POLICE OFFICER
PRE-EMPLOYMENT
MEDICAL EXAMINATION

(See Position Description at end of Form)

Requires: Police Officer Physical/Drug Screen including:

- **EKG;**
- **LSSP X-Ray;**
- **Hearing; and**
- **Vision**

WAYNE COUNTY

DEPARTMENT OF PERSONNEL/HUMAN RESOURCES

Return original and all test data to: Department of Personnel/Human resources 500 Griswold St. 9th Floor Detroit, MI 48226 Fax #: (313) 967-1264	**WAYNE COUNTY** **DEPARTMENT OF PERSONNEL/HUMAN RESOURCES** **POLICE OFFICER PRE-EMPLOYMENT MEDICAL EXAMINATION**	BILL TO: Personnel/HR- Talent Management 500 Griswold St. 9th Floor Detroit, MI 48226 (313) 224-5901 ATTN: NECOLE GLASKER

PERSONAL INFORMATION:

Name: _____ SS#: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Age: _____ Date of Birth: _____ Sex: _____ Phone Number: _____

MEDICAL HISTORY	YES	NO
1. Have you ever been medically examined for employment in this agency before?		
2. Does your family have a history of diabetes, heart disease, cancer, high blood pressure, hereditary disease, or TB? If **"yes"**, when was your last eye exam?		
3. Have you ever claimed or received compensation for a work related injury or occupational disease?		
4. Do you wear glasses? If **"yes"**, when was your last eye exam? _____		
5. Do you smoke? If **"yes"**, do you smoke a pipe, cigar or cigarettes, and how many per day? _____ For how many years? _____		
6. When is the approximate date of your last Chest X-Ray?		
7. Have you ever had an EKG?		
8. Have you ever had a Pulmonary Function Test?		
9. Are you on a special diet? If **"yes"**, what type of diet? _____		
10. Have you ever had a sigmoidoscopy?		
11. **a.** Have you ever been hospitalized?		
If **"yes"**, list reason, approximate date and length: _____		
b. List any surgeries not included above: _____		
12. List any medications you have taken in the last 2 weeks (including vitamins, laxatives, aspirin and prescription drugs) and Reason:		
13. Are you presently seeing a doctor because of a continuing medical condition? If so, explain condition:		
14. List any drugs which have given you an allergic reaction: _____		
15. Have you ever been rejected for employment (including military service) for medical reasons? If yes, explain reason:		
a. Were you ever in the Armed Services? If **"yes"**, answer **"b"** below:		
b. Did you receive a medical discharge?		
16. Have you ever had a lower GI (barium enema)?		
17. Have you ever had Gallbladder X-Rays?		

MEDICAL HISTORY					
	YES	NO		YES	NO
18. Alcohol or Drug Dependency			61. High Blood Pressure		
19. Allergies (Hay Fever)			62. Histoplasmosis		
20. Anxiety or nervous disorder			63. Irregular heartbeat		
21. Arthritis, Rheumatism			64. Kidney or bladder infections		
22. Asthma			65. Lightheadedness		
23. Awaken at night unable to breathe			66. Liver Disease (Hepatitis, Cirrhosis, etc.)		
24. Awaken frequently at night to urinate			67. Lonely and depressed		
25. Back or spinal problem/injury			68. Lung Disease (Emphysema, etc.)		
26. Black, brown or bloody urine			69. Mental Health Disorder		
27. Blood disorder/disease (anemia, hemophilia, etc.)			70. Mucus in stools		
28. Bloody, black, grey or watery stools			71. Musculoskeletal Disorder (muscle, bone, Joint)		
29. Bronchitis			72. Nasal or sinus problems (polyps, etc.)		
30. Burning or pain with urination			73. Need to sit up or sleep with pillow to breathe		
31. Cancer			74. Nose Bleeds		
32. Chest pain or tightness			75. Pale, cold or discolored hands or feet		
33. Chronic cough or morning cough			76. Pancreas problems		
34. Circulatory problems (varicose veins, gout, etc.)			77. Phlebitis		
35. Colitis			78. Pneumonia or Rheumatic Fever		
36. Coughed up blood			79. Positive TB (tuberculosis) skin test		
37. Cramping in calves or buttocks while walking			80. Produced phlegm upon coughing		
38. Decrease in emptying force of the urinary System			81. Recent changes in bowel habits		
39. Diabetes			82. Scarlet Fever		
40. Diarrhea or constipation			83. Seizures		
41. Difficult or painful swallowing			84. Serious eye infections or injury		
42. Difficulty sleeping			85. Shortness of breath on exertion		
43. Ear problems (infections, earaches, etc.)			86. Sickle cell disease		
44. Easily upset or irritated			87. Skin disorder/diseases (rashes, eczema etc.)		
45. Easily bruised			88. Stomach/intestinal problems (ulcer, duodenal, etc.)		
46. Encephalitis, meningitis			89. Stroke		
47. Epilepsy or convulsions			90. Swelling of your ankles or feet		
48. Excessive perspiration			91. Throat problems		
49. Excessive gas or belching			92. Thyroid Disease (Hyper or Hypothyroidism)		
50. Fainting, dizziness, or shortness of breath			93. Trouble starting or stopping urinary stream		
51. Fast heart rate			94. Tuberculosis		
52. Fracture, dislocation or broken bones			95. Tumors		
53. Frequent or severe headaches or migraines			96. Typhoid Fever		
54. Gained or lost 5 lbs or more within last 6 mos.			97. Unusual fatigue or weakness		
55. Gall Bladder trouble or gallstones			98. Unusual thirst or hunger		
56. Head injuries, skull fractures, unconscious			99. Urinary frequency or urgency		
57. Heat or cold intolerance			100. Valley fever (coccidioidomycosis)		

	YES	NO		YES	NO
58. Heart Disease (heart attack, heart murmur, etc.)			101. Venereal disease (Syphilis, Gonorrhea)		
59. Hemorrhoids			102. Vision problems (Blurred, loss of Glaucoma, etc.)		
60. Hiatal or diaphragmatic hernia			103. Wound that won't heal		

	YES	NO
104. Have you gained or lost more than 10 lbs. in the past 2 years without trying to do so?		
105. Have you had any changes in your appetite in the past 6 months?		
106. Have you been told by a doctor that you have trouble with your thyroid gland?		
107. Do you suffer from indigestion?		
108. Do you frequently have pain in your stomach or abdomen?		
109. Do you frequently take antacid medications, such as Tums or Rolaids?		
110. Have you vomited blood or coffee ground-like material?		
111. Are your bowel movements ever painful?		
112. Have you ever been told by a doctor that you have sugar or pus in your urine?		
113. Have you ever passed a kidney stone?		
114. Have you ever had a minor ☐ or severe ☐ back injury or pain? If **"yes"** answer the following questions:		
114(a). How many times have you had an attack of this condition(s)? _____		
114(b). How many days were you unable to work because of this condition(s)? _____		
115. Have you had problems with low back pain?		
116. When you have a headache, is it relieved by aspirin?		
117. Have you had bleeding gums in the past year?		
118. Do you have ringing or buzzing noises in your ears?		
119. Do you sometimes have difficulty hearing words?		
120. Have you noticed changes in your hair or skin color or texture?		
121. Have you had a change in size or color of a mole (dark growth) or wart in the past year?		
122. Have you had any skin cancers removed?		
123. Do you have colds more than twice a year?		
124. Have you had any exposure to prolonged loud noises, skin or eye irritants, insect/plant sprays or powders, or prolonged x-ray/irradiation?		
125. Have you ever had severe night sweats?		

Please give a detailed explanation for any of the conditions list in questions 18-125 that you answered "yes" to, using the number as a reference:

MENTAL/EMOTIONAL STABILITY		
	YES	NO
126. Have you ever been treated for any psychological/mental symptoms in the past?		
127. Have you taken any medications to treat psychological or psychiatric conditions in the past?		
128. Have you ever been hospitalized for any psychological and/or psychiatric conditions in the past?		
129. Do you now or have you ever had suicidal thoughts?		
130. Do you now or have you ever had homicidal thoughts or thoughts of harming another person in a serious manner?		
131. Have you ever been treated or been recommended for treatment for alcohol or substance abuse?		
THE FOLLOWING QUESTIONS ARE FOR MALES ONLY		
132. Have you ever been told by a doctor that you had prostate trouble or infection?		
133. Have you ever had a swelling or pain in your scrotum or testicles?		

THE FOLLOWING QUESTIONS ARE FOR FEMALES ONLY

Check off all problems that apply to you:

- ☐ Irregular Periods
- ☐ PMS
- ☐ Spotting between periods
- ☐ Excessive vaginal discharge
- ☐ Hot Flashes
- ☐ Breast lumps or unusual discharge
- ☐ Painful periods
- ☐ Complications with child birth
- ☐ Breast lumps or unusual discharge

Date of last period: _____ Date of last Pap Smear: _____ Number of pregnancies: _____

PHYSICIAN INFORMATION

134. Give name of physician last consulted, with date and reason?

_____

_____

135. Give name, address and phone number of your physician:

_____

136. Why and when were you last confined because of illness?

_____

_____

Describe anything else which you feel may be important in your medical history, including any conditions not specifically referred to in the preceding questions.

_____

_____

I certify that the information provided above is a full, complete and true statement of my medical history and my present medical condition and I understand that any false statements or omissions may result in the forfeiture of all employment rights with the County of Wayne. I authorize the release of all medical information in regards to employment with Wayne County.

DATE: _____ **SIGNATURE:** _____ **WITNESS:** _____

PHYSICAL EXAMINATION

NOTE: To be completed and signed by Physician licensed to practice in the State of Michigan.

HT. in.	WT. lbs.	BP / Limits+ Retaken /	PULSE _____ 90+, Retaken After Exercise _____	TEMP	LMP: ☐ Regular ☐ Painful ☐ Disabling	Urine: Dipstick Blood _____ Albumin _____ Sediment _____ Sugar _____ Spec. Grav. _____

VISION:	COLOR: ____ /14 DEPTH: ____/9 PERIPHERAL	HEARING:
WITH GLASSES – WITHOUT GLASSES	(ISHIHARA)	L R
R R	☐ NORMAL ☐ NORMAL O O	☐ NORMAL ☐ NORMAL
L L	☐ ABNORMAL ☐ ABNORMAL L____ R____	☐ ABNORMAL ☐ ABNORMAL

PHYSICAL FINDINGS				DIAGNOSTIC TESTS/LAB				
	INCLUDING:	Normal	Abnormal		ACCEPTABLE	ABNORMAL	Medical Clearance by Family doctor or Specialist Required	Follow up suggested with family doctor, but ok to work
1. Head	Scalp			1. EKG				
2. Neck	Nodes			Back X-Ray				
3. Thorax				2. Urinalysis (Dipstick)				
4. Mouth				3. Drug Screen (Urine)				
5. Ears				4. Hearing Test (Audiogram)				
6. Eyes				5. Vision 20/20				
7. Nose				6. Color Vision: Farnsworth (If fails Ishihara)				
8. Throat	Tonsils			7. OTHER				
9. Teeth	Gums			COMMENTS				
10. Heart	Rhythm							
	Murmurs							
	Aprical Reaction							
11. Lungs	Lagging							
	Aprical Reaction							
	Auscultation							
	Rales							
12. Abdomen								
13. Inguinal Region	Hernia							
14. Genitalia	Hydrocele							
	Hernia							
	Varicocele							
15. Back	ROM							
	Deformaties							
	SLR ( ) Neg ( ) Pos							
	DTR ( ) Neg ( ) Pos							
16. Spine								
17.Neurological	Motor							
	Sensory							
	Reflex							
18. Extremities	Joints							
	ROM							
	Phalanx ( ) Neg ( ) Pos							
	Pulses							

19. Skin	Scars			
	Birthmarks			
	Tattoos			
20. Mental Status Ex				
21. OTHER				

MEDICAL CLEARANCE REQUIRED

☐ **MEDICAL CLEARANCE REQUIRED**
(If "checked" explain below)

☐ **MEDICAL CLEARANCE NOT REQUIRED**

FINDINGS OF PHYSICIAN

☐ **QUALIFIED FOR POSITION**

☐ ***NOT QUALIFIED FOR POSITION EXPLAIN BELOW**

***NOTE:** **BE SPECIFIC AND LIST ALL REASONS FOR DISQUALIFICATIONS. ANY POSITIVE DRUG TEST RESULTS WITHOUT A CLEAR CUT MEDICAL EXPLAINING OR VERIFIED PRESCRIPTION IN THE EXAMINEE'S NAME WARRANTS DISQUALIFICATION.**

1. What physical or mental condition do you believe disqualifies this individual from performing the duties of this position?

2. How does the physical or mental condition prohibit this individual from performing the duties of this position? be specific; relate the physical or mental conditions to the particular duty(ies) you believe this individual would be unable to perform and why.

Print
Physician's Name: _____

_____ ____/____/____
PHYSICIAN'S SIGNATURE DATE

NAME OF CLINIC

PHYSICIAN'S STATEMENT OF APPLICANT'S MEDICAL CONDITION
FOR WAYNE COUNTY POLICE OFFICER'S

PART 1: Applicant Information

Name: Last	First:	Middle:	Suffix (Jr. Sr. III):
Social Security #:	Date of Birth:	Height:	Weight:
Driver's License #:		**Agency Requesting Medical Form: Wayne County P/HR**	

PART 2: To Be Completed by Examining Physician

Date Medical Exam Conducted:	Applicant's completed Medical History Statement provided to Examining Physician as required: ☐ **Yes** ☐ **No**

Instructions:

If any box is checked "NO" or there are any remarks regarding a "YES" answer, the physician must attach an explanation, with his/her signature to the form. The explanation should include the exact nature of the medical condition, any treatment currently being provided to the candidate and any other information that the examining physician believes is appropriate.

If Sections B, C, and/or D are conducted by a medical provider other than the examining physician conducting the screening in Section A, the medical provider's information and signature should be entered in the available fields for that section.

A. Physical Condition		**COMMENTS:**
Free from physical defects?	☐ **Yes** ☐ **No**	
Free from chronic diseases?	☐ **Yes** ☐ **No**	
Free from organic diseases?	☐ **Yes** ☐ **No**	
Free from organic or functional conditions?	☐ **Yes** ☐ **No**	
Height and Weight proportional?	☐ **Yes** ☐ **No**	
Well-developed physically?	☐ **Yes** ☐ **No**	
Extremities present and functioning normally?	☐ **Yes** ☐ **No**	
Free from impediment of the senses?	☐ **Yes** ☐ **No**	

B. Vision		**COMMENTS:**
Right eye uncorrected 20/20 vision or better? If "No": Right eye corrected to 20/20 or better?	☐ **Yes** ☐ **No**	
Left eye uncorrected 20/20 Vision or better? If "No": Left eye corrected to 20/20 or better?	☐ **Yes** ☐ **No**	
Peripheral vision: Free from large scotomas?	☐ **Yes** ☐ **No**	
Horizontal Binocular field = or >120 degrees?	☐ **Yes** ☐ **No**	
Total vertical field = or> 100 degrees?	☐ **Yes** ☐ **No**	
Stereopsis: 80 seconds of arc or better, and/or dot #6	☐ **Yes** ☐ **No**	
Color Vision: Must test the unaided eye. X-Chrom Lenses or colored spectacle lenses are not allowed.		
Type of pseudoisochromatic plates test administered:		Note: A minimum of 14 plates must be viewed.

Number of plates viewed:	Number of plates correctly identified:	☐ Pass	☐ Fail
Examiner signature (if other than physician):		**Printed Name:**	
Address:	**Date:**	**Phone:**	

C. Hearing		
Unaided Criteria I:		
Pure tone sensitivity thresholds shall not exceed a level of 25 dBHL at 500, 1000, 2000, 3000 and 45 dBHL at 4000 Hz.	☐ Pass	☐ Fail

Unaided Criteria II: Required **only** if applicant fails Unaided Criteria I				
4- frequency average pure tone sensitivity thresholds shall not exceed 25 dBHL at 500, 1000, 2000 & 3000 Hz.			☐ Pass	☐ Fail
No one frequency poorer than 35 dBHL:				
500 Hz	Right: ☐ Pass ☐ Fail		Left: ☐ Pass ☐ Fail	
1000 Hz	☐ Pass ☐ Fail		☐ Pass ☐ Fail	
2000 Hz	☐ Pass ☐ Fail		☐ Pass ☐ Fail	
3000 Hz	☐ Pass ☐ Fail		☐ Pass ☐ Fail	
Speech recognition in an audiometric sound field shall be 90% or better in both ears.	%	☐ Pass ☐ Fail	%	☐ Pass ☐ Fail
Speech recognition for both ears in sound field (with a +5 S/N ratio) will be 70% or better. Speech stimuli shall be presented at 50 dB.	%	☐ Pass ☐ Fail	%	☐ Pass ☐ Fail

Aided Criteria: Required **only** if applicant fails Unaided Criteria I and Unaided Criteria II				
Average aided pure tone sensitivity thresholds shall not exceed 25 dBHL at 500, 1000, 2000 & 3000 Hz.			☐ Pass	☐ Fail
No one frequency poorer than 35 dBHL:				
500 Hz	Right: ☐ Pass ☐ Fail		Left: ☐ Pass ☐ Fail	
1000 Hz	☐ Pass ☐ Fail		☐ Pass ☐ Fail	
2000 Hz	☐ Pass ☐ Fail		☐ Pass ☐ Fail	
3000 Hz	☐ Pass ☐ Fail		☐ Pass ☐ Fail	
Speech recognition in an audiometric sound field shall be 90% or better in both ears.	%	☐ Pass ☐ Fail	%	☐ Pass ☐ Fail
Speech recognition for both ears in sound field (with a +5 S/N ratio) will be 70% or better. Speech stimuli shall be presented at 50 dB. In the case where only 1 year has been fitted with an aid, the unaided ear shall not be plugged or masked.	%	☐ Pass ☐ Fail	%	☐ Pass ☐ Fail

Examiner signature (if other than physician):		**Printed Name:**	
Address:	**Date:**	**Phone:**	
☐ **Audiologist (required for Unaided II or Aided**	☐ **Certificate of Clinical Competence**	☐ **OHC**	☐ **NBC-HIS**

D. Mental and Emotional	Examination date if different than above:
NOTE: This standard may be assessed by licensed psychologist.	
Free from mental or emotional instability?	☐ Yes ☐ No

Supervising/Licensed Psychologist (if applicable)		Professional License Number:
I certify that I have examined this person for mental and emotional stability.		
Signature:		**Printed Name:**
Address:	**Date:**	**Phone:**

Examining Physician		Medical License Number:
I certify that I have examined this person under all Wayne County agreed medical standards.		
Signature:		**Printed Name:**
Address:	**Date:**	**Phone:**

AUTHORITY: 203 PA 1965 COMPLIANCE: Voluntary PENALTY: No License Activation/Academy Enrollment	--This information is confidential. Confidential information is protected by the Federal Privacy Act. If necessary the Social Security Number will be used for identification purposes to ensure that proper records are obtained.

Revised: 7/2018

Attach to Requisition for Personnel	Department of Personnel/Human Resources **POSITION DESCRIPTION**	POSITION NUMBER: _____

Classification: Police Officer **Department/Division:** Sheriff's Office

Location: Jail Divisions 1, 2, and 3 **Supervisor of Position:** Police Sergeant

Does this position supervise other employees? ☐ Yes ☐ No

ESSENTIAL JOB FUNCTIONS OF THIS POSITION: **Hours/week**

1. Possess the willingness and ability to abide by and to conform with all rules, policies, procedures, orders, etc. of the Wayne County Sheriff's Office (WCSO). 40.5
2. Maintain and ensure the security of the jails and its inmates by preventing the entrance of unauthorized individuals into and the escape of inmates from the secure areas of the jails. 40.5
3. Provide for safe, secure, and humane treatment of inmates. 40.5
4. Provide supervisory oversight of inmates. 40.5
5. Provide the appropriate response to violations of jail rules, regulations, and laws. 40.5
6. Prepare the appropriate police reports in response to criminal violations and the appropriate administrative reports as required by WCSO policy, rules, etc. 40.5
7. Conduct preliminary administrative and criminal investigations as required/instructed. 40.5
8. Transport jail inmates, via foot and/or vehicle, inside and/or outside of the jails. 40.5
9. Possess the mental and physical ability to use the appropriate, reasonable and level of physical force in response to a physical altercation in which a inmate or other person is engaging in conduct that could or is actually causing physical injury to himself/herself, and/or the safety and welfare of others, i.e., another officer, a staff member, a citizen, and/or another inmate. 40.5
10. Possess the mental and physical ability to respond appropriately in the event another, officer staff member, a citizen, and/or a inmate is experiencing a medical emergency. Examples include initiating an emergency response, administering CPR and/or the operation and administration of an AED. 40.5
11. Possess the mental and physical ability to appropriately respond to situations in which an inmate appears to be mentally disturbed and appears to represent a substantial danger to himself/herself or a serious threat to the welfare or safety of others within the jail. Examples include, but are not limited to situations in which an inmate is engaged in attempts of self-mutilation, attempting to commit suicide, or has actually committed suicide. An officer is expected to physically intervene to stop an attempt of self-mutilation and attempted suicide, or in the case of an actual suicide by hanging, to have the ability to lift the inmate's body and to cut down the body. 40.5

ESSENTIAL JOB FUNCTIONS OF THIS POSITION:	Hours/week
12. Respond to Emergency Alarms and Situation - Each officer must possess the mental and physical ability to appropriately respond to calls for assistance in the event of a physical altercation, a medical emergency, or to a fire or other hazardous situation that is occurring in the jail or any other area of operations.	40.5
13. The mental and physical ability to work a minimum of 40.5 hours per week.	40.5
14. On each day the officer is assigned to work, the officer must have the mental and physical ability to work ordered, mandatory overtime and perform all of the essential job functions of this position.	40.5
15. On each shift the officer is ordered to or volunteers to work overtime, the officer must have the the mental and physical ability to perform all of the essential job functions of this position. ***	

***40.5 hours represents a standard work week, exclusive of overtime. The employee may be ordered to work up to (2) additional shifts of (8) hours each week. The employee is also eligible to volunteer to work additional overtime during the week.

The essential job functions of this position will include the regular operation of the following:

☑ Typewriter	☑ Personal Computer/Printer	☑ Copy Machine	☑ Fax Machine
☑ Hand Tools	☑ Handcuffs	☑ Push buttons/levers	☑ Keys
☑ Weapons	☑ Firearms (If qualified & required)	☑ Phone	☑ Vehicles
☑ Pen/Pencil	☑ Other equipment and/or tools as may be assigned		

☐ As specified: _____

CERTIFICATION BY THE OFFICER

INSTRUCTIONS: The officer is required to complete the applicable certification section.

Option 1: I have read this two page Position Description and I have provided it to my attending physician/medical caregiver. I am able to perform all of the above duties and can work under the conditions as described without a job accommodation.

_____ _____

Officer's Printed Name and Signature Date

Option 2: I have read this two page Position Description, and I have provided it to my attending physician/medical caregiver. I am not able to perform all of the above duties and I cannot work under the conditions as described without a job accommodation. I understand that I must immediately complete and submit the required forms to the Department of Personnel/Human Resources to initiate a request for a reasonable accommodation.

_____ _____

Officer's Printed Name and Signature Date

Employment Eligibility Verification

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

USCIS
Form I-9
OMB No. 1615-0047
Expires 10/31/2022

►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 10/31/2022

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 - Sections 2 & 3
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

Last Name of Employer or Authorized Representative	First Name of Employer or Authorized Representative	Employer's Business or Organization Name

Employer's Business or Organization Address *(Street Number and Name)*	City or Town	State	ZIP Code

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

Print in ink only.

Wayne County Department of Personnel/Human Resources

DECLARATION OF SOCIAL SECURITY CARD NAME AND NUMBER

Instructions

Fill in your name and Social Security Number below as they appear on your current Social Security Card. You **must** present your Social Security Card and picture identification for verification purposes.

Current Information

First Name:_____ Middle:_____ Last Name:_____

Social Security Number: _____

NOTE: Wayne County is subject to fines for errors in reporting your payroll information to the Internal Revenue Service. Please carefully answer the following questions:

Have you ever changed your name?

☐ YES ☐ NO

If you answered YES, was your last name change recorded with the Social Security Administration?

☐ YES ☐ NO ☐ NOT SURE

If you answered NO or NOT SURE, what name (include middle initial) appears on your most recent Social Security Card:

First Name:_____

Middle Initial:_____

Last Name:_____

Have you ever used more than one Social Security Number?

☐ YES ☐ NO

If you answered YES, list other numbers you have used and why you stopped using them.

_____

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Certification

By Signing this form I agree to the terms and conditions stated herein and certify that the information that I have provided is accurate and true.

Signature:_____ Date:_____

Warren C. Evans

Wayne County Executive

BACKGROUND INVESTIGATION FORM

RE: Employment with the County of Wayne

I, _____, understand that the Wayne County Department of Personnel/Human Resources, as a condition of employment, will run a complete check of any possible criminal record(s) that I might have. I understand that any information found regarding convictions or felony charges may result in my being refused and/or disqualified from employment with the County of Wayne.

Have you ever been convicted (fined, placed on probation, sentence to jail or given a suspended sentence) for any violation of law other than a minor traffic violation? All driving convictions must be disclosed. ☐ **Yes** ☐ **No**

If **"yes"**, to the above question, explain in full detail the nature of the charge (s), date (s) and the current disposition.

Required Information:

NAME: _____ Date of Birth: _____

Print Full Name **Month/Date/Year**

Gender: ☐ Female ☐ Male Race: _____ Driver's License#: _____

Last four (4) digits of Social Security #: **XXX-XX-**_____

CERTIFICATE OF APPLICANT: My signature below certifies that all the information provided in this application is true. I understand and agree that any misstatement of material facts contained in this application may cause me to forfeit all my rights to employment with the County of Wayne. I understand that any claims related to this application will be fully waived if not brought within 180 days. I further certify that this application is made under my correct legal name. I authorize my former employers to furnish any and all information concerning my previous employment to the Wayne County Department of Personnel/Human Resources. I hereby release my former employers from any liability for providing this information. A copy of this authorization shall be considered as effective and valid as the original. I understand that Wayne County, as a condition of employment, may run a complete check of any possible reference, background and criminal records I might have.

DATE: _____SIGNATURE: _____

DO NOT WRITE BELOW THIS LINE

{ } NO BACKGROUND RECORD ATTACHED

{ } BACKGROUND RECORD- ATTACHED

Revised: 2/1/2023