FLORIDA DEPARTMENT OF CORRECTIONS
EMPLOYER'S COMMUNITY WORK AGREEMENT

Inmate Name _____ DC Number _____
True or Legal Name _____
Center _____ Social Security Number _____
Address _____ Telephone Number _____
_____

1. If this employee is to work overtime or work days not regularly scheduled, you will notify center staff in time so that transportation arrangements can be made. If this employee is to be released early from work you will notify center staff.
2. This employee is not to leave his/her designated job assignment, have visitors on the job site and/or make phone calls without the center staff's permission.
3. If this employee does not report to work and/or leaves work without permission, you will notify center staff immediately. The employee must return to the center promptly upon conclusion of each day's work. If the employment is terminated for any reason, the employer will immediately notify center staff.
4. I understand that this employee will be given equal consideration as pertains to other employees. Any salary deductions, other than state and federal taxes, will be approved by the center staff to which this employee is assigned.
5. I understand that upon request I may be required to hold the above listed employee's paycheck(s) to be picked up by center staff.
6. I understand that as employer I will either provide Workers' Compensation Insurance or other medical insurance coverage for this employee.
7. I understand as employer the possession or consumption of alcoholic beverages, controlled substances not lawfully possessed, or other illegal drugs specified in Chapter 893 Florida Statutes by this employee is prohibited.
8. As employer, I will notify center staff in the event of any unusual incident involving this employee.
9. If my employment site (primary or temporary) is at a location in which the primary clients are children, I agree to remove the inmate from the location and advise the appropriate center staff.
10. I understand that inmates assigned to community release centers may be on electronic monitoring and will be required to maintain possession of the EM equipment on their person.

I understand the above policies and do hereby agree to cooperate fully with the Department of Corrections in carrying out these policies in the event I should employ an inmate of the Department of Corrections under the Community Work Release Program. This agreement does not obligate me to employ any inmate and any offer of employment to an inmate will be of my discretion and will be contingent upon the availability of the position when the inmate is approved.

_____ _____
Employer Signature Date

EMPLOYER INFORMATION

Employer Name: _____
Mailing Address: _____
Telephone Number: _____ Emergency Phone Number: _____
Job Site: _____
Position Title/Duties: _____
Work Duration: Inmate work hours from _____ to _____ _____
(time) (time) (days of week - specify)
Primary Supervisor: _____
Secondary Supervisor: _____

INMATE START DATE: _____ WAGES: _____
PAY PERIOD BEGINNING: _____ AND ENDING: _____
DATE OF FIRST CHECK: _____ PAY DAYS: _____
ARE PAYDAYS WEEKLY/BIWEEKLY/OTHER: PLEASE CIRCLE
PAYROLL CONTACT PERSON _____ PHONE/EXT. _____

MEDICAL INSURANCE OR WORKERS' COMPENSATION INFORMATION

AGENT: _____ PHONE: _____
CONTACT PERSON: _____ POLICY #: _____
EXPIRATION DATE: _____

INMATE FILE (Original)
EMPLOYER (Copy)

DC6-124 (Effective 7/14) Incorporated by Reference in Rule 33-601.602, F. A. C.

In accordance with s. 119.071(5)(a)2., F.S., your social security number is being collected for verification purposes. This collection is imperative for the performance of this agency's duties and responsibilities as prescribed by law. The Department will not use your social security number for any purpose other than verification of your employment.