



CITY OF CORAL GABLES

FIREFIGHTER APPLICATION

DATE OF APPLICATION: _____

TO PROSPECTIVE APPLICANTS:

WE ARE PLEASED THAT YOU ARE INTERESTED IN EMPLOYMENT WITH THE CITY OF CORAL GABLES FIRE DEPARTMENT. WE HOPE THAT YOU ARE SUCCESSFUL IN OUR SELECTION PROCESS AND WILL BECOME PART OF THE TEAM.

WE ARE IN THE PROCESS OF GATHERING STATISTICAL DATA REGARDING OUR RECRUITMENT EFFORTS. THEREFORE, WE ARE REQUESTING THAT YOU COMPLETE THE SURVEY BELOW. AFTER YOU HAVE FINISHED THE SURVEY, PLEASE PROCEED TO THE REST OF THE APPLICATION BY FOLLOWING THE CHECKLIST.

TO RECEIVE CONSIDERATION FOR EMPLOYMENT WITH THE CORAL GABLES FIRE DEPARTMENT, A FULLY COMPLETED APPLICATION PACKET MUST BE SUBMITTED WITH THE CHECKLIST TO THE HUMAN RESOURCES DEPARTMENT AT 2801 SALZEDO STREET, 2ND FLOOR, CORAL GABLES, FL. 33134. OFFICE HOURS: 8:00 A.M. TO 4:30 P.M., MONDAY THROUGH FRIDAY, EXCLUDING OBSERVED HOLIDAYS. **UNDER NO CIRCUMSTANCES WILL ANY APPLICATIONS BE ACCEPTED AT ANY OTHER LOCATION.** OUT OF TOWN APPLICANTS MAY MAIL THE PACKAGE. ALL APPLICANTS WILL ONLY BE GIVEN THIRTY DAYS FROM THE DATE THE APPLICATION IS RECEIVED BY THE HUMAN RESOURCES DEPARTMENT TO CORRECT ANY DEFICIENCIES OR OMISSIONS. APPLICANTS WILL BE DISQUALIFIED IF THEY FAIL TO COMPLY. **NO EXCEPTIONS.**

PLEASE BE ADVISED THAT THE CITY OF CORAL GABLES FIRE DEPARTMENT HAS A STRICT POLICY REGARDING PAST AND PRESENT DRUG USAGE FOR ALL APPLICANTS FOR EMPLOYMENT. APPLICANTS MUST NOT HAVE USED ANY ILLEGAL SUBSTANCES, INCLUDING PRESCRIPTION DRUGS WITHOUT A PRESCRIPTION, WITH THE EXCEPTION OF EXPERIMENTAL MARIJUANA USAGE. MARIJUANA USAGE MUST NOT BE WITHIN THE 3 YEAR PERIOD PRIOR TO THE DATE OF APPLICATION OR AT ANY TIME AFTER THE DATE OF APPLICATION. APPLICANTS SEEKING EMPLOYMENT WITHIN THE CITY OF CORAL GABLES POLICE DEPARTMENT NOT MEETING THESE STANDARDS WILL BE DISQUALIFIED FROM EMPLOYMENT.

1. LAST NAME:	FIRST NAME:	MIDDLE NAME:	2. MALE	FEMALE
			<input type="checkbox"/>	<input type="checkbox"/>
3. RACE:				
<input type="checkbox"/> WHITE <input type="checkbox"/> BLACK <input type="checkbox"/> ASIAN <input type="checkbox"/> AMERICAN INDIAN OR ALASKAN NATIVE <input type="checkbox"/> UNKNOWN				
<input type="checkbox"/> IF YOU ARE OF HISPANIC DESCENT, PLEASE CHECK HERE, IN ADDITION TO ONE OF THE OPTIONS ABOVE.				
4. HOW DID YOU LEARN OF OUR POSITION?				
<input type="checkbox"/> NEWSPAPER AD (NAME OF NEWSPAPER): _____				
<input type="checkbox"/> BULLETIN OR ANNOUNCEMENT		<input type="checkbox"/> WALK-IN		
<input type="checkbox"/> CITY WEBSITE		<input type="checkbox"/> INTERNET SOURCE: _____		
<input type="checkbox"/> CITY EMPLOYEE (NAME & EMP. NUMBER): _____				
<input type="checkbox"/> OTHER: _____				

Human Resources Department
2801 Salzedo Street, 2nd Floor • Coral Gables, FL 33134
Telephone: 305-460-5523 • Website: www.coralgables.com

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DRUG FREE WORKPLACE



The City Beautiful™

City of Coral Gables

CERTIFIED FIREFIGHTER APPLICATION CHECKLIST

APPLICANT NAME: _____

Applications will only be accepted if all required documentation listed below is submitted with the checklist to the **Human Resources Department, 2801 Salzedo Street, 2nd Floor, Coral Gables, FL 33134.** Office Hours 8:00a.m. to 5:00p.m. Monday through Friday. Out of town applicants may mail the package to Human Resources at the address mentioned above.

ITEM#	ITEM	DESCRIPTION	RECEIVED
1.	Firefighter Questionnaire	Required. Must be notarized. Do not include a photo or thumb print.	
2.	Birth Certificate	Required. Must submit a copy of Birth Certificate.	
3.	Verification of Naturalization	If applicable.	
4.	Photocopy of State of Florida Firefighter Certification	Required.	
5.	Photocopy of State of Florida EMT or Paramedic Certification	If applicable.	
6.	High School Diploma or Equivalent	Required. Copies accepted.	
7.	Copy of active Physical Ability Test or successful completion of Candidate Physical Ability Test (CPAT) from certified agency.	Required.	
8.	College Transcripts	If applicable.	
9.	Legal Name Change Documentation	If applicable, must submit copies of any documentation that shows change of name (i.e. marriage and or divorce certificate, etc.)	

10.	Attestment of Military Service	Required. Must be <u>notarized</u>.	
11.	Honorable Discharge DD214-Long Form	If applicable, submit copy. If claiming Veteran's Preference must submit original.	
12.	Social Security Administration Consent for Release of Information	Required.	
13.	Consent to release confidential records and information	Required. Must be <u>notarized</u> and all five (5) forms must be completed.	
14.	Waiver of Consumer Report Records	Required by State Law.	
15.	Criminal Records Disclosure Requirement.	Required by State Law.	
16.	Photocopy of Social Security Card	Required.	
17.	Photocopy of Driver's License	Required. Must be valid.	
18.	Driving Record	Required. Copy of Driving Record from the Department of Motor Vehicles is required.	
19.	Neighborhood List	Required. Provide names, addresses and telephone numbers of at least five to six neighbors.	
20.	Twelve (12) Letters of Recommendation	Required. Must provide 3 letters from supervisors, 3 letters from co-workers, 3 letters from subordinates (if applicable), and 3 letters from personal references. Must include address, telephone number and original signatures. <u>Must be current and signed originals. No Photocopies accepted.</u>	
13.	Non-Smoking Affidavit	Required. <u>Must be notarized.</u>	

Date and Time

HRD Signature

C O N F I D E N T I A L



**CITY OF CORAL GABLES, FLORIDA
CERTIFIED FIREFIGHTER
APPLICANT QUESTIONNAIRE**

APPLICATION #: _____

LAST NAME

FIRST NAME

MIDDLE NAME

MAILING ADDRESS

CITY

STATE

ZIP CODE

RESIDENCE TELEPHONE

CELLULAR TELEPHONE

BUSINESS TELEPHONE

OTHER CONTACT NUMBER

EMAIL ADDRESS

HUMAN RESOURCES DEPARTMENT
2801 Salzedo Street, 2nd Floor, Coral Gables, FL 33134
305-460-5519 hrd@coralgables.com

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The City of Coral Gables

Human Resources Department
2801 SALZEDO STREET - SUITE 200
CORAL GABLES, FLORIDA 33134

ATTESTMENT OF MILITARY SERVICE

1) I, _____, do attest that I have never served
in the Armed Forces of the United States.

Applicant's Signature

Date

2) I, _____, do attest that I have served in the
Armed Forces of the United States.

Applicant's Signature

Date

STATE OF _____ (COUNTY OF _____)

The foregoing instrument was executed before me this _____ day of
_____, 20____ by _____
who is personally known by me (or who has produced _____ for
identification) and who did/did not take an oath.

Notary Public
State of _____ at Large

Commission Expires

INSTRUCTION AND INFORMATION SHEET FOR SF 180, REQUEST PERTAINING TO MILITARY RECORDS

1. General Information. The Standard Form 180, Request Pertaining to Military Records (SF180) is used to request information from military records. Certain identifying information is necessary to determine the location of an individual's record of military service. Please try to answer each item on the SF 180. If you do not have and cannot obtain the information for an item, show "NA," meaning the information is "not available". Include as much of the requested information as you can. Incomplete information may delay response time. To determine where to mail this request see Page 2 of the SF180 for record locations and facility addresses.

Online requests may be submitted to the National Personnel Records Center (NPRC) by a veteran or deceased veteran's next-of-kin using eVetRecs at <http://www.archives.gov/veterans/military-service-records/>.

2. Personnel Records/Military Human Resource Records/Official Military Personnel File (OMPF) and Medical Records/Service Treatment Records (STR). Personnel records of military members who were discharged, retired, or died in service **LESS THAN 62 YEARS AGO** and medical records are in the legal custody of the military service department and are administered in accordance with rules issued by the Department of Defense and the Department of Homeland Security (DHS, Coast Guard). STRs of persons on active duty are generally kept at the local servicing clinic. After the last day of active duty, STRs should be requested from the appropriate address on page 2 of the SF 180. (See item 3, Archival Records, if the military member was discharged, retired or died in service more than 62 years ago.)

a. **Release of information:** Release of information is subject to restrictions imposed by the military services consistent with Department of Defense regulations, the provisions of the Freedom of Information Act (FOIA) and the Privacy Act of 1974. The service member (either past or present) or the member's legal guardian has access to almost any information contained in that member's own record. The authorization signature of the service member or the member's legal guardian is needed in Section III of the SF180. Others requesting information from military personnel records and/or STRs must have the release authorization in Section III of the SF 180 signed by the member or legal guardian. If the appropriate signature cannot be obtained, only limited types of information can be provided. If the former member is deceased, the surviving next-of-kin may, under certain circumstances, be entitled to greater access to a deceased veteran's records than a member of the general public. The next-of-kin may be any of the following: unremarried surviving spouse, father, mother, son, daughter, sister, or brother. Requesters **MUST provide proof of death, such as a copy of a death certificate, newspaper article (obituary) or death notice, coroner's report of death, funeral director's signed statement of death, or verdict of coroner's jury.**

b. **Fees for records:** There is no charge for most services provided to service members or next-of-kin of deceased veterans. A nominal fee is charged for certain types of service. In most instances, service fees cannot be determined in advance. If your request involves a service fee, you will receive an invoice with your records.

3. Archival Records. Personnel records of military members who were discharged, retired, or died in service **62 OR MORE YEARS AGO** have been transferred to the legal custody of NARA and are referred to as "archival records".

a. **Release of Information:** Archival records are open to the public. The Privacy Act of 1974 does not apply to archival records, therefore, written authorization from the veteran or next-of-kin is not required. In order to protect the privacy of the veteran, his/her family, and third parties named in the records, the personal privacy exemption of the Freedom of Information Act (5 U.S.C. 552 (b) (6)) may still apply and may preclude the release of some information.

b. **Fees for Archival Records:** Access to archival records are granted by offering copies of the records for a fee (44 U.S.C. 2116 (c)). If a fee applies to the photocopies of documents in the requested record, you will receive an invoice. Photocopies will be sent after payment is made. For more information see <http://www.archives.gov/st-louis/archival-programs/military-personnel-archival/ompf-archival-requests.html>.

4. Where reply may be sent. The reply may be sent to the service member or any other address designated by the service member or other authorized requester. If the designated address is NOT registered to the addressee by the U.S. Postal Service (USPS), provide BOTH the addressee's name AND "in care of" (c/o) the name of the person to whom the address is registered on the NAME line in Section III, item 3, on page 1 of the SF 180. The COMPLETE address must be provided, INCLUDING any apartment/suite/unit/lot/space/etc. number.

5. Definitions and abbreviations. DISCHARGED -- the individual has no current military status; SERVICE TREATMENT RECORD (STR) -- The chronology of medical, mental health, and dental care received by service members during the course of their military career (does not include records of treatment while hospitalized); TDRL -- Temporary Disability Retired List.

6. Service completed before World War I. National Archives Trust Fund (NATF) forms must be used to request these records. Obtain the forms by e-mail from inquire@nara.gov or write to the Code 6 address on page 2 of the SF 180.

PRIVACY ACT OF 1974 COMPLIANCE INFORMATION

The following information is provided in accordance with 5 U.S.C. 552a(e)(3) and applies to this form. Authority for collection of the information is 44 U.S.C. 2907, 3101, and 3103, and Public Law 104-134 (April 26, 1996), as amended in title 31, section 7701. Disclosure of the information is voluntary. If the requested information is not provided, it may delay servicing your inquiry because the facility servicing the service member's record may not have all of the information needed to locate it. The purpose of the information on this form is to assist the facility servicing the records (see the address list) in locating the correct military service record(s) or information to answer your inquiry. This form is then retained as a record of disclosure. The form may also be disclosed to Department of Defense components, the Department of Veterans Affairs, the Department of Homeland Security (DHS, U.S. Coast Guard), or the National Archives and Records Administration when the original custodian of the military health and personnel records transfers all or part of those records to that agency. If the service member was a member of the National Guard, the form may also be disclosed to the Adjutant General of the appropriate state, District of Columbia, or Puerto Rico, where he or she served.

PAPERWORK REDUCTION ACT PUBLIC BURDEN STATEMENT

Public burden reporting for this collection of information is estimated to be five minutes per request, including time for reviewing instructions and completing and reviewing the collection of information. Send comments regarding the burden estimate or any other aspect of the collection of information, including suggestions for reducing this burden, to National Archives and Records Administration (ISSD), 8601 Adelphi Road, College Park, MD 20740-6001. **DO NOT SEND COMPLETED FORMS TO THIS ADDRESS. SEND COMPLETED FORMS TO THE APPROPRIATE ADDRESS LISTED ON PAGE 2 OF THE SF 180.**

REQUEST PERTAINING TO MILITARY RECORDS

Requests from veterans or deceased veteran's next-of-kin may be submitted online by using eVetRecs at <http://www.archives.gov/veterans/military-service-records/>
To ensure the best possible service, please thoroughly review the accompanying instructions before filling out this form. PLEASE PRINT LEGIBLY OR TYPE BELOW.

SECTION I - INFORMATION NEEDED TO LOCATE RECORDS (Furnish as much information as possible.)

1. NAME USED DURING SERVICE (last, first, full middle)	2. SOCIAL SECURITY #	3. DATE OF BIRTH	4. PLACE OF BIRTH
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5. SERVICE, PAST AND PRESENT (For an effective records search, it is important that ALL service be shown below.)						
	BRANCH OF SERVICE	DATE ENTERED	DATE RELEASED	OFFICER	ENLISTED	SERVICE NUMBER (If unknown, write "unknown")
a. ACTIVE						
b. RESERVE						
c. STATE NATIONAL GUARD						

6. IS THIS PERSON DECEASED? NO YES - *MUST* provide Date of Death if veteran is deceased: _____

7. DID THIS PERSON RETIRE FROM MILITARY SERVICE? NO YES

SECTION II - INFORMATION AND/OR DOCUMENTS REQUESTED

1. CHECK THE ITEM(S) YOU ARE REQUESTING:

DD Form 214 or equivalent. Year(s) in which form(s) issued to veteran: _____
This form contains information normally needed to verify military service. A copy may be sent to the veteran, the deceased veteran's next-of-kin, or other persons or organizations, if authorized in Section III, below. **An UNDELETED DD214 is ordinarily required to determine eligibility for benefits.** If you request a DELETED copy, the following items will be blacked out: authority for separation, reason for separation, reenlistment eligibility code, separation (SPD/SPN) code, and, for separations after June 30, 1979, character of separation and dates of time lost.
An UNDELETED copy will be sent UNLESS YOU SPECIFY A DELETED COPY by checking this box: I want a DELETED copy.

Medical Records Includes Service Treatment Records, Health (outpatient) and Dental Records. *IF HOSPITALIZED (inpatient) the FACILITY NAME and DATE (month and year) for EACH admission MUST be provided:* _____

Other (Specify): _____

2. **PURPOSE:** (Providing information about the purpose of the request is **strictly voluntary**; however, it may help to provide the best possible response and may result in a faster reply. Information provided will in no way be used to make a decision to deny the request.)

Benefits (explain) Employment VA Loan Programs Medical Genealogy Correction Personal Other (explain)

Explain here: _____

SECTION III - RETURN ADDRESS AND SIGNATURE

1. **REQUESTER NAME:** _____

2. I am the MILITARY SERVICE MEMBER OR VETERAN identified in Section I, above. I am the VETERAN'S LEGAL GUARDIAN (*MUST submit copy of Court Appointment*) or AUTHORIZED REPRESENTATIVE (*MUST submit copy of Authorization Letter or Power of Attorney*)

I am the DECEASED VETERAN'S NEXT-OF-KIN (*MUST submit Proof of Death. See item 2a on instruction sheet.*) OTHER

(Relationship to deceased veteran) (Specify type of Other)

3. **SEND INFORMATION/DOCUMENTS TO:**
(Please print or type. See item 4 on accompanying instructions.)

Name _____

Street _____ Apt. _____

City _____ State _____ Zip Code _____

4. **AUTHORIZATION SIGNATURE:** I declare (or certify, verify, or state) under penalty of perjury under the laws of the United States of America that the information in this Section III is true and correct and that I authorize the release of the requested information. (See items 2a or 3a on accompanying instruction sheet. Without the Authorization Signature of the veteran, next-of-kin of deceased veteran, veteran's legal guardian, authorized government agent, or other authorized representative, only limited information can be released unless the request is archival. No signature is required if the request is for archival records.)

Signature Required - Do not print _____ Date _____

() _____ () _____
Daytime phone Fax Number

Email address _____

* This form is available at <http://www.archives.gov/veterans-military-service-records/standard-form-180.pdf> on the National Archives and Records Administration (NARA) web site. *

The various categories of military service records are described in the chart below. For each category there is a code number which indicates the address at the bottom of the page to which this request should be sent. Please refer to the Instruction and Information Sheet accompanying this form as needed.

BRANCH	CURRENT STATUS OF SERVICE MEMBER		
		Personnel Record	Medical or Service Treatment Record
AIR FORCE	Discharged, deceased, or retired before 5/1/1994	14	14
	Discharged, deceased, or retired 5/1/1994 – 9/30/2004	14	11
	Discharged, deceased, or retired 10/1/2004 – 12/31/2013	1	11
	Discharged, deceased, or retired on or after 1/1/2014	1	13
	Active (including National Guard on active duty in the Air Force), TDRL, or general officers retired with pay	1	
	Reserve, IRR, Retired Reserve in non-pay status, current National Guard officers not on active duty in the Air Force, or National Guard released from active duty in the Air Force	2	
	Current National Guard enlisted not on active duty in the Air Force	2	13
COAST GUARD	Discharge, deceased, or retired before 1/1/1898	6	
	Discharged, deceased, or retired 1/1/1898 – 3/31/1998	14	14
	Discharged, deceased, or retired 4/1/1998 – 9/30/2006	14	11
	Discharged, deceased, or retired 10/1/2006 – 9/30/2013	3	11
	Discharged, deceased, or retired on or after 10/1/2013	3	14
	Active, Reserve, Individual Ready Reserve or TDRL	3	
MARINE CORPS	Discharged, deceased, or retired before 1/1/1895	6	
	Discharged, deceased, or retired 1/1/1895 – 12/31/1904	15	
	Discharged, deceased, or retired 1/1/1905 – 4/30/1994	14	14
	Discharged, deceased, or retired 5/1/1994 – 12/31/1998	14	11
	Discharged, deceased, or retired 1/1/1999 – 12/31/2013	4	11
	Discharged, deceased, or retired on or after 1/1/2014	4	8
	Individual Ready Reserve	5	
Active, Selected Marine Corps Reserve, TDRL	4		
ARMY	Discharged, deceased, or retired before 11/1/1912 (enlisted) or before 7/1/1917 (officer)	6	
	Discharged, deceased, or retired 11/1/1912 – 10/15/1992 (enlisted) or 7/1/1917 – 10/15/1992 (officer)	14	
	Discharged, deceased, or retired 10/16/1992 – 9/30/2002	14	11
	Discharged, deceased, or retired (including TDRL) 10/1/2002 – 12/31/2013	7	11
	Discharged, deceased, or retired (including TDRL) on or after 1/1/2014	7	9
	Current Soldier (Active, Reserve (including Individual Ready Reserve) or National Guard)	7	
NAVY	Discharged, deceased, or retired before 1/1/1886 (enlisted) or before 1/1/1903 (officer)	6	
	Discharged, deceased, or retired 1/1/1886 – 1/30/1994 (enlisted) or 1/1/1903 – 1/30/1994 (officer)	14	14
	Discharged, deceased, or retired 1/31/1994 – 12/31/1994	14	11
	Discharged, deceased, or retired 1/1/1995 – 12/31/2013	10	11
	Discharged, deceased, or retired on or after 1/1/2014	10	8
	Active, Reserve, or TDRL	10	
PHS	Public Health Service - Commissioned Corps officers only	12	

ADDRESS LIST OF CUSTODIANS and SELF-SERVICE WEBSITES (BY CODE NUMBERS SHOWN ABOVE) – Where to write/send this form

1	Air Force Personnel Center HQ AFPC/DPSIRP 550 C Street West, Suite 19 Randolph AFB, TX 78150-4721	6	National Archives & Records Administration Research Services (RDT1R) 700 Pennsylvania Avenue NW Washington, DC 20408-0001	11	Department of Veterans Affairs Records Management Center ATTN: Release of Information P.O. Box 5020 St. Louis, MO 63115-5020
2	Air Reserve Personnel Center Records Management Branch (DPTSC) 18420 E. Silver Creek Avenue Building 390 MS 68 Buckley AFB, CO 80011	7	US Army Human Resources Command's web page: https://www.hrc.army.mil/TAGD/Accessing%20or%20Requesting%20Your%20Official%20Military%20Personnel%20File%20Documents or 1-888-ARMYHRC (1-888-276-9472)	12	Division of Commissioned Corps Officer Support ATTN: Records Officer 1101 Wootton Parkway, Plaza Level, Suite 100 Rockville, MD 20852
3	Commander, Personnel Service Center (BOPS-C-MR) MS7200 US Coast Guard 2703 Martin Luther King Jr Ave SE Washington, DC 20593-7200 MR_CustomerService@uscg.mil	8	Navy Medicine Records Activity (NMRA) BUMED Detachment St. Louis 4300 Goodfellow Boulevard, Building 103 St. Louis, MO 63120	13	AF STR Processing Center ATTN: Release of Information 3370 Nacogdoches Road, Suite 116 San Antonio, TX 78217
4	Headquarters U.S. Marine Corps Manpower Management Records & Performance (MMRP-10) 2008 Elliot Road Quantico, VA 22134-5030	9	AMEDD Record Processing Center 3370 Nacogdoches Road, Suite 116 San Antonio, TX 78217	14	National Personnel Records Center (Military Personnel Records) 1 Archives Drive St. Louis, MO 63138-1002 eVetRecs: http://www.archives.gov/veterans/military-service-records/
5	Marine Forces Reserve 2000 Opelousas Avenue New Orleans, LA 70146-5400	10	Navy Personnel Command (PERS-313) 5720 Integrity Drive Millington, TN 38055-3120	15	National Archives at St. Louis P.O. Box 38757 St. Louis, MO 63138

Instructions for Using this Form

Complete this form only if you want us to give information or records about you, a minor, or a legally incompetent adult, to an individual or group (for example, a doctor or an insurance company). If you are the natural or adoptive parent or legal guardian, acting on behalf of a minor child, you may complete this form to release only the minor's non-medical records. We may charge a fee for providing information unrelated to the administration of a program under the Social Security Act.

NOTE: Do not use this form to:

- Request the release of medical records on behalf of a minor child. Instead, visit your local Social Security office or call our toll-free number, 1-800-772-1213 (TTY-1-800-325-0778), or
- Request detailed information about your earnings or employment history. Instead, complete and mail form SSA-7050-F4. You can obtain form SSA-7050-F4 from your local Social Security office or online at www.ssa.gov/online/ssa-7050.pdf.

How to Complete this Form

We will not honor this form unless all required fields are completed. An asterisk (*) indicates a required field. Also, we will not honor blanket requests for "any and all records" or the "entire file." You must specify the information you are requesting and you must sign and date this form. We may charge a fee to release information for non-program purposes.

- Fill in your name, date of birth, and social security number or the name, date of birth, and social security number of the person to whom the requested information pertains.
- Fill in the name and address of the person or organization where you want us to send the requested information.
- Specify the reason you want us to release the information.
- Check the box next to the type(s) of information you want us to release including the date ranges, where applicable.
- You, the parent or the legal guardian acting on behalf of a minor child or legally incompetent adult, must sign and date this form and provide a daytime phone number.
- If you are not the individual to whom the requested information pertains, state your relationship to that person. We may require proof of relationship.

PRIVACY ACT STATEMENT

Section 205(a) of the Social Security Act, as amended, authorizes us to collect the information requested on this form. We will use the information you provide to respond to your request for access to the records we maintain about you or to process your request to release your records to a third party. You do not have to provide the requested information. Your response is voluntary; however, we cannot honor your request to release information or records about you to another person or organization without your consent. We rarely use the information provided on this form for any purpose other than to respond to requests for SSA records information. However, the Privacy Act (5 U.S.C. § 552a(b)) permits us to disclose the information you provide on this form in accordance with approved routine uses, which include but are not limited to the following:

1. To enable an agency or third party to assist Social Security in establishing rights to Social Security benefits and or coverage;
2. To make determinations for eligibility in similar health and income maintenance programs at the Federal, State, and local level;
3. To comply with Federal laws requiring the disclosure of the information from our records; and,
4. To facilitate statistical research, audit, or investigative activities necessary to assure the integrity of SSA programs.

We may also use the information you provide when we match records by computer. Computer matching programs compare our records with those of other Federal, State, or local government agencies. We use information from these matching programs to establish or verify a person's eligibility for Federally-funded or administered benefit programs and for repayment of incorrect payments or overpayments under these programs. Additional information regarding this form, routine uses of information, and other Social Security programs is available on our Internet website, www.socialsecurity.gov, or at your local Social Security office.

PAPERWORK REDUCTION ACT STATEMENT

This information collection meets the requirements of 44 U.S.C. § 3507, as amended by section 2 of the Paperwork Reduction Act of 1995. You do not need to answer these questions unless we display a valid Office of Management and Budget control number. We estimate that it will take about 3 minutes to read the instructions, gather the facts, and answer the questions. **SEND OR BRING THE COMPLETED FORM TO YOUR LOCAL SOCIAL SECURITY OFFICE.** You can find your local Social Security office through SSA's website at www.socialsecurity.gov. Offices are also listed under U.S. Government agencies in your telephone directory or you may call 1-800-772-1213 (TTY 1-800-325-0778). You may send comments on our time estimate above to: SSA, 6401 Security Blvd., Baltimore, MD 21235-6401. *Send only comments relating to our time estimate to this address, not the completed form.*

REQUEST FOR SOCIAL SECURITY EARNINGS INFORMATION

1. Provide your name as it appears on your most recent Social Security card or the name of the individual whose earnings you are requesting.

First Name: Middle Initial:

Last Name:

Social Security Number (SSN) - - One SSN per request

Date of Birth: / / Date of Death: / /

Other Name(s) Used
(Include Maiden Name)

2. What kind of earnings information do you need? (Choose ONE of the following types of earnings or SSA must return this request.)

Itemized Statement of Earnings \$136

(Includes the names and addresses of employers)

If you check this box, tell us why you need this information below.

Verification of my employment history and earnings.

Year(s) Requested: to

Year(s) Requested: to

Check this box if you want the earnings information **CERTIFIED** for an additional \$56.00 fee.

Certified Yearly Totals of Earnings \$56

(Does not include the names and addresses of employers)
Yearly earnings totals are FREE to the public if you do not require certification. To obtain FREE yearly totals of earnings, visit our website at www.ssa.gov/myaccount.

Year(s) Requested: to

Year(s) Requested: to

3. If you would like this information sent to someone else, please fill in the information below.

I authorize the Social Security Administration to release the earnings information to:

Name Coral Gables Police Department c/o Police Department Personnel Selection Unit

Address 2801 Salzedo Street

State FL

City Coral Gables

ZIP Code 33134

4. I am the individual to whom the record pertains (or a person authorized to sign on behalf of that individual). I understand that any false representation to knowingly and willfully obtain information from Social Security records is punishable by a fine of not more than \$5,000 or one year in prison.

Signature AND Printed Name of Individual or Legal Guardian

SSA must receive this form within 120 days from the date signed

Date: / /

Relationship (if applicable, you must attach proof) Self

Daytime Phone:

Address

State

City

ZIP Code

Witnesses must sign this form ONLY if the above signature is by marked (X). If signed by mark (X), two witnesses to the signing who know the signee must sign below and provide their full addresses. Please print the signee's name next to the mark (X) on the signature line above.

1. Signature of Witness <p style="text-align: center; font-size: 1.5em;">N/A</p>	2. Signature of Witness <p style="text-align: center; font-size: 1.5em;">N/A</p>
Address (Number and Street, City, State and ZIP Code) <p style="text-align: center; font-size: 1.5em;">N/A</p>	Address (Number and Street, City, State and ZIP Code) <p style="text-align: center; font-size: 1.5em;">N/A</p>

Social Security Administration
Consent for Release of Information

Form Approved
OMB No. 0960-0566

You must complete all required fields. We will not honor your request unless all required fields are completed. (**signifies a required field*).

TO: Social Security Administration

***My Full Name**

***My Date of Birth
(MM/DD/YYYY)**

***My Social Security Number**

I authorize the Social Security Administration to release information or records about me to:

***NAME OF PERSON OR ORGANIZATION:**

CORAL GABLES POLICE DEPARTMENT c/o

POLICE DEPARTMENT PERSONNEL SELECTION UNIT

***ADDRESS OF PERSON OR ORGANIZATION:**

2801 Salzedo Street

CORAL GABLES, FL

***I want this information released because:** Verification of my employers and earnings history.
We may charge a fee to release information for non-program purposes.

***Please release the following information selected from the list below:**

You must specify the records you are requesting by checking at least one box. We will not honor a request for "any and all records" or "my entire file." Also, we will not disclose records unless you include the applicable date ranges where requested.

1. Social Security Number
2. Current monthly Social Security benefit amount
3. Current monthly Supplemental Security Income payment amount
4. My benefit or payment amounts from date _____ to date _____
5. My Medicare entitlement from date _____ to date _____
6. Medical records from my claims folder(s) from date _____ to date _____
If you want us to release a minor child's medical records, do not use this form. Instead, contact your local Social Security office.
7. Complete medical records from my claims folder(s)
8. Other record(s) from my file (you must specify the records you are requesting, e.g., doctor report, application, determination or questionnaire)

Itemized Statement of Earnings; Complete Historical Data

I am the individual, to whom the requested information or record applies, or the parent or legal guardian of a minor, or the legal guardian of a legally incompetent adult. I declare under penalty of perjury (28 CFR § 16.41(d)(2004)) that I have examined all the information on this form, and any accompanying statements or forms, and it is true and correct to the best of my knowledge. I understand that anyone who knowingly or willfully seeks or obtain access to records about another person under false pretenses is punishable by a fine of up to \$5,000. I also understand that I must pay all applicable fees for requesting information for a non-program-related purpose.

***Signature:** _____ ***Date:** _____

***Address:** _____

Relationship (if not the subject of the record): SELF ***Daytime Phone:** _____

Witnesses must sign this form ONLY if the above signature is by mark (X). If signed by mark (X), two witnesses to the signing who know the signee must sign below and provide their full addresses. Please print the signee's name next to the mark (X) on the signature line above.

1. Signature of witness N/A	2. Signature of witness N/A
Address(Number and street, City, State, and Zip Code) N/A	Address(Number and street, City, State, and Zip Code) N/A

CITY OF CORAL GABLES



NOTIFICATION OF SOCIAL SECURITY NUMBER COLLECTION AND USAGE

In compliance with Florida Statutes §119.071(5), the City of Coral Gables Human Resources Department collects and uses your Social Security number only for the following purposes in performance of the City's duties and responsibilities.

Your Social Security number is used for legitimate employment business purposes in compliance with:

- Completing an Employment Application/Packet;
- Completing and processing Federal I-9 (Employment Eligibility Verification Form);
- Completing and processing Federal W4, W2 and 1099 (tax forms);
- Completing and processing Federal Social Security taxes;
- Completing and processing Quarterly Unemployment Reports;
- Completing and processing Federal and State Employee and Educational Reports;
- Completing and processing group health, life and dental coverage enrollment;
- Completing and processing Supplemental Insurance Deduction Reports;
- Completing and processing Workers' Compensation Claims;
- Completing the employee's background screening and validating the employee's educational credentials;
- Completing and processing Retirement Contribution Reports;
- Processing retirement benefits;
- Processing employee benefits;
- Any other reason that is determined imperative for the performance of the City's duties and responsibilities, as prescribed by law; and/or
- Any other reason specifically authorized by law to do so.

NOTIFICATION

Providing a Social Security number is a condition of employment at the City of Coral Gables.

The City may disclose Social Security numbers to another agency or governmental entity if such disclosure is necessary for the receiving agency or entity to perform its duties and responsibilities.

The City may not deny a commercial entity engaged in the performance of a commercial activity access to Social Security numbers, provided the Social Security numbers will be used only in the performance of a commercial activity, and provided the commercial entity makes a written request for the Social Security numbers.

The written request must (1) be verified as provided in Fla. Stat. § 92.525; (2) be legibly signed by an authorized officer, employee, or agent of the commercial entity; (3) contain the commercial entity's name, business mailing and location addresses, and business telephone number; and (4) contain a statement of the specific purposes for which it needs the social security numbers and how the social security numbers will be used in the performance of a commercial activity. Commercial activity includes verification of the accuracy of personal information received identifying and preventing fraud; use in matching, verifying, or retrieving information; and use in research activities. It **does not** include the display or bulk sale of social security numbers to the public or the distribution of such numbers to any customer that is not identifiable by the commercial entity.

I understand the above information and have been given a copy of this document.

Employee/Applicant Name (Print)

Employee/Applicant Signature

Date



The City of Coral Gables

Human Resources Department
2801 Salzedo Street – Suite 200
Coral Gables, FL 33134

CONSENT TO RELEASE CONFIDENTIAL RECORDS AND INFORMATION

As a person applying for a position at the Coral Gables Fire Department ("Department"), I hereby consent to a routine background investigation conducted by the Department. In connection with this investigation, I consent to the release of any and all records and information concerning me, to the Department upon the Department's request.

This consent includes the release of all records and information concerning me to the full extent permitted by law, including the release of all confidential records and information that may not be released without my prior written consent.

I understand that such records and information may include, but is not necessarily limited to: reasons for termination of employment, including military service; criminal history; on-the-job performance; educational records; credit reports; or any other personal information which may not otherwise be obtained without my prior written consent.

SIGNATURE: _____
PRINT NAME: _____
DATE SIGNED: _____
SOCIAL SECURITY NUMBER: _____

STATE OF _____ (COUNTY OF _____)
The foregoing instrument was executed before me this _____ day of _____,
20____ by _____, who is personally known by me (or who has produced _____ as identification) and who took an oath.

Notary Public State of Florida at Large
Name of Notary (Type or Print)



The City of Coral Gables

Human Resources Department
2801 Salzedo Street – Suite 200
Coral Gables, FL 33134

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PRINT NAME: _____
DATE SIGNED: _____
SOCIAL SECURITY NUMBER: _____

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20____ by _____, who is personally known by me (or who has produced _____ as identification) and who took an oath.

Notary Public State of Florida at Large
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Human Resources Department
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SIGNATURE: _____

PRINT NAME: _____

DATE SIGNED: _____

SOCIAL SECURITY NUMBER: _____

STATE OF _____ (COUNTY OF _____)

The foregoing instrument was executed before me this _____ day of _____,

20____ by _____, who is personally known by me (or who has produced _____ as identification) and who took an oath.

Notary Public State of Florida at Large

Name of Notary (Type or Print)



The City of Coral Gables

Human Resources Department
2801 Salzedo Street – Suite 200
Coral Gables, FL 33134

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SIGNATURE: _____
PRINT NAME: _____
DATE SIGNED: _____
SOCIAL SECURITY NUMBER: _____

STATE OF _____ (COUNTY OF _____)
The foregoing instrument was executed before me this _____ day of _____,
20____ by _____, who is personally known by me (or who has produced _____ as identification) and who took an oath.

Notary Public State of Florida at Large
Name of Notary (Type or Print)



The City of Coral Gables

Human Resources Department
2801 SALZEDO STREET - SUITE 200
CORAL GABLES, FLORIDA 33134

WAIVER OF CONSUMER REPORT RECORDS
WRITTEN DISCLOSURE

The Federal Fair Credit Reporting Act (FCRA) allows employers to obtain consumer credit report information for employment purpose, including hiring and promotion decisions, where the consumer has given written permission, Sections 604 (a)(3)(B) and 604 (b).

Permission is hereby given to The City of Coral Gables Police Department to obtain consumer credit report information.

I understand that if any adverse action is to be taken based on the consumer report, a copy of the report and a summary of the consumer rights will be provided to me.

Applicant's Signature Date
Applicant's Printed Name
Social Security Number Date of Birth
Address City, State & Zip Code

STATE OF (COUNTY OF)

The foregoing instrument was executed before me this day of , 20 by who is personally known by me (or who has produced as identification) and who took an oath.

Notary Public Name of Notary (Type or Print)
State of at Large



The City of Coral Gables

Human Resources Department
2801 SALZEDO STREET - SUITE 200
CORAL GABLES, FLORIDA 33134

CRIMINAL RECORDS DISCLOSURE REQUIREMENT

If you have expunged or Court sealed records, the following Florida State Statute applies to your application with the City of Coral Gables for the position of Police Officer.

Sections 943.0585 and 943.059, Florida Statutes, state that a person who is the subject of a criminal history record that is expunged under Section 943.0585 or that is sealed under 943.059, or that is expunged or sealed under any other provisions of law, including former Sections 893.14, 901.33 and 943.058, "may lawfully deny or fail to acknowledge the events covered by the sealed record, except when the subject of the record... (i) is a candidate for employment with a criminal justice agency." Fla. Stat. § 943.059 (4) (a) (1) (West Supp. 1994) (emphasis added). See also Fla. Stat. § 943.0585 (4) (a) (1) (dealing with expunged records).

Based upon the above-cited statutes, the law requires that you, as an applicant for employment with a criminal justice agency (such as the Coral Gables Police Department), must not deny or fail to acknowledge the events in any expunged or sealed criminal records.

A denial or failure to acknowledge the events in any expunged or sealed records will result in disqualification, termination, or criminal charges.

Applicant's Signature

Date

Applicant's Printed Name

STATE OF _____ (COUNTY OF _____)

The foregoing instrument was executed before me this _____ day of _____, 20____ by _____ who is personally known by me (or who has produced _____ as identification) and who took an oath.

Notary Public
State of _____ at Large

Name of Notary (Type or Print)

Sample Format Reference Letter

**Company Letter Head, or provide
the information below**

Name of Reference:
Address:
City/State:
Zip Code:
Telephone Number:

Date:

Marc Stolzenberg
Fire Chief
2801 Salzedo Street
Coral Gables, FL 33134

RE: _____
Applicant name

Dear Chief:

Sincerely,

(Must be signed in ink)

Print Name, title (if applicable)



The City of Coral Gables

Human Resources Department
2801 Salzedo Street – Suite 200
Coral Gables, FL 33134

The City of Coral Gables does not employ individuals for the position of Certified Firefighter Paramedic or Certified Firefighter EMT who now use or have used tobacco products within the last twelve (12) months.

NON-SMOKING AFFIDAVIT

I, _____, do hereby affirm that I have not been a user of tobacco or tobacco products for at least one (1) year immediately preceding my application for employment, in accordance with the Florida State Statute Title XXXVII, Chapter 633.

Under penalties of perjury, I declare that I have read the foregoing affidavit and that the facts stated in it are true.

Signature

Date

STATE OF _____ (COUNTY OF _____)

THE FOREGOING INSTRUMENT WAS EXECUTED BEFORE ME THIS ____ DAY OF _____, 20 ____, BY _____, WHO IS PERSONALLY KNOWN BY ME (OR WHO HAS PRODUCED _____ AS IDENTIFICATION) AND WHO TOOK AN OATH.

NOTARY PUBLIC
STATE OF _____ AT LARGE

NAME OF NOTARY

NOTARY SEAL: