PART TIME NEW HIRE FORMS

AL DOL _____
I-9 WITH 2 FORMS OF IDENTIFICATION _____
FEDERAL WITHOLDING W-4 _____
STATE WITHOLDING A-4 _____
DIRECT DEPOSIT _____
PROBATIONARY RECOGNITION FORM _____
ERS ENROLLMENT _____
HANDBOOK ACKNOWLEDGEMENT _____
INTERNET AND EMAIL POLICY _____
PRE-EMPLOYMENT SUBSTANCE TESTING _____
DRUG FREE WORKPLACE CONSENT _____
ETHICS TRAINING CERTIFICATE _____

HR WILL COMPLETE AL NEW HIRE
HR WILL COMPLETE E-VERIFY

Employment Eligibility Verification

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

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

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

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

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

Last Name *(Family Name)*	First Name *(Given Name)*	Middle Initial	Other Last Names Used *(if any)*

Address *(Street Number and Name)*	Apt. Number	City or Town	State	ZIP Code

Date of Birth *(mm/dd/yyyy)*	U.S. Social Security Number	Employee's E-mail Address	Employee's Telephone Number
	☐☐☐ - ☐☐ - ☐☐☐☐		

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

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

☐ 1. A citizen of the United States

☐ 2. A noncitizen national of the United States *(See instructions)*

☐ 3. A lawful permanent resident (Alien Registration Number/USCIS Number): _____

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

Aliens authorized to work must provide only one of the following document numbers to complete Form I-9: An Alien Registration Number/USCIS Number OR Form I-94 Admission Number OR Foreign Passport Number.

1. Alien Registration Number/USCIS Number: _____
OR
2. Form I-94 Admission Number: _____
OR
3. Foreign Passport Number: _____
Country of Issuance: _____

QR Code - Section 1
Do Not Write in This Space

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

Preparer and/or Translator Certification (check one):

☐ I did not use a preparer or translator. ☐ A preparer(s) and/or translator(s) assisted the employee in completing Section 1.

(Fields below must be completed and signed when preparers and/or translators assist an employee in completing Section 1.)

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

Signature of Preparer or Translator	Today's Date *(mm/dd/yyyy)*

Last Name *(Family Name)*	First Name *(Given Name)*

Address *(Street Number and Name)*	City or Town	State	ZIP Code

STOP *Employer Completes Next Page* STOP

Employment Eligibility Verification

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

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

Section 2. Employer or Authorized Representative Review and Verification

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

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

List A Identity and Employment Authorization	OR	List B Identity	AND	List C Employment Authorization
Document Title		Document Title		Document Title
Issuing Authority		Issuing Authority		Issuing Authority
Document Number		Document Number		Document Number
Expiration Date *(if any)(mm/dd/yyyy)*		Expiration Date *(if any)(mm/dd/yyyy)*		Expiration Date *(if any)(mm/dd/yyyy)*
Document Title				
Issuing Authority				
Document Number				
Expiration Date *(if any)(mm/dd/yyyy)*				
Document Title				
Issuing Authority				
Document Number				
Expiration Date *(if any)(mm/dd/yyyy)*				

Additional Information

QR Code - Section 2
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)*: _____ ***(See instructions for exemptions)***

Signature of Employer or Authorized Representative	Today's Date *(mm/dd/yyyy)*	Title of Employer or Authorized Representative
		HUMAN RESOURCES

Last Name of Employer or Authorized Representative	First Name of Employer or Authorized Representative	Employer's Business or Organization Name
FORMAN	JENNIFER	ST. CLAIR COUNTY COMMISSION

Employer's Business or Organization Address (Street Number and Name)	City or Town	State	ZIP Code
165 5TH AVENUE SUITE 100	ASHVILLE	AL	35953

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

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

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

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

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

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

FORM
A4
(REV. 3/2014)

ALABAMA DEPARTMENT OF REVENUE
50 North Ripley Street • Montgomery, AL 36104 • InfoLine (334) 242-1300
www.revenue.alabama.gov

Employee's Withholding Tax Exemption Certificate

Every employee, on or before the date of commencement of employment, shall furnish his or her employer with a signed Alabama withholding exemption certificate relating to the number of withholding exemptions which he or she claims, which in no event shall exceed the number to which the employee is entitled. In the event the employee inflates the number of exemptions allowed by this Chapter on Form A4, the employee shall pay a penalty of five hundred dollars ($500) for such action pursuant to Section 40-29-75.

Part I – To be completed by the employee

EMPLOYEE NAME | EMPLOYEE SOCIAL SECURITY NUMBER

STREET ADDRESS | CITY | STATE | ZIP CODE

HOW TO CLAIM YOUR WITHHOLDING EXEMPTIONS

1. If you claim no personal exemption for yourself and wish to withhold at the highest rate, write the figure "0", sign and date Form A4 and file it with your employer. ..... _____
2. If you are SINGLE or MARRIED FILING SEPARATELY, a $1,500 personal exemption is allowed. Write the letter "S" if claiming the SINGLE exemption or "MS" if claiming the MARRIED FILING SEPARATELY exemption ..... _____
3. If you are MARRIED or SINGLE CLAIMING HEAD OF FAMILY, a $3,000 personal exemption is allowed. Write the letter "M" if you are claiming an exemption for both yourself and your spouse or "H" if you are single with qualifying dependents and are claiming the HEAD OF FAMILY exemption ..... _____
4. Number of dependents (other than spouse) that you will provide more than one-half of the support for during the year. *See dependent qualification below.* ..... _____
5. Additional amount, if any, you want deducted each pay period ..... $ _____
6. **This line to be completed by your employer:** Total exemptions (example: employee claims "M" on line 3 and "2" on line 4. Employer should use column M-2 (married with 2 dependents) in the withholding tables) ..... _____

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

Employee's Signature _____ **Date** _____

Part II – To be completed by the employer

EMPLOYER NAME: St. Clair County Commission | EMPLOYER IDENTIFICATION NUMBER (EIN)

ADDRESS: 165 5th Ave., Suite 100 | CITY: Ashville | STATE: AL | ZIP CODE: 35953

Employers are required to keep this certificate on file. If the employee is believed to have claimed more exemption than legally entitled or claims 8 or more dependent exemptions, the employer should contact the Department at the following address or phone number for verification: Alabama Department of Revenue, Withholding Tax Section, P.O. Box 327480, Montgomery, AL 36132-7480, by phone at (334) 242-1300, or by fax at (334) 242-0112. If the employee does not qualify for the exemptions claimed upon verification, the employer is required to withhold at the highest rate until the employee submits a corrected Form A4 reflecting the proper exemption they are entitled to claim.

DEPENDENTS: To qualify as your dependent (Line 4 above), a person must receive more than one-half of his or her support from you for the year and must be related to you as follows:

Your son or daughter (including legally adopted children), grandchild, stepson, stepdaughter, son-in-law, or daughter-in-law;
Your father, mother, grandparent, stepfather, stepmother, father-in-law, or mother-in-law;
Your brother, sister, stepbrother, stepsister, half-brother, half-sister, brother-in-law, or sister-in-law;
Your uncle, aunt, nephew, or niece (but only if related by blood).

Form **W-4**

Department of the Treasury
Internal Revenue Service

Employee's Withholding Certificate

▶ **Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay.**
▶ **Give Form W-4 to your employer.**
▶ **Your withholding is subject to review by the IRS.**

OMB No. 1545-0074

2022

Step 1: Enter Personal Information

(a) First name and middle initial	Last name	(b) Social security number
Address		▶ **Does your name match the name on your social security card?** If not, to ensure you get credit for your earnings, contact SSA at 800-772-1213 or go to *www.ssa.gov*.
City or town, state, and ZIP code		

(c) ☐ **Single** or **Married filing separately**
☐ **Married filing jointly** or **Qualifying widow(er)**
☐ **Head of household** (Check only if you're unmarried and pay more than half the costs of keeping up a home for yourself and a qualifying individual.)

Complete Steps 2–4 ONLY if they apply to you; otherwise, skip to Step 5. See page 2 for more information on each step, who can claim exemption from withholding, when to use the estimator at *www.irs.gov/W4App*, and privacy.

Step 2: Multiple Jobs or Spouse Works

Complete this step if you (1) hold more than one job at a time, or (2) are married filing jointly and your spouse also works. The correct amount of withholding depends on income earned from all of these jobs.

Do **only one** of the following.

(a) Use the estimator at *www.irs.gov/W4App* for most accurate withholding for this step (and Steps 3–4); **or**

(b) Use the Multiple Jobs Worksheet on page 3 and enter the result in Step 4(c) below for roughly accurate withholding; **or**

(c) If there are only two jobs total, you may check this box. Do the same on Form W-4 for the other job. This option is accurate for jobs with similar pay; otherwise, more tax than necessary may be withheld . . ▶ ☐

TIP: To be accurate, submit a 2022 Form W-4 for all other jobs. If you (or your spouse) have self-employment income, including as an independent contractor, use the estimator.

Complete Steps 3–4(b) on Form W-4 for only ONE of these jobs. Leave those steps blank for the other jobs. (Your withholding will be most accurate if you complete Steps 3–4(b) on the Form W-4 for the highest paying job.)

Step 3: Claim Dependents

If your total income will be $200,000 or less ($400,000 or less if married filing jointly):

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

Multiply the number of other dependents by $500 . . . . ▶ $ _____

Add the amounts above and enter the total here . . . . . **3** $

Step 4 (optional): Other Adjustments

(a) Other income (not from jobs). If you want tax withheld for other income you expect this year that won't have withholding, enter the amount of other income here. This may include interest, dividends, and retirement income . . . . . **4(a)** $

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

(c) Extra withholding. Enter any additional tax you want withheld each **pay period** . . **4(c)** $

Step 5: Sign Here

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

▶ _____ ▶ _____

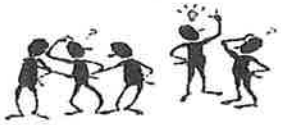
Employee's signature (This form is not valid unless you sign it.) **Date**

Employers Only

Employer's name and address	First date of employment	Employer identification number (EIN)

SIGN UP FOR DIRECT DEPOSIT TODAY!

RETURN THIS FORM WITH THE ORIGINAL SIGNATURE TO THE COUNTY COMMISSION OFFICE



Direct deposit is fast, safe and reliable. To take advantage of this benefit, enroll below.

It's fast-Your money will be deposited in your account on payday and available for you that morning. You do not have to worry about vacations, sick time or being just too busy.
It's safe-Your paycheck cannot be stolen or lost.

It's reliable-You'll still get a pay stub to show your deposit that includes your deductions and amount of pay.

Please return the form with the original signature to the County Commission Office.

Enrollment:
I authorize St. Clair County Commission to credit my account for direct deposit. I also authorize St. Clair County Commission to debit my account for any correction that may need to be made in an event there was an error. I also understand it is my responsibility to notify the St. Clair County Commission immediately in writing about any changes I make with my bank account. I am providing the following account information to allow processing of my payroll.

Print Name: Social Security Number:

Signature: Date:

Please complete the following:

Name of Bank:

Account #

Routing #

Checking or Savings:

Attach a Voided Check/ Bank Notification:

ERS Enrollment Member Information Record

Employees' Retirement System of Alabama
PO Box 302150, Montgomery, Alabama 36130-2150
877.517.0020 • 334.517.7000 • www.rsa-al.gov

Your SSN ☐☐☐ ☐☐ ☐☐☐☐

Check One: ☐ New Member ☐ Transfer from another ERS Agency

Your Information

No initials please

Name _____
First Middle/Maiden Last

Address _____
Street or P.O. Box City State ZIP Code

Daytime Telephone _____ Email Address _____

Date of Birth _____ Sex ☐ Male ☐ Female

Status ☐ Married ☐ Single ☐ Widowed ☐ Divorced

Employer Information

Employing Agency _____ Section or Division _____

Classification or title of position or elected office you hold _____

Daytime Telephone _____ Email Address _____

Are you an Elected Official?	☐ Yes ☐ No
Have you ever been employed by any agency of public education in Alabama?	☐ Yes ☐ No
Have you ever been a member of the Employees' Retirement System of Alabama?	☐ Yes ☐ No
Were you a member before beginning employment with your current employer?	☐ Yes ☐ No
Have you ever withdrawn contributions from the Retirement Systems?	☐ Yes ☐ No

If you answered yes to any of the preceding four questions, please provide the information requested below, listing most recent employment first.

Employing Agency	City	Year	Under What Name	Date Terminated

Sign Here → **Your Signature** _____ **Date** _____

Employer Certification

To be completed by the employing agency

Employing Agency _____

Annual Salary _____ Employment Date _____

Number of Pay Periods Per Year _____ Employment Status (full-time, ½ time, ¾ time, etc.) _____

Sign Here → **Employer Signature** _____ **Date Submitted** _____
Employer

Title _____

THIS BOX IS FOR EMPLOYEES' RETIREMENT SYSTEM USE ONLY

Comments: _____

continued on next page

ERS Enrollment Member Information Record

Employees' Retirement System of Alabama
PO Box 302150, Montgomery, Alabama 36130-2150
877.517.0020 • 334.517.7000 • www.rsa-al.gov

Name _____ **SSN** ☐☐☐ ☐☐ ☐☐☐☐

Designation of Primary Beneficiary(ies)

Please give complete information

I, the undersigned, do hereby designate the following individuals as my primary beneficiary(ies) to whom I instruct the Board of Control of the Employees' Retirement System of Alabama to pay, in the event of my death before retirement on pension, the total amount of the accumulated contributions standing to my credit in the retirement system.

Name _____ Relationship _____ Date of Birth _____

Address _____
Street or P.O. Box City State ZIP Code

Name _____ Relationship _____ Date of Birth _____

Address _____
Street or P.O. Box City State ZIP Code

Designation of Contingent Beneficiary(ies)

Please give complete information

In the event the primary beneficiary(ies) designated above does **not** survive me, I hereby authorize the Employees' Retirement System of Alabama to pay the benefits to the beneficiary(ies) named below.

Name _____ Relationship _____ Date of Birth _____

Address _____
Street or P.O. Box City State ZIP Code

Name _____ Relationship _____ Date of Birth _____

Address _____
Street or P.O. Box City State ZIP Code

Signature Certification

I agree on behalf of myself, my heirs, and assigns that payment so made shall be a complete discharge of the claim and shall constitute a release of the System from any further obligation on account of the benefit. I hereby direct that should I survive either or both of the before mentioned beneficiaries, the amount which otherwise would have been payable to the beneficiary had he/she been living shall be paid to my estate or to such other beneficiary as I shall hereafter nominate by written designation filed with the Employees' Retirement System of Alabama in accordance with the rules and regulations prescribed by the Board of Control. Divorce or annulment of a marriage shall not revoke or void the designation of a spouse as beneficiary for any benefits payable by RSA.

Sign Here → **Your Signature** _____ **Date** _____

Please have your signature acknowledged before a Notary Public.

STATE OF _____, COUNTY OF _____

On this _____ day of _____, 20_____ , personally appeared before me, the above named individual and made oath that the statements made are true.

Signature of Notary Public _____

Seal My Commission Expires _____

Employee Probationary Recognition

The probationary period is intended to give new employees the opportunity to demonstrate their ability to achieve a satisfactory level of performance and to determine whether the new position meets their expectations. The Appointing Authority uses this period to evaluate employee capabilities, work habits, and overall performance. Either the employee or the Appointing Authority may end the employment relationship at will at any time during the probationary period, with or without cause or advance notice. Probationary employees are not entitled to use the Employee Right of Appeal/"Due Process" Procedure.

All new and rehired employees work on a probationary basis for the first 90 calendar days after their date of hire. Any significant absence will automatically extend the probationary period by the length of the absence. If the Appointing Authority determines that the designated probationary period does not allow sufficient time to thoroughly evaluate the employee's performance, the probationary period may be extended for a specified period.

During the probationary period, all new employees are eligible for those benefits that are required by law, such as workers' compensation insurance and Social Security. Full-time probationary employees are granted the same benefits as regular full-time employees with the exception that accrued annual and sick leave may not be used until the employee has successfully completed the probationary period. During the probationary period, a new employee must be on the job for a full 80 hours each pay period to be eligible to accrue leave time. Upon successful completion of the probationary period, the employee will enter the regular employment classification, either full-time or part-time.

I, _____, hereby understand and recognize that with the promotion/employment with the St. Clair County _____ I will be placed on probation for an allotted amount of time. This time is to be determined based on my employment status.

(Check one)

____ Full Time (180 days probation)

____ Part Time (180 days probation)

____ Occasional/Seasonal (continuous probation)

_____ _____

Employee Supervisor/Elected Official

Date of Hire: _____

SHERIFF DEPARTMENT EMPLOYEES

Employees of the St. Clair County Sheriff's department, including deputies, jailers, etc., are exclusively employees of the Sheriff's department and are in no manner employees of St. Clair County or the St. Clair County Commission. The regulations and policies set forth in this handbook are not applicable whatsoever to said employees. The St. Clair County Sheriff shall manage the personnel within the Sheriff's department as he or she sees fit and without interference from St. Clair County and/or the St. Clair County Commission.

Employee Acknowledgment Form

The employee handbook describes important information about St. Clair County, and I understand that I should consult my supervisor or the Personnel Department regarding any questions not answered in the handbook. Furthermore, I acknowledge that this handbook is not a contract of employment and that my employment is at will and that either St. Clair County or I can terminate my employment at any time.

Since the information, policies, and benefits described here are necessarily subject to change, I acknowledge that revisions to the handbook may occur. All such changes will be communicated through official notices, and I understand that revised information may supersede, modify, or eliminate existing policies.

I have received the handbook, and I understand that it is my responsibility to read and comply with the policies contained in this handbook and any revisions made to it.

Employee's Signature _____

Date _____

Employee's Name (Printed) _____

County network has sufficient antivirus and antimalware software in place. Remote users are solely and exclusively responsible for any damage caused by their use of the system.

Retention of Email

Employees should be aware that when they have deleted a message from their workstation mailbox it might not have been deleted from the central mail system. The message may be residing in either the sender or receiver's mailbox or forwarded to other recipients. Furthermore, the message may be stored on any of the aforementioned backups for an indefinite period. Emails have been classified as "public" documents, which should be kept in mind when you create or store email. Users should delete email messages as soon as possible after reading. An accumulation of files will degrade system performance and response times.

Enforcement and Violations

Violation of this policy may result in termination of Internet Access or email services, possible disciplinary action, up to and including dismissal and criminal charges where appropriate. Termination of services may be at the request or determination of the department head, County Administrator or County Commission. Any disciplinary action will be in accordance with the St. Clair County Personnel Policy.

Conflict Repealer

Any policy, practice or procedure of St. Clair County currently in effect which is in conflict with the provisions of this policy is hereby repealed to the extent of such conflict and only to the extent of such conflict.

Written Agreement Required

The county requires employees to read and signify acceptance of the terms of this policy by printing this page and signing the following "Understanding of Policy" before making Internet Access or email service available.

Signature _____ Date_____

St. Clair County
Pre-Employment Substance Testing Consent and Release Form

I hereby certify that I have been given notice of the St. Clair County's pre-employment substance testing policy; that I have been provided with access to a copy of the St. Clair County's Drug-Free Workplace Policy Statement; and that I have read or waived my right to read it. I hereby freely and voluntarily consent to submit to urinalysis and/or other screening or tests as shall be determined by St. Clair County in the selection process of final applicants for employment, for the purpose of determining the presence of, and content of, any or all of the following substances:

1.	Amphetamines	6.	Methadone
2	Cannabinoids	7.	Methaqualone
3.	Cocaine	8.	Barbiturates
4.	Phencyclidine (PCP)	9.	Benzodiazepines
5.	Opiates	10.	Propoxyphene

I agree that the employer representative, collection site, physician, or clinic or may collect these specimens for screening or testing and may screen them or forward them to a testing laboratory designated by the St. Clair County for analysis.

I further agree to and hereby authorize the release of the results of said tests to St. Clair County and to St. Clair County's Medical Review Officer and its agents as provided in the Policy Statement. I further agree to release and hold harmless St. Clair County and its agents individually and collectively, including each person or business entity involved in the sample request, collecting, screening, testing, evaluation, and reporting; and for any decisions, adverse or otherwise, made concerning my application for employment based on the screening or test results.

I understand that a negative screen or test is a pre-condition of employment with St. Clair County and that the refusal to submit to screening or testing, or a positive screen or test result will result in the rejection of my application, or the rescinding of a conditional offer of employment as described in St. Clair County's Drug-Free Workplace Policy Statement. I also understand that it is not the purpose of this screen or test to identify any disability I may have and that pre-employment screening and testing activities are conducted in compliance with ADA requirements.

I further agree that a reproduced copy of this pre-employment consent and release form shall have the same force and effect as the original I have carefully read the foregoing and fully understand as contents. I acknowledge that my signing of this consent and release form is a voluntary act on my part and that I have not been coerced into signing this document by anyone.

Applicant Printed Name: _____ SS#_____

Applicant Signature: _____ Date_____

Witness Printed Name:_____ Witness Signature:_____

St. Clair County Active Employee Certificate of Agreement and
Receipt of Employee Policy Statement Consent Form

I certify that I have received and read the St. Clair County Drug-Free Workplace Policy Statement. The terms and conditions of the County's drug-free workplace program have been explained to me and I freely and voluntarily consent to submit to the drug and alcohol screening or testing as set forth in the County's program. I understand and acknowledge that under the Alabama Code, no workers' compensation benefits will be paid to me if I test positive for drugs or alcohol in a confirmed laboratory test at the time of a work-related injury or death, or if I refuse to submit to either a drug or alcohol test or screening at the time of a work accident.

I also understand that a positive confirmed laboratory result from a post-accident drug or alcohol test is evidence of willful misconduct so as to disqualify me from Workers' Compensation benefits. I also understand and acknowledge that under the Alabama Code, no unemployment benefits will be paid to me under certain circumstances related to a drug and alcohol test, including if I am dismissed as the result of a positive confirmed laboratory test for drugs or alcohol; if I refuse to submit to an initial screening or a laboratory test for drugs or alcohol; if I refuse to cooperate with the County's representative in an initial screening; or if I knowingly alter or adulterate any screening or test sample.

I understand that if I refuse to submit to screening or testing or if there is a positive confirmed laboratory test result, that it will affect my continued employment and result in disciplinary action as described in the County's Drug-Free Workplace Policy Statement, up to and including termination. I also understand that the purpose of screening and/or testing is not to identify any disability I may have and that all testing activities will be conducted in accordance with regulations under the Americans with Disabilities Act (ADA).

I give my consent to the County and/or its designated representative to collect specimens, as set out in the policy, for the purpose of determining the presence of drugs and alcohol. I further agree to and hereby authorize the release of the results of said tests to St. Clair County, to the County Medical Review Officer, and as set forth in the Policy Statement.

I further agree that a reproduced copy of this consent form shall have the same force and effect as the original. I have carefully read the foregoing and fully understand its contents. I acknowledge that my signing of this consent form is a voluntary act on my part and that I have not been coerced into signing this document by anyone. I expressly authorize the County, its agents, and its Medical Review Officer to release any screening or testing-related information, including positive confirmed laboratory test results, to the Alabama Department of Industrial Relations, Unemployment Compensation Agency, St. Clair County's workers' compensation administrator or carrier, officials of the government agency investigating my employment or the termination thereof, or in any related administrative or court proceeding, and as set forth in the Policy Statement. I understand that this agreement in no way limits my right to terminate my employment or be terminated and the Policy Statement is not in any manner contractual in nature.

Employee Printed Name: _____
Employee Signature:_____
Date: _____
Witness Printed Name: _____
Witness Signature:_____

(This form is to be signed by employee and retained in personnel file.)