

INCOME WITHHOLDING FOR SUPP T

- ☐ ORIGINAL INCOME WITHHOLDING ORDER/NOTICE FOR SUPPORT (IWO)
☒ AMENDED IWO
☐ LUMP SUM PAYMENT
☐ TERMINATION of IWO

Date: 01/08/2014

☒ Child Support Enforcement (CSE) Agency ☐ Court ☐ Attorney ☐ Private Individual/Entity (Check One)
NOTE: This IWO must be regular on its face. Under certain circumstances you must reject this IWO and return it to the sender (see IWO instructions <http://www.acf.hhs.gov/programs/cse/newhire/employer/publication/publication.htm> - forms). If you receive this document from someone other than a State or Tribal CSE agency or a Court, a copy of the underlying order must be attached.

State/Tribe/Territory Ohio Remittance Identifier (include w/payment) [REDACTED]
 City/County/Dist./Tribe PICKAWAY COUNTY CSEA Order Identifier [REDACTED]
 Private Individual/Entity [REDACTED] CSE Agency Case Identifier [REDACTED]

CITY OF CIRCLEVILLE

Employer/Income Withholder's Name

104 E FRANKLIN ST

Employer/Income Withholder's Address

CIRCLEVILLE, OH 43113-1718

Employer/Income Withholder's FEIN 316400222

Bureau of Worker's Compensation Claim Number

Child(ren)'s Name(s) (Last, First, Middle)

Child(ren)'s Birth Date

07/19/2005

12/15/2003

06/23/2000

RE: DAVIS, DOUGLAS, A

Employee/Obligor's Name (Last, First, Middle)

Employee/Obligor's Social Security Number

Custodial Party/Obligee's Name (Last, First, Middle)

ORDER INFORMATION: This document is based on the support or withholding order from Ohio. You are required by law to deduct these amounts from the employee/obligor's income until further notice. See the **Additional Information** section for specific provisions of Ohio law.

\$563.31	Per MONTH current child support
\$0.00	Per MONTH past-due child support - Arrears greater than 12 weeks? ☐ yes ☒ no
\$0.00	Per MONTH current cash medical support.
\$0.00	Per MONTH past-due cash medical support
\$563.31	Per MONTH sub-total (for withholding from unemployment benefits ORC section 3121.07)
\$0.00	Per MONTH current spousal support
\$0.00	Per MONTH past-due spousal support
\$11.27	Per MONTH other (must specify) 2% process chrg & other obligations

for a Total Amount to Withhold of \$574.58 per MONTH.

AMOUNTS TO WITHHOLD: You do not have to vary your pay cycle to be in compliance with the Order Information. If your pay cycle does not match the ordered payment cycle, withhold one of the following amounts:

\$132.60 per weekly pay period \$287.29 per semimonthly pay period (twice a month)
 \$265.19 per biweekly pay period (every two weeks) \$574.58 per monthly pay period
 \$ Lump Sum Payment: Do not stop any existing IWO unless you receive a termination order.

REMITTANCE INFORMATION: If the employee/obligor's principal place of employment is Ohio, you must begin withholding no later than the first pay period that occurs 14 days after the date of 01-08-2014. Send Payment within 7 working days of the pay date. If you cannot withhold the full amount of support for any or all orders for this employee/obligor, withhold up to 50% of disposable income for all orders. See the **Additional Information** section for specific provisions of Ohio law. If the employee/obligor's

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Handwritten signature/initials

PICKAWAY COUNTY CSEA , Issuing Agency
110 ISLAND ROAD
P.O. BOX 610
CIRCLEVILLE OH 43113-0439

Telephone Number: (740) 474-5437
Toll Free Number: 1-800-822-5437
Fax Number: (740) 420-9945

City of Circleville HR

JAN 10 2014

RECEIVED

CITY OF CIRCLEVILLE
104 E FRANKLIN ST

CIRCLEVILLE OH 43113-1718

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Liability: If you have any doubts about the validity of this IWO, contact the sender. If you fail to withhold income from the employee/obligor's income as the IWO directs, you are liable for both the accumulated amount you should have withheld and any penalties set by State or Tribal law/procedure.

Anti-discrimination: You are subject to a fine determined under State or Tribal law for discharging an employee/obligor from employment, refusing to employ, or taking disciplinary action against an employee/obligor because of this IWO.

Withholding Limits: You may not withhold more than the lesser of: 1) the amounts allowed by the Federal Consumer Credit Protection Act (CCPA) (15 U.S.C. 1673(b)); or 2) the amounts allowed by the State or Tribe of the employee/obligor's principal place of employment (see REMITTANCE INFORMATION). Disposable income is the net income left after making mandatory deductions such as: State, Federal, local taxes; Social Security taxes; statutory pension contributions and Medicare taxes. The Federal limit is 50% of the disposable income if the obligor is supporting another family and 60% of the disposable income if the obligor is not supporting another family. However, those limits increase 5% - to 55% and 65% - if the arrears are greater than 12 weeks. If permitted by the State, you may deduct a fee for administrative costs. The combined support amount and fee may not exceed the limit indicated in this section. For Tribal IWOs, you may not withhold more than the amounts allowed under the law of the issuing Tribe. For Tribal employers/income withholders who receive a State IWO, you may not withhold more than the lesser of the limit set by the law of the jurisdiction in which the employer/income withholder is located or the maximum amount permitted under section 303(d) of the CCPA (15 U.S.C. 1673(b)). Depending upon applicable State law, you may need to also consider the amounts paid for health care premiums in determining disposable income and applying appropriate withholding limits.

Arrears greater than 12 weeks? If the *Order Information* does not indicate that the arrears are greater than 12 weeks, then the Employer should calculate the CCPA limit using the lower percentage.

OMB Expiration Date - 05/31/2014. The OMB Expiration Date has no bearing on the termination date of the IWO; it identifies the version of the form currently in use.

Additional Information:

ORDER INFORMATION: In accordance with Ohio Revised Code (ORC) section 3121.03, you are required to: Implement the withholding no later than the first pay period that occurs after 14 business days following the date the notice was mailed, and are required to continue the withholding at the intervals specified in the notice until further notice from the court or child support enforcement agency (CSEA); and send the amount withheld immediately but not later than 7 business days after the date the obligor is paid. Withholding under this order is binding until further notice from the court or CSEA.

PRIORITY: In accordance with ORC section 3121.034, except for deductions from lump sum payments made in accordance with section 3121.0311 of the Revised Code, withholding in accordance with this notice has priority over any other legal process under the law of this state against the same income.

WITHHOLDING LIMITS: In accordance with section 3121.037, you may not withhold an amount for support and other purposes, including the fee described below, that exceeds the maximum amounts permitted under section 303(b) of the "Consumer Credit Protection Act," 1673(b).

EMPLOYEE/OBLIGOR WITH MULTIPLE SUPPORT WITHHOLDINGS: In accordance with ORC section 3121.034, when two or more withholding notices are received by a payor, the payor shall comply with all of the requirements contained in the notices to the extent that the total amount withheld from the obligor's income does not exceed the maximum amount permitted under section 303(b) of the "Consumer Credit Protection Act," 1673(b), withhold amounts in accordance with the allocation set forth below, notify each court or CSEA that issued one of the notices of the allocation, and give priority to amounts designated in each notice as current support in the following manner:

- o If the total amounts designated in the notices as current support exceeds the amount available for withholding under section 303(b) of the "Consumer Credit Protection Act," 1673(b), the payor shall allocate to each notice an amount for current support equal to the amount designated in that notice as current support multiplied by a fraction in which the numerator is the amount of income available for withholding and the denominator is the total amount designated in all of the notices as current support.

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principal place of employment is not Ohio, obtain withholding limitations, state requirements, and any allowable employer fees at http://www.acf.hhs.gov/programs/cse/newhire/employer/contacts/contact_map.htm for the employee/obligor's principal place of employment.

For electronic payment requirements and centralized payment collection and disbursement facility information (State Disbursement Unit SDU), see http://www.acf.hhs.gov/programs/cse/newhire/employer/contacts/contact_map.htm

Include the **Remittance Identifier** with the payment and if necessary this FIPS code: 39129
Remit payment to SDU: Ohio Child Support Payment Central (CSPC) at P.O. Box 182394, Columbus, Ohio 43218-2394.

If you are an employer that employs more than 50 employees, please see the **Additional Information** section for specific provisions of Ohio law.

- ☐ **Return to Sender Completed by Employer/Income Withholder.** Payment must be directed to an SDU in accordance with 42 USC section 666(b)(5) and (b)(6) or Tribal Payee (see Payments to SDU below). If payment is not directed to an SDU/Tribal Payee or this IWO is not regular on its face, you *must* check this box and return the IWO to the sender.

Signature of Judge/Issuing Official (if required by State or Tribal law): <u>Not required by Ohio law</u> Print Name of Judge/Issuing Official: <u>LISA M LEACH</u> Title of Judge/Issuing Official: <u>Authorized Representative</u> Date of Signature: <u>01-09-2014</u>

If the employee/obligor works in a State or for a Tribe that is different from the State or Tribe that issued this order, a copy of this IWO must be provided to the employee/obligor.

- ☐ If checked, you are required to provide a copy of this form to the employee/obligor.

ADDITIONAL INFORMATION FOR EMPLOYERS AND OTHER INCOME WITHHOLDERS

State-specific contact and withholding information can be found on the Federal Employer Services website located at:

http://www.acf.hhs.gov/programs/cse/newhire/employer/contacts/contact_map.htm

Priority: Withholding for support has priority over any other legal process under State law against the same income (USC 42 section 666(b)(7)). If a Federal tax levy is in effect, please notify the sender. See the **Additional Information** section for specific provisions of Ohio law.

Combining Payments: When remitting payments to an SDU or Tribal CSE agency, you may combine withheld amounts from more than one employee/obligor's income in a single payment. You must, however, separately identify each employee/obligor's portion of the payment. See the **Additional Information** section for specific provisions of Ohio law.

Payments to SDU: Employer/income withholder must send child support payments payable by income withholding to the appropriate SDU. If this IWO instructs the employer/income withholder to send a payment to an entity other than an SDU (e.g., payable to the custodial party, court, or attorney), the employer/income withholder must check the box above and return this notice to the sender. Exception: If this IWO was sent by a Court, Attorney or Private Individual/Entity and the initial order was entered before January 1, 1994 or the order was issued by a Tribal CSE agency, the employer/income withholder must follow the payment instructions on this form.

Reporting the Pay Date: You must report the pay date when sending the payment. The pay date is the date on which the amount was withheld from the employee/obligor's wages. You must comply with the law of the State (or Tribal law if applicable) of the employee/obligor's principal place of employment regarding time periods within which you must implement the withholding and forward the support payments.

Multiple IWOs: If there is more than one IWO against this employee/obligor and you are unable to fully honor all IWOs due to Federal, State, or Tribal withholding limits, you must honor all IWOs to the greatest extent possible, giving priority to current support before payment of any past-due support. Follow the State or Tribal law/procedure of the employee/obligor's principal place of employment to determine the appropriate allocation method. See the **Additional Information** section for specific provisions of Ohio law.

Lump Sum Payments: You may be required to notify a State or Tribal CSE agency of upcoming lump sum payments to this employee/obligor such as bonuses, commissions, or severance pay. Contact the sender to determine if you are required to report and/or withhold. See the **Additional Information** section for specific provisions of Ohio law.

Employer's Name: CITY OF CIRCLEVILLE
Employee/Obligor's Name: DOUGLAS A DAVIS
Case Identifier: [REDACTED]

Employer FEIN: 316400222

Order Identifier: [REDACTED]

NOTIFICATION OF EMPLOYMENT TERMINATION OR INCOME STATUS: See the Additional Information

section for specific provisions of Ohio law. If this employee/obligor never worked for you or you are no longer withholding income for this employee/obligor, an employer must promptly notify the CSE agency and/or the sender by returning this form to the address listed in the Contact Information:

- ☐ This person has never worked for this employer or received periodic income.
☐ This person no longer works for this employer or receives periodic income.

Please provide the following information for the employee/obligor:

Termination date: _____ Last known phone number: _____

Date of birth: _____ Social Security number: _____

Last known address: _____

Final payment date to SDU/Tribal Payee: _____ Final payment amount: _____

New employer/income source's name (if known): _____

New employer/income source's telephone number (if known): _____

New employer/income source's address: _____

CONTACT INFORMATION

To employer: If the employer/income withholder has any questions, contact

LISA M LEACH _____ by phone at 1-800-822-5437, by fax at (740) 420-9945
by email or website at: _____

Send termination notice and other correspondence to:

PICKAWAY COUNTY CSEA
110 ISLAND ROAD
P.O. BOX 610
CIRCLEVILLE OH 43113-0439

To employee/obligor: If the employee/obligor has questions, contact

LISA M LEACH _____ by phone at 1-800-822-5437, by fax at (740) 420-9945
by email or website at: _____

IMPORTANT: The person completing this form is advised that the information may be shared with the employee/obligor.

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- o If the total of the amounts designated in the notices as current support does not exceed the amount available for withholding under section 303(b) of the "Consumer Credit Protection Act," 1673(b), the payor shall pay all of the amounts designated as current support in the notices and shall allocate to each notice an amount for past-due support equal to the amount designated in that notice as past-due support multiplied by a fraction in which the numerator is the amount of income remaining available for withholding after the payment of current support and the denominator is the total amount designated in all of the notices as past-due support.

EMPLOYERS WITH 50 OR MORE EMPLOYEES: In accordance with ORC section 3121.19, if you are an employer that employs more than 50 employees, you are required to submit withholding amounts to the state via electronic transfer and combine all of the payments to be forwarded in one payment. The payment shall clearly identify: each employee/obligor covered by the payment; each child support case number covered by the payment; and the portion of the payment attributable to each employee/obligor and case number.

COMBINING PAYMENTS: In accordance with ORC section 3121.20, a payor required to withhold a specified amount from the income of more than one obligor under a withholding notice and to forward the amounts withheld or deducted to the office of child support may combine all of the amounts to be forwarded in one payment if the payment is accompanied by a list that clearly identifies all of the following: Each obligor covered by the payment; each child support case, numbered as provided on the withholding or deduction notice, that is covered by the payment; and the portion of the payment attributable to each obligor and each case number.

LUMP SUM PAYMENTS: In accordance with ORC section 3121.037, no later than the earlier of 45 days before a lump sum payment is to be made or, if the obligor's right to the lump sum payment is determined less than 45 days before it is to be made, the date on which that determination is made, the payor notify the child support enforcement agency administering the support order of any lump sum payment of any kind of \$150 or more that is to be paid to the obligor, hold each lump sum payment of \$150 or more for 30 days after the date on which it would otherwise be paid to the obligor and, on order of the court or agency that issued the support order, pay all or a specified amount of the lump sum payment to the office of child support.

NOTIFICATION OF TERMINATION OF EMPLOYMENT: In accordance with ORC section 3121.037, you must promptly notify the CSEA administering the support order, in writing, within 10 business days after the date of any situation that occurs in which the payor ceases to pay income to the obligor in an amount sufficient to comply with the order, including termination of employment, layoff of the obligor from employment, any leave of absence of the obligor from employment without pay, termination of workers' compensation benefits, or termination of any pension, annuity, allowance, or retirement benefit. Include with the notification:

- o The obligor's last known address and telephone number; the obligor's date of birth, social security number, and case number; if known, the name, telephone number, and business address of any new employer or income source.
- o Identify any types of benefits other than personal earnings the obligor is receiving or is eligible to receive as a benefit of employment or as a result of the obligor's termination of employment, including, but not limited to, unemployment compensation, workers' compensation benefits, severance pay, sick leave, lump sum payments of retirement benefits or contributions, and bonuses or profit-sharing payments or distributions, and the amount of the benefits.

FEE: In accordance with ORC section 3121.18, a payor ordered to withhold a specified amount from the income of an employee under a withholding notice may deduct from the income of the person, in addition to the amount withheld for purposes of support, a fee of the greater of \$2 or an amount not exceeding 1% of the amount withheld as a charge for its services in complying with the withholding notice.

EFT: For EFT/EDI instructions, contact CSPC at 1-888-965-2676 or go to http://jfs.ohio.gov/OCS/employers/CSPC_Overview.stm#Employers

HEALTH INSURANCE DISCLOSURE INFORMATION

Date: 02/07/14

City of Circleville HR

FEB 10 2014

To: CITY OF CIRCLEVILLE
104 E FRANKLIN ST
CIRCLEVILLE, OH 43113-1718

RECEIVED

Re: Case# [REDACTED]
Obligor Name: DOUGLAS A. DAVIS
Obligor SSN: [REDACTED] DOB: 01/29/1980

To Whom It May Concern:

The Child Support Enforcement Agency is required by federal regulations and Ohio statutes to secure child support for children receiving Ohio Works First (OWF), and for children on whose behalf support enforcement services have been requested.

In order to assist the Agency in determining this person's ability to pay child support, please provide any information you may have on the above named individual whom we believe to be currently or previously employed with your company. This information is considered confidential and will be used solely for the purpose of enforcing a child support obligation. The information should be sent to my attention in the enclosed envelope. Your prompt attention to this matter is appreciated. Thank you.

LISA M. LEACH

Authorized Representative
PICKAWAY County CSEA
740-474-7588

*mailed
2-11-14*

HEALTH INSURANCE DISCLOSURE INFORMATION

City of Circleville HR

EMPLOYER USE ONLY

FEB 11 2014

RECEIVED

Enter the following information about the Employee

Name:

Douglas Davis

Case #:

Address:

City:

Name of Insurance Provider:

United Health Care of Ohio

Address:

P.O. BOX 30555

City:

SALT LAKE CITY

State:

UT

Zip Code:

84130-0555

Type of Insurance Coverage: ☐ Vision ☐ Dental ☒ Major Medical

Insurance Effective Date:

Jan. 29, 2014

Insurance Policy Number:

Group Number:

Presently Employed? Yes ☒ No ☐

Do you know where defendant is currently employed? Yes ☐ No ☐

Name of new employer:

Address:

City:

State:

Zip Code:

If insurance is not being provided by the employee is it available? Yes ☐ No ☐

Cost for Individual coverage? \$

\$ 150.69/mo

Cost for Family coverage? \$

421.92/mo

Are the following child(ren) currently covered on the employee's policy?

(Circle Yes or No)

07/19/2005 ☒ Yes ☐ No

Yes No

12/15/2003 ☒ Yes ☐ No

Yes No

06/23/2000 ☒ Yes ☐ No

Yes No

Yes No

Yes No

Yes No

Yes No

Yes No

Yes No

Contact person with your Company:

Name:

Valerie Dille

Phone:

740 477-8200

Title:

HR Assistant

Ext. 5055

INCOME WITHHOLDING FOR SUPPORT

- ☐ ORIGINAL INCOME WITHHOLDING ORDER/NOTICE FOR SUPPORT (IWO)
☒ AMENDED IWO
☐ LUMP SUM PAYMENT
☐ TERMINATION of IWO

Date: 01/09/2014

☒ Child Support Enforcement (CSE) Agency ☐ Court ☐ Attorney ☐ Private Individual/Entity (Check One)
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State/Tribe/Territory Ohio Remittance Identifier (include w/payment) [REDACTED]
 City/County/Dist./Tribe PICKAWAY COUNTY CSEA Order Identifier [REDACTED]
 Private Individual/Entity [REDACTED] CSE Agency Case Identifier [REDACTED]

CITY OF CIRCLEVILLE Employer/Income Withholder's Name	RE: DAVIS, DOUGLAS, A Employee/Obligor's Name (Last, First, Middle)
104 E FRANKLIN ST Employer/Income Withholder's Address	[REDACTED] Employee/Obligor's Social Security Number
CIRCLEVILLE, OH 43113-1718	[REDACTED] Custodial Party/Obligee's Name (Last, First, Middle)
Employer/Income Withholder's FEIN <u>316400222</u>	[REDACTED]
Bureau of Worker's Compensation Claim Number	
Child(ren)'s Name(s) (Last, First, Middle) <u>[REDACTED]</u> Child(ren)'s Birth Date <u>07/19/2005</u> <u>12/15/2003</u> <u>06/23/2000</u>	

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\$11.27	Per MONTH other (must specify) 2% process chrg & other obligations

for a Total Amount to Withhold of \$574.58 per MONTH.

AMOUNTS TO WITHHOLD: You do not have to vary your pay cycle to be in compliance with the Order Information. If your pay cycle does not match the ordered payment cycle, withhold one of the following amounts:

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REMITTANCE INFORMATION: If the employee/obligor's principal place of employment is Ohio, you must begin withholding no later than the first pay period that occurs 14 days after the date of 01-09-2014. Send Payment within 7 working days of the pay date. If you cannot withhold the full amount of support for any or all orders for this employee/obligor, withhold up to 50% of disposable income for all orders. See the **Additional Information** section for specific provisions of Ohio law. If the employee/obligor's

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[Handwritten signature]

PICKAWAY COUNTY CSEA , Issuing Agency
110 ISLAND ROAD
P.O. BOX 610
CIRCLEVILLE OH 43113-0439

Telephone Number: (740) 474-5437
Toll Free Number: 1-800-822-5437
Fax Number: (740) 420-9945

CITY OF CIRCLEVILLE
104 E FRANKLIN ST

CIRCLEVILLE OH 43113-1718

City of Circleville HR

JAN 14 2014

RECEIVED

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Liability: If you have any doubts about the validity of this IWO, contact the order. If you fail to withhold income from the employee/obligor's income as the IWO directs, you are liable for both the accumulated amount you should have withheld and any penalties set by State or Tribal law/procedure.

Anti-discrimination: You are subject to a fine determined under State or Tribal law for discharging an employee/obligor from employment, refusing to employ, or taking disciplinary action against an employee/obligor because of this IWO.

Withholding Limits: You may not withhold more than the lesser of: 1) the amounts allowed by the Federal Consumer Credit Protection Act (CCPA) (15 U.S.C. 1673(b)); or 2) the amounts allowed by the State or Tribe of the employee/obligor's principal place of employment (see REMITTANCE INFORMATION). Disposable income is the net income left after making mandatory deductions such as: State, Federal, local taxes; Social Security taxes; statutory pension contributions and Medicare taxes. The Federal limit is 50% of the disposable income if the obligor is supporting another family and 60% of the disposable income if the obligor is not supporting another family. However, those limits increase 5% - to 55% and 65% - if the arrears are greater than 12 weeks. If permitted by the State, you may deduct a fee for administrative costs. The combined support amount and fee may not exceed the limit indicated in this section. For Tribal IWOs, you may not withhold more than the amounts allowed under the law of the issuing Tribe. For Tribal employers/income withholders who receive a State IWO, you may not withhold more than the lesser of the limit set by the law of the jurisdiction in which the employer/income withholder is located or the maximum amount permitted under section 303(d) of the CCPA (15 U.S.C. 1673(b)). Depending upon applicable State law, you may need to also consider the amounts paid for health care premiums in determining disposable income and applying appropriate withholding limits.

Arrears greater than 12 weeks? If the *Order Information* does not indicate that the arrears are greater than 12 weeks, then the Employer should calculate the CCPA limit using the lower percentage.

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Additional Information:

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PRIORITY: In accordance with ORC section 3121.034, except for deductions from lump sum payments made in accordance with section 3121.0311 of the Revised Code, withholding in accordance with this notice has priority over any other legal process under the law of this state against the same income.

WITHHOLDING LIMITS: In accordance with section 3121.037, you may not withhold an amount for support and other purposes, including the fee described below, that exceeds the maximum amounts permitted under section 303(b) of the "Consumer Credit Protection Act," 1673(b).

EMPLOYEE/OBLIGOR WITH MULTIPLE SUPPORT WITHHOLDINGS: In accordance with ORC section 3121.034, when two or more withholding notices are received by a payor, the payor shall comply with all of the requirements contained in the notices to the extent that the total amount withheld from the obligor's income does not exceed the maximum amount permitted under section 303(b) of the "Consumer Credit Protection Act," 1673(b), withhold amounts in accordance with the allocation set forth below, notify each court or CSEA that issued one of the notices of the allocation, and give priority to amounts designated in each notice as current support in the following manner:

- o If the total amounts designated in the notices as current support exceeds the amount available for withholding under section 303(b) of the "Consumer Credit Protection Act," 1673(b), the payor shall allocate to each notice an amount for current support equal to the amount designated in that notice as current support multiplied by a fraction in which the numerator is the amount of income available for withholding and the denominator is the total amount designated in all of the notices as current support.

principal place of employment, not Ohio, obtain withholding limitations, the requirements, and any allowable employer fees at http://www.acf.hhs.gov/programs/cse/newhire/employer/contacts/contact_map.htm for the employee/obligor's principal place of employment.

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Include the **Remittance Identifier** with the payment and if necessary this FIPS code: 39129
Remit payment to SDU: Ohio Child Support Payment Central (CSPC) at P.O. Box 182394, Columbus, Ohio 43218-2394.

If you are an employer that employs more than 50 employees, please see the **Additional Information** section for specific provisions of Ohio law.

- ☐ **Return to Sender Completed by Employer/Income Withholder.** Payment must be directed to an SDU in accordance with 42 USC section 666(b)(5) and (b)(6) or Tribal Payee (see Payments to SDU below). If payment is not directed to an SDU/Tribal Payee or this IWO is not regular on its face, you *must* check this box and return the IWO to the sender.

Signature of Judge/Issuing Official (if required by State or Tribal law): <u>Not required by Ohio law</u>
Print Name of Judge/Issuing Official: <u>LISA M LEACH</u>
Title of Judge/Issuing Official: <u>Authorized Representative</u>
Date of Signature: <u>01-08-2014</u>

If the employee/obligor works in a State or for a Tribe that is different from the State or Tribe that issued this order, a copy of this IWO must be provided to the employee/obligor.

- ☐ If checked, you are required to provide a copy of this form to the employee/obligor.

ADDITIONAL INFORMATION FOR EMPLOYERS AND OTHER INCOME WITHHOLDERS

State-specific contact and withholding information can be found on the Federal Employer Services website located at:

http://www.acf.hhs.gov/programs/cse/newhire/employer/contacts/contact_map.htm

Priority: Withholding for support has priority over any other legal process under State law against the same income (USC 42 section 666(b)(7)). If a Federal tax levy is in effect, please notify the sender. *See the Additional Information section for specific provisions of Ohio law.*

Combining Payments: When remitting payments to an SDU or Tribal CSE agency, you may combine withheld amounts from more than one employee/obligor's income in a single payment. You must, however, separately identify each employee/obligor's portion of the payment. *See the Additional Information section for specific provisions of Ohio law.*

Payments to SDU: Employer/income withholder must send child support payments payable by income withholding to the appropriate SDU. If this IWO instructs the employer/income withholder to send a payment to an entity other than an SDU (e.g., payable to the custodial party, court, or attorney), the employer/income withholder must check the box above and return this notice to the sender. Exception: If this IWO was sent by a Court, Attorney or Private Individual/Entity and the initial order was entered before January 1, 1994 or the order was issued by a Tribal CSE agency, the employer/income withholder must follow the payment instructions on this form.

Reporting the Pay Date: You must report the pay date when sending the payment. The pay date is the date on which the amount was withheld from the employee/obligor's wages. You must comply with the law of the State (or Tribal law if applicable) of the employee/obligor's principal place of employment regarding time periods within which you must implement the withholding and forward the support payments.

Multiple IWOs: If there is more than one IWO against this employee/obligor and you are unable to fully honor all IWOs due to Federal, State, or Tribal withholding limits, you must honor all IWOs to the greatest extent possible, giving priority to current support before payment of any past-due support. Follow the State or Tribal law/procedure of the employee/obligor's principal place of employment to determine the appropriate allocation method. *See the Additional Information section for specific provisions of Ohio law.*

Lump Sum Payments: You may be required to notify a State or Tribal CSE agency of upcoming lump sum payments to this employee/obligor such as bonuses, commissions, or severance pay. Contact the sender to determine if you are required to report and/or withhold. *See the Additional Information section for specific provisions of Ohio law.*



Employer EIN: 316400222

Employee/Obligor's Name: DOUGLAS A DAVIS

Case Identifier:

Order Identifier:

NOTIFICATION OF EMPLOYMENT TERMINATION OR INCOME STATUS: See the *Additional Information* section for specific provisions of Ohio law. If this employee/obligor never worked for you or you are no longer withholding income for this employee/obligor, an employer must promptly notify the CSE agency and/or the sender by returning this form to the address listed in the Contact Information:

- ☐ This person has never worked for this employer or received periodic income.
☐ This person no longer works for this employer or receives periodic income.

Please provide the following information for the employee/obligor:

Termination date: _____ Last known phone number: _____

Date of birth: _____ Social Security number: _____

Last known address: _____

Final payment date to SDU/Tribal Payee: _____ Final payment amount: _____

New employer/income source's name (if known): _____

New employer/income source's telephone number (if known): _____

New employer/income source's address: _____

CONTACT INFORMATION

To employer: If the employer/income withholder has any questions, contact

LISA M LEACH by phone at 1-800-822-5437, by fax at (740) 420-9945

by email or website at: _____

Send termination notice and other correspondence to:

PICKAWAY COUNTY CSEA
110 ISLAND ROAD
P.O. BOX 610
CIRCLEVILLE OH 43113-0439

To employee/obligor: If the employee/obligor has questions, contact

LISA M LEACH by phone at 1-800-822-5437, by fax at (740) 420-9945

by email or website at: _____

IMPORTANT: The person completing this form is advised that the information may be shared with the employee/obligor.

0000000000X00071000600



000000000X00011000500

- o If the total of the amounts designated in the notices as current support does not exceed the amount available for withholding under section 303(b) of the "Consumer Credit Protection Act," 1673(b), the payor shall pay all of the amounts designated as current support in the notices and shall allocate to each notice an amount for past-due support equal to the amount designated in that notice as past-due support multiplied by a fraction in which the numerator is the amount of income remaining available for withholding after the payment of current support and the denominator is the total amount designated in all of the notices as past-due support.

EMPLOYERS WITH 50 OR MORE EMPLOYEES: In accordance with ORC section 3121.19, if you are an employer that employs more than 50 employees, you are required to submit withholding amounts to the state via electronic transfer and combine all of the payments to be forwarded in one payment. The payment shall clearly identify: each employee/obligor covered by the payment; each child support case number covered by the payment; and the portion of the payment attributable to each employee/obligor and case number.

COMBINING PAYMENTS: In accordance with ORC section 3121.20, a payor required to withhold a specified amount from the income of more than one obligor under a withholding notice and to forward the amounts withheld or deducted to the office of child support may combine all of the amounts to be forwarded in one payment if the payment is accompanied by a list that clearly identifies all of the following: Each obligor covered by the payment; each child support case, numbered as provided on the withholding or deduction notice, that is covered by the payment; and the portion of the payment attributable to each obligor and each case number.

LUMP SUM PAYMENTS: In accordance with ORC section 3121.037, no later than the earlier of 45 days before a lump sum payment is to be made or, if the obligor's right to the lump sum payment is determined less than 45 days before it is to be made, the date on which that determination is made, the payor notify the child support enforcement agency administering the support order of any lump sum payment of any kind of \$150 or more that is to be paid to the obligor, hold each lump sum payment of \$150 or more for 30 days after the date on which it would otherwise be paid to the obligor and, on order of the court or agency that issued the support order, pay all or a specified amount of the lump sum payment to the office of child support.

NOTIFICATION OF TERMINATION OF EMPLOYMENT: In accordance with ORC section 3121.037, you must promptly notify the CSEA administering the support order, in writing, within 10 business days after the date of any situation that occurs in which the payor ceases to pay income to the obligor in an amount sufficient to comply with the order, including termination of employment, layoff of the obligor from employment, any leave of absence of the obligor from employment without pay, termination of workers' compensation benefits, or termination of any pension, annuity, allowance, or retirement benefit. Include with the notification:

- o The obligor's last known address and telephone number; the obligor's date of birth, social security number, and case number; if known, the name, telephone number, and business address of any new employer or income source.
- o Identify any types of benefits other than personal earnings the obligor is receiving or is eligible to receive as a benefit of employment or as a result of the obligor's termination of employment, including, but not limited to, unemployment compensation, workers' compensation benefits, severance pay, sick leave, lump sum payments of retirement benefits or contributions, and bonuses or profit-sharing payments or distributions, and the amount of the benefits.

FEE: In accordance with ORC section 3121.18, a payor ordered to withhold a specified amount from the income of an employee under a withholding notice may deduct from the income of the person, in addition to the amount withheld for purposes of support, a fee of the greater of \$2 or an amount not exceeding 1% of the amount withheld as a charge for its services in complying with the withholding notice.

EFT: For EFT/EDI instructions, contact CSPC at 1-888-965-2676 or go to http://jfs.ohio.gov/OCS/employers/CSPC_Overview.stm#Employers

City of Circleville
EMPLOYEE CHANGE OF INFORMATION

City of Circleville HR

JUL 31 2014

RECEIVED



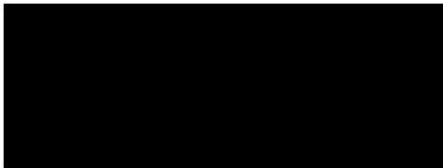
Complete retirement fund information on back of this form and return form to Human Resources.

Employee Name DOUGLAS A. DAVIS

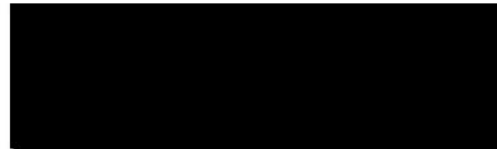


Change of Address

From



To



Is new address inside municipal boundaries?

YES

☐

NO

☒

What school district is new address located in?

CIRCLEVILLE

☐

Change of Telephone Number

From

To

☐

Change of Name

From

To

This change is effective

7/29/14

Emergency Contact:



Phone



cc:

Auditor's Office

7-31-14

HR
Revised 7/2008

HR Checklist	
<u>7-31-14</u>	Health updated
<u>7-31-14</u>	Dental updated
<u>7-31-14</u>	VSP updated
<u>7-31-14</u>	HR File updated
<u>7-31-14</u>	Retirement updated

City of Circleville
EMPLOYEE CHANGE OF INFORMATION

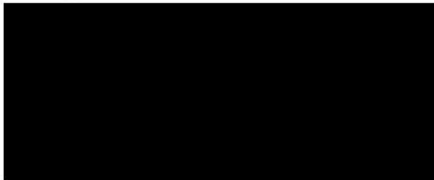


Complete retirement fund information on back of this form and return form to Human Resources.

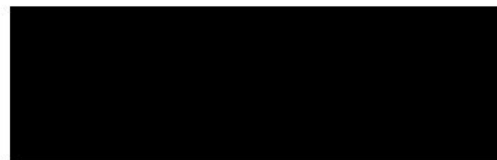
Employee Name DOUGLAS A. DAVIS

☒ Change of Address

From



To



Is new address inside municipal boundaries?

YES ☐ NO ☒

What school district is new address located in?

CIRCLEVILLE

☐ Change of Telephone Number

From _____

To _____

☐ Change of Name

From _____

To _____

This change is effective 7/29/14

Emergency Contact: _____

Phone _____

cc: Auditor's Office

HR
Revised 7/2008

HR Checklist

_____	Health updated
_____	Dental updated
_____	VSP updated
_____	HR File updated
_____	Retirement updated



Ohio Police & Fire Pension Fund
140 East Town Street
Columbus, OH 43215
Phone: 888-864-8363
Fax: (614) 628-1777
www.op-f.org

CHANGE OF ADDRESS

Use this form to change your address on file with the Ohio Police and Fire Pension Fund (OP&F). OP&F cannot accept address changes by phone or e-mail.

If you are receiving your pension benefit or division of property order (DPO) payment by mail, OP&F must receive and process your change of address by the 15th of the month in order for the following month's pension or DPO payment to be sent to your new address.

If you are a guardian or power of attorney for an OP&F member, please ensure that OP&F has a copy of the appropriate documents on file. Changes can only be made after review and approval of these documents.

Your signature and Social Security number are required to process your change of address.

Send your completed form to:

Ohio Police & Fire Pension Fund
140 East Town Street
Columbus, Ohio 43215-5164

You may also fax your completed form to:

(614) 628-1777

Section A — Member information

Name: first, middle, last, suffix (Jr., III, etc.)

DOUGLAS ALAN DAVIS

- ☒ Police officer
☐ Firefighter

Social Security number

Street / P.O. box

Date of birth

01 29 1980

E-mail address

☐ New

Home telephone

☐ New

Alternate telephone

☐ New

☐ Yes ☒ No Is this a temporary address? (Start date: _____ /stop date: _____)

Please check all that apply to you:

- ☒ Active member (Employer name: CITY OF CLEVELAND)
☐ Retired member
☐ Survivor benefit recipient
☐ Deferred Retirement Option Plan (DROP) participant
☐ Re-employed retiree in public sector
☐ Alternate payee / Division of Property Order (DPO)
☐ Former member

Section B — Signature and acknowledgement

By my signature, I authorize OP&F to change my address.

Member's signature/power of attorney or guardian

Date of signature



7/29/14

**The Finder
School District Income Tax**

The Finder > School District Income Tax > Lookup By Address > Results

ESSPRODWEB01

Lookup By Address

The system has successfully matched the address you entered:

Input Address (Modify)	Found Address
Address: [REDACTED]	Address: [REDACTED]
Suite, Apt, Lot: [REDACTED]	Suite, Apt, Lot: [REDACTED]
City: [REDACTED]	City: [REDACTED]
State: [REDACTED]	State: [REDACTED]
Zip Code: [REDACTED]	Zip Code: [REDACTED]
	Physical City: [REDACTED]

**School District Income Tax
Year: 2014**

School District Name:	CIRCLEVILLE CSD
School District Number:	6501
Income Tax Rate:	0.75%
Department of Education Number:	043760

Note: Do not use the Department of Education's school district number when filing your Ohio income tax or employer withholding tax returns.

Reference Number: [REDACTED]

Please note that this system does not provide information on municipal income taxes that may apply in portions of townships within a joint economic development district ("JEDD") or a joint economic development zone ("JEDZ"). Neither the State of Ohio nor the Ohio Department of Taxation assumes any liability for any errors or omissions in the data provided by this system, or in any other respect. That said, if a school district income tax filing error occurs because of incorrect information provided by this system, the Department of Taxation will waive the penalty that would have been imposed based on school district income tax liability. On the other hand, the Ohio Department of Taxation cannot waive additional tax or interest that results from such errors, and penalties imposed by a municipality must be resolved with the appropriate taxing authority.

After receiving tax jurisdiction information for your address in The Finder, it is a good idea to verify this information with the appropriate municipality or county auditor even if no tax liability is indicated. If you feel there is an error or have questions regarding the information you have received, please e-mail the Department of Taxation at TheFinderHelp@tax.state.oh.us. Please refer to the reference number 0714-300590 displayed on this page.

[The Finder](#) | [Contact Us](#) | [Exit](#) | [Privacy Policy](#)

Controlled Substance and / or Alcohol Test Notification

You've Been Randomly Selected for Testing

Company
City of Circleville Police - BG (ind)

Type of Test(s)
Controlled Substance

Employee
Davis, Douglas

Location of Testing Facility
Berger Health Systems
Clyde I. Deffenbaugh Occupational Health Center
1434 Circleville Plaza Drive
Circleville, OH 43113
740-420-6133

City of Circleville HR

MAR 26 2014

RECEIVED

49 CFR 382.113-NOTIFICATION REQUIREMENTS

Before Performing an Alcohol or Controlled Substance test under this part, each employer shall notify a driver/employee that the alcohol and/or controlled substance test is required by this part.

Compliance is Mandatory

You are hereby notified that you must submit to the above listed test(s) in compliance with the Federal Regulations. Pursuant to those regulations, YOU MUST PROCEED DIRECTLY AND IMMEDIATELY to the testing site listed above.

SPECIAL INSTRUCTIONS TO DRIVER:

Present this notice with your photo I.D. to clinic staff and please cooperate with clinic staff at all times.

SPECIAL INSTRUCTIONS TO COMPANY:

If driver/employee fails to comply with 49 CFR 382, notify your program administrator for instructions.

Declaration of Agreement

I understand, as a condition of my membership, compliance with the above scheduled test(s) is required.

Mon. 4/28/14 before 330pm
Expected Testing Date

Employee Signature

4/28/14
Date / Time Notified

Valerie Dillee
Company Representative Signature

4/28/14
Date / Time Notified

This area is reserved for clinic use only . . .

ID Presented

Date Tested

Clinic Notes

City of Circleville

Employee Emergency Contact Information



Employee - Please complete the following information to the best of your knowledge.
This information shall only be released in the event of a true emergency and held as confidential medical information.

PERSONAL INFORMATION

Name (full legal name): DOUGLAS ALAN DAVIS
Address (with City, State and Zip): [REDACTED]
Telephone Number (area code): N/A Cell Number (area code): [REDACTED]
Social Security Number: [REDACTED] Date of Birth: 01-29-1980

MEDICAL INFORMATION

Are you covered under the City's medical insurance? If so, please circle type. Single Double Family
Are you covered under the City's dental insurance? If so, please circle type. Single Double Family
Are you covered under the City's vision insurance? If so, please circle type. Single Double Family
List any medication you are allergic to: _____
Do you have any known medical conditions? (asthma, diabetes, etc.) _____

EMERGENCY CONTACT INFORMATION

Name of Spouse: _____ Day Phone: _____ Cell Phone: _____
Day Address: _____

If your spouse can not be reached, who should be notified in case of an emergency?

Name: [REDACTED] Day Phone: _____ Cell Phone: [REDACTED]
Address: [REDACTED]
Name: [REDACTED] Day Phone: _____ Cell Phone: [REDACTED]
Address: [REDACTED]

City of Circleville

New Employee Checklist (to be completed by the HR Office.)

City of Circleville HR

JAN 02 2014



Douglas Davis
Employee Name
Officer
Title

12-29-13
Date of Hire
Police
Department

RECEIVED
Employee #

- ☒ Employee Data Form
- ☒ Retirement Personal History Record Type OP&F Date P&F Medical & Appointment Letter Mailed _____
- ☒ Social Security statement (submit w/retirement record)
- ☒ W-4 (Federal Withholding)
- ☒ W-2 (State of Ohio Withholding)
- ☒ I-9 (Employment Eligibility Verification) Copy of drivers license ☒ AND Copy of SS Card/birth cert./passport ☒
- ☒ New Hire Reporting Form 7048 Date filed (online) 1-2-2014
- ☒ Direct Deposit Form (mandatory) with banking information
- ☐ OBMV Record Request (mandatory)
- ☒ Medical Insurance Enrollment Application (UHC)
Date submitted 1-2-14 Effective 1-29-14 Type Emp+Children
- ☒ Dental Insurance Enrollment Application (PRINCIPAL)
Date submitted 1-2-14 Effective 1-29-14 Type Family
- ☒ Life Insurance Enrollment Application (PRINCIPAL)
Date submitted 1-2-14 Effective 12-29-14 Term ☒ VTL _____
- ☒ Vision Enrollment Application (VSP)
Date submitted 1-2-14 Effective 2-1-14 Type Family
- ☒ FLSA Exemption Certification (if applicable)
- ☒ Union Deduction Form (if applicable) _____
- ☒ Credit Card Authorization and Use Agreement
- ☒ Ohio Auditor of State Fraud Reporting Acknowledgment
- ☒ YMCA Membership Form (voluntary)
- ☒ Job Description (to be signed by employee and filed)
- ☒ Homeland Security Form
- ☐ Deferred Comp. Election Form (voluntary) Wants to speak to rep on Jan 8th
- ☒ Handbook Acknowledgement Form
- ☒ Insurance Rate Form
- ☒ Appointment Letter
- ☒ Added to HR address list
- ☐ Employee Info Email (includes: handbook, PPM, Union Contract -- if applicable -- and Insurance Booklets)
- ☐ Email Address DDavis@Circlevillepolice.com New Hire Packet submitted to Auditor 1-2-14

Form W-4 (2013)

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 2013 expires February 17, 2014. See Pub. 505, Tax Withholding and Estimated Tax.

Note. If another person can claim you as a dependent on his or her tax return, you cannot claim exemption from withholding if your income exceeds \$1,000 and includes more than \$350 of unearned income (for example, interest and dividends).

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

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

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

Tax credits. You can take projected tax credits into account in figuring your allowable number of withholding allowances. Credits for child or dependent care expenses and the child tax credit may be claimed using the **Personal Allowances Worksheet** below. See Pub. 505 for information on converting your other credits into withholding allowances.

Nonwage income. If you have a large amount of nonwage income, such as interest or dividends, consider making estimated tax payments using Form 1040-ES, Estimated Tax for Individuals. Otherwise, you may owe additional tax. If you have pension or annuity

income, see Pub. 505 to find out if you should adjust your withholding on Form W-4 or W-4P.

Two earners or multiple jobs. If you have a working spouse or more than one job, figure the total number of allowances you are entitled to claim on all jobs using worksheets from only one Form W-4. Your withholding usually will be most accurate when all allowances are claimed on the Form W-4 for the highest paying job and zero allowances are claimed on the others. See Pub. 505 for details.

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

Check your withholding. After your Form W-4 takes effect, use Pub. 505 to see how the amount you are having withheld compares to your projected total tax for 2013. See Pub. 505, especially if your earnings exceed \$130,000 (Single) or \$180,000 (Married).

Future developments. Information about any future developments affecting Form W-4 (such as legislation enacted after we release it) will be posted at www.irs.gov/w4.

Personal Allowances Worksheet (Keep for your records.)

A	Enter "1" for yourself if no one else can claim you as a dependent	A	<u>0</u>
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	<u>0</u>
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	<u>0</u>
D	Enter number of dependents (other than your spouse or yourself) you will claim on your tax return	D	<u>0</u>
E	Enter "1" if you will file as head of household on your tax return (see conditions under Head of household above)	E	<u>0</u>
F	Enter "1" if you have at least \$1,900 of child or dependent care expenses for which you plan to claim a credit	F	<u>0</u>
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 \$65,000 (\$95,000 if married), enter "2" for each eligible child; then less "1" if you have three to six eligible children or less "2" if you have seven or more eligible children. • If your total income will be between \$65,000 and \$84,000 (\$95,000 and \$119,000 if married), enter "1" for each eligible child	G	<u>0</u>
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	<u>0</u>

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 are single and have more than one job or are married and you and your spouse both work and the combined earnings from all jobs exceed \$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.

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

Form W-4 Department of the Treasury Internal Revenue Service		Employee's Withholding Allowance Certificate		OMB No. 1545-0074
▶ 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.		2013		
1 Your first name and middle initial DOUGLAS A	Last name DAVIS	2 Your social security number [REDACTED]		
Home address (number and street or rural route) [REDACTED]		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.		
		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 <u>0</u>		
6 Additional amount, if any, you want withheld from each paycheck		6 \$ <u>0</u>		
7 I claim exemption from withholding for 2013, 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 <u>0</u>		
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.) ▶ <i>Douglas A Davis</i>		Date ▶ <u>12/29/13</u>		
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)
City of Circleville, 104 E. Franklin Street, Circleville, OH 43113				31-6400222

For Privacy Act and Paperwork Reduction Act Notice, see page 2. Cat. No. 10220Q Form W-4 (2013)

Notice to Employee

1. For state purposes, an individual may claim only natural dependency exemptions. This includes the taxpayer, spouse and each dependent. Dependents are the same as defined in the Internal Revenue Code and as claimed in the taxpayer's federal income tax return for the taxable year for which the taxpayer would have been permitted to claim had the taxpayer filed such a return.

2. You may file a new certificate at any time if the number of your exemptions **increases**.

You must file a new certificate within 10 days if the number of exemptions previously claimed by you **decreases** because:

- (a) Your spouse for whom you have been claiming exemption is divorced or legally separated, or claims her (or his) own exemption on a separate certificate.
- (b) The support of a dependent for whom you claimed exemption is taken over by someone else.
- (c) You find that a dependent for whom you claimed exemption must be dropped for federal purposes.

The death of a spouse or a dependent does not affect your withholding until the next year but requires the filing of a new certificate. If possible, file a new certificate by Dec. 1st of the year in which the death occurs.

For further information, consult the Ohio Department of Taxation, Personal and School District Income Tax Division, or your employer.

3. If you expect to owe more Ohio income tax than will be withheld, you may claim a smaller number of exemptions; or under an agreement with your employer, you may have an additional amount withheld each pay period.

4. A married couple with both spouses working and filing a joint return will, in many cases, be required to file an individual estimated income tax form IT 1040ES even though Ohio income tax is being withheld from their wages. This result may occur because the tax on their combined income will be greater than the sum of the taxes withheld from the husband's wages and the wife's wages. This requirement to file an individual estimated income tax form IT 1040ES may also apply to an individual who has two jobs, both of which are subject to withholding. In lieu of filing the individual estimated income tax form IT 1040ES, the individual may provide for additional withholding with his employer by using line 5.

✂ please detach here

Ohio

Department of
Taxation

Employee's Withholding Exemption Certificate

IT 4
Rev. 5/07

Print full name DOUGLAS ALAN DAVIS Social Security number [REDACTED]

Home address and ZIP code [REDACTED]

Public school district of residence [REDACTED] School district no. 7107
(See *The Finder* at tax.ohio.gov.)

1. Personal exemption for yourself, enter "1" if claimed	<u>0</u>
2. If married, personal exemption for your spouse if not separately claimed (enter "1" if claimed)	<u>0</u>
3. Exemptions for dependents	<u>0</u>
4. Add the exemptions that you have claimed above and enter total	<u>0</u>
5. Additional withholding per pay period under agreement with employer	\$ <u>0</u>

Under the penalties of perjury, I certify that the number of exemptions claimed on this certificate does not exceed the number to which I am entitled.

Signature Douglas A. Davis Date 12/29/13

**The Finder
School District Income Tax**

The Finder > School District Income Tax > Lookup By Address > Results

ESSPRODWEB02

Lookup By Address

The system has successfully matched the address you entered:

Input Address (Modify)		Found Address	
Address:		Address:	
Suite, Apt, Lot:		Suite, Apt, Lot:	
City:		City:	
State:		State:	
Zip Code:		Zip Code:	
		Physical City:	

**School District Income Tax
Year: 2014**

? School District Name:	ZANE TRACE LSD
? School District Number:	7107
? Income Tax Rate:	0.00%
? Department of Education Number:	049544

Note: Do not use the Department of Education's school district number when filing your Ohio income tax or employer withholding tax returns.

Reference Number: [REDACTED] ?

[Enter New Address/Year](#) ?

Please note that this system does not provide information on municipal income taxes that may apply in portions of townships within a joint economic development district ("JEDD") or a joint economic development zone ("JEDZ"). Neither the State of Ohio nor the Ohio Department of Taxation assumes any liability for any errors or omissions in the data provided by this system, or in any other respect. That said, if a school district income tax filing error occurs because of incorrect information provided by this system, the Department of Taxation will waive the penalty that would have been imposed based on school district income tax liability. On the other hand, the Ohio Department of Taxation cannot waive additional tax or interest that results from such errors, and penalties imposed by a municipality must be resolved with the appropriate taxing authority. After receiving tax jurisdiction information for your address in The Finder, it is a good idea to verify this information with the appropriate municipality or county auditor even if no tax liability is indicated. If you feel there is an error or have questions regarding the information you have received, please e-mail the Department of Taxation at TheFinderHelp@tax.state.oh.us. Please refer to the reference number 0114-19703 displayed on this page.

[The Finder](#) | [Contact Us](#) | [Exit](#) | [Privacy Policy](#)

Statement Concerning Your Employment in a Job Not Covered by Social Security

Employee Name DOUGLAS A. DAVIS Employee ID# 3000-260
Employer Name City of Circleville Employer ID# 31-6400222

Your earnings from this job are not covered under Social Security. When you retire, or if you become disabled, you may receive a pension based on earnings from this job. If you do, and you are also entitled to a benefit from Social Security based on either your own work or the work of your husband or wife, or former husband or wife, your pension may affect the amount of the Social Security benefit you receive. Your Medicare benefits, however, will not be affected. Under the Social Security law, there are two ways your Social Security benefit amount may be affected.

Windfall Elimination Provision

Under the Windfall Elimination Provision, your Social Security retirement or disability benefit is figured using a modified formula when you are also entitled to a pension from a job where you did not pay Social Security tax. As a result, you will receive a lower Social Security benefit than if you were not entitled to a pension from this job. For example, if you are age 62 in 2013, the maximum monthly reduction in your Social Security benefit as a result of this provision is \$395.50. This amount is updated annually. This provision reduces, but does not totally eliminate, your Social Security benefit. For additional information, please refer to Social Security Publication, "Windfall Elimination Provision."

Government Pension Offset Provision

Under the Government Pension Offset Provision, any Social Security spouse or widow(er) benefit to which you become entitled will be offset if you also receive a Federal, State or local government pension based on work where you did not pay Social Security tax. The offset reduces the amount of your Social Security spouse or widow(er) benefit by two-thirds of the amount of your pension.

For example, if you get a monthly pension of \$600 based on earnings that are not covered under Social Security, two-thirds of that amount, \$400, is used to offset your Social Security spouse or widow(er) benefit. If you are eligible for a \$500 widow(er) benefit, you will receive \$100 per month from Social Security (\$500 - \$400=\$100). Even if your pension is high enough to totally offset your spouse or widow(er) Social Security benefit, you are still eligible for Medicare at age 65. For additional information, please refer to Social Security Publication, "Government Pension Offset."

For More Information

Social Security publications and additional information, including information about exceptions to each provision, are available at www.socialsecurity.gov. You may also call toll free 1-800-772-1213, or for the deaf or hard of hearing call the TTY number 1-800-325-0778, or contact your local Social Security office.

I certify that I have received Form SSA-1945 that contains information about the possible effects of the Windfall Elimination Provision and the Government Pension Offset Provision on my potential future Social Security Benefits.

Signature of Employee



Date 12/29/13

Union New Hire Reporting

Ohio Revised Code section 3121.89 to 3121.8910 requires all Ohio employers, both public and private, to report all contractors and newly hired, rehired, or returning to work employees to the state of Ohio within 20 days of the contract, hire, or rehire date. Information about new hire reporting and online reporting is available on our website: www.oh-newhire.com

Send completed forms to:
Ohio New Hire Reporting Center
PO Box 15309
Columbus, OH 43215-0309
Fax: (614) 221-7088 or toll-free fax (888) 872-1611

To ensure the highest level of accuracy, please print neatly in capital letters and avoid contact with the edges of the boxes. The following will serve as an example:

A	B	C	1	2	3
---	---	---	---	---	---

EMPLOYER INFORMATION

Federal Employer ID Number (FEIN) (Please use the same FEIN as the listed employee's quarterly wages will be reported under):

		31-6400222			
--	--	------------	--	--	--

Employer Name:

								CITY OF CIRCLEVILLE									
--	--	--	--	--	--	--	--	---------------------	--	--	--	--	--	--	--	--	--

Employer Address (Please indicate the address where the Income Withholding Orders should be sent).

[illegible][illegible]

Employer City: _____ Employer State: _____ Zip Code (5 digit): _____

			CIRCLEVILLE			
--	--	--	-------------	--	--	--

OH		43113	
----	--	-------	--

Employer Phone (optional):

Extension:

Employer Fax (optional):

[illegible][illegible]

EMPLOYEE OR CONTRACTOR INFORMATION

Social Security Number (SSN) ☐ (Check here if using FEIN for the Contractor)

State of Hire:

O	H
---	---

First Name:

Middle Initial:

D	O	U	G	L	A	S
---	---	---	---	---	---	---

A

Last Name:

D	A	V	I	S
---	---	---	---	---

Address:

[illegible]

City:

State:

Zip Code (5 digit):

QIV.

O	H
---	---

Date of Hire:

Date of Birth:

Is this a Contractor?

1	2	2	9	1	3
---	---	---	---	---	---

0	1	2	9	8	0
---	---	---	---	---	---

Yes ☐ No ☒

Date payments will begin for Contractor:

Length of time the Contractor will be performing services:

--	--	--	--	--	--

months

REPORTS WILL NOT BE PROCESSED IF REQUIRED INFORMATION IS MISSING

City of Circleville

DIRECT DEPOSIT AUTHORIZATION FORM



I hereby authorize, CITY OF CIRCLEVILLE, to initiate credit entries to my account(s) indicated below for recurring payroll transactions. I understand that if corrections in the credit amount are necessary, it may involve an adjustment (credit or debit) to my account. This authority is to remain in full force and effect until written notification from me of its termination in such time in such manner as to allow my employer reasonable time to act on it.

(please print)

Name: DOUGLAS A. DAVIS

Social Security Number: [REDACTED]

Complete below and attach a voided check.

Bank Name: [REDACTED]

Checking Account Number: [REDACTED]

Routing Transit Number: [REDACTED]

Signature: *Doug A Davis* Date: 12/29/13

719

DATE _____

PAY TO THE ORDER OF _____ \$ HHH

VOID

DOLLARS

The Savings Bank
SmartBanking
www.thesavingsbankcircleville.com
1-800-582-2265 • Member FDIC

SMARTCLUB

MEMO _____

MP

Dir _____

Eff. 3/2005

CITY OF CIRCLEVILLE

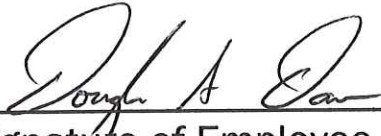
OPBA MEMBERSHIP DEDUCTION FORM

All employees whose position falls within the bargaining unit are allowed membership in the Ohio Patrolmen's Benevolent Association. Union dues are payroll deducted on a monthly basis. All members of the bargaining unit shall (1) maintain their membership in the OPBA, (2) become members of the OPBA, or (3) pay a service fee to the OPBA in an amount determined by the OPBA, in accordance with ORC Section 4117.09.

DOUGLAS A. DAVIS
Name of Employee (Printed)

Amount of Deduction

- ☒ New Employee Authorization of Membership
- ☐ New Employee Refusal of Membership/Fair Share Fee Only
- ☐ Established Employees Authorization for Membership
- ☐ Revoking OPBA Membership/Fair Share Fee Only


Signature of Employee

12/29/13
Date

City of Circleville

Credit Card Authorization and Use Agreement
(Reference Policy A42)

Auditor Use Only

Date: _____ Amount Approved: _____

Auditor's Signature: _____



To be completed by the cardholder (employee) and his/her Department Head and forwarded to the Auditor for approval.

Employee Name: DOUGLAS A. DAVIS

Department: POLICE DEPARTMENT

Type of Credit Card: _____

Credit Card Number: _____

I understand that improper use of this card may result in disciplinary action, as outlined in the employee handbook, as well as personal liability for any improper purchases. As a cardholder, I agree to comply with the terms and conditions of this agreement, including the Credit Card Policy(A42).

I acknowledge receipt of the agreement and Policy A42 and confirm that I have read and understand the terms and conditions. I understand that by using this card, I will be making financial commitments on behalf of the City of Circleville and that the City will be liable for all charges made on this card. .

I will strive to obtain the best value for the City when purchasing merchandise and/or services with this card.

As a holder of the City credit card, I agree to accept the responsibility and accountability for the protection and proper use of the card, as enumerated above. I will return the card to the department head, upon request, during the period of my employment. I further agree to return the card upon termination of employment. I understand that the card is not to be used for personal purchases. If the card is used for personal purchases or for purchases for any other entity, the City will be entitled to reimbursement from me of such purchase(s). The City shall be entitled to pursue legal action, if required, to recover the cost of such purchase(s).

Employee Signature: 

Date: 12/29/13

Department Head Signature: _____

Date: _____

cc: HR Personnel File

Form A42

Ohio Auditor of State Fraud Hotline Acknowledgment

The Ohio Auditor of State's office maintains a system for the reporting of fraud, including misuse of public money by an official or office. The system allows all Ohio citizens, including public employees, the opportunity to make anonymous complaints through a toll free number, the Auditor of State's website, or through the United States mail.

Auditor of State's fraud contact information:

Telephone: 1+866-FRAUD OH (1-866-372-8364)

US Mail: Ohio Auditor of State's Office

Special Investigations Unit

88 East Broad Street

PO Box 1140

Columbus OH 43215

Web: www.ohioauditor.gov

Acknowledgement of receipt of Auditor of State fraud reporting system information

Pursuant to Ohio Revised Code 117.103(B)(1), a public office shall provide information about the Ohio fraud-reporting system and the means of reporting fraud to each new employee upon employment with the public office.

Each new employee has thirty days after beginning employment to confirm receipt of this information.

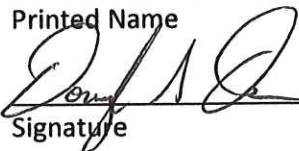
By signing below you are acknowledging the City of Circleville, Ohio provided you information about the fraud-reporting system as described by Section 117.103(A) of the Revised Code, and that you read and understand the information provided. You are also acknowledging you have received and read the information regarding Section 124.341 of the Revised Code and the protections you are provided as a classified or unclassified employee if you use the before-mentioned fraud reporting system.

I, DOUGLAS A. DAVIS, have read the information provide by my employer regarding the fraud-reporting system operated by the Ohio Auditor of State's office. I further state that the undersigned signature acknowledges receipt of this information.

DOUGLAS A. DAVIS
Printed Name

Police Officer
Title

Circleville Police Dept
Department


Signature

12/29/13
Date



Ohio Department of Public Safety
DIVISION OF HOMELAND SECURITY
<http://www.homelandsecurity.ohio.gov>

PUBLIC EMPLOYMENT

In accordance with section 2909.34 of the Ohio Revised Code

DECLARATION REGARDING MATERIAL ASSISTANCE/NO ASSISTANCE TO A TERRORIST ORGANIZATION

This form serves as a declaration of the provision of material assistance to a terrorist organization or organization that supports terrorism as identified by the U.S. Department of State Terrorist Exclusion List (see the Ohio Homeland Security Division Web site for the Terrorist Exclusion List).

Any answer of "yes" to any question, or the failure to answer "no" to any question on this declaration shall serve as a disclosure that material assistance to an organization identified on the U.S. Department of State Terrorist Exclusion List has been provided. Failure to disclose the provision of material assistance to such an organization or knowingly making false statements regarding material assistance to such an organization is a felony of the fifth degree.

For the purposes of this declaration, "material support or resources" means currency, payment instruments, other financial securities, funds, transfer of funds, and financial services that are in excess of one hundred dollars, as well as communications, lodging, training, safe houses, false documentation or identification, communications equipment, facilities, weapons, lethal substances, explosives, personnel, transportation, and other physical assets, except medicine or religious materials.

LAST NAME DAVIS		FIRST NAME DOUGLAS		MIDDLE INITIAL A.	
HOME ADDRESS [REDACTED]					
CITY [REDACTED]		STATE OH	ZIP [REDACTED]	COUNTY [REDACTED]	
HOME PHONE [REDACTED]			WORK PHONE (740) 474-8888		

DECLARATION

In accordance with section 2909.32 (A)(2)(b) of the Ohio Revised Code

For each question, indicate either "yes," or "no" in the space provided. Responses must be truthful to the best of your knowledge.

1. Are you a member of an organization on the U.S. Department of State Terrorist Exclusion List? ☐ Yes ☒ No
2. Have you used any position of prominence you have with any country to persuade others to support an organization on the U.S. Department of State Terrorist Exclusion List? ☐ Yes ☒ No
3. Have you knowingly solicited funds or other things of value for an organization on the U.S. Department of State Terrorist Exclusion List? ☐ Yes ☒ No
4. Have you solicited any individual for membership in an organization on the U.S. Department of State Terrorist Exclusion List? ☐ Yes ☒ No
5. Have you committed an act that you know, or reasonably should have known, affords "material support or resources" to an organization on the U.S. Department of State Terrorist Exclusion List? ☐ Yes ☒ No
6. Have you hired or compensated a person you knew to be a member of an organization on the U.S. Department of State Terrorist Exclusion List, or a person you knew to be engaged in planning, assisting, or carrying out an act of terrorism? ☐ Yes ☒ No

In the event of a denial of licensure due to a positive indication that material assistance has been provided to a terrorist organization, or an organization that supports terrorism as identified by the U.S. Department of State Terrorist Exclusion List, a review of the denial may be requested. The request must be sent to the Ohio Department of Public Safety's Division of Homeland Security. The request forms and instructions for filing can be found on the Ohio Homeland Security Division Web site.

CERTIFICATION

I hereby certify that the answers I have made to all of the questions on this declaration are true to the best of my knowledge. I understand that if this declaration is not completed in its entirety, it will not be processed and I will be automatically disqualified. I understand that I am responsible for the correctness of this declaration. I understand that failure to disclose the provision of material assistance to an organization identified on the U.S. Department of State Terrorist Exclusion List, or knowingly making false statements regarding material assistance to such an organization is a felony of the fifth degree. I understand that any answer of "yes" to any question, or the failure to answer "no" to any question on this declaration shall serve as a disclosure that material assistance to an organization identified on the U.S. Department of State Terrorist Exclusion List has been provided by myself or my organization. If I am signing this on behalf of a company, business or organization, I hereby acknowledge that I have the authority to make this certification on behalf of the company, business or organization referenced above.

X *Douglas A. Davis*
APPLICANT SIGNATURE

12/29/13
DATE

READ BEFORE COMPLETING YOUR DMA FORM

Forms not conforming to the specifications listed below or not submitted to the appropriate agency or office will not be processed.

- To complete this form, you will need a copy of the Terrorist Exclusion List for reference. The Terrorist Exclusion List can be found on the Ohio Homeland Security Web site at the following address:

<http://www.homelandsecurity.ohio.gov/dma.asp>

- Be sure you have the correct DMA form. If you are applying for a state issued license, permit, certification or registration, the "State Issued License" DMA form must be completed (HLS 0036). If you are applying for employment with a government entity, the "Public Employment" DMA form must be completed (HLS 0037). If you are obtaining a contract to conduct business with or receive funding from a government entity, the "Government Business and Funding Contracts" DMA form must be completed (HLS 0038). The Pre-certification form (HLS 0035) should only be completed if you are specifically instructed to do so by the agency or office requesting the form.
- Your DMA form is to be submitted to the issuing agency or entity. "Issuing agency or entity" means the government agency or office that has requested the form from you or the government agency or office to which you are applying for a license, employment or a business contract. For example, if you are seeking a business contract with the Ohio Department of Commerce's Division of Financial Institutions, then the form needs to be submitted to the Department of Commerce's Division of Financial Institutions. Do NOT send the form to the Ohio Department of Public Safety UNLESS you are seeking a license from or employment or business contract with one of its eight divisions listed below.
- Department of Public Safety Divisions:

Administration	Ohio Homeland Security*
Ohio Bureau of Motor Vehicles	Ohio Investigative Unit
Ohio Emergency Management Agency	Ohio Criminal Justice Services
Ohio Emergency Medical Services	Ohio State Highway Patrol
- * DO NOT SEND THE FORM TO OHIO HOMELAND SECURITY UNLESS OTHERWISE DIRECTED. FORMS SENT TO THE WRONG AGENCY OR ENTITY WILL NOT BE PROCESSED.

PERSONAL HISTORY RECORD

This form must be completed and filed with the Ohio Police & Fire Pension Fund (OP&F) for each new employee who is hired as a full-time police officer or firefighter in a position qualifying for enrollment in OP&F as part of an employer's reporting requirements. Ohio law requires an employer to cause the employee to undergo a physical examination in the form established by OP&F prior to his or her employment and, with limited exceptions, timely file the required documentation with OP&F. Otherwise, penalties and interest may be imposed against the employer.

Ohio law sets forth the eligibility requirements for individuals who are required to become a member of OP&F. Before enrolling in OP&F, the employer should review the eligibility requirements listed below and confirm that the individual meets these requirements for OP&F membership. If the individual meets the requirements, the employer must complete the Personal History Record form to begin the process of enrollment in OP&F, as well as filing the appropriate documentation for the pre-employment physical. OP&F reserves the right to reject membership or service credit at a later date as information becomes available.

A summary of OP&F's membership eligibility requirements are as follows:

Firefighters contributing to OP&F must be paid from public funds of the employing municipal entity and be:

- A full-time firefighter who is employed by a fire department of the state, instrumentality of the state, or of a municipal corporation, township, joint fire district, or other political subdivision in a position in which he or she is required to satisfactorily complete, or to have satisfactorily completed, a firefighter training course approved under former Ohio Revised Code (ORC) Section 3303.07 or Section 4765.55, or conducted under ORC Section 3737.33.

Police officers contributing to OP&F must be paid from public funds of the employing municipal entity and be:

- A full-time, regular police officer in a police department of a municipal corporation appointed from a duly-established civil service eligible list or pursuant to ORC Section 124.411 [124.41.1];
- A full-time, regular police officer in a police department who is appointed pursuant to ORC Section 737.15 or 737.16 and is paid solely out of public funds of the employing municipal corporation; or
- A full-time police officer with a police department who is required to satisfactorily complete a peace officer training course in compliance with ORC Section 109.77.

Once completed, this entire form (Pages 1-4) must be submitted to OP&F and contain original signatures. OP&F will not accept this form if the signatures have been faxed, photocopied or scanned.

The employee required to enroll in OP&F membership must complete Sections A through F. The employer must complete Sections G, H, and I.

Section A: Employee information

Name: First, MI, Last, suffix (Jr, III, etc.)

DOUGLAS A. DAVIS

☒ Police officer ☒ Male
☐ Firefighter ☐ Female

Social Security number

Date of Birth

01 29 1980

Street Address / Post office box

Date of hire as a police officer or firefighter

12 29 2013

City, State, ZIP code

Home phone

☒ New

Alternate phone

☒ New

Email address

☒ New

ddavis@circlevillepolice.com

Section B: Marital and dependent information**Current spouse**

Name

Gender:

☐ Male ☐ Female

Marriage date

--	--	--	--	--	--	--	--	--	--

Social Security number

--	--	--	--	--	--	--	--	--	--

Birth date

--	--	--	--	--	--	--	--	--	--

Dependent information (excluding current spouse)

Relationship	Dependent name	Gender (M/F)	Social Security number	Birth date
Children, under the age of 18				6-23-00
				12-15-03
				7-19-05
Children, 18-22 if unmarried and a student				
Children, any age if dependent and disabled				

Section C: Multiple Ohio retirement system membership

☒ Yes ☐ No Are you **currently receiving**, or eligible to receive in the future, an age/service retirement benefit or disability benefit from any of the following Ohio retirement systems? (Please check all that apply)

☐ State Highway Patrol Retirement System	☐ School Employees Retirement System
☒ Ohio Public Employees Retirement System	☐ State Teachers Retirement System
☐ Cincinnati Retirement System	☐ Ohio Police & Fire Pension Fund

☐ Yes ☒ No Are you **currently contributing** to any of the following Ohio retirement systems? (Please check all that apply)

☐ State Highway Patrol Retirement System	☐ School Employees Retirement System
☐ Ohio Public Employees Retirement System	☐ State Teachers Retirement System
☐ Cincinnati Retirement System	☐ Ohio Police & Fire Pension Fund

☒ Yes ☐ No Have you **received a refund of contributions** for full-time service from any of the following Ohio retirement systems? (Please check all that apply)

☐ State Highway Patrol Retirement System	☐ School Employees Retirement System
☒ Ohio Public Employees Retirement System	☐ State Teachers Retirement System
☐ Cincinnati Retirement System	☐ Ohio Police & Fire Pension Fund

☒ Yes ☐ No Do you have **contributions on deposit for full-time service, but are not currently contributing** to any of the following Ohio retirement systems? (Please check all that apply)

☐ State Highway Patrol Retirement System	☐ School Employees Retirement System
☒ Ohio Public Employees Retirement System	☐ State Teachers Retirement System
☐ Cincinnati Retirement System	☐ Ohio Police & Fire Pension Fund

Section D: Out-of-state, federal or military employment information

☐ Yes ☒ No Have you ever been employed full-time by an **out-of-state public employer** or as a **civil employee of the federal government**? If yes, please provide your employer's name, address, date of hire and termination date.

☐ Yes ☒ No Do you have previous active duty service in the **Armed Forces**? If yes, please provide your branch and dates of service.

Section E: Employee signature and acknowledgement

I, the employee described in section A of this *Personal History Record*, who, having been duly sworn, represent that I am the person herein described, and I certify that all the statements made herein are true and correct.

Signature

[Handwritten Signature]

Date of signature

12/29/13

Section F: Notary public requirement

The notary public in good standing must sign in the space provided in this section and affix their seal.

State of OHIO, County of PICKAWAY, ss:

The foregoing *Personal History Record* was acknowledged before me by the person named in the foregoing Section E, this 29th day of December, 2013.

Affix seal



VALERIE DILLEY
Notary Public, State of Ohio
My Commission Expires 7-19-16

Notary's signature

Print name

My commission expires

[Handwritten Signature]
Valerie Dilley
7-19-2016

Sections G, H and I (on Page 4 of this form) must be completed by an authorized employer representative.

The following sections (G, H and I) must be completed by an authorized employer representative.

Section G: Employer Information

Employer name <i>City of Circleville</i>	Employer Code <i>3041-00</i>	Check one: ☒ Police ☐ Fire
Street address / Post office box <i>133 S Court St</i>	Employer phone <i>740-477-8606</i>	Employer fax <i>740-477-8235</i>
City, State / ZIP code <i>Circleville OH 43113</i>	Employer e-mail address: <i>debra.hammond@ci.circleville.oh.us</i>	

Section H: Certification of membership eligibility

In order to assist OP&F in determining the employee's eligibility for OP&F membership, please complete this section. OP&F reserves the right to reject membership or service credit at a later date as information becomes available.

- ☒ Yes ☐ No The employee received an original appointment as a full-time, regular **police officer**.
Check one of the following:
- ☒ A full-time, regular police officer in a police department of a municipal corporation appointed from a duly-established civil service eligible list or pursuant to Ohio Revised Code (ORC) Section 124.411 [124.41.1];
 - ☐ A full-time, regular police officer in a police department who is appointed pursuant to ORC Section 737.15 or 737.16 and is paid solely out of public funds of the employing municipal corporation; or
 - ☐ A full-time, regular police officer in a police department who is required to satisfactorily complete a peace officer training course in compliance with ORC Section 109.77.

- ☐ Yes ☐ No The employee has been employed as a full-time **firefighter** employed by a fire department of the state, instrumentality of the state, or of a municipal corporation, township, joint fire district or other political subdivision in a position in which he or she is required to satisfactorily complete, or to have satisfactorily completed, a firefighter training course approved under former ORC Section 3303.07 or Section 4765.55, or conducted under ORC Section 3737.33. **Please submit a copy of the certificate earned upon the completion of the training course.**

12/29/13
(month/day/year)

Date employee began contributing a percentage of his/her salary to OP&F (first date that compensation was earned as a full-time police officer or firefighter).

12/29/13
(month/day/year)

Date employee was appointed to a full-time police officer or firefighter position. **Please attach a copy of the appointment letter confirming full-time status for the member.**

\$ *17.39* per hour
(per year)

Member's initial salary rate (starting annual salary).

Jan 2014
(month/year)

Date pension contributions will first appear on the *Report of Retirement Deductions*.

A
(A, B, C or D)

Payroll reporting pick-up plan (A, B, C or D) that the member contributions will be submitted under on the *Report of Retirement Deductions*.

Section I: Employer certification

I hereby certify the person named in Section A is employed as a full-time police officer or firefighter by the employer named in Section G, and that all the statements made herein are true and correct.

Signature <i>Debra A Hammond</i>	Date of signature <i>1-3-14</i>
Print name <i>Debra A Hammond</i>	Title <i>Payroll Clerk</i>

Once completed, this entire form (Pages 1-4) must be submitted to OP&F and contain original signatures. OP&F will not accept this form if the signatures have been faxed, photocopied or scanned.

OP&F USE ONLY

Entered/Date:

Reviewed/Date:

CITY OF CIRCLEVILLE
Health ☒ Dental ☒ Vis...
Single ☐ Double ☒ Family
Coverage Waived
☒ New Hire ☐ OE ☐ Open Enroll
Effective 1-29-2014

✓ Life 1-2-14
E 12-29-13

Dental & Life

110

Principal

Financial
Group

Mailing Address
Des Moines, IA 50392-0002

Principal Life
Insurance Company

Employee
Enrollment &
Waiver - OH

Company name CITY OF CIRCLEVILLE	Division level	Account number/unit number H37681
-------------------------------------	----------------	--------------------------------------

Employee Information

Name DOUGLAS A. DAVIS	Social security number [REDACTED]	
Mailing address (street) [REDACTED]	Birth date 01-29-1980	☒ male ☐ female
(city) [REDACTED]	(state) OH	(ZIP code) [REDACTED]
Do you have an eligible spouse or child? ☒ Yes ☐ No		
Date employed full-time 12-29-2013	Hours worked per week 40	Job occupation/class POLICE OFFICER
Location CIRCLEVILLE		
Salary amount 16.72	Salary mode ☐ yearly ☐ weekly ☒ hourly ☐ monthly ☐ bi-weekly	
What is your payroll mode? ☐ monthly ☐ semi-monthly ☐ weekly ☒ bi-weekly	Employer ZIP 43113	Employer county PICKAWAY

WARNING: IF YOU OR YOUR FAMILY MEMBERS ARE COVERED BY MORE THAN ONE HEALTH CARE PLAN, YOU MAY NOT BE ABLE TO COLLECT BENEFITS FROM BOTH PLANS. EACH PLAN MAY REQUIRE YOU TO FOLLOW ITS RULES OR USE SPECIFIC DOCTORS AND HOSPITALS, AND IT MAY BE IMPOSSIBLE TO COMPLY WITH BOTH PLANS AT THE SAME TIME. BEFORE YOU ENROLL IN THIS PLAN, READ ALL OF THE RULES VERY CAREFULLY AND COMPARE THEM WITH THE RULES OF ANY OTHER PLAN THAT COVERS YOU OR YOUR FAMILY.

Dental

Employee: ☒ Elect ☐ Decline
Spouse: ☐ Elect ☒ Decline
Children: ☒ Elect ☐ Decline
In the past 12 months, have you, the applicant, had continuous group orthodontia coverage (for yourself and/or your dependents) with a prior carrier? ☒ Yes ☐ No

Group Term Life

Employee:
☒ Elect

Group Term Life Beneficiary Designation (Complete if covered for group term life coverage.)

All primary and contingent beneficiaries, whether adults or minors, should be included in the beneficiary designation below.

Primary	Percentage	Relationship	Social security number
[REDACTED]	33.33	[REDACTED]	[REDACTED]
[REDACTED]	33.33	[REDACTED]	[REDACTED]
[REDACTED]	33.33	[REDACTED]	[REDACTED]

Contingent Beneficiaries:

Name	Percentage	Relationship
Address		Social security number
Name	Percentage	Relationship
Address		Social security number

Voluntary Term Life

Employee: ☐ Elect ☒ Decline	\$ _____
Spouse: ☐ Elect ☒ Decline	\$ _____ Birth date _____
Children: ☐ Elect ☒ Decline	\$ _____

Voluntary Term Life Beneficiary Designation (Complete if covered for voluntary term life coverage. If you want to use the same beneficiary designation as indicated for group term life coverage above, write "same as above" in the beneficiary section below.)

All primary and contingent beneficiaries, whether adults or minors, should be included in the beneficiary designation below.

Primary Beneficiaries:

Name	Percentage	Relationship
Address		Social security number
Name	Percentage	Relationship
Address		Social security number
Name	Percentage	Relationship
Address		Social security number

Contingent Beneficiaries:

Name	Percentage	Relationship
Address		Social security number
Name	Percentage	Relationship
Address		Social security number

The right to make future changes is reserved. If two or more beneficiaries are named, the proceeds shall be paid to the named beneficiaries, or to the survivor or survivors, in equal shares, unless specified otherwise.

If any beneficiary is designated as trustee, it is understood and agreed that Principal Life Insurance Company shall not be a party to nor bound by the conditions of any trust and payment of the net proceeds of said policy on the death of the

insured to the then designated beneficiary shall be a complete discharge as to Principal Life.

If you have designated a minor child(ren) as your beneficiary, you must complete the Uniform Transfers to Minors Act form.

NOTE: You are covered by both group term life and voluntary term life coverage and if you only indicate a beneficiary designation for one of these, the facility of payment provision in the group policy will be used to determine how proceeds will be paid for the other coverage.

Important! If declining any coverage for yourself or any dependent, give reason. Covered under:

- ☐ spouse's group coverage ☐ individual insurance
☐ other ☐ other coverage offered by my employer

Eligible Dependent Information (Complete if you have elected benefits for your spouse or children)

Spouse's name	Birth date	☐ male ☐ female	Social security number	
Name(s) of child(ren)	Birth date	☐ male ☐ female	Social security number	☐ foster child* ☐ disabled or handicapped child **
		☐ male ☐ female		☐ foster child* ☐ disabled or handicapped child **
		☐ male ☐ female		☐ foster child* ☐ disabled or handicapped child **

* If you checked foster child, was the child placed with you by an authorized state placement agency or by order of a court? ☐ Yes ☐ No

** When your child, who is developmentally disabled or physically handicapped, reaches/exceeds the maximum age, an Application to Continue Handicapped Child form must be completed and reviewed to determine eligibility.

Is your spouse employed by this company? ☐ Yes ☐ No

Employee Signature (Read and sign)

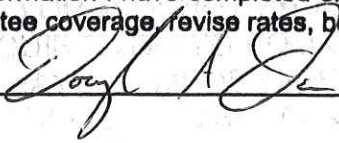
I understand and agree with the following statements:

- My dependents are not eligible for coverages I don't have. My dependents, including step and foster children and any over the maximum age, are eligible based on plan provisions but those over the maximum age will be verified when a claim is filed.
- If I refuse dental coverage, I and my dependents may enroll later but this will affect the level of benefits.
- If I refuse coverage, I cannot enroll after retirement.
- If I refuse life or disability coverage, I may apply later but I must show proof of good health and coverage will be subject to approval by Principal Life Insurance Company.
- If the group policy does not require my contribution, I cannot decline coverage unless the policy indicates otherwise.

- If the group policy requires my contribution, I authorize my employer to deduct from my pay.
- I represent all information on this form and attachments is complete and true to the best of my knowledge. They are part of this request for coverage. I agree Principal Life is not liable for a claim before the effective date of coverage and all policy provisions apply. I have read, or had read to me, the information and my answers on this form. During the first two years coverage is in force, fraud or intentional misrepresentations can cause changes in my coverage, including cancellation back to the effective date.
- Any person who, with intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.
- Explanation of Benefits reflecting claims payments for myself and my dependents will be sent to my home address. I also understand collection of social security numbers for myself and/or my dependents will be used by Principal Life only as allowed by law.
- I authorize Principal Life to release data as required by law. If signed in connection with an application, reinstatement or a change in benefits, this form will be valid two years from the date below. I may revoke authorization for information not yet obtained. I understand data obtained will be used by Principal Life for claims administration and determining eligibility for life and disability coverage. Information will not be used for any purposes prohibited by law.
- For life coverage, I understand that as the employee, the insurance I and my dependents have applied for will begin on the effective date of coverage provided I am at work on that date. If I am not actively at work on such date, subject to the terms of the group policy, coverage may not go into effect until after my return to work. Furthermore, I understand that no insurance may become effective for any member of my family while he/she is in a period of limited activity.

A copy of this form will be as valid as the original.

I declare that the information I have completed on this enrollment form is complete and true. I understand an agent or broker cannot guarantee coverage, revise rates, benefits or provisions without written approval from Principal Life.

Your signature X  Date Signed 12/29/13

Instructions

After this form is completed and signed, make two copies and send the original to Principal Life Insurance Company:

- One for the employee
- One for the employer

City of Circleville

Vision Service Plan (VSP) Enrollment Form

CITY OF CIRCLEVILLE
Health ☐ Dental ☐ Vision ☒
Single ☐ Double ☐ Family ☐
Coverage Waived ☐
☒ New Hire ☐ QE ☐ Open Enroll
Effective 2-1-2014



Member Information									
Social Security Number [REDACTED]	Member Last Name DAVIS	Member First Name DOUGLAS	Date of Birth (MM/DD/YYYY) 01/29/1980						
Dependant Information		Dual Coverage Information	Plan Selection						
Do you have dependant children? <u>YES</u> Do your dependant children if over 18, attend school full-time? <u>N/A</u> Are you enrolling your dependants in the VSP plan? <u>YES</u>		Does your spouse have a vision plan? <u>N/A</u> If yes, who is covered? <u>N/A</u>	<table border="1"><thead><tr><th>Employee Only</th><th>Employee + 1</th><th>Family</th></tr></thead><tbody><tr><td>\$4.58 per pay</td><td>\$6.99 per pay</td><td>\$12.53 per pay</td></tr></tbody></table>	Employee Only	Employee + 1	Family	\$4.58 per pay	\$6.99 per pay	\$12.53 per pay
Employee Only	Employee + 1	Family							
\$4.58 per pay	\$6.99 per pay	\$12.53 per pay							
Please list all of your dependents below (if Employee + 1 or Family coverage is selected).									
Last Name, First Name		Social Security Number	Date of Birth						
[REDACTED]		[REDACTED]	6/23/00						
[REDACTED]		[REDACTED]	12/15/03						
[REDACTED]		[REDACTED]	7/19/05						
Please return to the HR Office. Do not return to VSP.									

Signature: _____

Doug A Davis

Date: _____

12/29/13



Employment Eligibility Verification

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

USCIS
Form I-9

OMB No. 1615-0047
Expires 03/31/2016

▶ **START HERE.** 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 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) DAVIS		First Name (Given Name) DOUGLAS		Middle Initial A	Other Names Used (if any)	
Address (Street Number and Name) [REDACTED]		Apt. Number	City or Town		State	Zip Code
Date of Birth (mm/dd/yyyy) 01/29/1980	U.S. Social Security Number [REDACTED]	E-mail Address ddavis@circlevillepolice.com			Telephone Number [REDACTED]	

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 Registration Number/USCIS Number): _____
- ☐ An alien authorized to work until (expiration date, if applicable, mm/dd/yyyy) _____. Some aliens may write "N/A" in this field. (See instructions)

For aliens authorized to work, provide your Alien Registration Number/USCIS Number **OR** Form I-94 Admission Number:

1. Alien Registration Number/USCIS Number: _____

OR

2. Form I-94 Admission Number: _____

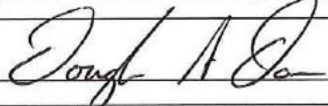
If you obtained your admission number from CBP in connection with your arrival in the United States, include the following:

Foreign Passport Number: _____

Country of Issuance: _____

Some aliens may write "N/A" on the Foreign Passport Number and Country of Issuance fields. (See instructions)

3-D Barcode
Do Not Write in This Space

Signature of Employee: 	Date (mm/dd/yyyy): 12/29/2013
--	--------------------------------------

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.

Signature of Preparer or Translator:		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



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 examine a combination of one document from List B and one document from List C as listed on the "Lists of Acceptable Documents" on the next page of this form. For each document you review, record the following information: document title, issuing authority, document number, and expiration date, if any.)

Employee Last Name, First Name and Middle Initial from Section 1:

List A Identity and Employment Authorization	OR	List B Identity	AND	List C Employment Authorization
Document Title: DL		Document Title: SS		Document Title:
Issuing Authority: OHIO		Issuing Authority: Federal		Issuing Authority:
Document Number: [REDACTED]		Document Number: [REDACTED]		Document Number:
Expiration Date (if any) (mm/dd/yyyy): 1-29-2017		Expiration Date (if any) (mm/dd/yyyy): NA		Expiration Date (if any) (mm/dd/yyyy):
Document Title:				
Issuing Authority:				
Document Number:				
Expiration Date (if any) (mm/dd/yyyy):				
Document Title:				
Issuing Authority:				
Document Number:				
Expiration Date (if any) (mm/dd/yyyy):				

3-D Barcode
Do Not Write in This Space

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): 12-29-13 (See instructions for exemptions.)

Signature of Employer or Authorized Representative Valerie Dille		Date (mm/dd/yyyy) 12-30-13	Title of Employer or Authorized Representative HR Asst.	
Last Name (Family Name) Dille		First Name (Given Name) Valerie	Employer's Business or Organization Name City of Circleville	
Employer's Business or Organization Address (Street Number and Name) 104 E. Franklin Street		City or Town Circleville	State OH	Zip Code 43113

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

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

C. If employee's previous grant of employment authorization has expired, provide the information for the document from List A or List C the employee presented that establishes current employment authorization in the space provided below.

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

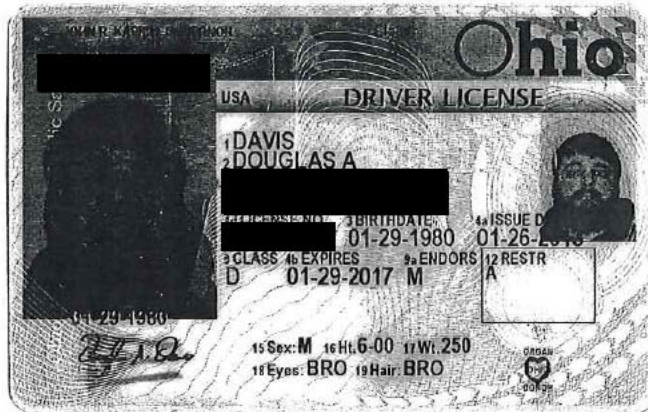
I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented document(s), the document(s) I have examined appear to be genuine and to relate to the individual.

Signature of Employer or Authorized Representative:	Date (mm/dd/yyyy):	Print Name of Employer or Authorized Representative:
---	--------------------	--

OHIO
USA DRIVER LICENSE

1 DAVIS
2 DOUGLAS A
3 [REDACTED]
4 BIRTHDATE: 01-29-1980
5 ISSUE D: 01-26-2013
6 CLASS 4b EXPIRES: 01-29-2017
7 ENDORS: M
8 RESTR: A
9 Sex: M 10 Ht: 6-00 11 Wt: 250
12 Eyes: BRO 13 Hair: BRO

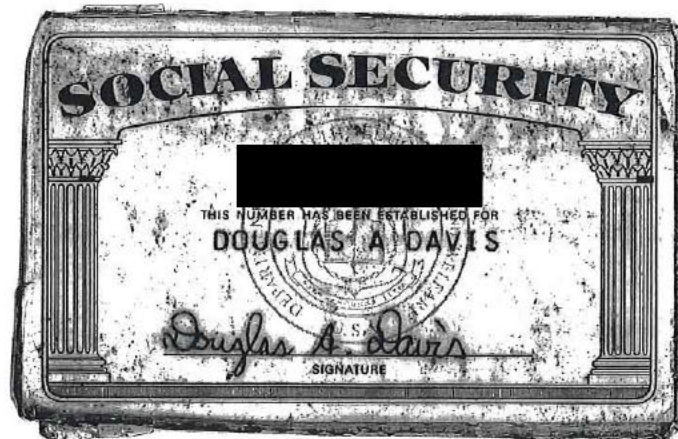
01-29-1980

An Ohio Driver License for Douglas A. Davis. The license is rectangular with a textured background. It features a black and white photo of a man with a beard on the right side. The text is printed in a sans-serif font. The name "DAVIS DOUGLAS A" is printed in the center. The birthdate "01-29-1980" is printed below the name. The issue date "01-26-2013" is printed to the right of the birthdate. The class "D" and expiration date "01-29-2017" are printed below the birthdate. The sex "M", height "6-00", and weight "250" are printed at the bottom. The eye color "BRO" and hair color "BRO" are printed at the bottom right. There is a small "OHIO" logo in the top right corner. The license is marked with "USA DRIVER LICENSE" at the top.

SOCIAL SECURITY

THIS NUMBER HAS BEEN ESTABLISHED FOR
DOUGLAS A DAVIS

Douglas A. Davis
SIGNATURE

A Social Security Card for Douglas A. Davis. The card is rectangular with a textured background. It features a large "SOCIAL SECURITY" title at the top. Below the title is a black box redacting the Social Security number. The text "THIS NUMBER HAS BEEN ESTABLISHED FOR DOUGLAS A DAVIS" is printed below the redacted box. At the bottom, there is a signature "Douglas A. Davis" and the word "SIGNATURE" below it. The card is framed by a decorative border.

Enrollment Application/Change/Cancellation Request



✓ 1-2-2014

✓ CITY OF CIRCLEVILLE
Health _____ Dental _____ Vision _____
Single _____ Double _____ Family _____
Coverage Waived _____
New Hire _____ QE _____ Open Enroll _____
Effective 1-29-14

☐ Enroll ☐ Address Change
☐ Cancel ☐ Name Change
☐ Change Date of Change ____/____/____

To Be Completed By Employer

ATTENTION EMPLOYER REPRESENTATIVE: To ensure accurate processing of application, 1) please review all sections and confirm the employee completed the appropriate information, 2) complete the information in this section and 3) provide your signature and today's date. If the employee is waiving coverage, do not submit the application but retain it for your records.

Company Name _____ Group # _____ Department # _____

Plan Variation Medical _____ Vision _____ Dental _____ Life _____	Reporting Code Medical _____ Vision _____ Dental _____ Life _____	Benefit Level/Class Code, if applicable Life/AD&D _____ Suppl. Life _____ Spouse Life _____ Suppl. AD&D _____
--	--	--

☐ **New Enrollment/Additions: (Check one)**

Date of Hire ____/____/____ Requested Date of Coverage ____/____/____
☐ New Hire ☐ Status Change (PT to FT)
☐ Return from Leave/Layoff
☐ Birth ☐ Marriage ☐ Adoption
☐ Court ordered dependent
☐ Other (describe) _____
☐ COBRA/State Continuation start date _____ stop date _____
☐ Annual Open Enrollment Requested Effective Date of Enrollment ____/____/____

☐ **Cancellations:** Last Date of Employment ____/____/____
Requested Effective Date of Cancellation ____/____/____
☐ Cancel all coverage
☐ Cancel all listed below - Section B
Reason: (check one)
☐ Death ☐ Employee Terminated ☐ Divorce
☐ Moved out of service area
☐ Dependent reached student/dependent max age
☐ Other (describe) _____

Employee Type ☐ Union ☐ Non-union ☐ Salaried ☐ Hourly ☐ Active ☐ Retire Date _____ ☐ COBRA/State Cont. _____

Signature _____ Date _____

A. Employee Information

Employer Position _____ Phone Number _____

Last Name DAVIS	First Name DOUGLAS	MI A	Social Security Number [REDACTED]	Home Phone [REDACTED]	Work Phone [REDACTED]
Address [REDACTED]		Apt # [REDACTED]	City [REDACTED]	State OH	Zip Code [REDACTED]
Date of Birth 01/29/80	Sex ☒ M ☐ F	Physician* (First & Last Name) / Physician's ID Number		Email Address ddavis@circlevillepolice.com	
Primary Care Dentist Number*					

Marital Status

☒ Single ☐ Married
☐ Divorced ☐ Widowed

Race - Check all that apply (Optional)**

☐ American Indian/Alaska Native ☐ Asian ☐ Black/African-American ☐ Hispanic/Latino
☐ Native Hawaiian/Pacific Islander ☒ White ☐ Other-Please specify _____

*IMPORTANT: Please see employer representative as some plans require a Primary Physician (Primary Care) and/or a Primary Care Dentist (PCD) selection.

**Data collected will be used only to help communicate with enrollees and inform them of specific programs to enhance their well-being and not for eligibility or claim payment determination.

Coverage Provided by "UnitedHealthcare and Affiliates":

Medical coverage provided by United HealthCare Insurance Company of Ohio or United HealthCare of Ohio, Inc.
Dental coverage provided by United HealthCare Insurance Company of Ohio or United HealthCare of Ohio, Inc.
Life Insurance coverage provided by United HealthCare Insurance Company of Ohio or Unimerica Insurance Company
Vision coverage provided by United HealthCare Insurance Company of Ohio or Unimerica Insurance Company

B. Family Information

List All Enrolling/Changing/Cancelling (Attach sheet if necessary)

Check appropriate box	Last Name	First Name	MI	Sex	Relationship**	Birthdate	Full Time Student***	Physician*(First and Last Name) Physician's ID Number
☐ Enroll ☐ Cancel ☐ Change				M F	Spouse			
Race - Check all that apply (Optional)**** ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African-American ☐ Hispanic/Latino ☐ Native Hawaiian/Pacific Islander ☐ White ☐ Other-Please specify _____								Primary Care Dentist Number*
☒ Enroll ☐ Cancel ☐ Change				Dependent		6/23/00	☒ Yes ☐ No	
Race - Check all that apply (Optional)**** ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African-American ☐ Hispanic/Latino ☐ Native Hawaiian/Pacific Islander ☒ White ☐ Other-Please specify _____								Primary Care Dentist Number*
☒ Enroll ☐ Cancel ☐ Change				Dependent		12/15/03	☒ Yes ☐ No	
Race - Check all that apply (Optional)**** ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African-American ☐ Hispanic/Latino ☐ Native Hawaiian/Pacific Islander ☒ White ☐ Other-Please specify _____								Primary Care Dentist Number*
☒ Enroll ☐ Cancel ☐ Change				Dependent		7/19/05	☒ Yes ☐ No	
Race - Check all that apply (Optional)**** ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African-American ☐ Hispanic/Latino ☐ Native Hawaiian/Pacific Islander ☒ White ☐ Other-Please specify _____								Primary Care Dentist Number*
☐ Enroll ☐ Cancel ☐ Change				M F	Dependent		☐ Yes ☐ No	
Race - Check all that apply (Optional)**** ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African-American ☐ Hispanic/Latino ☐ Native Hawaiian/Pacific Islander ☐ White ☐ Other-Please specify _____								Primary Care Dentist Number*

* IMPORTANT: Please see employer representative as some plans require a Primary Physician (Primary Care) and/or a Primary Care Dentist (PCD) selection.

** For some cases, such as Qualified Medical Child Support, additional documentation may be required. Please see employer representative for more information.

*** Please see employer representative for student status qualifications.

**** Data collected will be used only to help communicate with enrollees and inform them of specific programs to enhance their well-being and not for eligibility or claim payment determination.

C. Product Selection

Please check all that apply. Benefit offerings are dependent upon employer selection.

Person	Medical	Dental	Vision	Life/Amount	Sup Life	Sup AD&D	STD	LTD	Dual Option Plan Selected
Employee	☒	☒	☒	☐ \$ _____	☐	☐	☐	☐	
Spouse	☐	☐	☐	☐					
Dependents	☒	☒	☒	☐ Salary _____ Required only if Life Plan based on salary					

Life Insurance Beneficiary's Full Name and Address

Relationship

D. Other Medical Coverage Information This section must be completed. (Attach sheet if necessary.)

On the day this coverage begins, will you, your spouse or any of your dependents be covered under any other medical health plan or policy, including another UnitedHealthcare plan or Medicare? ☐ YES (continue completing this section) ☒ NO (skip the rest of this section)

Name of other carrier _____

Other Group Medical Coverage Information (only list those covered by other plan)	Type (B/S/F)*	Effective Date	End Date	Name and date of birth of policyholder for other coverage
Spouse Name: _____				
Dependent Name: _____				
Dependent Name: _____				
Dependent Name: _____				

*B. Enter 'B' when this dependent is covered under both you and your spouse's insurance plan (married)

S. Enter 'S' if you are the parent awarded custody of this dependent and no other individual is required to pay for this dependent's medical expenses.

F. Enter 'F' if this dependent is covered by another individual (not a member of your household) required to pay for this dependent's medical expenses.

Medicare – Employee Information: If enrolled in Medicare, please attach a copy of your Medicare ID card.

- ☐ Enrolled in Part A: Effective Date _____ ☐ Ineligible for Part A* ☐ Not Enrolled in Part A (chose not to enroll)
☐ Enrolled in Part B: Effective Date _____ ☐ Ineligible for Part B* ☐ Not Enrolled in Part B (chose not to enroll)
☐ Enrolled in Part D: Effective Date _____ ☐ Ineligible for Part D* ☐ Not Enrolled in Part D (chose not to enroll)
Reason for Medicare eligibility: ☐ Over 65 ☐ Kidney Disease ☐ Disabled ☐ Disabled but actively at work

Medicare – Spouse/Dependent Name: _____

- ☐ Enrolled in Part A: Effective Date _____ ☐ Ineligible for Part A* ☐ Not Enrolled in Part A (chose not to enroll)
☐ Enrolled in Part B: Effective Date _____ ☐ Ineligible for Part B* ☐ Not Enrolled in Part B (chose not to enroll)
☐ Enrolled in Part D: Effective Date _____ ☐ Ineligible for Part D* ☐ Not Enrolled in Part D (chose not to enroll)
Reason for Medicare eligibility: ☐ Over 65 ☐ Kidney Disease ☐ Disabled ☐ Disabled but actively at work

*Only check "Ineligible" if you have received documentation from your Social Security benefits that indicate that you are not eligible for Medicare.

E. Waiver of Coverage

I decline coverage for:

- ☐ Myself
☐ Spouse
☐ Dependent Children
☐ Myself and all dependents

Declining coverage due to existence of other coverage:

- ☐ Spouse's Employer's Plan ☐ Individual Plan
☐ Covered by Medicare ☐ Medicaid
☐ COBRA from Prior Employer ☐ VA Eligibility
☐ Tri-Care
☐ I (we) have no other coverage at this time
☐ Other _____

I understand that by waiving coverage at this time, I will not be allowed to participate unless I experience a life change event, at the next open enrollment period or as a late enrollee, if applicable. I acknowledge that I have received the "Important Information" statement which is included with this form.

Employee Initials _____ Date _____

F. Signature

I confirm that the information I have provided on this form is complete and accurate.

I understand that the health benefit plan that I have selected provides reimbursement for certain medical costs, which are more fully described in the current Certificate of Coverage. I understand there may be instances where treatment decisions made by my physician or me or medical expenses which I have incurred may not be covered by my health benefit plan.

I understand that information collected in connection with administration of the benefit plan may be used to bring to my attention health products or services that might be valuable to me and otherwise as permitted by law. I understand that you may combine that information with other information so that it is no longer individually identifiable and use it for commercial and other purposes.

I acknowledge that I have received the "Important Information" statement which is included on the back of this form.

Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Date 12/29/13 Employee Signature for all applying and waiving [Signature] Spouse Signature (if applying for coverage) _____
Primary Language Spoken ☒ English ☐ Spanish ☐ Other _____

IMPORTANT INFORMATION

In order to make choices about your health care coverage and treatment, we believe that it is important for you to understand how your plan operates and how it may affect you. In an ever-changing environment, the information can never be complete and we urge you to contact us if, after enrollment, your Certificate of Coverage or other materials do not answer your questions. Further information is available at www.myuhc.com or at the toll-free Customer Care number located on the back of your identification card or on other plan materials.

1. We do not provide health care services or make treatment decisions. We help finance and/or administer the health benefit plan in which you are enrolled. That means:
 - We make decisions about whether the health benefit plan you chose will reimburse you for care that you may receive.
 - We do not decide what care you need or will receive. You and your provider make those decisions.
2. We may enter into arrangements where another entity carries out some of our duties, but those entities must operate consistently with our commitment to your plan.
3. We may use individually identifiable information about you to identify for you (and you alone) procedures, products, and services that you may find valuable.
4. We contract with networks of physicians and other providers. Our credentialing process confirms public information about the providers' licenses and other credentials, but does not assure the quality of the services provided.
5. Physicians and other providers in our networks are independent contractors and are not our employees or agents. We do not control nor do we have a right to control your provider's treatment or plan.
6. We may enter into agreements with your physician or other provider to share in the cost savings that our approach may generate. We encourage providers in our network to disclose the nature of those arrangements with you. If they do not, we encourage you to talk to your provider about these arrangements.
7. We encourage physicians and other providers to talk with you about care you or your provider think might be valuable.
8. We will use individually identifiable information about you as permitted by law, including in our operations and in our research. We will use anonymous data for commercial purposes including research.

Statement of affirmation and authorization to obtain and disclose information in connection with eligibility for coverage.

I (we) request the indicated group coverage for myself and, if the plan provides, for my dependents. I authorize any required premium contributions to be deducted from earnings.

I (we) authorize all providers of health services or supplies and any of their representatives to give the following to the HMO/insurance company(ies): any available information about the health history, condition, or treatment of any persons named in this request. I (we) authorize the HMO/insurance company(ies) to use this information to determine eligibility for health coverage and eligibility for benefits under an existing policy.

I (we) also authorize the HMO/insurance company(ies) to give this information to its (their) representatives or to any other organization for the reason notified above. I (we) agree that this authorization is valid for 30 months from the date below. I (we) know that I (we) have the right to ask for and to receive a copy of this authorization.

I understand that the Certificate of Coverage and other documents, notices, and communications regarding my health benefit plan may be transmitted electronically.

I (we) have not given the agent or any other persons any health information not included on the Request for Coverage. I (we) understand that the HMO/insurance company(ies) is not bound by any statements I (we) have made to any agent or to any other persons, if those statements are not written or printed on this Request for Coverage and any attachments.

Davis

2000260

New Employee Check List

- ☒ Name & Address
- ☒ Title
- ☒ Social Security Number
- ☒ Phone Number
- ☒ Sex
- ☒ Marital Status (Use federal tax form)
- ☒ Birthday
- ☒ Account Number
- ☒ Vacation & Sick Leave Tables
- ☒ Pay Cycle (2- Bi-weekly, 4- Monthly)
- ☒ Pay Rate
- ☒ Federal Exempt
- ☒ State Exempt
- ☒ City Taxes (CI-Circleville)
- ☒ Pension – Employee Pension ; Pension Pickup
- ☒ Union Type (1-Fire, 2-NUEO, 3-Police)
- ☒ Medicare (.0145)
- ☒ Unemployment status
- ☒ School Tax
- ☒ Check medical insurance deduct if applicable
- ☒ Direct Deposit

Def Comp

Day

M

CITY EMPLOYEE YMCA MEMBERSHIP

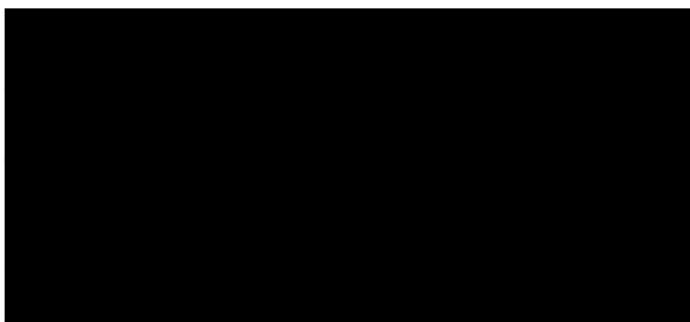


The City of Circleville agrees to pay the cost of a membership, not to exceed \$150.00, towards a YMCA membership. After approval from the HR office, the employee must take this form the YMCA office for membership enrollment.

Name: DOUGLAS A. DAVIS

Address:

Phone:



(To be completed by the HR)

Employed by the City of Circleville since December 2013

Approved by:

Date:

Valerie Riley
12-31-2013

cc: Auditor's Office
YMCA file



OHIO DEFERRED COMPENSATION

OHIO PUBLIC EMPLOYEES DEFERRED COMPENSATION PROGRAM

SUPPLEMENTAL RETIREMENT ACCOUNT ELECTION FORM

Instructions

1. As a public employee you are required to complete and file this form within 45 days of beginning employment. Please fill out the form in blue or black ink.
2. Sign the form in Section 4.
3. Your employer is required to send the completed form to Ohio Deferred Compensation immediately upon hire.

Section 1: Personal Information

Last Name DAVIS First Name DOUGLAS
Gender: ☒ Male ☐ Female Date of Birth 01 / 29 / 1980 (MM/DD/YYYY)
Address [REDACTED]
City [REDACTED] State OH Zip [REDACTED]
Email Address ddavis@circlevillepolice.com
Work Phone (740) 474-8888 Home Phone N/A Cell Phone [REDACTED]

Section 2: Employer Information

Employer Name CITY OF CIRCLEVILLE
Department Name POLICE DEPT.
Pension System: (circle one) ☐ OPERS ☐ STRS ☐ SERS ☒ OP&F ☐ HPRS ☐ Other _____

Section 3: Election

- ☒ Yes, I would like to begin saving tax-deferred money for retirement. I would like to begin by saving \$ 50.00 per pay period (minimum \$15) into Ohio Deferred Compensation. A pre-tax deduction will be invested in a LifePath Portfolio closest to the year in which I turn age 65. My payroll deductions will begin on the next pay period following 30 days from the date my form is received by the Program. Upon receipt of this form I will be mailed a Program welcome kit with additional details. I can make changes to my deduction and my investment selection at any time.

Social Security Number (required) [REDACTED]

- ☐ No, I have received information about the Program and choose to decline the opportunity to save tax-deferred money for retirement.

Section 4: Signature & Acknowledgment

I acknowledge that I have read the terms and conditions on the reverse side of this form.

[Signature]
Signature

1/24/13
Date

Ohio Deferred Compensation
257 East Town Street, Suite 457
Columbus, Ohio 43215-4626
1-877-644-6457
614-222-9457 (fax)
www.Ohio457.org

Start building a brighter future today!

The time is right — now

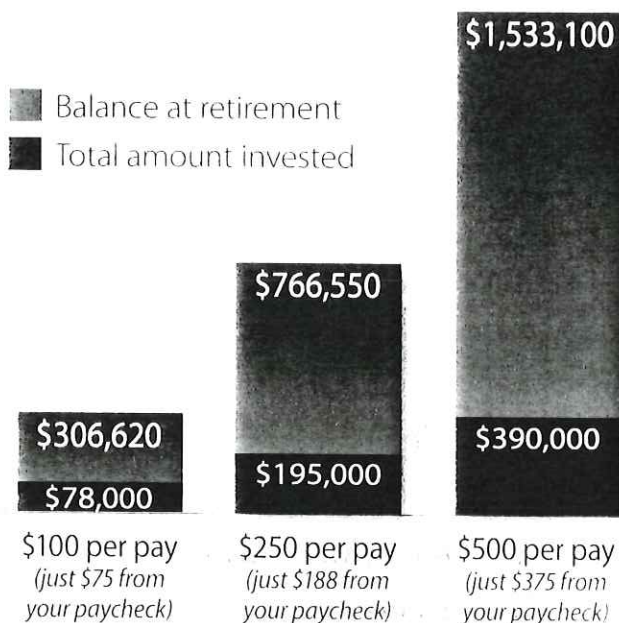
It's never too soon (or too late) to begin investing. And time is your new best friend. No matter what your age, you should be financially preparing for retirement. The more time money has to grow, the more you could potentially have later. That's why it's important to start now.

The power of time

We've provided the hypothetical illustration here to show you how much different deferral amounts per biweekly paycheck could accumulate over 30 years, given an 8% annual effective rate of return. The black sections show how much is actually deferred in, and the red shows how much your account could be worth after 30 years.

The tax-deferred advantage

Ohio Deferred Compensation is tax-deferred, which means the money that goes into your account comes out of your paycheck **before** it is subject to state and federal income taxes. By putting the power of tax-deferral to work for you, **more goes into your account than comes out of your paycheck.** Plus, the assets in your account, including any earnings, will have the opportunity to grow tax-deferred until you decide to withdraw them — usually in retirement. *Withdrawals will be taxed as ordinary income.*



Remember, there are no guarantees. Investing involves risk, including possible loss of principal.

Upon enrollment, you will be mailed a welcome kit that will include a copy of the Cancellation Form, Beneficiary Form, Memorandum of Understanding, and Plan Document with more detailed information on the provisions outlined below:

- My account balance will be held by Ohio Deferred Compensation in trust on behalf of my employer for the exclusive benefit of me or my beneficiaries.
- I may cancel my participation, before my forms are processed, by calling 1-877-644-6457 within seven days from the date that I signed this election form.
- Based on market fluctuations, the rate of return on my account could be either positive or negative. This could result in my account balance being worth less than my contributions.
- Investments may have underlying expenses or management fees that will reduce the investment results. Information on these expenses can be found in the investment profiles or the respective prospectus(es).
- Fund prospectuses can be obtained by calling 1-877-644-6457. Before investing, carefully consider the fund's investment objectives, risks, charges, and expenses. The fund prospectus contains this and other important information. Read the prospectuses carefully before investing.

The Internal Revenue Service imposes rules that limit the times I can make changes or receive withdrawals from the Program.

- At any time, I may change the amount I defer or the allocation of future investment options.
- I may withdraw funds from the Program only upon:
 1. Severance from employment (including termination or death)
 2. An Unforeseeable Emergency (as defined by Section 457 of the IRC)
 3. Small Balance Distribution (see Plan Document for eligibility)
- Withdrawals may begin after my severance from employment and the Program's receipt of my employer's verification of severance, final deferral, and Withdrawal Election form.
- Distributions must satisfy certain minimum requirements upon attaining age 70½.
- The funds in my account may be eligible for rollover to a traditional IRA or to an eligible retirement plan upon severance from employment.
- I realize my participation is for long-term retirement savings and I should maintain separate, available emergency funds to cover day-to-day, unanticipated, financial shortages.
- An Unforeseeable Emergency is defined by the IRS as a severe financial hardship. Please see the Program Plan Document for specific details. The purchase of a home, credit card debt, and the need to send your children to college are not qualifying events.



OHIO DEFERRED COMPENSATION

OHIO PUBLIC EMPLOYEES DEFERRED COMPENSATION PROGRAM

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Address [REDACTED]
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Email Address ddavis@circlevillepolice.com
Work Phone (740) 474-8888 Home Phone N/A Cell Phone [REDACTED]

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Department Name POLICE DEPT.
Pension System: (circle one) OPERS STRS SERS OP&F HPRS Other _____

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Social Security Number (required) [REDACTED]

- ☐ No, I have received information about the Program and choose to decline the opportunity to save tax-deferred money for retirement.

Section 4: Signature & Acknowledgment

I acknowledge that I have read the terms and conditions on the reverse side of this form.

[Signature]
Signature

1/24/13
Date

Ohio Deferred Compensation
257 East Town Street, Suite 457
Columbus, Ohio 43215-4626
1-877-644-6457
614-222-9457 (fax)
www.Ohio457.org

Faxed 1/24/14

HP Officejet 6600 e-All-in-One Series

Fax Log for
City of Circleville HR
740-477-5829
00-00-00 00:00AM

Last Transaction

Date	Time	Type	Station ID	Duration	Pages	Result
				Digital Fax		
00 00	00:00AM	Fax Sent	716142229457	0:58 N/A	1	OK

City of Circleville

DIRECT DEPOSIT AUTHORIZATION FORM



I hereby authorize, **CITY OF CIRCLEVILLE**, to initiate credit entries to my account(s) indicated below for recurring payroll transactions. I understand that if corrections in the credit amount are necessary, it may involve an adjustment (credit or debit) to my account. This authority is to remain in full force and effect until written notification from me of its termination in such time in such manner as to allow my employer reasonable time to act on it.

Additional
(please print)

Name: DOUGLAS A DAVIS

Social Security Number: [REDACTED]

Complete below and attach a voided check.

Amount
\$ 241.⁰⁰
Bi-weekly

Bank Name: [REDACTED]

Checking Account Number: [REDACTED]

Routing Transit Number: [REDACTED]

Signature: [Signature] Date: 1/3/15

PLEASE CANCEL MY CURRENT DIRECT DEPOSIT

Bank Name: _____

Checking Account Number: _____

Signature: _____ Date: _____

Don McIlroy
Mayor

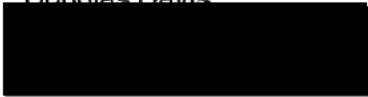
City of Circleville
Department of Public Safety

180 S. Court Street
Circleville, Ohio 43113
740/477-2551
fax 740/477-8247

Tom Hamman
Director of Public Safety

Harold Wayne Gray, Jr.
Chief of Police

December 17, 2013

Douglas Davis


Mr. Davis:

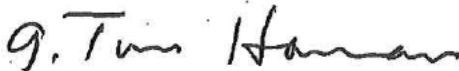
This letter will serve as notification that you have been selected to fill the position of entry level Police Officer for the City of Circleville Police Department effective Sunday, December 29, 2013. Please report to Sgt. Shawn Baer at 0800 hours. Accordingly, your rate of pay is \$16.72 per hour.

In order to complete your new hire paperwork, please bring a copy of your drivers' license and your social security card or birth certificate. You will be given a copy of the City of Circleville Employee Handbook and your benefits will be explained to you. Insurance benefits, if you choose to enroll, are effective 30 days from your date of hire.

Note: As a City of Circleville employee you are required to complete a twelve month probationary period and may be terminated for any reason, including pending results of any background investigations or pre-employment testing, at any time during this period.

Welcome to the City of Circleville. Good luck and we look forward to working with you.

Sincerely,



G. Tom Hamman
Director of Public Safety

cc: Mayor
Chief of Police
Auditor
Civil Service Commission
HR Personnel File

City Of Circleville
Department Of Public Safety
Police Department

POLICE OFFICER

General Description Of Classification & Duties

Under the direct supervision of a Sergeant, a Police Officer patrols designated areas of the City protecting the lives, safety, property and peace of the citizens of Circleville by ensuring compliance with and enforcing all applicable laws and City Ordinances; answers calls when a crime is suspected or an emergency exists; takes such actions as are necessary to prevent crime, to apprehend a criminal, to maintain safety, to assist citizens in a wide range of emergency and non-emergency situations; monitors and controls traffic, enforces traffic laws and investigates traffic crashes; and performs other related duties, tasks, and assignments as required and directed by a Sergeant, Lieutenant, or the Chief of Police. The duties and assignments of a Police Officer are quite varied in nature and occur in a variety of settings and places.

Job Objectives

(Illustration of nature of work)

1. Patrols designated areas by vehicle, foot or bicycle.
2. Drives a police vehicle under a variety of conditions and circumstances such as weather, time of day, terrain and traffic conditions during regular patrol, emergency response and pursuits.
3. Reports unsafe conditions, such as obstructions in streets.
4. Directs and regulates traffic.
5. Issues citations for violations of traffic laws.
6. Investigates traffic crashes, determining conditions, causes and other pertinent facts regarding the crash.
7. Looks for and investigates conditions or situations which may indicate a crime is about to be, or has been, committed.
8. Conducts investigations of crimes, preserves crime scene, gathers and preserves evidence.
9. Makes arrests, sometimes requiring the use of physical effort.
10. Transports prisoners.
11. Books in and cares for prisoners while incarcerated.
12. Writes reports for input into police Department's records system. Fills out forms, prepares affidavits and statements, draws sketches and diagrams of accident and crime scenes.
13. Takes statements from witnesses and suspects.
14. Assists injured persons, notifies families of injury.
15. Checks doors and windows of homes and businesses for security.
16. Testifies in court.

17. Where juveniles are involved, interviews parents, appears in court, and works with school authorities.
18. May be designated as an Instructor/Training Officer, Field Training Officer, Firearms instructor or other similar duties as required.
19. May be designated as a plainclothes Investigator or other similar duties as required.
20. Acts as an "Officer-In -Charge" during the absence of a Sergeant and/or Lieutenant, as designated by the Chief of Police.
21. Performs duties of Communication/Jail Officer as required.
22. Performs public relation activities. Promotes good public relation.
23. Promotes good working relationships with external agencies.
24. Maintain personal and professional competence and awareness.
25. Appropriately uses Police department facilities and equipment.
26. Performs other related duties as assigned.

Essential Job Functions

(Functions essential to attaining job objectives)

1. Regular and predictable job attendance.
2. Excellent eyesight.
3. Good hearing.
4. Ability to communicate well in English.
5. Ability to subordinate personal preference to lawful authority.
6. Ability to get along well with others.
7. Ability to drive an automobile with valid operator license and remain insurable under the City's auto insurance carrier.
8. Ability to read reports, periodicals, and legal documents and laws in English well.
9. Good skills in basic mathematics.
10. Good grammatical skills in writing.
11. Ability to load, aim, fire, unload and clean handguns, shotguns and rifles.
12. Ability to operate traffic speed detections devices (ie: moving and stationary radar, laser devices, VASCAR, etc.).
13. Ability to operate typewriter or computer keyboard.
14. Ability to use fingerprinting lifting and rolling techniques.
15. Ability to overcome resistance and control arrestees.
16. Ability to work in sometimes noisy, close-quartered areas under great mental, physical, and emotional stress.
17. Ability to exercise judgment in the use of deadly force if appropriate.
18. Ability to sketch crime and accident scenes.
19. Ability to cast foot, shoe, tire, or tool marks.
20. Ability to use drug identification kits.
21. Ability to read a map and give directions.
22. Ability to obtain Basic Ohio Peace Officer Training certificate.
23. Ability to obtain ODH certificate to operate BAC Datamaster.
24. Ability to obtain State certification to operate LEADS terminal.

Job Standards

(Minimum qualifications needed to perform essential job functions)

1. Visual acuity must be correctable to 20/20 and no more than 20/125 *binocular* uncorrected each eye. Vision must be free of color deficiencies that would preclude one from performing the essential job functions or would pose a direct threat to the health or safety of oneself or others.
2. Hearing correctable to normal range and adequate for use on standard telephone.
3. Capable of speaking to individuals or large groups of English-speaking persons and being understood.
4. Demonstrated ability to safely drive automobiles with automatic transmissions.
5. Ability to pass State-mandated standard firing requirements for handguns and long guns..
6. Ability to exercise sound reasoning and good judgment.
7. Capable of reading, understanding, and remembering information from printed or handwritten materials.
8. Capable of calculating (addition, subtraction, multiplication, division, percentages, fractions, and other algebraic formulae) numbers and properly count U.S. currency and change.
9. Capable of writing, spelling, printing, and typing English to high degree of grammatical correctness to convey the correct idea or intention to the reader.
10. Capable of typing on the typewriter and computer keyboard to adequately convey intended data or information to English-speaking persons.
11. Ability to demonstrate physical fitness. Mobility for climbing, running and lifting.
12. Capable of performing in a brutally graphic, morbid crime or accident scene.

Critical Skills/Expertise

(Needed for this job specifically)

1. Understanding of Police Department Standard Operating Procedures. **
2. Considerable knowledge of applicable Federal, State, and Local Laws related to law enforcement. **
3. Considerable knowledge of law enforcement methods, principles, practices, and procedures. **
4. Considerable knowledge of safety practices and procedures. **
5. General knowledge of municipal government structure and process and the judicial system. **
6. Good interpersonal and human relations skills.
7. Good written and verbal communication skills.
8. Ability to understand and carry out detailed oral and written instructions.
9. Ability to recognize unusual or threatening conditions and take appropriate action.
10. Ability to interpret and apply principles, concepts, methods, laws, ordinances, and techniques to field conditions.
11. Ability to recognize, analyze, and define problems, establish facts, draw valid conclusions, and initiate appropriate corrective actions.
12. Ability to organize and prioritize daily tasks and activities.

13. Ability to use proper research and investigative methods, techniques, and practices in gathering data.
14. Ability to gather, collate, and classify information and data regarding people, places, events, and activities.
15. Ability to prepare clear, concise, complete, and accurate reports, and complete and maintain accurate records.
16. Ability to copy records precisely without error and to maintain accurate records.
17. Certifiable in the use of firearms. **
18. Safe operation of automobiles.
19. Ability to work alone on most tasks.
20. Ability to cooperate with co-workers on group efforts.
21. Ability to establish and maintain good rapport with the public.
22. Ability to handle routine and sensitive inquiries from, and contact with, the public.
23. Ability to maintain confidentiality in the handling of sensitive events and issues.
24. Competence to be entrusted with highly sensitive and confidential information.
25. Ability to communicate with the public, peers, superiors, and other City Officials and employees in an effective, tactful, and courteous manner.
26. Ability to resolve complaints from angry citizens in an effective, tactful, and courteous manner.
27. Ability to establish and maintain effective working relationships with superiors and peers.
28. Ability to demonstrate physical strength and dexterity in the use of hands and feet as well as general physical fitness.

***May be developed or acquired after appointment.*

Non-Essential Functions

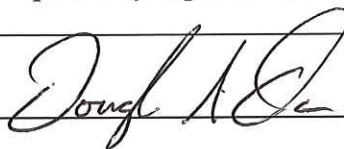
(Marginal tasks performed by incumbents of this position)

1. Operate 35mm camera or video recorder.
2. Stand in and direct motor traffic.
3. Operate standard transmission automobile or small truck.
4. Lifting file cabinet drawers.
5. Lifting file report boxes.
6. Alphabetize and locate files in alphabetic order.
7. Operate BAC Datamaster.
8. Use vehicle-entry lockjock tool.
9. Answering incoming telephone calls and redirect appropriately.
10. Pickup or deliver packages, correspondences and supplies for the Police department.
11. Basic first aid and CPR skills.

Required Education/Experience & Other Requirements

1. Must be a United States citizen.
2. At least 21 years of age and not more than 35 years of age at the time of original appointment.
3. High School Diploma, G.E.D. (GED average 4.8), or equivalent certificate.
4. Background must be free of prior felony convictions and certain misdemeanor convictions.
5. Possession of valid State of Ohio drivers' license and the ability to meet the City of Circleville's requirements for insurability.
6. Visual acuity must be correctable to 20/20 and no more than 20/125 *binocular* uncorrected each eye. Vision must be free of color deficiencies that would preclude one from performing the essential job functions or would pose a direct threat to the health or safety of oneself or others.
7. Must be physically capable of successfully performing the *Job Objectives and Essential Job Functions* of the Police Officer classification and be free of medical conditions that would preclude one from successfully performing said functions or would pose a direct threat to the health or safety of oneself or others.
8. Successful completion of all phases of the selection process prior to appointment. The selection process includes application phase, written examination, oral examination, record check, background investigation, physical fitness evaluation, polygraph or voice stress examination, psychological evaluation, final interview with the Director of Public Safety, medical examinations and drug screening.
9. Successful completion of a State Certified Peace Officer basic training program. *(Not required prior to appointment; however, if a new Officer, at the time of appointment, has not completed such a training program, he/she must enter such a program upon appointment)*
10. State certification to operate LEADS computer system. *(Not required prior to appointment)*
11. Must establish a primary place of residence within a 20-mile radius of the City of Circleville within 180 days after completion of probationary period and maintain such place of residence during employment with the City of Circleville.

This job specification should not be construed to imply that these requirements are the exclusive standards of the position. Incumbents will follow any other instructions, and perform any other related duties, as may be required by supervisors.

EMPLOYEE SIGNATURE:  DATE: 12/29/13

SUPERVISOR SIGNATURE: _____ DATE: _____

DEPARTMENT HEAD SIGNATURE: _____ DATE: _____

CITY OF CIRCLEVILLE

Employee Handbook Acknowledgement

This form is to acknowledge that I have received a copy of the Employee Handbook and/or have access to a copy outlining the responsibilities of an employee and the responsibilities of the City of Circleville. I have read and understand the information contained in this handbook and it has been explained during orientation. If I have any questions, I should contact the Human Resources office. I understand that the employee handbook is not an employment contract but does provide the City of Circleville's employment policies and procedures by which I am governed. I agree to comply with the guidelines of the City of Circleville. This handbook is subject to change without notice. It is understood that changes in procedure will supersede or eliminate those found in this book and I will be notified of such changes through normal communication channels.

Visit www.ci.circleville.oh.us for the most recent version of the City of Circleville Employee Handbook and City of Circleville Policies and Procedures Manual



Employee Signature

12/29/13

Date

DOUGLAS A. DAVIS

Employee Printed Name

12/29/13

Date of Hire

This form must be returned within 5 days of hire

NAARCO
OHIO NARCOTICS ASSOCIATION REGIONAL COORDINATING OFFICERS

OUTSTANDING NARCOTICS INVESTIGATION OF THE YEAR

Detective Doug Davis	Detective Robert Morningstar
Detective Tommy Royster	Detective Phillip Roar

Presented by the Ohio Narcotics Association of Regional Coordinating
Officers and its members for your outstanding contributions in drug
enforcement on behalf of the citizens of your community and the State of

Ohio



Dennis J. Lowe
President

George R. Romano
Vice President