth under the Servicemembers Civil Relief Act. Under the Act, a spouse of a servicemember may be exempt from Georgia income tax on income from services performed in Georgia if:
 - 1. The servicemember is present in Georgia in compliance with military orders;
 - 2. The spouse is in Georgia solely to be with the servicemember;
 - 3. The servicemember maintains domicile in another state; and
 - 4. The domicile of the spouse is the same as the domicile of the servicemember or the spouse of the servicemember has elected to use the same residence for purposes of taxation as the servicemember.

Additional information for employers regarding the Military Spouses Residency Relief Act:

- 1. On the W-2 the employer should not report any of the wages as Georgia wages.
- 2. If the spouse of a servicemember is entitled to the protection of the Military Spouses Residency Relief Act in another state and files a withholding exemption form in such other state, the spouse is required to submit a Georgia Form G-4 so that withholding will occur as is required by Georgia Law when a Georgia domiciliary works in another state and withholding is not required by such other state. If the spouse does not fill out the form, the employer shall withhold Georgia income tax as if the spouse is single with zero allowances.

Worksheet for calculating additional allowances. Enter the information as requested by each line. For Line D, enter items such as Retirement Income Exclusion, U.S. Obligations, and other allowable deductions per Georgia Law, see the IT-511 booklet for more information.

Do not complete Lines 4-7 if claiming exempt.

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

Employers are required to mail any Form G-4 claiming more than 14 allowances or exempt from withholding to the Georgia Department of Revenue. Employers should honor the properly completed form as submitted unless otherwise notified by the Department. Such forms remain in effect until changed or until February 15 of the following year. Employers who know that a G-4 is erroneous should not honor the form and should withhold as if the employee is single claiming zero allowances until a corrected form has been received.



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

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

- A. General:** Height and weight should not be such as to interfere with specific job activities.
- B. Vision:** **1) Distant vision** -- minimum vision of 20/40 in each eye, corrected (with glasses or contact lenses) and at least 20/100 in each eye uncorrected (without glasses or contacts). **2) Near vision** -- minimum of 20/40, corrected or uncorrected in each eye. **3) Adequate depth perception** and the ability to distinguish colors. **4) Peripheral vision** -- at least 70 degrees in each eye. All Category 5 positions are subject to the guidelines above for 2) Near Vision, 3) Depth perception and the ability to distinguish colors, and 4) Peripheral Vision. The following are position specific exceptions to the 1) Distant Vision guidelines only.

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

- C. Hearing:** Hearing loss no greater than 24dB (decibels) for the average of frequencies 500Hz, 1000Hz, 2000Hz, and 3000Hz in the better ear, unaided (without a hearing aid) or aided (with a hearing aid).

"Normal hearing" is a hearing loss no greater than 24 dB at 250Hz, 500Hz, 1000Hz, 2000Hz, 3000Hz, 4000Hz, 6000Hz, 8000Hz in both the right and left ears, unaided.

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

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

- If the testing indicates air conduction thresholds to be outside the stated hearing guidelines for employment, the results of the test are explained to the candidate and a complete audiological evaluation is recommended, at the individual’s expense for his/her own hearing healthcare benefit.
- In addition to the pure tone air conduction testing, warble sound field testing is required and results must be recorded for all candidates who wear a hearing aid and do not meet the guidelines on the air conduction test, to verify if an individual meets the guideline for employment with the use of a hearing aid. If the site does not have the personnel or equipment to satisfy this requirement, then a referral is indicated.
- A qualified individual should administer the audiometric testing and perform the otoscopic examination. Qualified individuals include licensed audiologists, otolaryngologists, physicians trained in hearing conservation, technicians who are certified by the Council for Accreditation of Occupational Hearing Conservation, or technicians trained by such a physician. A technician who performs audiometric tests must be responsible to an audiologist, otolaryngologist, or physician.
- All tests should be performed in an acoustic environment to meet the current ANSI standards.
- All audiometric equipment should be calibrated annually to meet current ANSI standards.

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

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

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

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

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

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

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

- K. Back and Neck:** History of significant injury, deformity, surgical procedure, or other spinal pathology should be thoroughly evaluated by the examining physician and commented on the examination report.
- L. Extremities:** ***If a prosthesis or orthosis is used, such prosthesis or orthosis must not interfere with the performance of duty.** 1) Upper Extremities -- both hands must have at least the index, middle, and one other finger and must not interfere with the performance of duty; both thumbs must be functional; or see (*) above. 2) Lower Extremities -- both lower extremities must be free from limitation of any joint motion which would interfere with the performance of duties; both great toes must be functionally normal; or see (*) above.
- M. Nervous System:** Central and peripheral nervous system disorders must be evaluated by the medical examiner. Applicants with seizures must be thoroughly evaluated by the examining physician and all findings included in the examination report. Special attention must be given to any history of seizure activity.
- N. Emotional Stability:** Any history of significant emotional instability or mental illness should be thoroughly evaluated by the examining physician and commented on in the examination report.
- O. Laboratory Analysis:** Items 1 through 4 are not required unless medical history or physical examination results indicate that such tests are needed to adequately assess the applicant's physical status. Item 5 is required for Correctional Officers (including Juvenile Correctional Officers) only.
1. Urinalysis (Multi-Test Stick): Abnormalities in the sugar and albumin tests must be evaluated further. If Glycosuria is significant, must have Glucose Tolerance Test and if albuminuria, must have the cause identified.
 2. Hemoglobin or Hematocrit.
 3. Chest x-ray.
 4. Resting Electrocardiogram.
 5. Tuberculin Skin Test. **(For Correctional Officer Series Only)** If there is a positive reaction of 10mm or greater, a chest x-ray is required to document the absence of tuberculosis.



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

STATE OF GEORGIA
MEDICAL AND PHYSICAL
EXAMINATION PROGRAM

Medical Findings

NOTE TO EXAMINING PHYSICIAN

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

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

1. Examinee's Name	2. SSN	3. Height (Feet, Inches)	4. Weight (pounds)
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5. Vision Evaluation	
Depth Perception Within Normal Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	Peripheral Vision Right Eye _____ Left Eye _____
Distant Vision	Near Vision
a. Without Glasses <input type="checkbox"/> Right 20/ _____ Left 20/ _____	b. Without Glasses <input type="checkbox"/> Right 20/ _____ Left 20/ _____
c. With Glasses <input type="checkbox"/> Right 20/ _____ Left 20/ _____	d. With Glasses <input type="checkbox"/> Right 20/ _____ Left 20/ _____
e. Is color vision normal when Ishihara or other color plate test is used? <input type="checkbox"/> Yes <input type="checkbox"/> No	f. If the answer is "No", can applicant pass lantern or other compatible? <input type="checkbox"/> Yes <input type="checkbox"/> No

6. Hearing Evaluation															
a. OTOSCOPIC EXAMINATION:	Right Ear _____ Left Ear _____														
b. PURE TONE AIR CONDUCTION TEST RESULTS: (This section is to be used for all pre employment air conduction hearing testing.)															
Right Ear								Left Ear							
250	500	1000	2000	3000	4000	6000	8000	250	500	1000	2000	3000	4000	6000	8000

c. SOUND FIELD PURE TONE/WARBLE TONE TEST RESULTS: (This section is to be used in conjunction with the pure tone air conduction testing section for all individuals with hearing aids who do not meet the guidelines on the air conduction test.)								
	250	500	1000	2000	3000	4000	6000	8000
Sound Field Test								

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

d. AUDIOMETER SERIAL #: _____	e. DATE OF CALIBRATION: _____
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f. MEETS HEARING GUIDELINES:	<input type="checkbox"/> Yes <input type="checkbox"/> No
------------------------------	--

RESTRICTED/MEDICAL

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

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

9. Allergies	
1.	3.
2.	4.

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

RESTRICTED/MEDICAL

11. Comments/Implications for Fitness for Duty

--

12. Physician Signature and Address

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

13. Employer Name and Address

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

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

DESCRIPTION OF WHAT A CORRECTIONAL OFFICER IS REQUIRED TO DO:

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

MEDICAL AND PHYSICAL EXAMINATION PROGRAM (MAPEP)

Inquiry Authority/Use Statement

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

A: Completed by Employee

1. Employee Name: _____			2. _____-_____-_____ Social Security Number	
Last	First	Middle		
3. Race _____	4. Sex: <input type="checkbox"/> Female <input type="checkbox"/> Male	5. _____ Date of Birth	6. _____ Daytime Telephone Number	
7. Address: _____ _____ _____		8. Position Title: _____		
		9. Position Number: _____		
		10. Location of Position: _____		
11. Direct Contact for Position Information				
a. Name: _____	f..	Dept.: _____		
b. Title: _____	g.	Unit: _____		
c. Telephone: _____	h.	Address: _____ _____ _____		
d. E-Mail: _____				
e. Fax Number: _____				

- | | |
|---|--|
| 12. Have you been provided detailed information on the duties of this position? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 13. Do you understand the functional requirements and environmental factors of this position? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 14. Are you capable of performing the duties and responsibilities of this position (with reasonable accommodations, if necessary, as described in Section A, Item #17)? | <input type="checkbox"/> Yes <input type="checkbox"/> No |

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

- | | |
|--|--|
| 15. Have you ever been employed by the State of Georgia? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 16. Have you had a physical examination for employment with the State of Georgia within the past twelve month period? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 17. Is there anything in your past medical history, of which you have knowledge that would prevent your being able to perform the duties of this position? | <input type="checkbox"/> Yes <input type="checkbox"/> No |

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

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

20. _____
Signature of Employee

8. _____
Date

B: Completed by Employer

1. Indicate type of job information used for medical review (check all that apply):

- ☐ Job description
☐ Performance standards
☐ Functional requirements analysis
☐ Environmental factors analysis
- ☐ Other (please specify) _____

2. Check job category:

- ☐ Category 1 Sedentary
☐ Category 2 Active
☐ Category 3 Food Handling
☐ Category 4 Health-related
☐ Category 5 Law Enforcement

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

4. Were any "reasonable accommodations" needed?

If "Yes," describe: ☐ Yes ☐ No

5. _____
(Type or Print Official Contact's Name)

6. _____
Signature of Official Contact

20. _____
Date

MEDICAL AND PHYSICAL EXAMINATION PROGRAM (MAPEP)

Health Information Checklist

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

Completed by Applicant/Employee

(Type or Print in Ink)

Section I

Date: _____		
Employee Name: _____	Social Security Number _____ - _____ - _____	
Last,	First	Middle
Employing Agency: _____		Date Employed: _____

Section II

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

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

REMARKS: _____

Signature of Employee

Date

STATE OF GEORGIA

Name _____ Soc. Sec. No. _____ - _____ - _____

MEDICAL AND PHYSICAL

Job Title _____ Department _____

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

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

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

EMPLOYEES' SIGNATURE: _____ DATE: _____

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

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

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

Health Condition	Yes	Year	No
28. Glasses			
29. Contact lenses			
RESPIRATORY SYSTEM (lungs & breathing)			
30. Persistent or severe colds			
31. Persistent or severe cough			
32. Coughing blood			
33. Asthma or breathing difficulty			
34. Emphysema			
35. Pneumonia			
36. Tuberculosis			
37. Other lung or breathing condition:			
CARDIOVASCULAR SYSTEM (heart & blood vessels)			
39. Heart attack			
39. Hardening of the arteries (Arteriosclerosis)			
40. High or low blood pressure			
41. Heart murmur			
42. Palpitations or irregular heart beat			
43. Episodes of chest pains, tightness, discomfort			
44. Shortness of breath			
45. Varicose veins			
46. Swelling of ankles, feet or legs (edema)			
47. Leg pains, cramps			
48. Other cardiac conditions:			
GASTROINTESTINAL SYSTEM (stomach & intestines)			
49. Persistent or severe nausea or indigestion			
50. Persistent or severe stomach pain			
51. Vomiting blood			
52. Persistent or severe vomiting			
53. Hernia (rupture)			
54. Stomach or duodenal ulcer			

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

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

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

B. CURRENT MEDICATIONS: _____

C. SURGICAL HISTORY

Have you ever had surgery? ☐ Yes ☐ No

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

TYPE OF SURGERY	DATE (Mo/Yr)
1. _____	_____
2. _____	_____

D. HOSPITALIZATION HISTORY

Have you ever been hospitalized? ☐ Yes ☐ No

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

REASON FOR HOSPITALIZATION	DATE (Mo/Yr)
1. _____	_____
2. _____	_____
3. _____	_____



Georgia Peace Officer Standards & Training Council

Physician's Affidavit

Physician's Affidavit – PAGE 1 of 2

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

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

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

Questions:

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

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

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

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

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

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

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



Georgia Peace Officer Standards & Training Council
Physician's Affidavit

Physician's Affidavit – PAGE 2 of 2

Candidate's Name:

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

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

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

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

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

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

EXAMINING PHYSICIAN'S NAME (printed)

SIGNATURE OF LICENSED
EXAMINING PHYSICIAN (required)

DATE (m/d/yyyy)

Last

First

ADDRESS OF LICENSED EXAMINING PHYSICIAN'S PRACTICE

Street

City, State, Zip

Phone:
Area Code+Number
()

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

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

AGENCY HEAD (OR DESIGNEE) Signature (required)

DATE

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



Georgia Peace Officer Standards & Training Council
Application for Certification

PERSONAL HISTORY RELEASE

I do hereby authorize the review of and full disclosure of all records concerning myself to the duly authorized agent of the Georgia Peace Officer Standards and Training Council.

The intent of this authorization is to give my consent for full and complete disclosure of the records of educational institutions; the records of the U.S. Department of Defense including any military records; financial statements and records wherever filed; medical and psychiatric treatment and/or consultation including hospitals, clinics, private practitioners, and the U.S. Veterans' Administration; employment and pre-employment records, including background reports, polygraph examinations or reports, efficiency ratings, complaints or grievances filed by or against me and the records and recollections of attorneys at law, or of other counsel, whether representing me or another person in any case, either criminal or civil, in which I presently have or have had an interest.

I understand that any information obtained by a personal history background investigation, which is developed directly or indirectly, in whole or part, upon this release authorization will be considered in compiling any report for the Georgia Peace Officer Standards and Training Council. I certify that any person(s) who may furnish such information concerning me shall not be held accountable for giving this information; and I do hereby release said person(s) from any and all liability, which may be incurred as a result of furnishing such information.

A photo copy of this release form will be valid as an original thereof, even though the said photocopy does not contain an original writing of my signature.

I understand that this information may be obtained through the use of this waiver at any time during which my registration or certification is maintained through the Georgia Peace Officer Standards and Training Council.

Last Name		First Name		Middle Name
DATE OF BIRTH (mdyyyy)	MAIDEN NAME		PHONE NUMBER (AREA CODE) - NUMBER ()- -	
Social Security Number:				
EMAIL ADDRESS				
ADDRESS: <i>Street</i>			Apartment/Unit#	
City:		State:	Zip Code:	

Candidate Signature (including maiden name)

Date

Notary Public Signature

Date

SELECTIVE SERVICE VERIFICATION

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

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

[check one]

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

OR

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

[Name of Official – please print]

[Title]

[Signature of Official]

[Date]

Published 11/1/00

GEORGIA DEPARTMENT OF CORRECTIONS

Name of Applicant

Date of Birth

AUTHORIZATION FOR RELEASE OF INFORMATION FOR EMPLOYMENT PURPOSES

I hereby request and authorize THE GEORGIA DEPARTMENT OF CORRECTIONS

Address of Local Hiring Authority

to obtain from: Any Law Enforcement Agency, Former Employee or Personal Reference
Name of Person or Agency Holding the Information

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

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

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

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

Date

Signature of **Applicant**

Signature of **Witness**

Title or Relationship to Applicant

USE THIS SPACE IF APPLICANT WITHDRAWS CONSENT

Date this consent is revoked by applicant

Signature of Applicant

Revised 1/11

Original

Instructions for accessing the new POST software - STEP 1

Go to the POST home page at www.gapost.org. Click on **P.O.S.T. Data Gateway** under ****Restricted Access****. (See below.)

[Home](#) | [About P.O.S.T.](#) | [FAQ's](#) | [Related Links](#) | [Contact/Directions](#)

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P.O.S.T. Divisions

It is the mission of the Georgia Peace Officer Standards and Training Council (P.O.S.T.) to provide the citizens of Georgia with qualified, professionally trained, ethical and competent peace officers and criminal justice professionals.

[More](#)

Notices

NOTICE: On Thursday September 1, 2011, POST will transfer to a new computer system. No change of status forms (C-11s) will be accepted after Wednesday August 30th. All future changes will be made in the new computer system. All efforts are being made to make this a smooth transition. Please be patient during this time.

- ▶ [Dates for new POST Software training](#)
- ▶ [Information regarding Barcoded ID's](#)
- [Petition for Modification of Probation](#)
- ▶ [2011 Legislation - Senate Bill 95](#)
- ▶ [Illegal Immigration Reform and Enforcement Act of 2011](#)
- ▶ [July 2011 POST Update](#)
- ▶ [Administrative Fee Schedule](#)
- ▶ [Equivalency of Training \(EOT\)](#)
- ▶ [FY 2010 Annual Report](#)
- ▶ [Georgia Chiefs \(GACP\) Training Approval Process](#)
- ▶ [Eyewitness Identification Training](#)
- ▶ [Revised Entrance Examination](#)
- ▶ [C12s available for purchase](#)
- ▶ [Questions Regarding POST Rule on Firearms Regualification](#)
- ▶ [POST Updates](#)
- ▶ [Background Investigation Manual](#)



Applications & Forms

Quick Access:

[Applications for Certification](#)

[Voluntary/Specialty Certifications](#)

[Career Development Applications](#)

[Miscellaneous Forms](#)

[Go to Forms/Applications to view full list including important notes](#)

Thursday, September 01, 2011

P.O.S.T. Staff

Operational Staff
Certification & Training Division
Operations Division
Investigations Division

[Message Center](#)

Upcoming Meetings

P.O.S.T. Council Meetings:

March 9, 2011

June 8, 2011

September 7, 2011

December 6, 2011

[More Information](#)

Questions?

See the list of frequently asked questions regarding training requirements, certification, etc.

[View FAQs](#)

****Restricted Access****



[POST Data Gateway](#)



[Staff Intranet](#)



STEP 2

Click on Register Now.

Returning User Login 

User Name

Password

[Forgot User Name or Password?](#)

New User?

Click on
Register Now
here



STEP 3

Fill in all fields. If you do not put information in a field marked with an *, then an error message will appear & you will be required to fill in the data before you can progress. Once all fields are completed click **submit registration**. Be sure to select "Officer" as User Type in the field identified below.

New User Registration

Do not use copy paste for verification.

You will **NOT** have the ability to update your name, social or date of birth later.

Legal Name, social security number and date of birth changes can only be performed through POST administration.

You must use your legal name in the registration.

REMEMBER: Please enter your legal name. If you have not updated your legal name with POST (marriage, etc), you may be under your previous name in the old system.

First Name*

Middle Name

Last Name*

Suffix (if applies)

Social Security Number* - - Not required for open records request

Date of Birth* / / (mm/dd/yyyy) Not required for open records request

Verify First Name*

Verify Middle Name

Verify Last Name*

Verify Suffix (if applies)

Verify Social Security Number* - - Not required for open records request

Verify Date of Birth* / / (mm/dd/yyyy) Not required for open records request

Email*

Verify Email*

User Type*

Select "Officer" for User Type for officers.

Note: Open Records users will need to select Open Records for user type.

Security Questions

Please select two different questions and provide answers.

Answer*

Answer*

Upon verification of your date of birth and social security number you will be emailed a valid username and password.

Submit Registration

Login

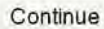
Required fields are highlighted and marked with *

STEP 4

This screen may appear if you have not been entered into the old POST software system. If you have a demographic record in the POST system, it will show that a record matches your info. Click Continue and it will take you to another screen to complete the registration data.



NOTICE: POST has no records on file that match your personal information. According to our records you have never been registered or certified by POST. If this information is correct, please continue and we will send a user name and password to test222@gapost.org. Please click continue to complete registration.

A rectangular button with the word "Continue" in a light gray font.

Click continue here.

STEP 5

Please complete the necessary data entry for all of the following fields on this screen and select continue.

Thank you Dirty. Please provide the following demographic information to complete registration.

Race *

Height * ft in

Weight * lbs

Hair Color *

Eye Color *

Sex/Gender * ☐ Male ☐ Female

Current Home Address:

Street *

City *

State *

Zip Code * -

Primary Telephone * () -

Cell Telephone () -

Other Telephone () -

Continue

Click continue when all the required fields (*) have been filled.

STEP 6

You will see a new user name. The example listed for DIRTY CALLAHAN is new user name "dcallahan" below.

New user dcallahan for DIRTY CALLAHAN added as an Officer
Please click continue to proceed.




Click **continue** to proceed.

STEP 7

At this login will need to enter your user name and password that was automatically sent to your e-mail address. (Note: Some internet service providers (ISP) may have spam filters that prevent you from receiving your username and password. Please contact POST Help Desk at 770-732-5974 between 9 am - 11am or 1 pm to 3 pm to get assistance.)



Returning User Login 
User Name <input type="text"/>
Password <input type="password"/>
<input type="button" value="Log In"/>
Forgot User Name or Password?
New User?
<input type="button" value="Register Now"/>