DOAA
Georgia Department
of Audits & Accounts

PERSONAL INFORMATION FORM

Name As It Appears on SS Card

Last 4 Digits of SS Number

Street Address

Apt. Number

City

State

Zip Code

County of Residence

Phone Number

Date of Birth

Date of employment with the Department of Audits and Accounts:

Previous employment:

Have you ever worked for any other State
Agency?If yes, give the dates of service:
Were you paid for accumulated annual leave?

Name you prefer on your name pin:

Employee ID# (if previously employed with the State of Georgia)

DOAA
Georgia Department
of Audits & Accounts

EMERGENCY CONTACT INFORMATION

Employee: Date:

PLEASE LIST ONLY PRIMARY CONTACT

Contact Name:
Primary Contact? yes
Relationship to Employee:
Home Address Same as Employee: yes
Address 1:
Address 2:
City: County: State: Zip:

Phone Numbers:
Home:
Business:
Cellular:

Contact Name:
Primary Contact? yes
Relationship to Employee:
Home Address Same as Employee: yes
Address 1:
Address 2:
City: County: State: Zip:

Phone Numbers:
Home:
Business:
Cellular:

Contact Name:
Primary Contact? yes
Relationship to Employee:
Home Address Same as Employee: yes
Address 1:
Address 2:
City: County: State: Zip:

Phone Numbers:
Home:
Business:
Cellular:

DOAA
Georgia Department
of Audits & Accounts

GEORGIA DEPARTMENT OF AUDITS OUTSTANDING WAGES FORM

PURPOSE: This form establishes the employees' designation of beneficiary(s) to receive any outstanding wages or other monies due to the employee from the Department of Audits upon their death.

Employee Name:

Address:

Last 4 Digits of SS Number:

Work Phone: Home Phone:

Beneficiaries

Primary Beneficiary

Last Name First Name Middle Initial

Address

Relationship Phone Number Last 4 Digits of SS Number:

Second Beneficiary (If the Primary Beneficiary is Deceased)

Last Name fsf First Name Middle Initial

Address

Relationship Phone Number Last 4 Digits of SS Number:

Third Beneficiary (1fthe Primary and Secondary Beneficiary are Deceased)

Last Name First Name Middle Initial

Address

Relationship Phone Number Last 4 Digits of SS Number:

I acknowledge that in the event of my death, if I have any wages or other monies due to me from the Department of Audits, I am authorizing the Department of Audits to pay the above-designated beneficiary(s).

Signature: Date:

DOAA
Georgia Department
of Audits & Accounts

ASSURANCES FOR USE OF CONFIDENTIAL DATA
DEPARTMENT OF AUDITS AND ACCOUNTS

Confidentiality of Information

For all engagements, I agree to protect confidential data as determined by law, regulation, and policy. I shall protect its confidentiality with at least the care and procedures by which it is protected by the custodial organization or substantially equivalent care and procedures.

I acknowledge that it is risky to continue accessing data no longer needed for an engagement. I agree to only access information relevant to the current engagement I am assigned. This includes but is not limited to data provided or data I have access to, including TeamWorks, or other custodial organizations' systems or databases.

Notification of Presentations

I agree to notify the client before formally presenting any material revealing confidential data. Formal presentation includes papers, articles, professional publications, speeches, and testimony.

Confidentiality Agreement

For all engagements, I agree to provide the client with a copy of the Department of Audits and Accounts Confidentiality Agreement and ensure that confidential data is properly stored and protected in our custody and adequately disposed of when no longer needed. Confidential data obtained may be shared/disclosed to other organizations and officers who are independently entitled to its receipt. If such confidential data is shared, the organization/officers receiving the data will acknowledge receipt of the data requested, identify the law, regulation, or policy that identifies their independent entitlement to this confidential data, and sign a Data Sharing Confidentiality Agreement Statement, which obligates them to protect the data with at least the same care as the custodial organization.

I acknowledge that I am responsible for proper security and disposition of any confidential or sensitive data obtained.

Printed Name

Division

Signature

Date

Director Signature

Date

DOAA
Georgia Department
of Audits & Accounts

DIRECT DEPOSIT NOTIFICATION FORM

(To be signed by all new hires and rehires on and after May 1, 2010)

In accordance with the Mandatory Direct Deposit policy, a person hired or rehired to a position in a State organization and who is paid by the central payroll system administered by the State Accounting Office (SAO), is required to accept all payroll related payments by direct deposit.

I understand that as a condition of employment, because I am a new hire or rehire applicant, I must comply with the policy and enroll in direct deposit using the Employee Self Service (ESS) feature of the system within 30 days of being hired or rehired and remain enrolled in direct deposit during the tenure of my employment. I understand that I can apply for an exemption from this requirement as provided by the policy.

Employee Name:

Employee Signature: Date:

To be completed by employing organization:

Employee ID Number: Position Title:

Hiring Organization Name: Department of Audits and Accounts

Hiring Supervisor or HR Official:

Copy 1 - Organization Human Resources Office
Copy 2 - Employee

DOAA
Georgia Department
of Audits & Accounts

EDUCATION INFORMATION

Please complete the sections below that are applicable

Name: Date:

Undergraduate College:

Degree Received: (i.e., BBA, BS)

Major:

Graduate College: (if applicable)

Degree Received:

Major:

List other degrees:

Other certifications: (please provide copies of certifications to Human Resources)

Certified Public Accountant	Date received:
Certified Internal Auditor	Date received:
Certified Government Financial Manager	Date received:
Certified Public Finance Officer	Date received:
Certified Fraud Examiner	Date received:
Certified Government Auditing Professional	Date received:
State Certified General Real Property Appraiser	Date received:
State Certified Residential Real Property Appraiser	Date received:
State Licensed Real Property Appraiser	Date received:
State Registered Real Property Appraiser	Date received:
Certified Information Systems Auditor	Date received:

DOAA
Georgia Department
of Audits & Accounts

To: All Employees

From: Administrative Division

Re: Injuries on the Job

Please review the Workers' Compensation Notice that is posted in each Department of Audits and Accounts office and on the Department's intranet. If you suffer an injury while performing your duties for the State of Georgia, you must immediately report this injury to your supervisor and to Human Resources. The injured employee, if able, or supervisor must complete an Employer's First Report of Injury form provided by Human Resources so that we can notify DOAS Workers' Compensation Unit immediately.

If Human Resources recommends it, the employee needs to call the toll-free telephone number on the accompanying card to report the incident to DOAS. The DOAS contact will record the claim and will transfer the call to a Nurse with the WC/MCO. The Nurse will assess the situation and provide guidance about where the employee must go for treatment for the on-the-job related injury. The employee may make one switch to a different participating physician after the initial treatment, if necessary. Any other changes in treatment require the permission of a qualified representative of the Department of Administrative Services, Risk Management Division.

In case of an emergency, the employee should seek treatment from the nearest hospital emergency room. However, all follow-up care should be obtained from a WC/MCO physician. An emergency incident needs to be reported as soon possible.

Failure to seek treatment for your job-related injuries from a WC/MCO physician may jeopardize payment of your medical bills under Workers' Compensation and you may be personally liable.

Please read and sign the page 2 memorandum and return it to:

Department of Audits
270 Washington Street, Suite 4-101
Atlanta, Georgia 30334-8400

DOAA
Georgia Department
of Audits & Accounts

MEMORANDUM TO PERSONNEL FILE

This is to certify that I have been advised of the Official Policy on reporting On-the-job/Workers' Compensation Injuries.

I understand that if I am involved in an on-the-job injury and emergency treatment is NOT necessary, I must accept the services of a Workers' Compensation Managed Care Organization (WC/MCO) physician. (If I desire to obtain medical service from a physician not participating in the WC/MCO program, I may do so; however, I will be liable for any medical expenses.) The WC/MCO physician selected may arrange for appropriate consultations, referrals and other specialized medical services as the nature of the injury requires. If I am dissatisfied with the physician selected, after contacting and obtaining the approval from a qualified representative of the Department of Administrative Services (DOAS), Risk Management Division, I may change physicians.

In the case of an emergency, I should be taken to the nearest emergency room. However, all follow up care must, thereafter, be rendered by a WC/MCO physician.

I further understand that I must notify my supervisor and the Dept. of Audits and Accounts HR Manager as soon as an injury occurs, or as soon as possible if the injury requires emergency care. Delay in notification can result in denial of payment for medical services rendered.

If my claim is accepted as compensable and I am receiving weekly indemnity benefits (or it has been no longer than one hundred twenty (120) days since I last received indemnity benefits) I understand I am entitled to ONE independent medical examination by a physician of my choice. Should I exercise this right, I will notify DOAS in writing in advance of the examination. The cost will be paid by DOAS but no diagnostic procedures performed since my on-the-job injury and costing in excess of $250.00 will be repeated by my independent physician. If this cost does exceed $250.00, I understand I may be expected to pay for such procedures.

The undersigned has read and agrees to adhere to the policy described and has received a Workers' Compensation Emergency Care wallet card for his/her use in the event of an on-the-job injury.

Signature of Employee Date:

Employment Eligibility Verification

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

USCIS Form I-9
OMB No.1615-0047
Expires 07/31/2026

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

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

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

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

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

Date of Birth (mm/dd/yyyy)	U.S. Social Security Number	Employee's Email Address	Employee's Telephone Number

I am aware that federal law provides for imprisonment and/or fines for false statements, or the use of false documents, in connection with the completion of this form. I attest, under penalty of perjury, that this information, including my selection of the box attesting to my citizenship or immigration status, is true and correct.

Check one of the following boxes to attest to your citizenship or immigration status (See page 2 and 3 of the instructions.):

- ☐ 1. A citizen of the United States
- ☐ 2. A noncitizen national of the United States (See Instructions.)
- ☐ 3. A lawful permanent resident (Enter USCIS or A-Number.)
- ☐ 4. A noncitizen (other than **Item Numbers 2.** and **3.** above) authorized to work until (exp. date, if any)

If you check **Item Number 4.**, enter one of these:

USCIS A-Number	OR	Form I-94 Admission Number	OR	Foreign Passport Number and Country of Issuance

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

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

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

	List A	OR	List B	AND	List C
Document Title 1					
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					
Document Title 2 (if any)					
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					
Document Title 3 (if any)					
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					

Additional Information

☐ Check here if you used an alternative procedure authorized by DHS to examine documents.

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

First Day of Employment (mm/dd/yyyy):

Last Name, First Name and Title of Employer or Authorized Representative	Signature of Employer or Authorized Representative	Today's Date (mm/dd/yyyy)
Ramsay, Meg Sr. HR Manager		

Employer's Business or Organization Name	Employer's Business or Organization Address, City or Town, State, ZIP Code
GA Dept. of Audits and Accounts	**270 Washington St. SW, Room 4-101, Atlanta, GA 30334**

For reverification or rehire, complete Supplement B, Reverification and Rehire on Page 4.

LISTS OF ACCEPTABLE DOCUMENTS

All documents containing an expiration date must be unexpired.
* Documents extended by the issuing authority are considered unexpired.
Employees may present one selection from List A or a
combination of one selection from List B and one selection from List C.
Examples of many of these documents appear in the Handbook for Employers (M-274).

LIST A Documents that Establish Both Identity and Employment Authorization	OR	LIST B Documents that Establish Identity	AND	LIST C Documents that Establish Employment Authorization
1. U.S. Passport or U.S. Passport Card		**1.** Driver's license or ID card issued by a State or outlying possession of the United States provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		**1.** A Social Security Account Number card, unless the card includes one of the following restrictions: **(1)** NOT VALID FOR EMPLOYMENT **(2)** VALID FOR WORK ONLY WITH INS AUTHORIZATION **(3)** VALID FOR WORK ONLY WITH DHS AUTHORIZATION
2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551)		**2.** ID card issued by federal, state or local government agencies or entities, provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		**2.** Certification of report of birth issued by the Department of State (Forms DS-1350, FS-545, FS-240)
3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa		**3.** School ID card with a photograph		**3.** Original or certified copy of birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal
4. Employment Authorization Document that contains a photograph (Form I-766)		**4.** Voter's registration card		**4.** Native American tribal document
5. For an individual temporarily authorized to work for a specific employer because of his or her status or parole: **a.** Foreign passport; and **b.** Form I-94 or Form I-94A that has the following: **(1)** The same name as the passport; and **(2)** An endorsement of the individual's status or parole as long as that period of endorsement has not yet expired and the proposed employment is not in conflict with any restrictions or limitations identified on the form.		**5.** U.S. Military card or draft record		**5.** U.S. Citizen ID Card (Form I-197)
		6. Military dependent's ID card		**6.** Identification Card for Use of Resident Citizen in the United States (Form I-179)
		7. U.S. Coast Guard Merchant Mariner Card		**7.** Employment authorization document issued by the Department of Homeland Security For examples, see **Section 7** and **Section 13** of the M-274 on **uscis.gov/i-9-central**. The Form I-766, Employment Authorization Document, is a List A, **Item Number 4.** document, not a List C document.
		8. Native American tribal document		
		9. Driver's license issued by a Canadian government authority		
		For persons under age 18 who are unable to present a document listed above:		
		10. School record or report card		
		11. Clinic, doctor, or hospital record		
		12. Day-care or nursery school record		
6. Passport from the Federated States of Micronesia (FSM) or the Republic of the Marshall Islands (RMI) with Form I-94 or Form I-94A indicating nonimmigrant admission under the Compact of Free Association Between the United States and the FSM or RMI				

Acceptable Receipts

May be presented in lieu of a document listed above for a temporary period.
For receipt validity dates, see the M-274.

• Receipt for a replacement of a lost, stolen, or damaged List A document. • Form I-94 issued to a lawful permanent resident that contains an I-551 stamp and a photograph of the individual. • Form I-94 with "RE" notation or refugee stamp issued to a refugee.	**OR**	Receipt for a replacement of a lost, stolen, or damaged List B document.	Receipt for a replacement of a lost, stolen, or damaged List C document.

*Refer to the Employment Authorization Extensions page on **I-9 Central** for more information.

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

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

USCIS Form I-9 Supplement A
OMB No. 1615-0047
Expires 07/31/2026

Last Name *(Family Name)* from **Section 1.**	First Name *(Given Name)* from **Section 1.**	Middle initial (if any) from **Section 1.**

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

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

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

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

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

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

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

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

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

Supplement B,
Reverification and Rehire (formerly Section 3)

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

USCIS
Form I-9
Supplement B
OMB No. 1615-0047
Expires 07/31/2026

Last Name *(Family Name)* from **Section 1.**	First Name *(Given Name)* from **Section 1.**	Middle initial (if any) from **Section 1.**

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

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

Reverification: If the employee requires reverification, your employee can choose to present any acceptable List A or List C documentation to show continued employment authorization. Enter the document information in the spaces below.

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

I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented documentation, the documentation I examined appears to be genuine and to relate to the individual who presented it.

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

Additional Information (Initial and date each notation.)

☐ Check here if you used an alternative procedure authorized by DHS to examine documents.

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

Reverification: If the employee requires reverification, your employee can choose to present any acceptable List A or List C documentation to show continued employment authorization. Enter the document information in the spaces below.

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

I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented documentation, the documentation I examined appears to be genuine and to relate to the individual who presented it.

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

Additional Information (Initial and date each notation.)

☐ Check here if you used an alternative procedure authorized by DHS to examine documents.

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

Reverification: If the employee requires reverification, your employee can choose to present any acceptable List A or List C documentation to show continued employment authorization. Enter the document information in the spaces below.

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

I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented documentation, the documentation I examined appears to be genuine and to relate to the individual who presented it.

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

Additional Information (Initial and date each notation.)

☐ Check here if you used an alternative procedure authorized by DHS to examine documents.

STATE SECURITY QUESTIONNAIRE
LOYALTY OATH

NOTICE TO APPLICANTS/EMPLOYEES: The Sedition and Subversive Activities Act of 1953 (Georgia Law 16-11-5 *et seq.*) requires each applicant/employee to complete and sign, prior to employment in State Government, a questionnaire which is designed to establish that there are no reasonable grounds to believe that he/she is a subversive person. A subversive person is defined as one who commits, advocates, or teaches any act intended to overthrow or destroy the government of the United States or government of the State of Georgia by force or violence, or who is a knowing member of a subversive organization. Georgia Code 45-3-11 requires all employees of the State of Georgia to take an oath that they will support the Constitution of the United States and the Constitution of the State of Georgia.

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

IMPORTANT WARNING: It is critical that you complete this form accurately. Material falsification or misrepresentation of any information, including criminal charges, will result in the employment offer being withdrawn or separation from employment. For clarification of any portion of this form, please discuss with the hiring official or Human Resource/Personnel Office prior to signing the form.

1. LIST FULL NAME (ALSO INCLUDE MAIDEN NAME, NAMES OF FORMER MARRIAGES, FORMER NAMES CHANGED LEGALLY OR OTHERWISE, ALIASES, NICKNAMES AND THE DATES USED).			
LAST NAME	FIRST NAME	MIDDLE NAME	PHONE NO.

MAIDEN NAME	DATES USED	NICKNAMES	DATES USED
OTHER NAMES, INCLUDING ALIASES & FORMER MARRIAGES	DATES USED		DATES USED
	DATES USED		DATES USED

2. ADDRESS (No and Street of Residence)	APT NO	CITY	STATE	COUNTY	ZIP CODE

3. DATE OF BIRTH	U.S. CITIZEN ☐ Yes ☐ No (NATIONALITY _____)	RACE	SEX

4. Are you now or have you been within the last ten (10) years a member of any organization which to your knowledge at the time of membership advocates or has as one of its objectives, the overthrow of the government of the United States or of the government of the State of Georgia by force or violence? ☐ Yes ☐ No. If "Yes", state the name of the organization and your past and present membership status including any offices held therein.

NOTE: If the answer to the above question is "Yes" and the employing authority deems further inquiry necessary, you will be notified of such determination. No action adverse to your application will be taken because of an affirmative answer until after such an inquiry, with notice to you and an opportunity for you to present evidence, and only if the result of such brings your application within the prohibition within the Sedition and Subversive Activities Act of 1953.

5. MILITARY SERVICE (Past or Present)

SERIAL NUMBER	BRANCH	ACTIVE SERVICE		ACTIVE OR INACTIVE RESERVE		DISCHARGED
		From	To	From	To	☐ Honorably ☐ Dishonorably ☐ Other If Discharge other than Honorable, explain in item 8.

6. Have you **ever** been convicted by Federal, State, or other law-enforcement authorities, for **any** violation of any Federal law, State law, County or Municipal law, regulation, or ordinance? (Do not include anything that happened before your sixteenth birthday. Do not include minor traffic violations for which a fine of $35.00 or less was imposed. All other convictions must be included even if they are pardoned.) ___Yes ___No. If the answer is "Yes", state the reason convicted, the date convicted, and the place where convicted.

CHARGE ON WHICH CONVICTED	DATE CONVICTED	NAME OF COURT & PLACE WHERE CONVICTED	PARDONED (yes or no)

7. Are there any charges now pending against you by Federal, State, or other law-enforcement authorities, for any violation of any Federal law, State law, County or Municipal law, regulation or ordinance? (Do not include anything that happened before your sixteenth birthday. Do not include minor traffic violations for which a fined of $35.00 or less would likely be imposed.) ___Yes ___No. If the answer is "Yes", provide the following information.

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

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

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

LOYALTY OATH

I,_____(Name of Applicant/Employee), a citizen of Georgia and being an employee of the State of Georgia and the recipient of public funds for services rendered as such employee, do hereby solemnly swear and affirm that I will support the Constitution of the United States and the Constitution of the State of Georgia.

GENERAL INFORMATION

MEDICAL AND PHYSICAL EXAMINATION PROGRAM (MAPEP)

Inquiry Authority/Use Statement

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

A: Completed by Employee

1. Employee Name: _____ (Last / First / Middle) 2. _____-_____-_____ (Social Security Number)

3. Race: _____ 4. Sex: Female Male 5. _____ (Date of Birth) 6. _____ (Daytime Telephone Number)

7. Address: _____

_____

_____

8. Position Title: _____

9. Position Number: _____

10. Location of Position: _____

11. Direct Contact for Position Information

a. Name:_____

b. Title:_____

c. Telephone: _____

d. E-Mail: _____

e. Fax Number: _____

f. Dept.: _____

g. Unit: _____

h. Address: _____

_____

_____

_____

12. Have you been provided detailed information on the duties of this position? ☐ Yes ☐ No

13. Do you understand the functional requirements and environmental factors of this position? ☐ Yes ☐ No

14. Are you capable of performing the duties and responsibilities of this position (with reasonable accommodations, if necessary, as described in Section A, Item #17)? ☐ Yes ☐ No

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

15. Have you ever been employed by the State of Georgia? ☐ Yes ☐ No

16. Have you had a physical examination for employment with the State of Georgia within the past twelve-month period? ☐ Yes ☐ No

17. Is there anything in your past medical history, of which you have knowledge, that would prevent you being able to perform the duties of this position? ☐ Yes ☐ No

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

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

18. _____
Signature of Employee

19. _____
Date

B: Completed by Employer

1. Indicate type of job information used for medical review (check all that apply):
   - ☐ Job description
   - ☐ Performance standards
   - ☐ Functional requirements analysis
   - ☐ Environmental factors analysis

   Other (please specify):

2. Check job category:
   - ☐ Category 1 Sedentary
   - ☐ Category 2 Active
   - ☐ Category 3 Food Handling
   - ☐ Category 4 Health-related
   - ☐ Category 5 Law Enforcement

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

4. Were any "reasonable accommodations" needed? If "Yes," describe: ☐ Yes ☐ No

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

6. _____
Signature of Official Contact

7. _____
Date