

EXHIBIT 1

BROWARD COUNTY
LIVING WAGE ORDINANCE COMPLIANCE AFFIDAVIT
(This certification must be provided prior to award of the contract)

Covered Employer:	
Address:	
Phone Number:	Local Contact:
Bid/Contract Number:	Address:
Contract Amount:	Phone Number:
Department Served:	

Bid/Contract Title:

Please check one:

By signing below I hereby certify that the covered employees listed below:

A. ___ Receive a minimum pay of \$_____ per hour and are provided health benefits valued at \$_____ per hour.

B. ___ Receive a minimum pay of \$_____ per hour and are not provided health benefits.

Provide names of employees and job classifications providing covered services for the above referenced contract:

Name	Job Class	A or B	Name	Job Class	A or B
_____	_____	<input type="checkbox"/>	_____	_____	<input type="checkbox"/>
_____	_____	<input type="checkbox"/>	_____	_____	<input type="checkbox"/>
_____	_____	<input type="checkbox"/>	_____	_____	<input type="checkbox"/>
_____	_____	<input type="checkbox"/>	_____	_____	<input type="checkbox"/>
_____	_____	<input type="checkbox"/>	_____	_____	<input type="checkbox"/>

(Attach additional sheets in the format above, if needed)

I, _____ of _____ hereby attest that

(Name) (Title) (Company)

(1) I have the authority to sign this notarized compliance affidavit, (2) the following information is true, complete and correct and (3) the Company certifies that it shall:

Pay all employees working on this contract/project, who are covered by the Broward County Living Wage Ordinance, as amended, in accordance with wage rates and provisions of the Living Wage Ordinance;

Provide the applicable living wage statement regarding wage rates with the employee's first paycheck or direct deposit receipt as required by the Living Wage Ordinance, as amended; and

(IF APPLICABLE) If health care benefits are provided under "A" above, the health care benefit meets the standard health benefit plan as described in Section 627.6699 (12)(b)(4), Florida Statutes, as amended. As a principle officer of the covered employer, the undersigned affirms that the referenced Florida Statute has been reviewed and the covered employer's health plan meets all the elements required by the statute, as amended.

_____ Signature _____ Title

SWORN TO AND SUBSCRIBED BEFORE ME this _____ day of _____, 20__

STATE OF _____ COUNTY OF _____

_____ My commission expires: _____ (SEAL)

Notary Public (Print, type or stamp commissioned name of Notary Public)

Personally Known _____ or Produced Identification _____

Type of Identification Produced: _____