



NAME: _____

EMPLOYEE#: _____

DIV: _____ / _____

DATE APP GIVEN: _____

Forest Lakes Fire District Employment Packet

**Applicant: some of the forms are
two sided – please fill out both
sides. All forms must be completed.**

Thank you!

****Two Pieces of Identification are required with this employment application. List of acceptable id is listed on the back cover of Form I-9 Employment Eligibility Verification.**

**** Attach legible copies of all CERT cards AND valid Identification cards as stated above.**



Forest Lakes Fire District
P.O. Box 1808
Forest Lakes, AZ 85931
Phone# 928-535-4644 Fax# 928-535-5448

EMPLOYMENT APPLICATION PLEASE PRINT

APPLICANT INFORMATION

Full Name: _____ Date: _____
Last First M.I.

Address: _____
Street Address Apartment/Unit #

City State ZIP Code

Phone: () E-mail Address: _____

Date Available: _____ Social Security No.: _____ Cell Phone# ()
Are you a citizen of the United States? YES ☐ NO ☐ If no, are you authorized to work in the U.S.? YES ☐ NO ☐
Have you ever worked for this company? YES ☐ NO ☐ If yes, when? _____
Have you ever been convicted of a felony? YES ☐ NO ☐
If yes, explain: _____

EDUCATION

High School: _____ Address: _____
From: _____ To: _____ Did you graduate? YES ☐ NO ☐ Degree: _____
College: _____ Address: _____
From: _____ To: _____ Did you graduate? YES ☐ NO ☐ Degree: _____
Other: _____ Address: _____
From: _____ To: _____ Did you graduate? YES ☐ NO ☐ Degree: _____

REFERENCES – NOT RELATED TO YOU, WHOM YOU HAVE KNOWN AT LEAST ONE YEAR

Please list three references.

Full Name: _____ Relationship: _____
Company: _____ Phone: ()
Address: _____
Full Name: _____ Relationship: _____
Company: _____ Phone: ()
Address: _____
Full Name: _____ Relationship: _____
Company: _____ Phone: ()
Address: _____

PREVIOUS EMPLOYMENT

Company: _____ Phone: ()
Address: _____ Supervisor: _____
Job Title: _____ Starting Salary: \$ _____ Ending Salary: \$ _____
Responsibilities: _____
From: _____ To: _____ Reason for Leaving: _____
May we contact your previous supervisor for a reference? YES ☐ NO ☐

PREVIOUS EMPLOYMENT CONTINUED

Company: _____ Phone: () _____

Address: _____ Supervisor: _____

Job Title: _____ Starting Salary: \$ _____ Ending Salary: \$ _____

Responsibilities: _____

From: _____ To: _____ Reason for Leaving: _____

May we contact your previous supervisor for a reference? YES ☐ NO ☐

Company: _____ Phone: () _____

Address: _____ Supervisor: _____

Job Title: _____ Starting Salary: \$ _____ Ending Salary: \$ _____

Responsibilities: _____

From: _____ To: _____ Reason for Leaving: _____

May we contact your previous supervisor for a reference? YES ☐ NO ☐

IN CASE OF AN EMERGENCY – NOTIFY

NAME: _____ Phone# _____

NAME: _____ Phone# _____

DISCLAIMER AND SIGNATURE

*I certify that my answers are true and complete to the best of my knowledge.
If this application leads to employment, I understand that false or misleading information in my application or interview may result in my release.*

Signature: _____ Date: _____

“APPLICANT - DO NOT WRITE BELOW THIS LINE”

Interviewed By: _____ Date: _____

Remarks: _____

Hire Date: _____ Start Date: _____ Position: _____

Employee # Issued: _____ Input Into Online Employer: _____ On Roster: _____

Employee File Made: _____ Other: _____

FOREST LAKES FIRE DISTRICT
Criminal Justice Information, Criminal History Record Information, Pre-Employment Drug Testing & Probation Period of Employment.

Applicant Review and Challenge Notice

You are receiving the Applicant Review and Challenge Notice to inform you that your fingerprints will be used to check the criminal history records of the FBI through the results of your Arizona Department of Public Safety Fingerprint Background Check. You may obtain a copy of your criminal history record and challenge the record by following the steps below.

1) To obtain a copy of your Arizona criminal history in order to review/update/correct the record, you can contact the Arizona Department of Public Safety Criminal History Records Unit at (602) 223-2222 to obtain a fingerprint card and Review and Challenge packet. Information on the review and challenge process can be found on the DPS website (www.azdps.gov). This will check the Arizona criminal history ONLY.

2) For a copy of an FBI criminal history record: U.S. Department of Justice Order rules and federal law allow the subject of an FBI record to request a copy of his/her own criminal history record. The individual may submit fingerprints, an Applicant Information Form, and payment directly to the FBI. The procedures for obtaining a change, correction, or updating of your FBI criminal history record are set forth in Title 28, Code of Federal Regulations (CFR), Section 16.30 through 16.34. Information on how to review and challenge, submittal forms, checklists, and more information on your FBI criminal history record can be found at www.fbi.gov under "Services" and then "Identity History Summary Checks" or by calling (304) 625-5590.

Please initial and acknowledge that you have been advised of how to review/challenge your criminal history record.

Please initial and acknowledge that you understand that you have the right to agree to either obtain or decline to provide our agency upon request, authentic documentation to a criminal history record in the event of a "No Dispo Recorded," (no disposition on file for that arrest) or if you deem the information has been inaccurately reported within your criminal history record **within 2 WEEKS of notification** upon determination of your suitability for employment, license, or volunteering.

Written Notification of Non-Criminal Justice Candidates Privacy Rights

As a candidate who has accepted a contingent job offer from the Forest Lakes Fire District you are now subject to a national fingerprint-based criminal history record check, as part of the pre-employment process, for a noncriminal justice purpose (such as an application for a job or license, an immigration or naturalization matter, security clearance, or adoption) you have certain rights which are listed below.

*You must be provided written notification that your fingerprints will be used to check criminal history records of the FBI.

*If you have a criminal history record, the officials making a determination of your suitability for the job, will provide you the opportunity to complete or challenge the accuracy of the information in the record.

*The officials must advise you that the procedures for obtaining a change, correction, or updating of your criminal history record are set forth at Title 28, Code of Federal Regulations (CFR) Section 16.34.

*If you have a criminal history record, you should be afforded a reasonable amount of time to correct or complete the record (or decline to do so) before the officials deny you the job based on information in the criminal history record. Forest Lakes Fire District will allow you two (2) weeks from the date of discovery to correct state and federal criminal history.

You have the right to expect that officials receiving the results of the criminal history record check will use it only for authorized purposes and will not retain or disseminate it in violation of federal statute, regulation or executive order, or rule, procedure or standard established by the Nation Crime Prevention and Privacy Compact Council.

Federal Laws, State Laws and the Forest Lakes Fire District policy does not permit us to provide you a copy of the record; however you may obtain a copy of the record by visiting <https://www.fbi.gov/services/cjis>

Written Notification of Pre-Employment Drug Testing

As a candidate who has accepted a contingent job offer from the Forest Lakes Fire District you are also subject to a pre-employment drug and alcohol test. Applicants who test positively for the presence of drugs and/or alcohol will be discontinued from the application process.

Written Notification of Probation Period of Employment

A candidate's first six (6) months of employment are on a trial basis and are considered a continuation of the employment selection process. The six (6) month probationary period provides the district an opportunity to observe and evaluate the capacity of the employee, which includes the employee's ability to satisfactorily perform the essential functions of his/her job; and to observe and evaluate the employee's work habits and conduct, including attendance and the employee's relationship with coworkers, superiors and the community in which we serve. During this probationary period the District may terminate employment immediately, with or without cause and with or without notice. Likewise, the employee may also terminate his/her employment at any time, with or without cause and/or notice. The six (6) month probationary period is not a term of employment and is not intended, nor does it, impact the at will nature of the relationship between the District and the employee.

By signing below, the candidate/potential employee understands & agrees to the content of the Review & Challenge Notice, the Criminal Justice Information, Criminal History Record Information, Pre-Employment Drug Testing and Probation Period of Employment.

Candidate Name (Print)

Date

Candidate Signature

By FLFD (Name Print)

Date

FLFD Personnel Signature

Rev:04-12-18



Arizona New Hire Reporting Form

Mail completed form to: Arizona New Hire Reporting Center
P.O. Box 402
Holbrook, MA 02343

Or fax completed form to: 1-888-282-0502 toll-free fax

EMPLOYER INFORMATION

Federal Employer Identification Number (FEIN): 52-155-0069

(Please use the same FEIN for which listed employee(s) quarterly wages will be reported under.)

Employer Name: Forest Lakes Fire District DBA: _____

Contact Name: Administration Telephone: 928-535-4644 Email: info@flfdaz.com

Address: P.O. Box 1808

(Please indicate the address where the Income Withholding Order will be sent.)

City: Forest Lakes State: AZ Zip Code: 85931 +4: 1808

Complete one entry for each new employee

EMPLOYEE INFORMATION

Social Security Number: _____ - _____ - _____

Employee First Name: _____ Middle: _____

Employee Last Name: _____

Employee Address: _____

City: _____ State: _____ Zip Code: _____ +4: _____

*Date of Birth: _____ *Date of Hire: _____

*Is medical insurance an employee benefit? Yes ☐ No ☐

*Is this employee eligible for an insurance benefit? Yes ☐ No ☐

* OPTIONAL

EMPLOYEE INFORMATION

Social Security Number: _____ - _____ - _____

Employee First Name: _____ Middle: _____

Employee Last Name: _____

Employee Address: _____

City: _____ State: _____ Zip Code: _____ +4: _____

*Date of Birth: _____ *Date of Hire: _____

*Is medical insurance an employee benefit? Yes ☐ No ☐

*Is this employee eligible for an insurance benefit? Yes ☐ No ☐

* OPTIONAL

For information please visit our web-site at www.az-newhire.com
or call us toll-free at 1-888-282-2064

The Arizona New Hire Reporting Center is an authorized agent of the Arizona Department of Economic Security

Rev 03/2010



Employment Eligibility Verification
Department of Homeland Security
U.S. Citizenship and Immigration Services

USCIS
Form I-9
OMB No. 1615-0047
Expires 08/31/2019

► **START HERE:** Read instructions carefully before completing this form. The instructions must be available, either in paper or electronically, during completion of this form. Employers are liable for errors in the completion of this form.

ANTI-DISCRIMINATION NOTICE: It is illegal to discriminate against work-authorized individuals. Employers **CANNOT** specify which document(s) an employee may present to establish employment authorization and identity. The refusal to hire or continue to employ an individual because the documentation presented has a future expiration date may also constitute illegal discrimination.

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

Last Name (Family Name)		First Name (Given Name)		Middle Initial	Other Last Names Used (if any)	
Address (Street Number and Name)			Apt. Number	City or Town		State ZIP Code
Date of Birth (mm/dd/yyyy)	U.S. Social Security Number [][] - [][] - [][][][]		Employee's E-mail Address		Employee's Telephone Number	

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

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

<input type="checkbox"/> 1. A citizen of the United States
<input type="checkbox"/> 2. A noncitizen national of the United States <i>(See instructions)</i>
<input type="checkbox"/> 3. A lawful permanent resident (Alien Registration Number/USCIS Number): _____
<input type="checkbox"/> 4. An alien authorized to work until (expiration date, if applicable, mm/dd/yyyy): _____ Some aliens may write "N/A" in the expiration date field. <i>(See instructions)</i>
<p><i>Aliens authorized to work must provide only one of the following document numbers to complete Form I-9: An Alien Registration Number/USCIS Number OR Form I-94 Admission Number OR Foreign Passport Number.</i></p> <p>1. Alien Registration Number/USCIS Number: _____ OR 2. Form I-94 Admission Number: _____ OR 3. Foreign Passport Number: _____ Country of Issuance: _____</p>
<p>QR Code - Section 1 Do Not Write In This Space</p>

Signature of Employee	Today's Date (mm/dd/yyyy)
-----------------------	---------------------------

Preparer and/or Translator Certification (check one):

☐ I did not use a preparer or translator. ☐ A preparer(s) and/or translator(s) assisted the employee in completing Section 1.
(Fields below must be completed and signed when preparers and/or translators assist an employee in completing Section 1.)

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		Today's Date (mm/dd/yyyy)	
Last Name (Family Name)		First Name (Given Name)	
Address (Street Number and Name)		City or Town	State ZIP Code



Employer Completes Next Page





Employment Eligibility Verification
Department of Homeland Security
U.S. Citizenship and Immigration Services

USCIS
Form I-9
OMB No. 1615-0047
Expires 08/31/2019

Section 2. Employer or Authorized Representative Review and Verification

(Employers or their authorized representative must complete and sign Section 2 within 3 business days of the employee's first day of employment. You must physically examine one document from List A OR a combination of one document from List B and one document from List C as listed on the "Lists of Acceptable Documents.")

Employee Info from Section 1	Last Name (Family Name)	First Name (Given Name)	M.I.	Citizenship/Immigration Status
-------------------------------------	-------------------------	-------------------------	------	--------------------------------

List A Identity and Employment Authorization	OR	List B Identity	AND	List C Employment Authorization
Document Title		Document Title		Document Title
Issuing Authority		Issuing Authority		Issuing Authority
Document Number		Document Number		Document Number
Expiration Date (if any)(mm/dd/yyyy)		Expiration Date (if any)(mm/dd/yyyy)		Expiration Date (if any)(mm/dd/yyyy)
Document Title		<div>Additional Information</div> <div>QR Code - Sections 2 & 3 Do Not Write In This Space</div>		
Issuing Authority				
Document Number				
Expiration Date (if any)(mm/dd/yyyy)				
Document Title				
Issuing Authority				
Document Number				
Expiration Date (if any)(mm/dd/yyyy)				
Document Title				
Issuing Authority				

Certification: I attest, under penalty of perjury, that (1) I have examined the document(s) presented by the above-named employee, (2) the above-listed document(s) appear to be genuine and to relate to the employee named, and (3) to the best of my knowledge the employee is authorized to work in the United States.

The employee's first day of employment (mm/dd/yyyy): _____ (See instructions for exemptions)

Signature of Employer or Authorized Representative		Today's Date (mm/dd/yyyy)	Title of Employer or Authorized Representative Administrative Assistant	
Last Name of Employer or Authorized Representative Allen		First Name of Employer or Authorized Representative Roxanna	Employer's Business or Organization Name Forest Lakes Fire District	
Employer's Business or Organization Address (Street Number and Name) 1522 Merzville Rd - PO Box 1808		City or Town Forest Lakes	State AZ	ZIP Code 85931

Section 3. Reverification and Rehires (To be completed and signed by employer or authorized representative.)

A. New Name (if applicable)			B. Date of Rehire (if applicable)	
Last Name (Family Name)	First Name (Given Name)	Middle Initial	Date (mm/dd/yyyy)	

C. If the employee's previous grant of employment authorization has expired, provide the information for the document or receipt that establishes continuing employment authorization in the space provided below.

Document Title	Document Number	Expiration Date (if any) (mm/dd/yyyy)
----------------	-----------------	---------------------------------------

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

Signature of Employer or Authorized Representative	Today's Date (mm/dd/yyyy)	Name of Employer or Authorized Representative
--	---------------------------	---

LISTS OF ACCEPTABLE DOCUMENTS

All documents must be UNEXPIRED

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

LIST A Documents that Establish Both Identity and Employment Authorization	OR	LIST B Documents that Establish Identity	AND	LIST C Documents that Establish Employment Authorization
<ol style="list-style-type: none"> 1. U.S. Passport or U.S. Passport Card 2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551) 3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa 4. Employment Authorization Document that contains a photograph (Form I-766) 5. For a nonimmigrant alien authorized to work for a specific employer because of his or her status: <ol style="list-style-type: none"> a. Foreign passport; and b. Form I-94 or Form I-94A that has the following: <ol style="list-style-type: none"> (1) The same name as the passport; and (2) An endorsement of the alien's nonimmigrant status as long as that period of endorsement has not yet expired and the proposed employment is not in conflict with any restrictions or limitations identified on the form. 6. Passport from the Federated States of Micronesia (FSM) or the Republic of the Marshall Islands (RMI) with Form I-94 or Form I-94A indicating nonimmigrant admission under the Compact of Free Association Between the United States and the FSM or RMI 		<ol style="list-style-type: none"> 1. Driver's license or ID card issued by a State or outlying possession of the United States provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address 2. ID card issued by federal, state or local government agencies or entities, provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address 3. School ID card with a photograph 4. Voter's registration card 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 		<ol style="list-style-type: none"> 1. A Social Security Account Number card, unless the card includes one of the following restrictions: <ol style="list-style-type: none"> (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

Examples of many of these documents appear in Part 13 of the Handbook for Employers (M-274).

Refer to the instructions for more information about acceptable receipts.

Form W-4 (2018)

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

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. You may claim exemption from withholding for 2018 if **both** of the following apply.

- For 2017 you had a right to a refund of **all** federal income tax withheld because you had **no** tax liability, **and**
- For 2018 you expect a refund of **all** federal income tax withheld because you expect to have **no** tax liability.

If you're exempt, complete **only** lines 1, 2, 3, 4, and 7 and sign the form to validate it. Your exemption for 2018 expires February 15, 2019. See Pub. 505, Tax Withholding and Estimated Tax, to learn more about whether you qualify for exemption from withholding.

General Instructions

If you aren't exempt, follow the rest of these instructions to determine the number of withholding allowances you should claim for withholding for 2018 and any additional amount of tax to have withheld. For regular wages, withholding must be based on allowances you claimed and may not be a flat amount or percentage of wages.

You can also use the calculator at www.irs.gov/W4App to determine your tax withholding more accurately. Consider

using this calculator if you have a more complicated tax situation, such as if you have a working spouse, more than one job, or a large amount of nonwage income outside of your job. After your Form W-4 takes effect, you can also use this calculator to see how the amount of tax you're having withheld compares to your projected total tax for 2018. If you use the calculator, you don't need to complete any of the worksheets for Form W-4.

Note that if you have too much tax withheld, you will receive a refund when you file your tax return. If you have too little tax withheld, you will owe tax when you file your tax return, and you might owe a penalty.

Filers with multiple jobs or working spouses. If you have more than one job at a time, or if you're married and your spouse is also working, read all of the instructions including the instructions for the Two-Earners/Multiple Jobs Worksheet before beginning.

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 might owe additional tax. Or, you can use the Deductions, Adjustments, and Other Income Worksheet on page 3 or the calculator at www.irs.gov/W4App to make sure you have enough tax withheld from your paycheck. If you have pension or annuity income, see Pub. 505 or use the calculator at www.irs.gov/W4App to find out if you should adjust your withholding on Form W-4 or W-4P.

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

Personal Allowances Worksheet

Complete this worksheet on page 3 first to determine the number of withholding allowances to claim.

Line C. Head of household please note: Generally, you can claim head of household filing status on your tax return only if you're unmarried and pay more than 50% of the costs of keeping up a home for yourself and a qualifying individual. See Pub. 501 for more information about filing status.

Line E. Child tax credit. When you file your tax return, you might be eligible to claim a credit for each of your qualifying children. To qualify, the child must be under age 17 as of December 31 and must be your dependent who lives with you for more than half the year. To learn more about this credit, see Pub. 972, Child Tax Credit. To reduce the tax withheld from your pay by taking this credit into account, follow the instructions on line E of the worksheet. On the worksheet you will be asked about your total income. For this purpose, total income includes all of your wages and other income, including income earned by a spouse, during the year.

Line F. Credit for other dependents. When you file your tax return, you might be eligible to claim a credit for each of your dependents that don't qualify for the child tax credit, such as any dependent children age 17 and older. To learn more about this credit, see Pub. 505. To reduce the tax withheld from your pay by taking this credit into account, follow the instructions on line F of the worksheet. On the worksheet, you will be asked about your total income. For this purpose, total income includes all of

----- Separate here and give Form W-4 to your employer. Keep the worksheet(s) for your records. -----

Form W-4 Department of the Treasury Internal Revenue Service		Employee's Withholding Allowance Certificate		OMB No. 1545-0074 2018	
1 Your first name and middle initial		Last name		2 Your social security number	
Home address (number and street or rural route)		3 <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Married, but withhold at higher Single rate. Note: If married filing separately, check "Married, but withhold at higher Single rate."			
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 800-772-1213 for a replacement card. <input type="checkbox"/>			
5 Total number of allowances you're claiming (from the applicable worksheet on the following pages)		5			
6 Additional amount, if any, you want withheld from each paycheck		6 \$			
7 I claim exemption from withholding for 2018, 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.) ▶					
8 Employer's name and address (Employer: Complete boxes 8 and 10 if sending to IRS and complete boxes 8, 9, and 10 if sending to State Directory of New Hires.)		9 First date of employment		10 Employer identification number (EIN)	

Type or print your Full Name		Your Social Security Number
Home Address – number and street or rural route		
City or Town	State	ZIP Code

Choose either box 1 or box 2:

☐ **1** Withhold from gross taxable wages at the percentage checked (**check only one percentage**):

☐ 0.8% ☐ 1.3% ☐ 1.8% ☐ 2.7% ☐ 3.6% ☐ 4.2% ☐ 5.1%

☐ Check this box and enter an extra amount to be withheld from each paycheck \$

☐ **2** I elect an Arizona withholding percentage of zero, and I certify that I expect to have no Arizona tax liability for the current taxable year.

I certify that I have made the election marked above.

SIGNATURE _____

DATE _____

Employee's Instructions

Arizona law requires your employer to withhold Arizona income tax from your wages for work done in Arizona. The amount withheld is applied to your Arizona income tax due when you file your tax return. The amount withheld is a percentage of your gross taxable wages from every paycheck. You may also have your employer withhold an extra amount from each paycheck. Complete this form to select a percentage and any extra amount to be withheld from each paycheck.

What are my "Gross Taxable Wages"?

For withholding purposes, your "gross taxable wages" are the wages that will generally be in box 1 of your federal Form W-2. It is your gross wages less any pretax deductions, such as your share of health insurance premiums.

New Employees

Complete this form within the first five days of your employment to select an Arizona withholding percentage. You may also have your employer withhold an extra amount from each paycheck. If you do not file this form, the department requires your employer to withhold 2.7% of your gross taxable wages.

Current Employees

If you want to change your current amount withheld, you must file this form to change the Arizona withholding percentage to change the extra amount withheld.

What Should I do With Form A-4?

Give your completed Form A-4 to your employer.

Electing a Withholding Percentage of Zero

You may elect an Arizona withholding percentage of zero if you expect to have no Arizona income tax liability for the current year. Arizona tax liability is gross tax liability less any tax credits, such as the family tax credit, school tax credits, or credits for taxes paid to other states. If you make this election, your employer will not withhold Arizona income tax from your wages for payroll periods beginning after the date you file the form. Zero withholding does not relieve you from paying Arizona income taxes that might be due at the time you file your Arizona income tax return. If you have an Arizona tax liability when you file your return or if at any time during the current year conditions change so that you expect to have a tax liability, you should promptly file a new Form A-4 and choose a withholding percentage that applies to you.

Voluntary Withholding Election by Certain Nonresident Employees

Compensation earned by nonresidents while physically working in Arizona for temporary periods is subject to Arizona income tax. However, under Arizona law, compensation paid to certain nonresident employees is not subject to Arizona income tax withholding. These nonresident employees need to review their situations and determine if they should elect to have Arizona income taxes withheld from their Arizona source compensation. Nonresident employees may request that their employer withhold Arizona income taxes by completing this form to elect Arizona income tax withholding.

**REQUEST TO PARTICIPATE IN
FOREST LAKES FIRE DISTRICT
ALTERNATE PENSION AND BENEFIT PLAN**

I, _____, elect to participate in the Alternate Pension and Benefit Plan allowed by Arizona Revised Statutes # 9-981. I am not a participant in the Public Safety Personnel Retirement System. I understand that by signing this election, I give up my right to participate in the Fire Fighters' Relief and Pension Fund authorized by Title 9, Chapter 8, Article 3, of the Arizona Revised Statutes. (Arizona Revised Statutes ## 9-951 through 9-973,)

I recognize that my benefits under the Alternate Pension and Benefit Plan will vary depending on the monies contributed to the Plan, the return on the Plan investments, and the obligations of the Plan.

Dated: _____

Name: _____

Address: _____

Phone: _____

SIGNATURE: _____

**457 Plan
Salary Reduction Agreement¹**

To the Plan Administrator of the Forest Lakes Fire District 457 Plan ("Plan").

In accordance with provisions of the Plan permitting Participants to make Salary Reduction Contributions, I enter into this Salary Reduction Agreement ("Agreement") with Forest Lakes Fire District (the "Employer").

Plan Compensation. The Plan defines compensation from which I may make Salary Reduction Contributions as my total Compensation from the Employer. This amount is my "Compensation" for purposes of this Agreement.

Compensation to which Agreement applies. I elect² to make Salary Reduction Contributions from the following portion of my Compensation:

☒ **Total Compensation.** My total Compensation (including bonus and other irregular amounts).

☐ **Total Compensation excluding bonus.** My total Compensation (but excluding bonus).

☐ **Bonus only.** My Compensation consisting only of the following bonus amount(s): _____ [identify by amount(s), payroll date(s), etc.]. In making this election, I do not intend to change my existing Salary Reduction Agreement (if any) as to Compensation *other than* the bonus described in this Agreement.

☐ **Accumulated sick pay.**³

☐ **Accumulation vacation pay.**⁴

☐ **Back pay.**⁴

☐ **Other:**⁴ _____.

Salary reduction amount. The Employer will withhold from my Compensation the following amount:

****Minimum deduction amount is 6% - if you want more than 6% elect percentage below.**

***{X}** _____% of my Compensation. [, but not less than 1% and I must specify a whole percentage number.⁵]

☐ \$_____. [, but not less than \$_____ and I must specify a whole dollar amount.⁶]

☐ \$_____ as a Normal Retirement Age catch-up for _____ (specify Taxable Year(s)).

☐ **Zero.** I hereby terminate my prior Salary Reduction Agreement. [*Note: If you have no Salary Reduction Agreement presently in effect and wish not to defer, do not complete this Agreement. Elect "zero" only if you wish to terminate Salary Reduction Contributions under a prior Salary Reduction Agreement now in effect.*]

Frequency. This Agreement applies to Compensation (i.e., to each paycheck) paid after the effective date⁶ of the Agreement, except that a "bonus only" or "other" election shall apply only to the Compensation described in these elections.

¹ A plan administrator may use this form for an eligible governmental or tax-exempt organization 457 plan. The plan administrator also could modify the form for use with an ineligible 457 plan.

² Any participant election (including the "other" election) must be consistent with the plan's compensation definition. See note 2 above.

³ Include only if the employer permits salary reduction contributions from these amounts.

⁴ A participant may elect to apply the agreement to specified "other" compensation (i.e., to compensation not described in the above elections). A participant also may use this blank to specify an unusual deferral commencement date, e.g., "My total compensation payable commencing in July 2004."

⁵ These are optional limitations the plan administrator may wish to impose for administrative convenience.

Vesting/distribution. I am 100% vested immediately in my Salary Reduction Contribution Account.¹⁵ I may receive distribution of my Account only in accordance with the Plan terms.

Investment.¹⁶ My Account will be subject to [Trust] investment gain or loss.

Dated this ____ day of _____, 20__.

PARTICIPANT: _____ [signature]

_____ [print/type name]

Accepted for the Plan Administrator on this ____ day of _____, 20__.

By: _____ [signature]

David V. Rodriguez, Fire Chief [print/type name, title]

PLEASE RETURN THIS FORM TO THE PLAN ADMINISTRATOR

¹⁵ Modify if salary reduction contributions are not immediately vested.

¹⁶ Select appropriate language or modify as necessary.

CONSENT OF SPOUSE FOR COMMUNITY PROPERTY STATE*

If a married Participant's sole primary Designated Beneficiary is a person other than the Participant's spouse, the spouse must indicate consent by signing below.

I, the undersigned spouse of the Participant named in the foregoing Plan Beneficiary Designation, hereby certify that I have read the Designation and fully understand that the property subject to the Designation might include property in which I possess a community property interest or other property interest. Being fully satisfied with its provisions, I hereby consent to and accept the Participant's election(s) in the Designation, without regard to whether I survive or predecease my spouse. This consent is irrevocable unless my spouse changes the Designation. If my spouse changes the Designation: *[Choose (a) or (b)]*:

- ☐ (a) I understand I must file a similar consent to the new Designation, or my consent is no longer effective.
- ☐ (b) I waive my right to withhold my consent to that change in designation. I understand I have the right to limit my consent to the specific beneficiary designated in the attached Designation by checking box (a).

I have executed this Consent this _____ day of _____, 20____.

Signature of Participant's Spouse

[Print or type name]

Signature of spouse witnessed this ____ day of _____, 20____, in the presence of:

Signature of Witness

_____ residing at _____
[Print or type name]

Signature of Witness

_____ residing at _____
[Print or type name]

* CAUTION: A Participant executing this form should review the form with a qualified advisor regarding community property law.

THIS FORM IS ONLY USED IF YOU DO NOT LIST YOUR SPOUSE AS A PRIMARY BENEFICIARY ON THE BENEFICIARY DESIGNATION FORM.

BENEFICIARY DESIGNATION

To the Plan Administrator/Trustee of Forest Lakes Fire District Alternate Pension and Benefit Plan

P.O. BOX 1808 - 1522 MERZVILLE RD - FOREST LAKES, AZ 85931

Plan ("Plan"):

Re: _____, Participant
(print full name of participant)

Pursuant to the provisions of the Plan permitting the designation of a Beneficiary or Beneficiaries by a Participant, I hereby designate the following person or persons as primary and secondary Beneficiaries of my Account under the Plan payable by reason of my death:

Primary Beneficiary(ies) [include address and relationship]:

Contingent Beneficiary(ies) [include address and relationship]:

Trust beneficiary. If you name a trust as a Beneficiary, you also must satisfy additional documentation requirements no later than your "required beginning date." The Plan Administrator will provide you with the additional forms you must complete.

Effect of divorce. A divorce decree or a decree of legal separation automatically revokes a designation of your spouse as a Beneficiary, unless the decree or a qualified domestic relations order provides otherwise.¹

Community property. If your 457 Account is community property, see the attached consent of Spouse for Community Property State.

I RESERVE THE RIGHT TO REVOKE OR CHANGE ANY BENEFICIARY DESIGNATION. I HEREBY REVOKE ALL PRIOR DESIGNATIONS (IF ANY) OF PRIMARY BENEFICIARIES AND CONTINGENT BENEFICIARIES.

The Plan Administrator/Trustee will pay all sums payable under the Plan by reason of my death to the primary Beneficiary, if he or she survives me, and if no primary Beneficiary survives me, then to the contingent Beneficiary, and if no named Beneficiary survives me, then the Plan Administrator/Trustee will pay all amounts in accordance with the Plan. I understand that, unless I have provided otherwise above, the Plan Administrator/Trustee will pay all sums payable to more than one Beneficiary equally to the living Beneficiaries.

Date of this Designation

Signature of Participant

¹ This notice is consistent with Section 6.01 of the 457 prototype plan unless the employer modifies the plan. The practitioner should modify or delete this sentence if necessary to conform to the employer's plan document.

FOREST LAKES FIRE DISTRICT
Reserve/Volunteer Plan Specifications
2011

Employer

Contribution: For purposes of distribution of the Employer Discretionary Nonelective Contributions, a firefighter shall receive points in accordance with the following schedule:

1 point For each two hour training session.

2 points For each medical response call.

3 points For each special duty response.

4 points For each fire response call.

5 points For each wildlife assignment.

5 points For the successful completion of each subject of classroom education.

5 points For attendance at fire department related meetings as assigned by the fire chief.

5 points For attendance at fire department related conferences as assigned by the fire chief.

All firefighters must accumulate a minimum of 24 points per Plan year to qualify in the distribution of the Employer Discretionary Nonelective Contributions and to receive a year of service under Section 5.11 (b) for purposes of vesting.

Participant Disability: Upon the determination of a participant's disability in accordance to the plan document a participants account balance shall be 100% vested.

Participant Death: Upon the death of a participant their account balance shall be 100% vested.

Plan Vesting: Employer contributions to the plan shall vest to participants as follows:

<u>Year of Service</u> <u>With the Sponsor</u>	<u>Vested interest in</u> <u>Account Balance</u>
Less than 5 years service	0%
At Least 5 years of Service	50 %
At Least 6 years of Service	60%
At Least 6 years of Service	70%
At Least 8 years of Service	80%
At Least 9 years of Service	90%
At Least 10 years of Service	100%

The District's records, plan document specifications and District bylaws established by the District shall be used in establishing a participants account balances

**FOREST LAKES FIRE DISTRICT
VOLUNTEER/RESERVE FIREFIGHTER
ALTERNATIVE FICA PENSION & BENEFIT PLAN**

Introduction:

The volunteer /reserve retirement program provides funding flexibility for both the plan participant and sponsor. Attached is a summary sheet of the current funding and vesting policy of your plan. An individual may be eligible to opt out of payroll FICA by meeting the requirements of the Alternative FICA Program. Participants may also defer wages, up to \$16,500, received from the Fire District. These contributions are done on a pre-tax bases and are fully vested. Participants will receive an annual statement of benefits summarizing their accounts.

Plan Summary:

Alternative FICA Program: Provided the participants account is funded correctly (i.e. 7 ½ % of a participants W-2 wages) the participant and Department/District may not be required to make FICA payments. The 7 ½ % contribution may come from either the participant and or District. The District and participant are still responsible for the Medicare tax on wages received. This is similar to how the participants in the Public Safety Retirement System are treated.

Volunteer Firefighter Alternate Pension and Benefit Program: The Arizona Revised Statutes Ann. 9-951& 9-981 provide for a retirement program for the Fire Departments/Districts of Arizona. The State program provides that those Districts that sign up for the program are entitled to receive a prorated share of the annual tax imposed on all premiums received on the policies and contracts of fire insurance covering property within the State of Arizona. These funds are prorated to each department/district annually. Our program operates under Article 4 of the State Statute. Article 4 allows the District's governing body to establish the terms and conditions of the Alternate Plan. Contributions made by the Fire District follow an allocation formula based on your service to the District. Monies contributed on behalf of the participants by the District may follow a vesting schedule determined by the Fire Department. This insures that all participants are treated fairly for their service given to the Department.

Participant Pre-Tax Deferral: The program allows participants to make a pre-tax deferral of wages earned from the department up to (\$16,500). These monies are always 100% vested to the participant.

Plan Benefits:

Separate accounts are maintained for the plan participants. Upon retirement or separation from the District, those vested account balances may be maintained in the plan or for qualified 457 Plan monies, rolled over to a qualified IRA. Eligible monies from the program may also be used to fund past eligible service in the Public Safety Retirement Program. Upon qualified disability a participant becomes fully vested and may receive their account balances. Upon a participant's death their account balances may be paid to their designated beneficiary.

Participate Forms:

Attached are the forms that should be completed by all participants. These forms are kept on file with the Fire District and should be updated as needed.

457 Salary Reduction Agreement: This form needs to be completed and signed by all participants. The Fire District may make contributions on your behalf which will be viewed as deferred income. The form allows participants to elect to make additional deferrals to the program up to the allowable limit (currently \$16,500 for 2011). This deferral amount may be changed at the election of the participant.

Request to Participate Alt Pension: State Statute requires that all participants sign a request to participate in the Article 4 Plan. The Fire District has elected to participate in the Article 4 plan and to use provided State funds to help fund it. In order for participants to receive State funds (account) this form needs to be signed.

Beneficiary Designation Form: This form should be completed by all participants to insure the transfer of a participant accounts/funds upon the death of a participant.

Maximum Salary Reduction Contributions/age 50 catch-up.⁷ My Salary Reduction Contributions [and any Employer contributions to my Account⁸] for any calendar year may not exceed the “457(b) limit” [or other period] Compensation⁹], unless I am age 50 or older (or will attain age 50) during the calendar year in which I defer. If I am or will attain age 50 during the calendar year, I may make additional deferrals, called “catch-up” contributions, in an amount not exceeding the applicable annual catch-up limit. The 402(g) limit and catch-up limit are indexed for inflation after 2006. The limits through 2006 are as follows:

<u>Calendar year</u>	<u>402(g) limit</u>	<u>Catch-up limit</u>
2010	\$16,500	\$5,500
2011	\$16,500	\$5,500

Normal Retirement Age Catch-up. If I am within three Taxable Years of the Plan’s Normal Retirement Age, I may be eligible to make additional catch-up contributions to the Plan. I may make a catch-up contribution in an amount equal to the greater of the age 50 or Normal Retirement Age catch-up amount. The Plan Administrator has additional information regarding the Plan’s Normal Retirement Age catch-up contributions.

Salary Reduction Contribution Account/[Contribution to Trust.]¹⁰ The Plan Administrator will credit my Salary Reduction Contributions to a Salary Reduction Contribution Account under the Plan for my benefit. [The Employer will transmit my deferrals to the Trust maintained under the Plan.¹¹]

Taxation. My Salary Reduction Contributions are not subject to federal or state income taxes until distributed from the Plan [or otherwise made available to me¹¹], [but are subject to FICA, FUTA and medicare taxes. The Employer will deduct from my remaining Compensation these taxes I owe with respect to my Salary Reduction Contributions.¹²]

Effective date/term/changes. This Agreement is effective as of the first day of the next month following the date the Plan Administrator accepts it. If I am a new Employee entering the Plan on my hire date, I may execute this Agreement on or before my hire date, effective as of my hire date. [If I am severing employment and this Agreement applies to accumulated sick or vacation pay or to back pay,¹³ I may enter into the Agreement during the month in which, but before, such amounts will be paid or made available to me, provided I remain employed on the date the amounts would be paid or made available.] This Agreement remains in effect until I change (revoke or modify) it. I may change my Agreement only by providing to the Plan Administrator a new Salary Reduction Agreement and any change may take effect no earlier than the next calendar month. [I must deliver to the Plan Administrator my completed Agreement at least five business days before the month for which my change is effective. If I change my Agreement, I may not file a new Agreement which is effective earlier than the beginning of the next calendar quarter following the change.¹⁴] If I enter into a new Agreement subsequent to the date of this Agreement, the subsequent Agreement acts a revocation of the prior Agreement, except as I specify otherwise in this Agreement.

⁶ The plan administrator, consistent with the plan terms, may impose reasonable effective date rules related to the timing of the participant’s execution and delivery of the agreement. See “Effective date/term/changes” below.

⁷ Modify this language as necessary if the plan does not permit age 50 catch-up contributions.

⁸ Include this language if the employer will or may contribute to the Plan.

⁹ Include this language as appropriate to specify a plan-imposed deferral limitation. Specify the time interval (e.g., per pay period, plan year) as applicable.

¹⁰ Include bracketed language for a governmental plan.

¹¹ Include bracketed language for a tax-exempt organization plan.

¹² Modify or delete bracketed language as appropriate.

¹³ Include if the plan permits salary reduction contributions from these amounts.

¹⁴ Revise the bracketed language as necessary consistent with the plan terms.

Forest Lakes Fire District
Personnel
Disclosure Statement

Name (Print)

The Arizona Revised Statutes place some restrictions on potential conflicts of interest, including disclosure of confidential information, business interests, and employment of relatives⁽¹⁾. To determine that you are in compliance with these provisions, you are required to complete the following information when you are first elected to the Forest Lakes Fire District Board of Directors, and any time there is a change in this information. This document will be retained with District records.

Outside Employment

☐ I am not engaged in any outside employment

☐ I am employed at:

Name of Employer _____

Summary of Duties, Work Schedule _____

Business Interests

Are you involved in any ownership, employment, public or private affiliations, or special arrangements which may have a substantial interest in any contract, sale, purchase, or service involving the Forest Lakes Fire District?

☐ No

☐ Yes. Please describe: _____

Are any of your relatives⁽¹⁾ involved in such activity?

☐ No

☐ Yes. Please describe: _____

Relatives at Forest Lakes Fire District

Are any of your relatives⁽¹⁾ currently employed by the Forest Lakes Fire District?

☐ No

☐ Yes. Please list names, relationships, and their positions with the District:

I understand that if there are any changes to the above information, I am responsible for submitting a new disclosure form.

Signature

Date

Notes:

- (1) RELATIVE means: spouse, child, grandchild, parent, grandparent, brother or sister of the whole or half blood and their spouses, and parent, brother, sister, or child of a spouse, pursuant to Arizona Revised Statute ~38-502.
- (2) Specific information on Conflict of Interest for fire district board members can be found in Chapter 8 of the AFDA Handbook.

Payson Regional Medical Center
ALS Base Hospital

**Initial Application For
Base Hospital Privileges**

Name _____ Cert Level _____ State Cert. # _____

Address _____ City _____, Az Zip _____

Home # _____ Cell # _____ E-mail _____

_____ Application is for Administrative and On-Line Privileges

X **Application for On-Line Privileges only**

Expiration Dates: CPR _____ ACLS _____ PALS _____ PHTLS/BTLS _____

Employer (EMS) **Forest Lakes Fire District PO Box 1808, Forest Lakes, AZ 85931**
Ph# 928-535-4644

List other current EMS
employers _____

Previous/Current
BaseHospital _____

ALS: National Registry Certification # _____ BLS: Last Combitude
Class _____

RN License # _____ Expiration _____

I certify that the information provided above is true to the best of my knowledge and that

1. I am in good standing as a certified provider in the State of Arizona.
2. I will review and agree to abide by the Policy and Procedures of this Base Hospital.
3. I will maintain current status in CPR, and if applicable, ACLS, PALS, PHTLS/BTLS and understand that if one of these certification lapses, I may not function as a certified provider of this base hospital.
4. I understand that I am only covered by the Medical Direction of this Base Hospital when employed by an EMS provider agency that has an active Base Hospital Agreement with Payson Regional Medical Center. I understand that I may only be assigned to one Administrative Base Hospital at a time.
5. I agree that I will function within my scope of practice at all times, as defined by the Arizona Revised Statutes and Administrative Code, and the administrative medical direction of this Base Hospital.
6. I understand that meeting the recertification requirements of my certification level is my sole responsibility.

****Attach a copy of all current licenses and certifications that are applicable.***

Signature _____ Date _____

Accepted on _____ by _____ Prehospital Manager

PayTech, Inc.

Direct Deposit Authorization Form

Company Name: Forest Lakes Fire District

Telephone No. 928-535-4644

Employee Name: _____

Employee No.: _____

Department: n/a

Division: n/a

I hereby authorize Pay-Tech, Inc. to deposit my pay directly into the bank account (s) listed below. I have attached a voided check for my checking account and/or deposit slip for my savings account so bank transit and account numbers can be verified.

Upon notification, I authorize Pay-Tech to correct any erroneous payment or overpayment to my account(s) by withdrawing funds in the amount of the excess payment.

This authorization remains in effect until Pay-Tech; Inc. has received written authorization from me of its termination or change.

Employee Signature: _____ Date: _____

Note: You can put a set amount or the whole check to a specific account. For every account setup on direct deposit a voided check is a must to process.

Financial Institution/Account Number(s):

XXAccount 1: Checking ☐ Savings ☐ Amount Deposited: 100%

Account Number: _____ Routing Number: _____

Account 2: Checking ☐ Savings ☐ Amount Deposited: _____

Account Number: _____ Routing Number: _____

Account 3: Checking ☐ Savings ☐ Amount Deposited: _____

Account Number: _____ Routing Number: _____

Note: In case of direct deposits to joint accounts that both account holders to sign checks or authorize payments, other account holder must indicate his/her agreement with the above term and the employee's direct deposit authorization by signing below.

Name of Joint Account Holder: _____

Signature of Joint Account Holder: _____

Date: _____

ATTACH VOIDED CHECK (s) HERE:

***If you have more than three accounts please use an additional forms**

VOIDED CHECK(s)

FOREST LAKES FIRE DEPT.

PLEASE PRINT INFORMATION!!



LAST NAME:						DAYTIME PHONE:
FIRST NAME:						
PATCH? YES or NO (CIRCLE ONE)						
TYPE OF PATCH: CFR / EMT / MEDIC (CIRCLE ONE)						
HOME ADDRESS:						
CITY/STATE/ZIP:				EMAIL:		
SCREENED ITEMS	QTY	SIZE	COLOR	COST	PRICE	
SHORT SLEEVE T-SHIRT with pocket S-XL 7100				\$16.75	\$0.00	
SHORT SLEEVE T-SHIRT with pocket XXL+				\$19.75	\$0.00	
LONG SLEEVE with pocket T-SHIRT 8100				\$21.75	\$0.00	
LONG SLEEVE with pocket T-SHIRT XXL+				\$24.75	\$0.00	
SHORT SLEEVE T-SHIRT NO pocket S-XL 5100				\$13.75	\$0.00	
SHORT SLEEVE T-SHIRT NO pocket XXL+				\$16.75	\$0.00	
LONG SLEEVE NO pocket T-SHIRT 6100				\$17.75	\$0.00	
LONG SLEEVE NO pocket T-SHIRT XXL+				\$20.75	\$0.00	
SHORT SLEEVE POLO SHIRT				\$0.00	\$0.00	
SHORT SLEEVE POLO SHIRT XXL+				\$0.00	\$0.00	
LONG SLEEVE POLO SHIRT				\$0.00	\$0.00	
LONG SLEEVE POLO XXL+				\$0.00	\$0.00	
SWEATPANT				\$0.00	\$0.00	
SWEATPANT XXL+				\$0.00	\$0.00	
HOOD/ZIP SWEATSHIRT F282				\$49.00	\$0.00	
HOOD/ZIP SWEATSHIRT XXL+				\$52.00	\$0.00	
CREWNECK SWEATSHIRT F280				\$39.00	\$0.00	
CREWNECK SWEATSHIRT XXL+				\$42.00	\$0.00	
ADDITIONAL ITEMS WE	QTY	SIZE	COLOR	COST	PRICE	
WILL CHECK FOR AVAILABILITY						
1/4 Zip Sweatshirt ST283 S-XL \$3.00 more for 2X				\$47.00		
Shorts ST310 S-XL \$3.00 more for 2X				\$18.00		
ADDITIONAL ITEMS OR NOTES:						

EMAIL TO: info@flagt.com Phone# 928-226-9800

FLFD PERSONNEL - BELOW IS YOUR ANNUAL ALOTMENT
IF YOU GO OVER ALOTMENT FlagT WILL CONTACT YOU FOR PAYMENT
Personnel: POC: \$72 OnDuty Staff: \$96 (including tax)

SUBTOTAL	\$0.00
TAX 8.3%	\$0.00
TOTAL	\$0.00