NORTHFIELD AMBULANCE SERVICE

PERSONNEL APPLICATION

NORTHFIELD AMBULANCE PERSONNEL APPLICATION

NAME:_____ _____

ADDRESS:_____ **OCCUPATION:**_____

_____ **CELL:**_____

HOME PHONE:_____ **EMAIL:**_____

NAME / ADDRESS / PHONE OF 3 CHARACTER REFERENCES: (Clergy, employer, etc)

1._____

2._____

3._____

DRIVING RECORD:

1. Have you been involved either as an operator or an owner in ANY motor vehicle accident(S) during the past three years? _____If yes, give date(s) and brief description(s). _____

   _____

2. Have you been convicted or forfeited bail at any time during the past three years for a moving traffic violation? _____ If yes, give date(s) and nature of violation(s). _____

   _____

3. Have you been convicted of anything other than a traffic violation in the past 5 years?_____If yes give details._____

   _____

4. Have you ever had your license suspended or your driving privileges revoked?_____If yes, explain_____

   _____

HEALTH RECORD:

1. Within the past five years have you had any physical or mental disorder (ie. diabetes, heart disorder, epilepsy, etc.)?_____
2. Have you been treated for a drug habit or alcoholism?_____
3. Do you regularly use barbiturates, narcotics or other drugs, except as prescribed by a physician?_____
4. Will any prescription medication you may be taking impair your ability to perform required duties?_____
5. Have you had any other illness or injury not mentioned?_____
6 Have you had hepatitis B imunization?_____ Is it current?_____

CRIMINAL RECORD:

Have you ever been convicted of a felony? _____ If yes, give date(s) and description(s)_____

_____

PARTICIPATION STATEMENT:

I am willing to participate in ANY & ALL NAVI activities and fundraisers as a a part of my membership with the department_____

I have read the statements and the answers to the above questions and hereby declare that they are complete and true to the best of my knowledge. I know of no reason, physically or mentally, that would preclude me from performing the required duties as a member of the **Northfield Ambulance Service.**

DATE:_____ **APPLICANT SIGNATURE:**_____

SPONSOR:_____ **NOTARY:**_____ **Date:**_____

at:_____ **County:**_____

Expires:_____

NORTHFIELD AMBULANCE PERSONNEL APPLICATION

PERSONNEL INFORMATION WORKSHEET

Name:_____
Last First Middle Initial

D.O.B.____/____/____ Driver's Lic #:_____State___Exp. Date:____/___

Age:_____ Social Security Number:_____

Address:_____
Box or House # Street

_____
City / Town State Zip Code

Phone #:_____(H) _____(W) _____(C)

Ht_____, Wt_____, Blood type_____, Eye Color_____

Pants Size: _____(W)_____(L) Shirt: S M L XL XXL XXXL

Coat Size: S M L XL XXL XXXL **Have coat** **Need coat**

Pager: Type:_____SN:_____ Case: Yes No

Radio: Type:_____SN:_____ Sp mic: Yes No

HEP-B #1 Date:_____ **Where are Medical Records??**

#2 Date:_____ _____

#3 Date:_____ **Test Pos Yes No**

In case of emergency: _____
Name Phone Number

Certifications held now and past: (attach copies)

NERMT Cert Level_____ #_____ exp._____

VT Cert Level _____ #_____ exp._____

ICS 100, 200, NIMS, 700

_____

_____

OMB No. 1615-0112; Expires 06/30/2013

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

Form I-9 CNMI, Employment Eligibility Verification

Read instructions carefully before completing this form. The instructions must be available during completion of this form.

ANTI-DISCRIMINATION NOTICE: It is illegal to discriminate against work-authorized individuals. Employers CANNOT specify which document(s) they will accept from an employee. The refusal to hire an individual because the documents have a future expiration date may also constitute illegal discrimination.

Section 1. Employee Information and Verification *(To be completed and signed by employee at the time employment begins.)*

Print Name: Last	First	Middle Initial	Maiden Name

Address *(Street Name and Number)*	Apt. #	Date of Birth *(month/day/year)*

City	State	Zip Code	Social Security #

I am aware that federal law provides for imprisonment and/or fines for false statements or use of false documents in connection with the completion of this form.

I attest, under penalty of perjury, that I am (check one of the following):

- ☐ A citizen of the United States
- ☐ A noncitizen national of the United States (see instructions)
- ☐ A lawful permanent resident (Alien #) _____
- ☐ An alien authorized to work (Alien # or Admission #) _____ until (expiration date, if applicable - *month/day/year*) _____

Employee's Signature — Date *(month/day/year)*

Preparer and/or Translator Certification *(To be completed and signed if Section 1 is prepared by a person other than the employee.) I attest, under penalty of perjury, that I have assisted in the completion of this form and that to the best of my knowledge the information is true and correct.*

Preparer's/Translator's Signature	Print Name

Address *(Street Name and Number, City, State, Zip Code)*	Date *(month/day/year)*

Section 2. Employer Review and Verification *(To be completed and signed by employer. Examine one document from List A OR examine one document from List B and one from List C, as listed on the reverse of this form, and record the title, number, and expiration date, if any, of the document(s).)*

	List A	OR	List B	AND	List C
Document title:					
Issuing authority:					
Document #:					
Expiration Date *(if any)*:					
Document #:					
Expiration Date *(if any)*:					

CERTIFICATION: I attest, under penalty of perjury, that I have examined the document(s) presented by the above-named employee, that the above-listed document(s) appear to be genuine and to relate to the employee named, that the employee began employment on *(month/day/year)* _____ **and that to the best of my knowledge the employee is authorized to work in the United States. (State employment agencies may omit the date the employee began employment.)**

Signature of Employer or Authorized Representative	Print Name	Title

Business or Organization Name and Address *(Street Name and Number, City, State, Zip Code)*	Date *(month/day/year)*

Section 3. Updating and Reverification *(To be completed and signed by employer.)*

A. New Name *(if applicable)*	B. Date of Rehire *(month/day/year) (if applicable)*

C. If employee's previous grant of work authorization has expired, provide the information below for the document that establishes current employment authorization.

Document Title: _____ Document #: _____ Expiration Date *(if any)*: _____

I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented document(s), the document(s) I have examined appear to be genuine and to relate to the individual.

Signature of Employer or Authorized Representative	Date *(month/day/year)*

Form W-4 (2011)

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

Exemption from withholding. If you are exempt, complete **only** lines 1, 2, 3, 4, and 7 and sign the form to validate it. Your exemption for 2011 expires February 16, 2012. See Pub. 505, Tax Withholding and Estimated Tax.

Note. If another person can claim you as a dependent on his or her tax return, you cannot claim exemption from withholding if your income exceeds $950 and includes more than $300 of unearned income (for example, interest and dividends).

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

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

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

Tax credits. You can take projected tax credits into account in figuring your allowable number of withholding allowances. Credits for child or dependent care expenses and the child tax credit may be claimed using the **Personal Allowances Worksheet** below. See Pub. 919, How Do I Adjust My Tax Withholding, for information on converting your other credits into withholding allowances.

Nonwage income. If you have a large amount of nonwage income, such as interest or dividends, consider making estimated tax payments using Form 1040-ES, Estimated Tax for Individuals. Otherwise, you may owe additional tax. If you have pension or annuity income, see Pub. 919 to find out if you should adjust your withholding on Form W-4 or W-4P.

Two earners or multiple jobs. If you have a working spouse or more than one job, figure the total number of allowances you are entitled to claim on all jobs using worksheets from only one Form W-4. Your withholding usually will be most accurate when all allowances are claimed on the Form W-4 for the highest paying job and zero allowances are claimed on the others. See Pub. 919 for details.

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

Check your withholding. After your Form W-4 takes effect, use Pub. 919 to see how the amount you are having withheld compares to your projected total tax for 2011. See Pub. 919, especially if your earnings exceed $130,000 (Single) or $180,000 (Married).

Personal Allowances Worksheet (Keep for your records.)

A	Enter "1" for **yourself** if no one else can claim you as a dependent	A _____
B	Enter "1" if: • You are single and have only one job; or • You are married, have only one job, and your spouse does not work; or • Your wages from a second job or your spouse's wages (or the total of both) are $1,500 or less.	B _____
C	Enter "1" for your **spouse.** But, you may choose to enter "-0-" if you are married and have either a working spouse or more than one job. (Entering "-0-" may help you avoid having too little tax withheld.)	C _____
D	Enter number of **dependents** (other than your spouse or yourself) you will claim on your tax return	D _____
E	Enter "1" if you will file as **head of household** on your tax return (see conditions under **Head of household** above)	E _____
F	Enter "1" if you have at least $1,900 of **child or dependent care expenses** for which you plan to claim a credit (**Note.** Do **not** include child support payments. See Pub. 503, Child and Dependent Care Expenses, for details.)	F _____
G	**Child Tax Credit** (including additional child tax credit). See Pub. 972, Child Tax Credit, for more information. • If your total income will be less than $61,000 ($90,000 if married), enter "2" for each eligible child; then **less** "1" if you have three or more eligible children. • If your total income will be between $61,000 and $84,000 ($90,000 and $119,000 if married), enter "1" for each eligible child plus "1" **additional** if you have six or more eligible children	G _____
H	Add lines A through G and enter total here. (**Note.** This may be different from the number of exemptions you claim on your tax return.) ▶	H _____

For accuracy, **complete all worksheets that apply.**
- If you plan to **itemize** or **claim adjustments to income** and want to reduce your withholding, see the **Deductions and Adjustments Worksheet** on page 2.
- If you have **more than one job** or are **married and you and your spouse both work** and the combined earnings from all jobs exceed $40,000 ($10,000 if married), see the **Two-Earners/Multiple Jobs Worksheet** on page 2 to avoid having too little tax withheld.
- If **neither** of the above situations applies, **stop here** and enter the number from line H on line 5 of Form W-4 below.

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

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

Employee's Withholding Allowance Certificate

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

OMB No. 1545-0074
2011

1 Type or print your first name and middle initial.	Last name	2 **Your social security number**
Home address (number and street or rural route)	3 ☐ Single ☐ Married ☐ Married, but withhold at higher Single rate. **Note.** If married, but legally separated, or spouse is a nonresident alien, check the "Single" box.	
City or town, state, and ZIP code	4 **If your last name differs from that shown on your social security card, check here. You must call 1-800-772-1213 for a replacement card.** ▶ ☐	

5	Total number of allowances you are claiming (from line **H** above **or** from the applicable worksheet on page 2)	5
6	Additional amount, if any, you want withheld from each paycheck	6 $
7	I claim exemption from withholding for 2011, and I certify that I meet **both** of the following conditions for exemption. • Last year I had a right to a refund of **all** federal income tax withheld because I had **no** tax liability **and** • This year I expect a refund of **all** federal income tax withheld because I expect to have **no** tax liability. If you meet both conditions, write "Exempt" here ▶	7

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

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

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

Deductions and Adjustments Worksheet

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

1	Enter an estimate of your 2011 itemized deductions. These include qualifying home mortgage interest, charitable contributions, state and local taxes, medical expenses in excess of 7.5% of your income, and miscellaneous deductions	1	$
2	Enter: { $11,600 if married filing jointly or qualifying widow(er); $8,500 if head of household; $5,800 if single or married filing separately }	2	$
3	**Subtract** line 2 from line 1. If zero or less, enter "-0-"	3	$
4	Enter an estimate of your 2011 adjustments to income and any additional standard deduction (see Pub. 919)	4	$
5	**Add** lines 3 and 4 and enter the total. (Include any amount for credits from the *Converting Credits to Withholding Allowances for 2011 Form W-4 Worksheet* in Pub. 919.)	5	$
6	Enter an estimate of your 2011 nonwage income (such as dividends or interest)	6	$
7	**Subtract** line 6 from line 5. If zero or less, enter "-0-"	7	$
8	**Divide** the amount on line 7 by $3,700 and enter the result here. Drop any fraction	8	
9	Enter the number from the **Personal Allowances Worksheet,** line H, page 1	9	
10	**Add** lines 8 and 9 and enter the total here. If you plan to use the **Two-Earners/Multiple Jobs Worksheet,** also enter this total on line 1 below. Otherwise, **stop here** and enter this total on Form W-4, line 5, page 1	10	

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

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

1	Enter the number from line H, page 1 (or from line 10 above if you used the **Deductions and Adjustments Worksheet**)	1	
2	Find the number in **Table 1** below that applies to the **LOWEST** paying job and enter it here. **However,** if you are married filing jointly and wages from the highest paying job are $65,000 or less, do not enter more than "3"	2	
3	If line 1 is **more than or equal to** line 2, subtract line 2 from line 1. Enter the result here (if zero, enter "-0-") and on Form W-4, line 5, page 1. **Do not** use the rest of this worksheet	3	

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

4	Enter the number from line 2 of this worksheet	4		
5	Enter the number from line 1 of this worksheet	5		
6	**Subtract** line 5 from line 4		6	
7	Find the amount in **Table 2** below that applies to the **HIGHEST** paying job and enter it here		7	$
8	**Multiply** line 7 by line 6 and enter the result here. This is the additional annual withholding needed		8	$
9	Divide line 8 by the number of pay periods remaining in 2011. For example, divide by 26 if you are paid every two weeks and you complete this form in December 2010. Enter the result here and on Form W-4, line 6, page 1. This is the additional amount to be withheld from each paycheck		9	$

Table 1

Married Filing Jointly		All Others	
If wages from **LOWEST** paying job are—	Enter on line 2 above	If wages from **LOWEST** paying job are—	Enter on line 2 above
$0 - $5,000	0	$0 - $8,000	0
5,001 - 12,000	1	8,001 - 15,000	1
12,001 - 22,000	2	15,001 - 25,000	2
22,001 - 25,000	3	25,001 - 30,000	3
25,001 - 30,000	4	30,001 - 40,000	4
30,001 - 40,000	5	40,001 - 50,000	5
40,001 - 48,000	6	50,001 - 65,000	6
48,001 - 55,000	7	65,001 - 80,000	7
55,001 - 65,000	8	80,001 - 95,000	8
65,001 - 72,000	9	95,001 -120,000	9
72,001 - 85,000	10	120,001 and over	10
85,001 - 97,000	11		
97,001 -110,000	12		
110,001 -120,000	13		
120,001 -135,000	14		
135,001 and over	15		

Table 2

Married Filing Jointly		All Others	
If wages from **HIGHEST** paying job are—	Enter on line 7 above	If wages from **HIGHEST** paying job are—	Enter on line 7 above
$0 - $65,000	$560	$0 - $35,000	$560
65,001 - 125,000	930	35,001 - 90,000	930
125,001 - 185,000	1,040	90,001 - 165,000	1,040
185,001 - 335,000	1,220	165,001 - 370,000	1,220
335,001 and over	1,300	370,001 and over	1,300

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

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

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

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

VERMONT CRIMINAL INFORMATION CENTER

NATIONAL CHILD PROTECTION ACT (NCPA) PROGRAM

FBI NATIONAL RECORD CHECK RELEASE FORM

Qualified Entity	NORTHFIELD AMBULANCE SERVICE			
Applicant	Last	First	Middle	
Maiden or Alias Names				
Social Security #	- -			
Place of Birth	City/Town	State	Country	
Date of Birth	Month / Day / Year			
Applicant's Telephone #	Include Area Code and Number - -			

RELEASE

I, _____, hereby acknowledge and agree to a check of any criminal record of convictions which may be maintained by the Vermont Criminal Information Center and the FBI. I understand that the results of that check will be made available to _____ for use in reviewing my suitability for _____. I further understand that I have the right to appeal the results of the criminal record check to the Vermont Criminal Information Center, Department of Public Safety, 103 South Main Street, Waterbury, Vermont, 05671-2101.

Signature of Applicant	Date
Identity verified by: Lawton W. Rutter (By Photo ID)	Date

NOTARY

_____ personally appeared before me and satisfied me that s/he is the person named in and who signed this Release Form. Thereupon s/he acknowledged the signing of this Release Form as his/her act and deed for the uses and purposes expressed in this document.

Printed Name of Notary Lawton W. Rutter	Notary Signature
Commission Number	Commission Expires

Hepatitis B Vaccine Declination Form

I understand that due to my occupational exposure to blood or other potentially infectious materials I may be at risk of acquiring hepatitis B virus (HBV) infection. I have been given the opportunity to be vaccinated with hepatitis B vaccine, at no charge to myself. However, I decline hepatitis B vaccination at this time. I understand that by declining this vaccine, I continue to be at risk of acquiring hepatitis B, a serious disease. If in the future I continue to have occupational exposure to blood or other potentially infectious materials and I want to be vaccinated with hepatitis B vaccine, I can receive the vaccination series at no charge to me.

_____ _____

Signature of Member or Employee Date

_____

Name of Member or Employee (print or type)

THIS FORM MUST BE COMPLETED ANNUALLY BY ALL EMPLOYEES

Vermont Department of Labor

DECLARATION OF HEALTH CARE COVERAGE

Employer: This form is ONLY to be completed by employees if you offer to pay a portion of a health care plan that provides hospital and physicians services to at least some of your employees. You are required to maintain these documents together in a file in the event of an audit (for a minimum of three years).

Employer's Legal Name: Town of Northfield

Print Employee's Full Name: _____

Employee ID or Social Security Number: _____ DOB _____

EMPLOYEE TO COMPLETE: *The purpose of this form is to obtain information regarding your health care coverage. The information certified on this form will be used solely for the purposes of determining if your employer must pay Health Care Contributions, as required under 21 V.S.A., Section 2003. Return to employer when complete.*

I AM OFFERED AND AM ELIGIBLE FOR HEALTH CARE COVERAGE BY MY EMPLOYER:

☐ I have elected to accept the health care coverage offered and provided by my employer.

I AM OFFERED AND AM ELIGIBLE FOR HEALTH CARE COVERAGE BY MY EMPLOYER BUT HAVE ELECTED NOT TO ACCEPT THE COVERAGE OFFERED (√ *appropriate box*):

☐ I have Health Care Coverage that includes hospital and physicians services from another source other than Medicaid or Vermont Health Benefit Exchange (VHBE): (Specify Below) _____	☐ I have no health care. ☐ I have Medicaid. ☐ I am a full time employee and have health care as an individual through the Vermont Health Benefit Exchange.

I AM NOT ELIGIBLE FOR HEALTH CARE COVERAGE OFFERED BY MY EMPLOYER: (√ *appropriate box*):

☒ I am a part-time employee who works less than 30 hours per week **AND** I have coverage from a source other than Medicaid that offers hospital and physicians services. ☐ I am a seasonal employee who expects to work for this employer 20 or fewer weeks during this calendar year **AND** I have coverage from a source other than Medicaid that offers hospital and physicians services. ☐ I have Health Care Coverage that includes hospital and physicians services: (Specify) _____ Employer Note: these individuals will need to be included in your uncovered hours, if you do not offer your plan to **ALL** of your full-time employees.	☐ I am a part-time or seasonal employee and I do not have health care coverage OR I am covered by Medicaid. ☐ I have no health care.

NOTE to Employee: If at some point within the next year your health care coverage changes, you are required to complete another declaration.

☐ I certify the above information is accurate and true to the best of my knowledge and belief.

_____ _____

Employee Signature Date

Employer – Retain this document on file for THREE YEARS

PAYROLL DIRECT DEPOSIT FORM

DIRECT DEPOSITS HAVE TO BE TESTED IN PAYROLL BEFORE THEY GO INTO EFFECT. THEREFORE, THIS WILL NOT OCCUR UNTIL THE 2ND PAYROLL.

Employee Name: _____

Social Security No.: _____

Employee Address: _____

1st Flat Amount:

Name of Bank/CU: _____

Bank Routing No.: _____

Bank Address: _____

_____

_____

Bank Telephone No.: _____

Your Account No.: _____

Deposit Amount: $ _____

Account Type (Circle your choice): Checking or Savings

2nd Flat Amount:

Name of Bank/CU: _____

Bank Routing No.: _____

Bank Address: _____

_____

_____

Bank Telephone No.: _____

Your Account No.: _____

Deposit Amount: $ _____

Account Type (Circle your choice): Checking or Savings

Net Deposit (Balance of your payroll check after all other deductions):

Name of Bank/CU: _____

Bank Routing No.: _____

Bank Address: _____

_____

_____

Bank Telephone No.: _____

Your Account No.: _____

Account Type (Circle your choice): Checking or Savings

I authorize the Town/Village of Northfield to electronically deposit my pay into the checking and/or savings accounts indicated above.

Signature: _____ Date: _____

Any new direct deposit accounts must have a copy of a void check/deposit slip or something printed from the bank with the account # on it.