Kentucky Tobacco Retail Inspection Program

Department of Alcoholic Beverage Control
1003 Twilight Trail
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How to Become an Investigative Aide with the Kentucky Tobacco Retail Inspection Program

1. What is the Kentucky Tobacco Retail Inspection Program?

The Department of Alcoholic Beverage Control (ABC) enforces federal and state retail tobacco laws, particularly those prohibiting tobacco retailers from selling tobacco products to persons under the age of 18.

With the help of Investigative Aides, ABC Investigators inspect tobacco retailers to make sure tobacco products are sold *only* to persons 18 years of age or older.

2. What is an Investigative Aide?

Investigative Aides make this program possible. An Investigative Aide is a person age 16 or 17 years-old who enters a tobacco retailer, such as a convenience store or grocery store, and attempts to purchase a tobacco product. This is called a "controlled buy."

Investigative Aides are accompanied by ABC Investigators who observe the "controlled buy." If a tobacco product is sold to an Investigative Aide, the product is given to the ABC Investigator who preserves it as evidence.

3. Why should you become an Investigative Aide?

Investigative Aides are paid $12.50 per hour. Scheduling is flexible, and done directly between the Investigative Aide and the Investigators with whom they work.

You are providing a public service. Youth tobacco use is a danger to public health and this is one way the Commonwealth works to prevent underage tobacco use and improve the health of our state.

4. How do you sign up?

Complete the attached application, and obtain your parent or guardian's consent. Submit the completed application to Kyle Hagerty either by mail or email at the address listed above.

FDA Investigative Aide Application
Revised 07/13/2017

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ALCOHOLIC BEVERAGE CONTROL

INVESTIGATIVE AIDE – FDA TOBACCO RETAIL INSPECTION PROGRAM

APPLICATION FORM

ATTACH PHOTO HERE

NAME _____

ADDRESS _____

_____ ZIP CODE_____

COUNTY_____

DATE OF BIRTH _____AGE _____

SOCIAL SECURITY NUMBER _____

HGT. _____ WGT. _____HAIR _____EYES _____

TELEPHONE (Home) _____ (Work) _____

(CELL) _____

EMAIL _____

Kentucky Resident: ☐ Yes ☐ No
Driver's license number and state issued: _____
Occupation: _____
Business / school: _____
Address: _____
Vehicle information (make – model – year): _____

Signature of Applicant for Investigative Aide_____Date_____

Signature of Applicant's Parent or Guardian_____Date_____

Witnessed by_____Date _____

How did you hear about this program (circle one)? Website - Social Media - Friend/Relative - School - Other

Attach a Copy of Drivers License & Birth Certificate

FOR ABC OFFICE USE ONLY

Date accepted into program: _____
Birth Certificate received: ☐ Yes ☐ No
Drivers License received: ☐ Yes ☐ No

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ABC Form-IA
Agreement of
Understanding
Revised 03/31/2017

FDA INVESTIGATIVE AIDE PROGRAM

AGREEMENT OF UNDERSTANDING

I, _____, being _____ years of age, and a Kentucky resident, agree to assist the Kentucky Department of Alcoholic Beverage Control ("Department") in all investigations of tobacco sales to underage persons. I understand these investigations may be conducted under state law or as an agent of the federal government. I affirm herein that no member of my immediate family owns any interest in any establishment regulated by the Department. My participation is voluntary and on an "as needed" basis. I voluntarily and knowingly enter into this agreement.

I agree to respond truthfully as to my legal age and date of birth if asked by the retailer or an employee during an investigation. I also agree that my attire and overall appearance will be such as to make me appear to be my true age. I will earn an hourly wage of $12.50. To enroll in this program, I agree to complete the Kentucky state investigative aide application, and complete a brief online training session. I will be paid for the time spent completing the training.

I understand that in the unlikely event of an enforcement or judicial action, my identity may be revealed and, if needed, I may be asked to provide a narrative report, declaration, and/or give oral testimony in a hearing. I agree to remain available to testify as a witness and provide oral testimony for a minimum of five (5) years after leaving the program. My identity will be kept private and the only time it would be used is in the case of a hearing or if ordered by as court of law or by the Office of the Attorney General for an open record request.

I understand that I am not a law enforcement officer and will not represent myself in that manner at any time, and that I am not entitled to carry a firearm or a badge. I understand that participation in this program does not entitle me to any special privileges. The following shall include, but not be limited to, grounds for immediate termination from the program: (1) any violation of law except while under the direction of the Department or its agents or employees; (2) failure to abide by the terms of this agreement; (3) failure to follow the instructions or procedures of the Department; (4) engaging in alcohol or tobacco use; or (5) suffering any school-related problems including attendance and grades.

I understand that I shall not engage in any tobacco or alcoholic beverage use while participating as an investigative aide with the Department. I understand that I am not to sample any tobacco products purchased on behalf of the Department and shall promptly turn over any tobacco evidence to the Department for evidentiary purposes. I understand that I may be required to testify in judicial or administrative enforcement proceedings on behalf of the Department of Alcoholic Beverage Control, the Commonwealth of Kentucky, or the Food and Drug Administration.

_____

Signature of Investigative Aide Date

_____

Witness Date

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ABC Form-Parental Consent & Waiver (IA) Program
Revised 03/31/2017

FDA INVESTIGATIVE AIDE PROGRAM

PARENTAL CONSENT & WAIVER

I swear and affirm that I am the legal guardian of _____ ("Minor"), whose date of birth is_____. I hereby give my consent for the minor to participate as an Investigative Aide with the Kentucky Department of Alcoholic Beverage Control in conducting state and federal tobacco compliance activities. I understand that participation in the Investigative Aide Program is voluntary. I, and on behalf of the Minor, agree to release the Department, its agents, and insurers from any liability arising from participation in this program resulting from or arising out of the Minor's negligent acts.

I understand that all investigations will be conducted by trained Department Investigators. Each purchase or attempted purchase of tobacco products will be under the observation and in the presence of no less than one adult employee of the Department. I fully understand and agree that the minor may be required to testify at judicial or administrative proceedings on behalf of the Department, the Commonwealth of Kentucky, or the Food and Drug Administration.

The procedures employed by the Department have been fully explained to me and I understand that my consent for the Minor's participation may be withdrawn at any time by notifying the Department in writing.

_____
Signature of Investigative Aide's Parent/Guardian Date

_____
Witness Date

Matthew G. Bevin
Governor

David A. Dickerson
Secretary

Christine Trout
Commissioner

ALCOHOLIC BEVERAGE CONTROL

PUBLIC PROTECTION CABINET
1003 Twilight Trail
Frankfort, Kentucky 40601
502-564-4850 (o)
502-564-7479 (f)

FDA INVESTIGATIVE AIDE PROGRAM

CONSENT TO OBTAIN EMERGENCY MEDICAL TREATMENT

The Department of Alcoholic Beverage Control's primary priority is the safety and well-being of Investigative Aides. Therefore, as a precaution, we ask that parents or guardians provide consent to obtain emergency medical care for their child in the unlikely event such care is necessary. ABC Investigators will have a copy of the consent during inspections and will contact you immediately. If your child has any allergies or conditions, please include that information as well.

I, the undersigned parent and/or legal guardian of _____, (mm/dd/yyyy), _____, do hereby give consent to the Kentucky Department of Alcoholic Beverage Control and/or its employees or agents to obtain emergency medical care for my child and as otherwise permitted by KRS 214.185. This consent is effective beginning on the date below through my child's eighteenth (18^{th}) birthday, and may be revoked at any time in writing.

Allergies/Conditions:
_____

_____ _____ _____
Name (please print) Signature Date