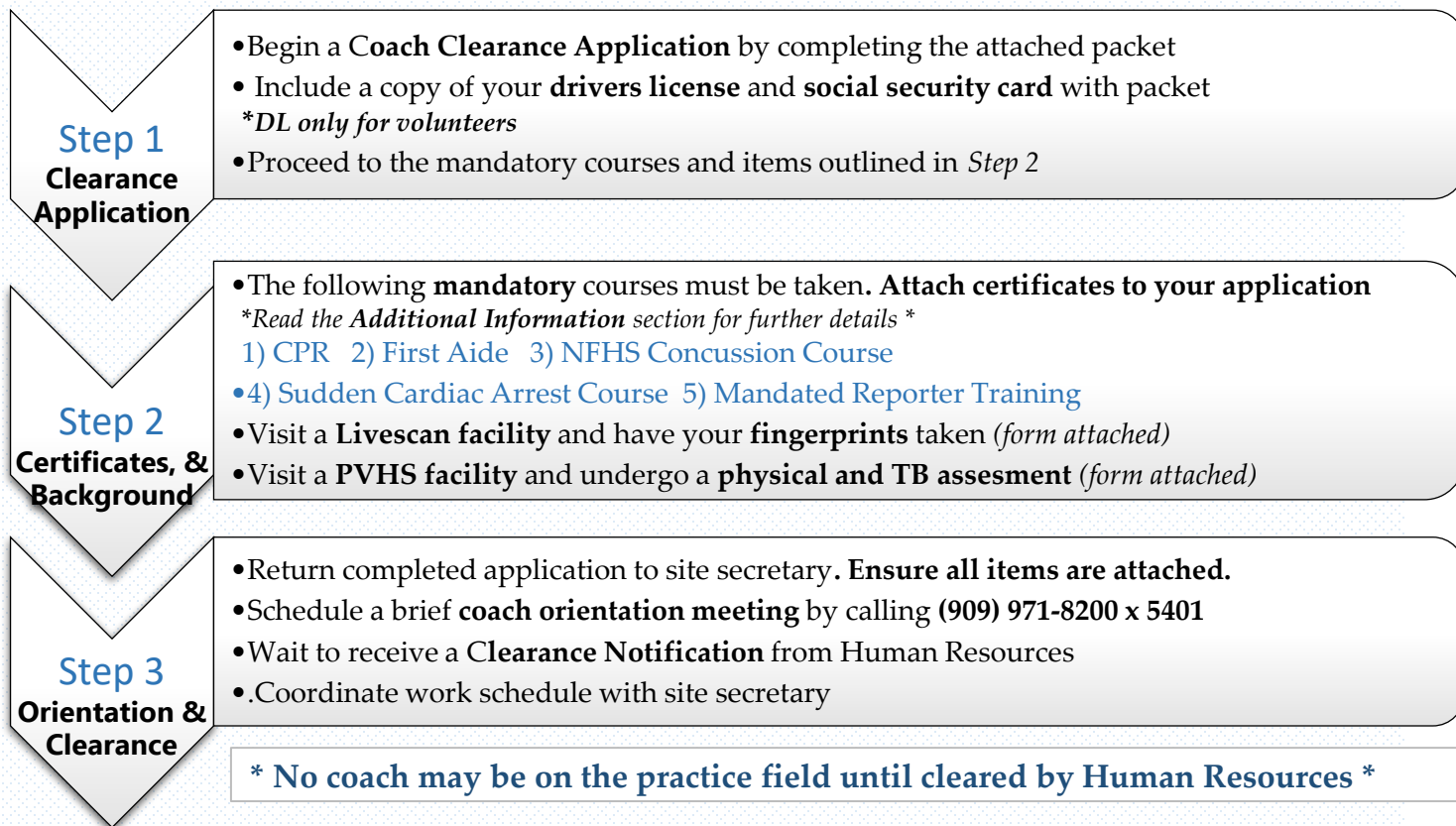




The Coach Clearance Process



Additional Information

◆ The cost of the **Live Scan** is approximately \$75. BUSD does not pay for this service. On the page following the Live Scan form, a nearby facility is suggested. If you already had your fingerprints processed for BUSD, do NOT process them again.

◆ Please make an appointment for a **pre-employment physical and TB Assesment**. Bonita USD will cover the cost. Please call the number on the Pomona Valley Health Center (PVHC) form to make the appointment. There are two locations for your convenience. Chest x-rays, if needed, will be the responsibility of the applicant. If you have a taken a TB test within the last four years, you may simply submit proof of your negative results.

◆ As a condition of employment, each new employee is required to undergo **Child Abuse Mandated Reporter Training**. To complete this training, register at <https://ascip.synlms.com/Signup> . Use a personal email address instead of a district email. Once logged in, click **Catalog** and go to the **Search** bar. Type in **AB1432** for the **Mandated Reporter Training** . Once you have completed and passed the training, print the certificate by clicking on the graduate cap (Transcript) icon.

◆ Both CPR **and** First Aide courses are required. BUSD does not pay the costs of these courses. Online courses of your choice are acceptable as long as a certificate is provided. The Red Cross provides these courses online at: <https://www.redcross.org/take-a-class/online-safety-classes> .

◆ The free online **Concussion Course** and the **Sudden Cardiac Arrest Course** MUST be taken online at www.nfhslearn.com.

BONITA UNIFIED SCHOOL DISTRICT

SITE: _____ SPORT: _____

No coach may be on the practice field until the site receives this letter of clearance signed by Human Resources Development. **All items outlined in *The Coach Clearance Process* must be completed and returned to the site with this application.** All certifications must be kept current as a condition of employment.

Acknowledgement of Application: _____
Signature

Date: _____

CLEARANCE OF TEMPORARY ATHLETIC COACH

The following individual has been cleared as an Athletic Coach.
All preliminary employment steps have been completed.

Print Name: _____

Date Cleared by HRD: _____

Approval: _____
Assistant Superintendent Human Resources Development

Expiration Date of CPR Card: _____

Expiration Date of 1st Aide Card: _____

Items to be completed before check is issued:

Employee Paperwork

Social Security Card presented to HRD: _____

Driver's License or Photo ID presented to HRD: _____

BONITA UNIFIED SCHOOL DISTRICT COACHING REQUIREMENTS

Name: _____ Site: _____

Position: _____ Sport: _____

- District Paid Booster Paid
 Certificated Classified Volunteer (bold items only)

- Pink Clearance Form** **T.B. Test Date:** _____
 Code of Ethics **WellComp & Work Comp (2)** _____
 First Aid Card Exp. on _____ **CPR Card Exp. on:** _____
 Fingerprint Clearance Date: _____ **Walk on coaching form**
 Concussion Training completed on _____ **(proof required)**
 Memo CIF Education Class ----OR---- **CIF Education Class Certificate**
 Physical Clearance (returning-within 5 years) **Date Cleared** _____
 Child Abuse Mandated Reporter Training Completion Certificate _____
 Application/Coaching App Annual Employee Notification Form
 Driver License – copy Confidential Data Collection Form
 Social Security Card – copy Contact Data Form
 Warrant Designation Coaches Athletic Policy
 W-4 /EDD Form Oath of Allegiance
 Social Security Form Direct Deposit (Optional)
 Sudden Cardiac Arrest I-9 Form

THE PACKET MUST BE REVIEWED AND SIGNED BY THE SITE BEFORE RETURNING TO HRD FOR PROCESSING. APPLICANT IS NOT ALLOWED TO WORK UNTIL THE HRD CLEARANCE FORM IS RECEIVED BY THE SITE. ANY QUESTIONS, PLEASE CALL SULA FERRER EXT 5404

Employee Signature: _____ Date: _____
 Site Review Signature: _____ Date: _____



BONITA UNIFIED SCHOOL DISTRICT

115 West Allen Avenue San Dimas, California 91773 (909) 971-8200 Fax (909) 971-8329

Superintendent

Matthew Wien – Superintendent

Assistant Superintendents

*Sonia Gomez Eckley – Business Services
Kevin Lee, Ed.D. – Human Resources Development*

Board of Education

*Derek Bahmanou
Glenn Creiman
Jim Elliot
Chris Ann Horsley
Greg Palatto*

TO: Walk on Coach
FROM: Kevin Lee, Assistant Superintendent Human Resources

Dear Walk on Coach,

We are pleased that you are joining the Bonita Unified School District. In this regard, we require all employees to sign certain formal documents regarding state laws and District policies.

Our reason for having you sign this letter is because as a walk-on coach, you will be working closely with students. From time to time, students may turn to you for guidance and assistance outside of the area of coaching. It is important you refer such students to qualified personnel, like their own counselor, for assistance. In addition, some students may turn to you for emotional support or guidance. Please do not take it upon yourself to provide assistance outside of the role and responsibility that you have as a coach. Remember that you are a professional and therefore you must act professionally at all times, both "on and off the field of play." Acting professionally means but is not limited to not dating your players or giving rides in your car before or after a game or practice. Do not put yourself in a compromising position or act inappropriately with any student.

We send this letter to you as a warning because from time to time, you will read in the newspaper about coaches who have engaged in unprofessional or even immoral conduct with students. Both criminal penalties and civil liability can and will be imposed when that happens. In addition, coaches can lose their teaching license or be ineligible from ever obtaining a teacher's license.

If you have any questions or need assistance with this important issue, I want you to contact the athletic director at your school. You may also contact me in the Human Resources Department at 909-971-8340.

Thank you,

Kevin Lee
Assistant Superintendent
Human Resources Development

As a part of the hiring process, I have received and have read a copy of this letter.

Name: _____ By: _____
Print Signature



BONITA UNIFIED SCHOOL DISTRICT

115 W. Allen Avenue
 San Dimas, CA 91773
 (909) 971-8340

Office use only:

Assistant Superintendent Initial For Approval: _____

APPLICATION FOR EMPLOYMENT

PRINT LEGIBLY IN BLUE OR BLACK INK.

Date available: _____

Name: _____		
Last	First	Middle
Address: _____		
Number		Street

City	State	Zip
Social Security #: _____	Telephone #: _____	
Email Address: _____		

Experience: Please list your last three positions starting with the most recent.

Total Yrs.	Mos.	Employer Name/Address	Phone
Dates From	To		Supervisor
Job title			Salary
Duties			Reason for leaving
Total Yrs.	Mos.	Employer Name/Address	Phone
Dates From	To		Supervisor
Job title			Salary
Duties			Reason for leaving
Total Yrs.	Mos.	Employer Name/Address	Phone
Dates From	To		Supervisor
Job title			Salary
Duties			Reason for leaving

Education: Circle highest year completed or appropriate certificate.

	HIGH SCHOOL	COLLEGE/UNIVERSITY	CURRENT CERTIFICATIONS:
SCHOOL NAME			
YEARS COMPLETED	9 10 11 12	1 2 3 4	
DIPLOMA/DEGREE	Yes - No	Yes - No	
COURSE OF STUDY			

Applicant must complete both sides of application

Bilingual Skills (Circle appropriate ability)

Language:	Speak	Read	Write
Language:	Speak	Read	Write

Please answer all questions below with explanations, if requested. An adverse answer does not disqualify you from consideration, but may be discussed with you by the Assistant Superintendent of Human Resources.

A. As an adult, have you ever been convicted of an offense other than a minor traffic violation?

If yes, give date, place, offense, and fine or sentence in each instance:

YES NO

B. Have you ever been discharged or forced to resign from a job?

If yes, give name of employer and explain situation:

YES NO

C. Are you related to or know any present employee of this district?

If yes, state name and relationship:

YES NO

D. Have you ever been employed by this district?

If yes, give job title, location and dates employed:

YES NO

E. May we contact your present employer?

YES NO

F. Can you provide documents to verify your identity and authorization to work in the United States?

YES NO

Documents may include, but are not limited to: Birth Certificate or Social Security Card and Driver's License; Citizenship or Naturalization certificate; Passport or Alien registration card; other approved documents.

G. Do you know of any reason why you cannot perform the essential functions of the job for which you are applying, with or without reasonable accommodations?

YES NO

Please describe any accommodations required below.

If you require special accommodation for testing or interviews due to a disability, please inform us by the end of the filing period so we may meet your needs.

Applicant's Declaration

I declare that the information in this application is true and correct to the best of my knowledge and I authorize the investigation of all statements herein recorded. I release from all liability persons and organizations reporting information required by this application. I understand that I will be subject to disqualification or dismissal if any statement in this application is found to be untrue.

Note: Employees are required to have their fingerprints processed, take a Mantoux TB test and file the results with the school district. Offers of employment may be made contingent upon the passage of a physical examination.

Signature

Date



Pursuing Victory With Honorsm

Code of Conduct for Coaches

CIF Member School: _____

We, in the California Interscholastic Federation, believe that high school athletic competition should be fun, but that it must also be a significant part of a sound educational program. We believe that those who coach student-athletes are, first and foremost, teachers who have a duty to assure that their sports programs promote important life skills and the development of good character.

We believe that the essential elements of character-building are embodied in the concept of sportsmanship and six core ethical values: trustworthiness, respect, responsibility, fairness, caring, and good citizenship (the “Six Pillars of Charactersm”). We believe, further, that the highest potential of sports is achieved when teacher-coaches consciously Teach, Enforce, Advocate and Model (T.E.A.M.) these values and are committed to the ideal of pursuing victory with honor. Finally, we believe that sincere and good-faith efforts to honor the words and spirit of this Code will improve the quality of our programs and the well being of our student-athletes. This Code of Conduct applies to all full-time and part-time coaches involved in interscholastic sports.

I understand that in my position as a coach, I must act in accord with the following code:

TRUSTWORTHINESS.

- **Trustworthiness** Be worthy of trust in all I do and teach student-athletes the importance of integrity, honesty, reliability and loyalty.
- **Integrity** Model high ideals of ethics and sportsmanship and always pursue victory with honor; teach, advocate and model the importance of honor and good character by doing the right thing even when it’s unpopular or personally costly.
- **Honesty** Don’t lie, cheat, steal or engage in or permit dishonest or unsportsmanlike conduct.
- **Reliability** Fulfill commitments; I will do what I say I will do; be on time.

- **Loyalty** Be loyal to my school and team; put the team above personal glory.
- **Primacy of Educational Goals** Be faithful to the educational and character-development missions of the school and assure that these objectives are not compromised to achieve sports performance goals; always place the academic, emotional, physical and moral well being of athletes above desires and pressures to win.
- **Counseling** Be candid with student-athletes and their parents about the likelihood of getting an athletic scholarship or playing on a professional level. Counsel them about the requirement of many colleges preventing recruitment of student-athletes that do not have a serious commitment to their education, the ability to succeed academically or the character to represent their institution honorably.
- **College Recruiters** Be honest and candid with college recruiters about the character and academic abilities and interest of student-athletes.

RESPECT

- **Respect** Treat all people with respect all the time and require the same of student-athletes
- **Class** Be a good sport, teach and model class, be gracious in victory and accept defeat with dignity; encourage student-athletes to give fallen opponents a hand, compliment extraordinary performance, and show sincere respect in pre- and post-game rituals.
- **Taunting** Don't engage in or allow trash-talking, taunting, boastful celebrations, or other actions that demean individuals or the sport.
- **Respect Officials** Treat contest officials with respect; don't complain about or argue with official calls or decisions during or after an athletic event.
- **Respect Parents** Treat the parents of student-athletes with respect; be clear about your expectations, goals and policies and maintain open lines of communication.
- **Profanity** Don't engage in or permit profanity or obscene gestures during practices, sporting events, on team buses, or any other situation where the behavior could reflect badly on the school or the sports program.
- **Positive Coaching** Use positive coaching methods to make the experience enjoyable, increase self-esteem and foster a love and appreciation for the sport. Refrain from physical or psychological intimidation, verbal abuse, and conduct that is demeaning to student-athletes or others.
- **Effort and Teamwork** Encourage student-athletes to pursue victory with honor, to think and play as a team, to do their best and continually improve through personal effort and discipline. Discourage selfishness and put less emphasis on the final outcome of the contest, than upon effort, improvement, teamwork, and winning with character.

- **Professional Relationships** Maintain appropriate, professional relationships with student athletes and respect proper teacher-student boundaries. Sexual or romantic contact with students is strictly forbidden as is verbal or physical conduct of a sexual nature directed to or in view of student-athletes.

RESPONSIBILITY

- **Life Skills** Always strive to enhance the physical, mental, social and moral development of student-athletes and teach them positive life skills that will help them become well-rounded, successful and socially responsible.
- **Advocate Education** Advocate the importance of education beyond basic athletic eligibility standards and work with faculty and parents to help student-athletes set and achieve the highest academic goals possible for them.
- **Advocate Honor** Prominently discuss the importance of character, ethics and sportsmanship in materials about the athletic program and vigorously advocate the concept of pursuing victory with honor in all communications.
- **Good Character** Foster the development of good character by teaching, enforcing, advocating and modeling (T.E.A.M.) high standards of ethics and sportsmanship and the six pillars of character.
- **Role-Modeling** Be a worthy role-model, always be mindful of the high visibility and great influence you have as a teacher-coach and consistently conduct myself in private and coaching situations in a manner that exemplifies all I want my student-athletes to be.
- **Personal Conduct** Refrain from profanity, disrespectful conduct, and the use of alcohol or tobacco in front of student-athletes or other situations where my conduct could undermine my positive impact as a role model.
- **Competence** Strive to improve coaching competence and acquire increasing proficiency in coaching principles and current strategies, character-building techniques, and first-aid and safety.
- **Knowledge of Rules** Maintain a thorough knowledge of current game and competition rules and assure that my student-athletes know and understand the rules.
- **Positive Environment** Strive to provide a challenging, safe, enjoyable, and successful experiences for the athletes by maintaining a sports environment that is physically and emotionally safe.
- **Safety and Health** Be informed about basic first aid principles and the physical capacities and limitations of the age-group coached.
- **Unhealthy Substances** Educate student-athletes about the dangers and prohibit the use of unhealthy and illegal substances including alcohol, tobacco and recreational or performance-enhancing drugs.
- **Eating Disorders** Counsel students about the dangers of and be vigilant for signs of eating disorders or unhealthy techniques to gain, lose or maintain weight.

- **Physician's Advice** Seek and follow the advice of a physician when determining whether an injured student-athlete is ready to play.
- **Privilege to Compete** Assure that student-athletes understand that participation in interscholastic sports programs is a privilege, not a right and that they are expected to represent their school, team and teammates with honor, on and off the field. Require student-athletes to consistently exhibit good character and conduct themselves as positive role models.
- **Self-Control** Control my ego and emotions; avoid displays of anger and frustration; don't retaliate.
- **Integrity of the Game** Protect the integrity of the game; don't gamble. Play the game according to the rules.
- **Enforcing Rule** Enforce this Code of Conduct consistently in all sports-related activities and venues even when the consequences are high.
- **Protect Athletes** Put the well being of student-athletes above other considerations and take appropriate steps to protect them from inappropriate conduct.
- **Access** Help make your sport accessible to all diverse communities.
- **Improper Commercialism** Be sensitive to and avoid unwholesome commercialism including inappropriate exploitation of my name or the name of the school and undue financial dependence on corporate entities. Make sure any affiliation or association with a corporate entity is approved by school and district officials.

FAIRNESS

- **Fair and Open** Be fair in competitive situations, selecting a team, disciplinary issues and all other matters; and be open-minded and willing to listen and learn.

CARING

- **Safe Competition** Put safety and health considerations above the desire to win; never permit student-athletes to intentionally injure any player or engage in reckless behavior that might cause injury to themselves or others.
- **Caring Environment** Consistently demonstrate concern for student-athletes as individuals and encourage them to look out for one another and think and act as a team

CITIZENSHIP

- ***Honor the Spirit of Rules*** Observe and require student-athletes to observe the spirit and the letter of all rules including the rules of the game and those relating to eligibility, recruitment, transfers, practices and other provisions regulating interscholastic competition.
- ***Improper Gamesmanship*** Promote sportsmanship over gamesmanship; don't cheat. Resist temptations to gain competitive advantage through strategies or techniques (such as devious rule violations, alteration of equipment or the field of play or tactics designed primarily to induce injury or fear of injury) that violate the rules, disrespect the highest traditions of the sport or change the nature of competition by practices that negate or diminish the impact of the core athletic skills that define the sport.

I have read and understand the requirements of this Code of Conduct. I will act in accord with this code. I understand that school (and district) officials as well as league and section officials will and should expect that I will follow this code.

Teacher-Coach Signature

Date

“Pursuing Victory With Honor” and the “Six Pillars of Character” are service marks of the CHARACTER COUNTS! Coalition, a project of the Josephson Institute of Ethics. For more information on promoting character education and good sportsmanship, visit www.charactercounts.com.

Memorandum

BONITA UNIFIED SCHOOL DISTRICT
Human Resources Development

TO: Applicant
FROM: Human Resources Development
SUBJECT: New Coaching Fingerprint Requirements (AB 346)

We have all been anxiously watching to see how the revision of AB 1025 was going to play out which would have required an Activity Supervisor Clearance Certificate through California Teacher Credentialing. After seven months of painstaking negotiations, Governor Schwarzenegger recently signed into law AB 346 which now requires the following to meet the new mandate:

1. AB 346 requires anyone who will work with pupils in an activity program must undergo a DOJ and FBI background check (fingerprints) which includes head coaches, assistant coaches, auxiliary coaches, volunteer coaches, and anyone who will be alone with a student in an official capacity during a pupil activity sponsored by the district. (Certificated teachers already meet this requirement).
2. Under AB 346, exempt from the background check are non-teaching volunteer aides and parents who volunteer in a classroom or on a field trip and/or community volunteers providing non-instructional services.

Therefore, all classified coaches, walk-on coaches, volunteer coaches, activity program volunteers working with students in a sport or activity sponsored by Bonita Unified School District are required to undergo a DOJ and FBI background check (fingerprinted) before being cleared to work with students.

This mandate is retroactive which requires current coaches and volunteers who are not certificated teachers to be fingerprinted again before working with students.

Attached you will find locations to complete LiveScan fingerprint clearance. The cost will be approximately \$70.00.

If you have any questions regarding the new requirements, please contact Human Resources.

Memorandum

**BONITA UNIFIED SCHOOL DISTRICT
HUMAN RESOURCES DEVELOPMENT**

TO: Applicant
FROM: Human Resources Development
SUBJECT: CIF Coaching Education Class

The new CIF rules mandate that all coaches, paid or volunteer, complete and pass the CIF Coaching Education Class. You may coach ONE sport season without this certification, this will allow you time to complete the course.

Coaches can go on their own to www.nfhslearn.com and take the Fundamentals of Coaching course or you can try to find a school that offers this class. Once completed you will be registered as being certified, you will also receive a certificate of completion.

If you have any questions regarding this procedure, please contact your athletic director at the school site.

Please acknowledge receipt of this letter with signature and date and return to Diane Fowler, District Office, HRD.

Signature

Print Name

Date



BONITA UNIFIED SCHOOL DISTRICT

115 West Allen Avenue San Dimas, California 91773 (909) 971-8200 FAX (909) 971-3829

CONTACT DATA

(Print Legibly)

Social Security Number _____ - _____ - _____

Prefix _____
(Mr., Mrs., Miss)

Suffix _____
(Jr., Sr.)

Last Name _____ First Name _____ MI _____

Current Address _____

City _____ State _____ Zip Code _____

Home Phone Number _____

Cell Phone Number _____

Email Address _____

Name of Emergency Contact _____

Relationship _____

Emergency Contact Phone Number _____

Office Use Only:

Access ID # _____

BONITA UNIFIED SCHOOL DISTRICT

Risky Behaviors - Red Flags

The best way staff members can protect themselves from false accusations is to avoid behaviors that can be misconstrued. The following risky behaviors are not absolute prohibitions, indisputable indicators of wrongdoing, or a substitute for common sense; they are intended as risk management guidelines.

1. Never be alone with a student in a classroom/office with the door closed or where you are not able to be seen by others.
2. Do not meet students outside of school for a meal, a drink, etc. Regardless of the motivation, there is seldom justification for such conduct. (School sanctioned events with parental involvement excluded)
3. In general, staff members should not counsel students in nonacademic matters. Although a bond of trust can form between students and staff, only trained and qualified counselors should provide mental health counseling and other "life" advice. Staff must consider the potential risk in discussing personal matters with students. If they believe that a student is in danger or some type of trouble, they should refer the student to the school's counseling team or administrator.
4. Do not transport students in your vehicle or allow students to have access to your vehicle.
5. Do not give students hall passes to come to a classroom on non-school related business.
6. Do not allow students to engage you in conversations regarding their romantic or sexual activities and do not discuss your own personal life with students.
7. Do not entertain students in your home.
8. Do not make sexual comments/innuendos, comment about students' bodies, tell sexual jokes, or share sexually oriented material with students.
9. Do not place your hands on students in a manner that is inappropriate, including, but not limited to, brush against their bodies; touch their hair; rub their necks, shoulders or backs; embrace them too tightly; or allow them to sit on your lap. Do not tickle, wrestle, poke, pat, pinch, or punch students.
10. Do not ask / allow students to give you a neck rub, back rub, etc.
11. Do not photograph or videotape students unless clearly related to instruction or at a sanctioned school activity/event with parental permission.
12. All staff should maintain separate professional and personal social media pages. They should not e-mail, "friend" or otherwise communicate via staff or students' personal pages. Staff should use privacy settings to control access to their personal social media sites.
13. Do not give nicknames to your students. Avoid "sweetie", "honey", etc.
14. Do not let students call you by affectionate or inappropriate nicknames.
15. Use discretion in attending a student's social function such as a birthday party; this could be construed as favoritism.
16. Do not babysit for students.
17. Use discretion when tutoring students. This could be construed as favoritism. If you do tutor, do not be alone with the student, either at their house, in your home, or a classroom.
18. Do not bully students verbally or physically (i.e. refrain from sarcastic comments, ridicule, etc.).
19. Do not exchange cell phone numbers with students.

Signature _____

Date _____



POMONA VALLEY HEALTH CENTERS

Affiliated with Pomona Valley Hospital Medical Center

Open everyday 365 days a year
Monday-Friday 8am - 8pm
Weekends & Most Holidays 9am - 5pm

Claremont Urgent Care
1601 Monte Vista Avenue, #190
Claremont, CA 91711
(909) 865-9977 • Fax (909) 946-0166

Chino Hills Crossroads Urgent Care
3110 Chino Avenue, #150-B
Chino Hills, CA 91709
(909) 630-7868 • Fax (909) 630-7869

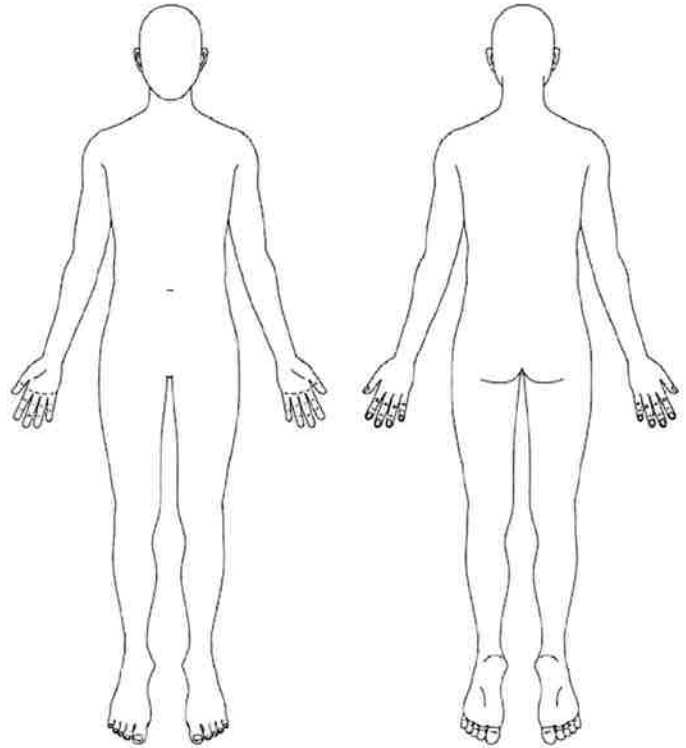
La Verne Urgent Care
2333 Foothill Blvd., Ste. C
La Verne, CA 91750
(909) 392-6511 • Fax (909) 392-6512

EMPLOYER ADVANTAGE

We truly value the health of your employees

Patient name:
Employer: Bonita Unified School District
Address: 115 W. Allen Avenue
San Dimas, CA 91773
Phone: (909) 971-8200
W/C Ins Co.:
Address:
Phone:
Authorized by: Jane Lamb
Title: Administrative Assistant, HR
Signature: [Handwritten Signature]
Date:
Occupation:
Date of injury or appointment:

Please circle where the employee was injured on the diagram below.



Our Occupational Medicine services are located in our Claremont, Chino Hills Crossroads and La Verne Urgent Care locations. Look for the Urgent Care entrance.

Work Related Injury
Bill W/C carrier
Bill employer
Drug Screens
Pre-placement
Non-regulated
DOT/DMV/Federal
B.A.T.
Physical Exams
Pre-placement/Pre-employment
DOT/DMV
Fit for duty exam (return to work)
Vision test
Chest X-ray
Audiogram
Immunizations
PFT
Lifting Test
TB Skin Test
Lab Work
Risk Assessment TB Questionnaire

AFTER HOURS INJURIES

When our offices are closed, please direct all injured employees to the Pomona Valley Hospital Medical Center located at 1798 N. Garey Avenue in Pomona. Give your employee a completed Pomona Valley Health Center authorization slip to initiate treatment. Follow up care will continue at either of our Urgent Care offices. If the employee is unconscious, bleeding badly or not breathing properly, call 911 immediately.

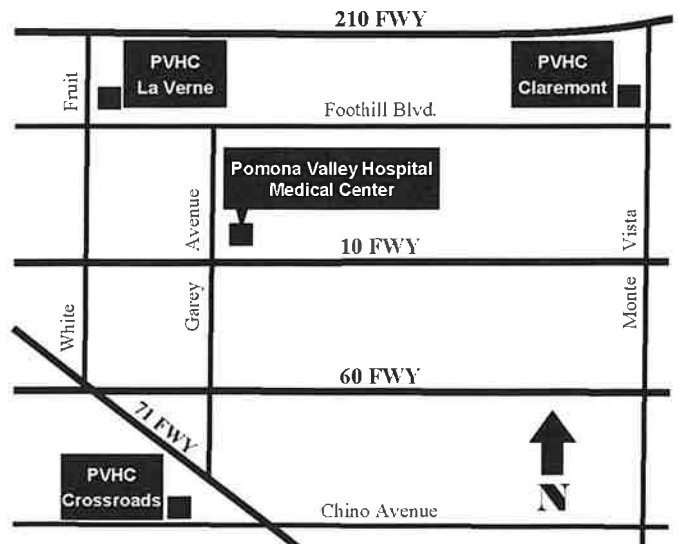
Other:
Comments:

Is employee a temp or leased? Yes No

Leasing company name & phone:

Phone authorization by: PVHC Associate

Date & time:





BONITA UNIFIED SCHOOL DISTRICT

115 West Allen Avenue San Dimas, California 91773 (909) 971-8200 Fax (909) 971-8349

PERSONAL PHYSICIAN PRE-DESIGNATION FORM

Date Employee was provided Pre-Designation Form: _____

Employee: _____

Department: _____

Pursuant to Labor Code 4600 (d), the definition of "personal Physician" means:

- ✓ The employee's regular physician and surgeon,
- ✓ Who, prior to the injury, has directed medical treatment of the employee, and
- ✓ Retains the medical records and medical history of the employee.

Name of Physician: _____

Specialty: _____

Address: _____

Telephone: _____

Employee Name: (print) _____

Employee Signature: _____

Date of Request: _____

If this form and the attached Certification is not completed and returned to your employer prior to an industrial injury, the employee is to seek medical treatment from the employer-designated medical facility as noted on the posted notices regarding workers' compensation.

Your personal physician is required to adhere to Title 8, California Code of Regulations 9785, the Reporting Duties of the Primary Treating Physician and Labor Code 4610. Your personal physician must agree to be your pre-designated physician and that they will accept payment for services in accordance with the California Official Medical Fee Schedule.

Please have your personal physician sign and return this form to your employer with the attached Certification acknowledging their responsibility as your treating physician Should you sustain and industrial injury.

Date: _____

Physician: _____

Employee: _____

CERTIFICATION

This is to certify that (employee) _____ is a patient of mine. I have treated him/her for non-work related medical problems and I maintain his/her medical records in my office.

I am willing to take responsibility for following rules required of a Treating Physician, per the California Code of Regulations, Title 8, Section 9785, when treating this employee for work-related injuries or illnesses. I acknowledge all requests for medical care will be governed by Labor Code 4610 outlining mandatory utilization review under the guidelines of the American College of Occupational and Environment Medicine (ACOEM).

Physician's Signature: _____

Print Name: _____

Date: _____

I decline the request of (employee) _____ to be his/her Treating Physician for work-related injuries.

Physician's Signature: _____

Print Name: _____

Date: _____



Child Abuse Mandated Reporter Training

As a condition of employment, each new employee is required to provide proof of Child Abuse Mandated Reporter Training per California Education Code 44691 (b) (2).

To complete the Child Abuse Mandated Reporter Training:

Go to: www.do.bonita.k12.ca.us

- Under the “District” tab, click “Human Resources”
- Under “Helpful Links” click: *Child Abuse Mandated Reporter Training*
- Start the training

Once you have completed and passed the training, an email with the Certification of Completion Certificate will be sent to you. This certificate **must** be included in your employment packet when returned to Human Resources.

Memorandum

**BONITA UNIFIED SCHOOL DISTRICT
HUMAN RESOURCES DEVELOPMENT**

TO: Applicant
FROM: Human Resources Development
SUBJECT: Coaching Athletic Policy

I have read the Bonita Unified School District Athletic Policy and I am aware of all my Responsibilities in Coaching for San Dimas High School or Bonita High School.

School

Sport

Position

Signature

Print Name

Date

Home Phone: _____

Cell Phone: _____

Email: _____



BONITA UNIFIED SCHOOL DISTRICT

115 West Allen Avenue San Dimas, California 91773 (909) 971-8200 FAX (909) 971-3829

OATH OF ALLEGIANCE

"I, _____, do solemnly swear (or affirm) that I will support and defend the Constitution of the United States and the Constitution of the State of California against all enemies, foreign and domestic; that I will bear true faith and allegiance to the Constitution of the United States and the Constitution of the State of California; that I take this obligation freely, without any mental reservation or purpose of evasion; and that I will well and faithfully discharge the duties upon which I am about to enter."

Signature of Employee _____
(Payroll Name)

Subscribed and affirmed to before me this _____ day of _____, 20_____

Signature of Employer

Position



Employment Eligibility Verification
Department of Homeland Security
U.S. Citizenship and Immigration Services

USCIS
Form I-9
 OMB No. 1615-0047
 Expires 08/31/2019

▶ 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):

<input type="checkbox"/> 1. A citizen of the United States	
<input type="checkbox"/> 2. A noncitizen national of the United States <i>(See instructions)</i>	
<input type="checkbox"/> 3. A lawful permanent resident (Alien Registration Number/USCIS Number): _____	
<input type="checkbox"/> 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. <i>(See instructions)</i> <i>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.</i> 1. Alien Registration Number/USCIS Number: _____ OR 2. Form I-94 Admission Number: _____ OR 3. Foreign Passport Number: _____ Country of Issuance: _____	
<div style="border: 1px solid black; padding: 5px; width: fit-content; margin: 0 auto;"> QR Code - Section 1 Do Not Write In This Space </div>	

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



Employer Completes Next Page





Employment Eligibility Verification
Department of Homeland Security
U.S. Citizenship and Immigration Services

USCIS
Form I-9
 OMB No. 1615-0047
 Expires 08/31/2019

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		<div style="border: 1px solid black; padding: 5px;"> Additional Information </div>		<div style="border: 1px solid black; padding: 5px; text-align: center;"> QR Code - Sections 2 & 3 Do Not Write In This Space </div>
Issuing Authority				
Document Number				
Expiration Date (if any)(mm/dd/yyyy)				
Document Title				
Issuing Authority				
Document Number				
Expiration Date (if any)(mm/dd/yyyy)				

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
----------------------------------------------------	---------------------------	-----------------------------------------------

LISTS OF ACCEPTABLE DOCUMENTS
All documents must be UNEXPIRED

Employees may present one selection from List A
or a combination of one selection from List B and one selection from List C.

LIST A Documents that Establish Both Identity and Employment Authorization	OR	LIST B Documents that Establish Identity	AND	LIST C Documents that Establish Employment Authorization
1. U.S. Passport or U.S. Passport Card		1. Driver's license or ID card issued by a State or outlying possession of the United States provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		1. A Social Security Account Number card, unless the card includes one of the following restrictions: (1) NOT VALID FOR EMPLOYMENT (2) VALID FOR WORK ONLY WITH INS AUTHORIZATION (3) VALID FOR WORK ONLY WITH DHS AUTHORIZATION
2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551)		2. ID card issued by federal, state or local government agencies or entities, provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		2. Certification of Birth Abroad issued by the Department of State (Form FS-545)
3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa		3. School ID card with a photograph		3. Certification of Report of Birth issued by the Department of State (Form DS-1350)
4. Employment Authorization Document that contains a photograph (Form I-766)		4. Voter's registration card		4. Original or certified copy of birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal
5. For a nonimmigrant alien authorized to work for a specific employer because of his or her status: a. Foreign passport; and b. Form I-94 or Form I-94A that has the following: (1) The same name as the passport; and (2) An endorsement of the alien's nonimmigrant status as long as that period of endorsement has not yet expired and the proposed employment is not in conflict with any restrictions or limitations identified on the form.		5. U.S. Military card or draft record		5. Native American tribal document
		6. Military dependent's ID card		6. U.S. Citizen ID Card (Form I-197)
		7. U.S. Coast Guard Merchant Mariner Card		7. Identification Card for Use of Resident Citizen in the United States (Form I-179)
		8. Native American tribal document		8. Employment authorization document issued by the Department of Homeland Security
		9. Driver's license issued by a Canadian government authority		
6. Passport from the Federated States of Micronesia (FSM) or the Republic of the Marshall Islands (RMI) with Form I-94 or Form I-94A indicating nonimmigrant admission under the Compact of Free Association Between the United States and the FSM or RMI		For persons under age 18 who are unable to present a document listed above:		
		10. School record or report card		
		11. Clinic, doctor, or hospital record		
	12. Day-care or nursery school record			

Examples of many of these documents appear in Part 8 of the Handbook for Employers (M-274).

Refer to the instructions for more information about acceptable receipts.

Statement Concerning Your Employment in a Job Not Covered by Social Security

Employee Name _____ Employee ID# _____

Employer Name _____ Employer ID# _____

Your earnings from this job are not covered under Social Security. When you retire, or if you become disabled, you may receive a pension based on earnings from this job. If you do, and you are also entitled to a benefit from Social Security based on either your own work or the work of your husband or wife, or former husband or wife, your pension may affect the amount of the Social Security benefit you receive. Your Medicare benefits, however, will not be affected. Under the Social Security law, there are two ways your Social Security benefit amount may be affected.

Windfall Elimination Provision

Under the Windfall Elimination Provision, your Social Security retirement or disability benefit is figured using a modified formula when you are also entitled to a pension from a job where you did not pay Social Security tax. As a result, you will receive a lower Social Security benefit than if you were not entitled to a pension from this job. For example, if you are age 62 in 2013, the maximum monthly reduction in your Social Security benefit as a result of this provision is \$395.50. This amount is updated annually. This provision reduces, but does not totally eliminate, your Social Security benefit. For additional information, please refer to Social Security Publication, "Windfall Elimination Provision."

Government Pension Offset Provision

Under the Government Pension Offset Provision, any Social Security spouse or widow(er) benefit to which you become entitled will be offset if you also receive a Federal, State or local government pension based on work where you did not pay Social Security tax. The offset reduces the amount of your Social Security spouse or widow(er) benefit by two-thirds of the amount of your pension.

For example, if you get a monthly pension of \$600 based on earnings that are not covered under Social Security, two-thirds of that amount, \$400, is used to offset your Social Security spouse or widow(er) benefit. If you are eligible for a \$500 widow(er) benefit, you will receive \$100 per month from Social Security (\$500 - \$400=\$100). Even if your pension is high enough to totally offset your spouse or widow(er) Social Security benefit, you are still eligible for Medicare at age 65. For additional information, please refer to Social Security Publication, "Government Pension Offset."

For More Information

Social Security publications and additional information, including information about exceptions to each provision, are available at www.socialsecurity.gov. You may also call toll free 1-800-772-1213, or for the deaf or hard of hearing call the TTY number 1-800-325-0778, or contact your local Social Security office.

I certify that I have received Form SSA-1945 that contains information about the possible effects of the Windfall Elimination Provision and the Government Pension Offset Provision on my potential future Social Security Benefits.

Signature of Employee _____ Date _____

Employee's Withholding Certificate

Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay.

Give Form W-4 to your employer.

Your withholding is subject to review by the IRS.

Step 1: Enter Personal Information	(a) First name and middle initial	Last name	(b) Social security number
	Address		Does your name match the name on your social security card? If not, to ensure you get credit for your earnings, contact SSA at 800-772-1213 or go to www.ssa.gov .
	City or town, state, and ZIP code		
	(c) <input type="checkbox"/> Single or Married filing separately <input type="checkbox"/> Married filing jointly or Qualifying surviving spouse <input type="checkbox"/> Head of household (Check only if you're unmarried and pay more than half the costs of keeping up a home for yourself and a qualifying individual.)		

Complete Steps 2–4 ONLY if they apply to you; otherwise, skip to Step 5. See page 2 for more information on each step, who can claim exemption from withholding, other details, and privacy.

Step 2: Multiple Jobs or Spouse Works

Complete this step if you (1) hold more than one job at a time, or (2) are married filing jointly and your spouse also works. The correct amount of withholding depends on income earned from all of these jobs.

Do **only one** of the following.

(a) Reserved for future use.

(b) Use the Multiple Jobs Worksheet on page 3 and enter the result in Step 4(c) below; **or**

(c) If there are only two jobs total, you may check this box. Do the same on Form W-4 for the other job. This option is generally more accurate than (b) if pay at the lower paying job is more than half of the pay at the higher paying job. Otherwise, (b) is more accurate

TIP: If you have self-employment income, see page 2.

Complete Steps 3–4(b) on Form W-4 for only ONE of these jobs. Leave those steps blank for the other jobs. (Your withholding will be most accurate if you complete Steps 3–4(b) on the Form W-4 for the highest paying job.)

Step 3: Claim Dependent and Other Credits	If your total income will be \$200,000 or less (\$400,000 or less if married filing jointly): Multiply the number of qualifying children under age 17 by \$2,000 \$ _____ Multiply the number of other dependents by \$500 \$ _____ Add the amounts above for qualifying children and other dependents. You may add to this the amount of any other credits. Enter the total here	3	\$
Step 4 (optional): Other Adjustments	(a) Other income (not from jobs). If you want tax withheld for other income you expect this year that won't have withholding, enter the amount of other income here. This may include interest, dividends, and retirement income	4(a)	\$
	(b) Deductions. If you expect to claim deductions other than the standard deduction and want to reduce your withholding, use the Deductions Worksheet on page 3 and enter the result here	4(b)	\$
	(c) Extra withholding. Enter any additional tax you want withheld each pay period	4(c)	\$

Step 5: Sign Here

Under penalties of perjury, I declare that this certificate, to the best of my knowledge and belief, is true, correct, and complete.

Employee's signature (This form is not valid unless you sign it.)

Date

Employers Only	Employer's name and address	First date of employment	Employer identification number (EIN)
-----------------------	-----------------------------	--------------------------	--------------------------------------



BONITA UNIFIED SCHOOL DISTRICT

115 West Allen Avenue San Dimas, California 91773 (909) 971-8200 FAX (909) 971-3849

WARRANT RECIPIENT DESIGNATION

In the event of your death, money may be owed to you as an employee of our district. The form below permits immediate release of any warrants (pay check or other monies) to a person you designate. This can often greatly assist in time of family stress or financial need. Please complete the form and return it to Human Resources Development.

As provided in Section 53245 of the California Government Code, in the event of my death, I hereby designate the following person (designee) to receive any and all warrants payable to me:

(Please print legibly)

Name of Designee _____

Relationship _____

Address _____

City _____ State _____ ZIP _____

This designation form revokes and replaces any designation previously signed for this purpose and shall remain in effect until cancelled in my writing. It is understood and agreed that the school district/agency is not obligated to deliver said warrants to the designee unless the designated person claims such warrants from the school district and provides proof of identity. A person so designated may negotiate the warrant(s) as if the payee.

(Please print legibly)

School District/Agency _____

Employee Name _____

Date _____

Employee Signature _____

(Signature Required)

Memorandum

BONITA UNIFIED SCHOOL DISTRICT

Human Resources Development

TO: All Employees
FROM: Kevin Lee, Assistant Superintendent, Human Resources Development
DATE: August 16, 2022
SUBJECT: Mandated Annual Employee Notification

Once a year, the District has a legal mandate to provide all employees with Annual Notifications. The Governing Board believes that providing clear communications to staff is essential to establishing a professional, positive work environment and enhancing their job performance. The Superintendent or designee shall provide district employees all notifications required by law and any other notifications he/she believes will promote staff knowledge of the district's policies, programs, activities, and operations.

When required by law, Board policy, or administrative regulation, district employees shall be asked to sign an acknowledgment indicating receipt of the notification. Such acknowledgments shall be retained in each employee's personnel file.

Below is a list of the notifications pursuant to Board Policy 4110.9:

- [Nondiscrimination in District Programs and Activities-Board Policy 0410](#)
- [Uniform Complaint Procedure-Board Policy 1312.3](#)
- [Tobacco Free School-Board Policy 3513.3](#)
- [Environmental Safety-Board Policy 3514](#)
- [Integrated Pest Management-Administrative Regulation 3514.2](#)
- [Drug and Alcohol-Free Workplace-Board Policy 4020\(a\)](#)
- [Nondiscrimination in Employment-Board Policy 4030](#)
- [Employee Use of Technology-Board Policy 4040](#)
- [Sexual Harassment Employees Administrative Regulations 4119.11 \(a\), 4219.11, 4319.11](#)
- [Sexual Harassment Students-Administrative Regulation - 5145.7\(a\)](#)
- [Universal Precautions-Administrative Regulation 4119.43](#)
- [Non-school Employment-Board Policy 4136](#)
- [Health and Welfare Benefits-Administrative Regulation 4154](#)
- [Work Related Injuries-Board Policy 4157.1](#)
- [Family Care and Medical Leave-Administrative Regulation 4161.8](#)
- [Appointment and Conditions of Employment-Administrative Regulation 4212](#)
- [Bullying-Board Policy 5131.2](#)
- [Administering Medication and Monitoring Health Conditions Administrative Regulation 5141.21](#)
- [Child Abuse Reporting-Board Policy 5141.4](#)
- [Student Use of Technology-Administrative Regulation 6163.4](#)
- [Oath of Allegiance Disaster Workers-Government Codes 3100, 3101, 3102, 3103, 3104, 3105, 3106, 3107, 3108, 3109;](#)
- [School Bus Drivers-Administrative Regulation 3542](#)
- [Drug and Testing for Bus Drivers-Board Policy 4112.42](#)

The aforementioned items can be accessed by clicking the hyperlink to each item or they can be accessed through the District's website. Upon request, the Human Resources Department will provide you with a hard copy.

I acknowledge that I have read, understand, and agree to comply with the above policies, regulations and codes.

Print Name

Signature

Date

Student Progress Is Our Business

BONITA UNIFIED SCHOOL DISTRICT

I have received the WellComp Medical Provider brochure along with the Facts about Workers' Compensation brochure.

Print Name: _____

Signature: _____

Date: _____

You do not need to print the following pages.

Please read the rest of the packet as it contains important information.

Pre-designation Of Personal Physician

In the event you sustain an injury or illness related to your employment, you may be treated for such injury/illness by your personal medical doctor (M.D) or doctor of osteopathic medicine (D.O.) or medical group if: You have health care insurance for injuries/illness that are not work related, the doctor is your regular physician, who shall be either a physician who has limited his or her practice of medicine to general practice or who is a board-certified or board-eligible internist, pediatrician, obstetrician-gynecologist, or family practitioner, and has previously directed your medical treatment, and retains your medical records; your "personal physician" may be a medical group if it is a single corporation or partnership composed of licensed doctors of medicine or osteopathy, which operates an integrated multispecialty medical group providing comprehensive medical services predominantly for non-occupational illnesses and injuries; prior to the injury your doctor agrees to treat you for work injuries or illnesses; prior to the injury you provided your employer the following in writing: (1) notice that you want your personal doctor to treat you for a work-related injury/illness, and (2) your personal doctor's name and business address.

You may use this form, a form provided by your employer or provide all the information in writing to notify your employer if you wish to have your personal medical doctor or a doctor osteopathic medicine treat you for a work-related injury/illness and the above requirements are met.

**Notice Of Pre-designation Of Personal Physician
Employee: Complete this section**

Employer _____

If I have a work-related injury or illness, I choose to be treated by:

(Name of doctor) (M.D., D.O., or medical group)

(street address, city, state, zip)

(telephone number)

Employee Name (please print): _____

Employee's Address: _____

Name of Insurance Company, Plan, or Fund providing health coverage for nonoccupational injuries or illnesses: _____

Employee Signature: _____ Date _____

Note to Employee: Unless you agree in writing, neither your employer or Sedgwick may contact your personal physician to confirm a pre-designation. If your physician does not sign this form, other documentation that they agreed to be pre-designated prior to the injury will be required. If you agree, your employer or Sedgwick may contact your personal physician to confirm this pre-designation, sign and date below:

Employee Signature _____

Employee # _____ Date _____

Physician: I agree to this Pre-designation:

Signature: _____ Date _____

(Physician or Designated Employee of the Physician)

The physician is not required to sign this form, however, if the physician or designated employee of the physician or medical group does not sign, other documentation of the physician's agreement to be pre-designated will be required pursuant to Title 8, California Code of Regulations, section 9780.1(a)(3). (Optional DWC Form 9783 July 1, 2014)

Notice Of Personal Chiropractic Or Personal Acupuncturist

If your employer or your employer's insurer does not have a Medical Provider Network (MPN), you may be able to change your treating physician to your personal chiropractor (D.C.) or acupuncturist (L.A.C.) following a work-related injury/illness. In order to be eligible to make this change, you must give your employer the name and business address of a personal D.C. or L.A.C. in writing prior to the injury/illness. Sedgwick generally has the right to select your treating physician within the first 30 days after your employer knows of your injury/illness. After your employer or Sedgwick has initiated your treatment with another physician during this period, you may then, upon request, have your treatment transferred to your personal D.C. or L.A.C. You may use this form to notify your employer of your personal D.C. or L.A.C., or your employer may have their own form. The D.C. or L.A.C. must be your regular D.C. or L.A.C. who has directed your treatment and retains your chiropractic records and history. If your employer has an MPN, you may only switch to a D.C. or L.A.C. within the MPN. A chiropractor cannot be your treating physician after 24 visits. If you still require medical treatment thereafter, you will have to select a physician who is not a chiropractor. This prohibition shall not apply to visits for postsurgical physical medicine visits prescribed by the surgeon, or physician designated by the surgeon, under the postsurgical component of the Division of Workers' Compensation's Medical Treatment Utilization Schedule.

Name of chiropractor or acupuncturist (D.C., L.A.C.)

(street address, city, state, zip code)

(telephone number)

Employee Name (Please Print): _____

Employee's Address: _____

Employee's Signature: _____

Date: _____

Title 8, California Code of Regulations, section 9783.1
(Optional DWC Form 9783.1 Effective date July 1, 2014)

WHEN A WORK INJURY OCCURS...

- **Quickly seek first aid.**
- **Call 9-1-1 for help immediately if emergency medical care is needed.**
- **Immediately report injuries to your supervisor or employer representative at _____**

Information & Assistance Office: _____

Employer MUST complete this information



The Facts About Workers' Compensation

Sedgwick
P.O. Box 14153
Lexington, KY 40512-4153
Phone (800) 922-5020
Fax (859) 264-4062

What is workers' compensation? Its purpose is to insure that an employee who is found to sustain an industrial injury or illness will be provided with benefits to medically cure or relieve them from the effects of the injury/illness, provide temporary compensation when they are medically unable to perform any occupational function, compensation for any residual handicap and/or impairment of bodily function, benefits for dependents if an employee dies as a result of an injury/illness, protection from discrimination by his/her employer because of the injury/illness.

Am I Covered? Nearly every person employed in California is protected by workers' compensation, however there are a few exceptions. People that are self-employed or volunteer workers may not be covered. Similar laws cover federal and maritime workers. Sedgwick is your employer's claims administrator. Your employer or Sedgwick can answer any questions you might have about coverage.

What Does Workers' Compensation Cover? If you have an injury/illness due to your job, it is covered. The cause can be a single event, like a fall or it can be due to repeated exposures, such as hearing loss due to constant loud noise. Injuries ranging from first-aid to serious accidents are covered. Even injuries related to a workplace crime, such as psychological or physical injuries, are covered under workers' compensation. Some injuries that result from voluntary activity, such as off duty social or athletic activities may not be covered. Check with your employer or Sedgwick if you have questions. Coverage begins the moment you start your job. There is no probationary period or wage rate.

Duty Of The Employee. Immediately notify your employer or Sedgwick so you can get the medical help that you need without delay. If your injury is greater than a first-aid injury, your supervisor will give you a Claim Form (Form DWC-1) for you to describe where, when and how it happened. To submit a claim, fill out the "Employee" section of the DWC-1. Keep one copy of this form and give the remaining pages to your supervisor. Your employer will fill out the "Employer" section and return a signed and dated copy of the form to you. Your employer will keep a copy of this form and forward another to Sedgwick. Sedgwick is in charge of handling your claim and informing you about your eligibility for benefits.

Your claim benefits do not start until your employer knows about your injury, so report and file the DWC-1 as quickly as possible. California law requires your employer to authorize medical treatment within one working day of receipt of your Claim Form. Employers are liable for up to \$10,000 in treatment pending a decision by Sedgwick for a claim to be accepted or rejected. Waiting to report may delay workers' compensation benefits. You may not receive benefits if you fail to file a claim within one year of the date of injury, the date you know the injury was work related, or the date benefits were last provided.

Duty of the Employer: Provide this form to every employee at the time of hire or by the end of their first pay period.

Within one working day, upon knowledge or notice from any source of a work injury/illness greater than first-aid, provide the employee with a Claim Form (DWC-1) and authorize medical treatment and report the claim to Sedgwick.

What are the benefits? You may be entitled to various kinds of benefits under California workers' compensation law including:

Medical Care: Medical treatment that is reasonably required to cure or relieve the injured worker from the effects of the injury/illness. There is no deductible or co-payment. These medical benefits may include lab tests, physical therapy, hospital services, medication and treatment by a doctor.

State law limits certain medical services as of January 1, 2004. You should never receive a medical bill. If additional treatment is necessary, Sedgwick will coordinate medical care that meets applicable treatment guidelines for the injury. The doctor may be a specialist for your specific type of injury, and he or she will be familiar with workers' compensation requirements and will report promptly to Sedgwick so your benefits can be paid.

The physician with overall responsibility for treating your injury/illness is your primary treating physician (PTP). The PTP decides what kind of medical care you need and if you have work restrictions. If necessary, the PTP will review your job description with you and your employer to define any limitation or restrictions that you may have. This doctor also is responsible for coordinating care between other medical providers and will write reports about any permanent impairment of bodily function(s) or the need for future medical care. Generally, your employer selects the PTP you will see for the first 30 days, but if you want to change doctors for any reason, ask your employer or Sedgwick. They're as interested as you are in your prompt recovery and return to work and will select a different doctor for you. If your employer has a Medical Provider Network (MPN) you will be directed to treat with a physician within the MPN and different rules apply regarding changing your physician.

You can be treated by your personal physician or medical group immediately if you have health care insurance for injuries or illness that are not work related, and your physician agrees in advance to treat you for any work injuries/illnesses and has previously directed your treatment and retains your medical records and agrees, prior to your injury/illness, to treat you for workplace injuries/illnesses and you gave your employer your physician's name and address in writing before the injury. You may use the form inside of this pamphlet or your employer may have a form for you to use.

If you give the name of your personal chiropractor or acupuncturist, different rules apply, and you may need to see an employer-selected physician first.

Temporary Disability Benefits: If you are not medically able to work for more than three days due to your work-related injury, counting weekends, you have a right to temporary disability (TD) payments to assist substituting your lost wages. After two weeks from reporting the injury, you will receive a check. If your employer has a salary continuation plan, your benefit may be included in your regular paycheck. TD is payable every 14 days until the doctor states you can return to work (Payments won't be made for the first three days, though, unless you're hospitalized as an inpatient or unable to work more than 14 days). The amount of the payments will be two-thirds of your average wage, subject to minimums and maximums set by the state legislature. Although the TD payment will not be the full amount of your regular paycheck, there are no deductions and the payments are tax-free. For injuries occurring on or after January 1, 2008, TD payments are limited to 104 compensable weeks within five years of date of injury. For a few long-term injuries such as chronic lung disease or severe burns, TD payments can last up to 240 weeks within five years from the date of injury. If you reach the maximum TD payment period before you can return to work or before your condition becomes permanent and stationary. See the "Other Benefits" section of this pamphlet for additional information. A timely filing with Employment Development Department may result in additional State Disability benefits when TD benefits are delayed, denied, or terminated.

Permanent Disability: If your doctor says your injury will always leave you with some permanent impairment of bodily function(s), you may receive permanent disability (PD) payments. The amount depends on the doctor's report, how much of the PD was directly caused by your work, and factors such as your age, occupation, type of injury, and date of injury. State law determines minimum and maximum amounts, and they vary by injury date. If you are entitled to PD,

Sedgwick will send you a letter explaining how the benefit was calculated. If the injury causes PD, the first payment of PD benefits is made within 14 days after the last payment of TD, unless your employer has offered you a position that pays at least 85% of your date of injury wages or if you are returned to a position that pays you 100% of the wages and, compensation paid to you on the date of injury, the PD would be paid after an Award issues.

Supplemental Job Displacement Benefit (SJDB): If you have a permanent whole person impairment, the eligibility for SJDB begins when your employer does not offer regular work, permanent, modified, or alternative work within 60 days of the receipt of a doctor's Medical Maximum Improvement (MMI) report. This is a nontransferable voucher for education-related retraining and/or skill development at state-approved schools, tools, licensing, certification fees and other resources as possible benefits. If you qualify for the supplemental job displacement benefit, Sedgwick will provide a voucher up to a maximum of \$6,000.

Death Benefits: If the injury/illness causes death, payments may be made to your dependents. State law sets these benefits and the total benefit depends on the number of dependents. The payments are made at the same rate as TD payments. In addition, workers' compensation provides a burial allowance.

Discrimination: It is a violation of Labor Code Section 132(a) and illegal for your employer to punish or fire you for having a workplace injury/illness, for filing a claim or for testifying in another person's workers' compensation case. If your employer is found guilty of discrimination, you would be entitled to increased benefits, reinstatement and reimbursement for lost wages and benefits.

Other Benefits: Sometimes people confuse workers' compensation with State Disability Insurance (SDI). Workers' compensation covers on-the-job injuries/illnesses and is paid for by your employer or their insurance. On the other hand, SDI covers off-the-job injuries or sicknesses, and is paid for by deductions from your paycheck. If you are not getting workers' compensation benefits, you may be able to get State Disability benefits. Contact the local office of the State Employment Development Department listed in the government pages of your phone book for more information.

You may be eligible to access the return-to-work fund, for the purposes of making supplemental payments to injured worker's whose PD benefits are disproportionately low in comparison to their earnings loss. If you have questions or think you qualify, contact the Information & Assistance office listed in this pamphlet or visit the DIR website at: www.dir.ca.gov.

If You Still Have Questions...ask your supervisor or employer representative. Or contact Sedgwick at the number indicated on workers' compensation posters at work and on this brochure. You can also contact the State Division of Workers' Compensation (DWC) and speak with an Information and Assistance Officer. These officers are available to review problems, answer questions and provide additional written information about workers' compensation at no charge. The local office is listed below and posted at your workplace. You can also call 800-736-7401 or visit the DWC website at: <http://www.dir.ca.gov/dwc>.

WORKERS' COMPENSATION FRAUD IS A FELONY

Anyone who makes or causes to be made any knowingly false or fraudulent material statement for the purpose of obtaining or denying workers' compensation benefits or payments is guilty of a felony. Fines can be up to \$150,000 and imprisonment up to five years.



Complete Written Employee Notification
WellComp MPN
MPN Identification Number: 2387

Access to Medical Care

This notice contains important information on accessing the WellComp MPN (referred herein as “WellComp”)

- Find out if you are covered
- Access medical care
- Learn about continuity of care
- Choose your own physician
- Transfer into the WellComp network ✓ Contact WellComp

Welcome to WellComp

Your employer has selected WellComp as your medical provider network (MPN), to provide you with the choice of a broad scope of medical services for work-related injuries and illnesses.

WellComp’s exclusive network of healthcare providers each have a thorough understanding of the California workers’ compensation system and its potential impact on you. The state of California has approved the WellComp MPN to cover your workers’ compensation medical care needs. If you suffer an injury or illness on or after your employer’s MPN implementation date and you have not predesignated a personal physician, you are automatically covered by the WellComp MPN.

Initial Care

In case of an emergency, you should call 911 or go to the closest emergency room.

If you experience a work-related injury or illness, immediately notify your supervisor and obtain medical authorization from your employer to designate an initial care provider within the network. If you are unable to reach your supervisor or employer, please contact the patient services department at WellComp. For non-emergency services, the MPN must ensure that you are provided an appointment for initial treatment within 3 business days of your employer’s or MPN receipt of request for treatment within the MPN.

Subsequent Care

If you still need treatment following your initial evaluation, you may be treated by a physician of your choice, or the initial physician may refer you to a medically and geographically appropriate specialist within the network who can provide the appropriate treatment for your injury or condition. Your employer is required to provide you with at least three physicians of each specialty expected to treat common injuries experienced by injured employees based on your occupation or industry. These physicians will be available within 30 minutes or 15 miles of your workplace or residence and specialists will be available within 60 minutes or 30 miles of your residence or workplace. For a directory of providers, please visit www.WellComp.com or call WellComp Patient Services.

Emergency Care

In an emergency, defined as a medical condition starting with the sudden onset of severe symptoms that without immediate medical attention could place your health in serious jeopardy, go to the nearest healthcare provider regardless of whether they are a WellComp participant. If your injury is work-related, advise your emergency care provider to contact WellComp to arrange for a transfer of your care to a WellComp provider at the medically appropriate time.

Hospital and Specialty Care

Your primary treating physician in the WellComp network can make all of the necessary arrangements and referrals for specialists, inpatient hospital, outpatient surgery center services, and ancillary care services.

Choosing a Treating Physician

If you still require treatment after your initial evaluation with your employer's designated provider, you may access the WellComp Directory and select an appropriate physician of your choice who can provide the necessary treatment for your condition or illness. For assistance determining physician options, please contact the Medical Access Assistant in the WellComp Patient Services Department or discuss your options with your initial care provider.

Physicians who provide only tele-health services will not be counted when determining if an MPN has met access standards, if the injured covered employee does not consent to see the tele-health physician. The physician, who provides only tele-health services or also provides services at a physical location and tele-health, will be counted when determining if an MPN has met access standards, if the injured covered employee consents to see the tele-health physician. The physician, who provides only tele-health services or also provides services at a physical location and tele-health, will not be counted when determining if an MPN has met access standards, if the injured covered employee retracts consent to received tele-health services prior to delivery of tele-health treatment. The physician who provides both physical location and tele-health services will be counted under the access standards if the physician's physical location is within the required access standards in accordance with 8 CCR 9767.5(a)(1) and (a)(2).

Scheduling Appointments

If you are having difficulty scheduling an appointment with your initial provider or subsequent provider, please contact the Medical Access Assistant in the WellComp Patient Services Department or your Claims Examiner.

Changing Primary Treating Physician

If you find it necessary to change your treating physician and it is determined that you require ongoing medical care for your injury or illness, you may select a new physician from the WellComp Directory and schedule an appointment. Once your appointment is scheduled, immediately contact WellComp Patient Services who will then coordinate the transfer of your medical records to your new provider.

Obtaining a Specialist Referral

If you continue to require medical treatment for your injury or illness, there are alternatives for obtaining a referral to a specialist:

- Your primary treating physician in the WellComp network can make all of the necessary arrangements for referrals to a specialist. This referral will be made within the network or outside of the network if needed.
- You may select an appropriate specialist by accessing the WellComp Directory.
- You may contact your Medical Access Assistants in the WellComp Patient Services who can help coordinate necessary arrangements.

If your primary treating physician makes a referral to a type of specialist not included in the network, you may select a specialist from outside the network.

For non-emergency specialist services, the MPN must ensure that you are provided an appointment within 20 business days of your employer's or MPN receipt of a referral to a specialist within the MPN.

Continuity of Care

What if I am being treated by a WellComp doctor and the doctor leaves WellComp?

Your employer has a written "Continuity of Care" Policy that may allow you to continue treatment with your doctor if your doctor is no longer actively participating in WellComp.

If you are being treated for a work-related injury in the WellComp network and your doctor no longer has a contract with WellComp, your doctor may be allowed to continue to treat you if your injury or illness meets one of the following conditions:

- (Acute) A medical condition that includes a sudden onset of symptoms that require prompt care and has a duration of less than 90 days.
- (Serious or Chronic) Your injury or illness is one that is serious and continues for at least 90 days without full cure or worsens and requires ongoing treatment. You may be allowed to be treated by your current treating doctor for up to one year, until a safe transfer of care can be made.
- (Terminal) You have an incurable illness or irreversible condition that is likely to cause death within one year or less.
- (Pending Surgery) You already have a surgery or other procedure that has been authorized by your employer or insurer that will occur within 180 days of the MPN contract termination date.

If any of the above conditions exist, WellComp may require your doctor to agree in writing to the same terms he or she agreed to when he or she was a provider in the WellComp network. If the doctor does not, he or she may not be able to continue to treat you.

If the contract with your doctor was terminated or not renewed by WellComp for reasons relating to medical disciplinary cause or reason, fraud or criminal activity, you will not be allowed to complete treatment with that doctor. For a complete copy of the Continuity of Care policy in English or Spanish, please visit www.WellComp.com or call WellComp Patient Services.

Transfer of Ongoing Care

What if you are already being treated for a work-related injury before the WellComp network begins?

Your employer has a "Transfer of Care" policy which describes what will happen if you are currently treating for a work-related injury with a physician who is not a member of the WellComp network. If your current treating doctor is a member of WellComp, then you may continue to treat with this doctor and your treatment will be under WellComp. If your current treating physician is not a participating physician within WellComp and you have not yet been transferred into the MPN, your physician can make referrals to providers within or outside the MPN. Your current doctor may be allowed to become a member of WellComp.

You will not be transferred to a doctor in WellComp if your injury or illness meets any of the following conditions:

- (Acute) The treatment for your injury or illness will be completed in less than 90 days.
- (Serious or Chronic) Your injury or illness is one that is serious and continues without full cure or worsens over 90 days. You may be allowed to be treated by your current treating doctor for up to one year from the date of receipt of the notification that you have a serious chronic condition.
- (Terminal) You have an incurable illness or irreversible condition that is likely to cause death within one year or less. Treatment will be provided for the duration of the terminal illness.
- (Pending Surgery) You already have a surgery or other procedure that has been authorized by your employer or insurer that will occur within 180 days of the MPN effective date.
- For a complete copy of the Transfer of Care policy in English or Spanish, please visit www.WellComp.com or call WellComp Patient Services.

Care Transfer Disputes

Notice of determination, from the employer or claims examiner, shall be sent to the covered employee's address and a copy of the letter shall be sent to the covered employee's primary treating physician. The notification shall be written in English and Spanish and use layperson's terms to the maximum extent possible. If WellComp is going to transfer your care and you disagree, you may ask your treating doctor for a report that addresses whether you are in one of the categories listed above. Your treating physician shall provide a report to you within twenty calendar days of the request. If the treating physician fails to issue the report, then you will be required to select a new provider from within the MPN. If either WellComp or you do not agree with your treating doctor's report, this dispute will be resolved according to Labor Code Section 4062. You must notify WellComp Patient Services Department if you disagree with this report.

If your treating doctor agrees that your condition does not meet one of those listed above, the transfer of care will go forward while you continue to disagree with the decision. If your treating doctor believes that your condition does meet one of those listed above, you may continue to treat with him or her until the dispute is resolved.

Second Opinion, Third Opinion and MPN Independent Medical Review Process:

If you disagree with your doctor or do not like your doctor for any reason, you may always choose another doctor in the MPN.

Obtaining Second and Third Opinions

If you disagree with the diagnosis or treatment plan determined by your treating physician or your second opinion physician, and would like a second or third opinion, you must take the following steps:

- Notify your claims examiner who will provide you with a regional area listing of physicians and/or specialists within the WellComp network who have the recognized expertise to evaluate or treat your injury or condition.
- Select a physician or specialist from the list Within 60 days of receiving the list, schedule an appointment with your selected physician or specialist from the list provided by your claims examiner. Should you fail to schedule an appointment within 60 days, your right to seek another opinion will be waived.
- Inform your claims examiner of your selection and the appointment date so that we can ensure your medical records can be forwarded in advance of your appointment date. You may also request a copy of your medical records.
- You will be provided information and a request form regarding the MPN Independent Medical Review (MPN IMR) process at the time you select a third opinion physician.
- If the Second/Third opinion doctor feels that your injury is outside of the type of injury he or she normally treats, the doctor's office will notify your employer or insurer. You will get another list of MPN doctors or specialists so you can make another selection.

If the 2nd/3rd opinion doctor agrees with your need for a treatment or test, you may be allowed to receive that recommended treatment or test from a provider inside or outside the MPN, including the 2nd or 3rd opinion physician.

Obtaining an MPN Independent Medical Review (MPN IMR)

If you disagree with the diagnosis or treatment plan determined by the third opinion physician, you may file the completed MPN Independent Medical Review Application form with the Administrative Director of the Division of Workers' Compensation. You may contact your claims examiner or the WellComp Patient Services Department for information about the MPN Independent Medical Review process and the form to request an MPN Independent Medical Review.

If the second opinion, third opinion or MPN IMR agrees with your treating doctor, you will need to continue to receive medical treatment with a network physician if the MPN contains a physician who can provide the recommended treatment. If the MPN IMR does not agree with your treating network physician, you will be allowed to receive that medical treatment from a provider either inside or outside of the WellComp network. Any physician chosen outside of the WellComp network must be within reasonable geographic area. The treatment or diagnostic test is limited to the recommendation of the MPN IMR.

Treatment Outside of the Geographic Area

WellComp has providers throughout California. If a situation arises which takes you out of the coverage area, such as temporary work, travel for work, or living temporarily or permanently outside the MPN geographic service area, please contact the WellComp Patient Services Department, your claims examiner, or your primary treating physician, and they will provide you with a selection of at least 3 approved out-of-network providers from whom you can obtain treatment or get second and third opinions from the referred selection of physicians.

Covered Medical Services:

The following is a summary of Workers' Compensation medical services available to employees covered by the WellComp network.

Primary treating and specialty services including consultations and referrals

Examples include general medical practitioners, chiropractors, dentists, orthopedists, surgeons, psychologists, internists, psychiatrists, cardiologists, neurologists.

Inpatient Hospital and Outpatient Surgery Center services

Examples include acute hospital services, general nursing care, operating room and related facilities, intensive care unit and services, diagnostic lab or x-ray services, necessary therapies.

Ancillary Care services

Examples include diagnostic lab or x-ray services, physical medicine, occupational therapy, medical and surgical equipment, counseling, nursing, medically appropriate home care, medication.

Emergency services Including Outpatient and Out of Area Emergency Care

Examples include outpatient and out-of-area emergency care.

WellComp Provider Directory

For more information about the MPN including access to a roster of all treating physicians and a roster of all participating providers in the MPN, go to www.WellComp.com where you can search by medical specialty, zip code, physician or provider group. For website assistance or to access a hard copy of the regional area listing and/or an electronic copy of the complete WellComp directory, please contact WellComp (your employer's designated medical provider network administrator).

Tele-Health Option

WellComp MPN has also made available providers who provide tele-health services. This service is optional and visible on our website designated by TH in the search results or using the Tele-Health search option. You may also call the network for assistance in finding a tele-health provider/and or facilitating an appointment. Our complete Tele-Health policy is visible on our website downloads.

Prior to delivery of health care via tele-health, the health care provider initiating the use of tele-health shall obtain verbal or written consent from the patient (Injured Covered Employee) for the use of tele-health as an acceptable mode of delivering health care services and public health. The consent shall be documented. (Pursuant to Business and Professions Code section 2290.5b)

WellComp Information

If you have questions or complaints about WellComp MPN, you may reach the MPN contact or WellComp Patient Services toll-free at (800) 544-8150. WellComp has individuals available to answer questions, provide website assistance, and generate provider listings. Medical Access Assistants (MAAs) are available to assist with finding an MPN physician of your choice, including scheduling and confirming

physician appointments. MAA's are available 7am to 8pm Pacific Standard Time, Monday through Saturday at the contact information below:

CareWorks Managed Care Services

8855 Haven Avenue

Rancho Cucamonga, CA 9173

Toll Free (800) 544-8150

Fax: (888) 620-6921

Email: info@WellComp.com

BONITA UNIFIED SCHOOL DISTRICT

NOTICE REGARDING AFFORDABLE CARE ACT

To: All Employees
From: Benefits Committee
Date: September 2, 2013

Please be advised that the Affordable Care Act requires that employers give all employees notice of the following information by October 1, 2013. For new employees, the notice must be provided within 14 days of their start date. In accordance with these requirements, the District must notify its employees of the following:

- Inform the employee of the existence of the Exchange including a description of the services provided by the Exchange, and the manner in which the employee may contact the Exchange to request assistance.

In California, the Exchange is called "Covered California." You may obtain health insurance that meets your needs and fits your budget through Covered California. Covered California offers "one-stop shopping" to find and compare private health insurance options. Open enrollment for health insurance coverage through Covered California begins on October 1, 2013, for coverage starting as early as January 1, 2014. For more information about coverage through Covered California, visit www.coveredca.com, or call (888) 975-1142.

If you are not eligible for health insurance coverage through BUSD, you and your family may be able to obtain health coverage through Covered California, with a new kind of tax credit that lowers your monthly premiums and with assistance for out-of-pocket costs.

- If the employer plan's share of the total allowed costs of benefits provided under the plan is less than 60 percent of such costs, then the employee may be eligible for a premium tax credit under section 36B of the Internal Revenue Code if the employee purchases a qualified health plan through the Exchange; and

BUSD's medical insurance plan meets the 60 percent minimum essential coverage requirement. The plan also meets the affordability standard of costing no more than 9.5% of household income for employee only coverage.

- If the employee purchases a qualified health plan through the Exchange, the employee may lose the employer contribution (if any) to any health benefits plan offered by the employer and that all or a portion of such contribution may be excludable from income for Federal income tax purposes.

For those employees who receive medical coverage through the BUSD's medical insurance plans, you may lose the District's contribution to any District health plan if you enroll in a Covered California plan. Please also note that all or a portion of such contribution may be excludable from income for Federal income tax purposes.

INFORMATION ABOUT HEALTH COVERAGE OFFERED BY BUSD

If you decide to complete an application for coverage in Covered California, you will be asked to provide the following information. This information is numbered to correspond to the Covered California application.

3. Employer Name: **Bonita Unified School District**
4. Employer Identification Number: **95-6000942**
5. Employer Address: **115 W. Allen Avenue**
6. Employer Phone Number: **909-971-8200**
7. City: **San Dimas**
8. State: **CA**
9. Zip code: **91773**
10. Who can we contact about employee health coverage at this job? **Benefits Technician**
11. Phone number (if different from above): **909-971-8200 ext 5404**
12. Email address: fowler@bonita.k12.ca.us

Here is some basic information about health coverage offered by BUSD:

- As your employer, we offer a health plan to:
 - Some employees. Eligible employees are:
 - Permanent full-time and permanent part-time employees working more than 4 hours per day
- With respect to dependents:
 - We do offer coverage. Eligible dependents are:
 - Current spouse / registered domestic partner
 - Natural, adopted, step or registered domestic partner's children up to age 26
 - Disabled children of any age if enrolled prior to age 26
 - Children up to age 26 for whom the subscriber has assumed a parent-child relationship and is considered the primary care parent
- The coverage offered meets the minimum value standard and the cost of this coverage to you is intended to be affordable, based on employee wages.*

* Even though BUSD's coverage is affordable, you may still be eligible for a premium discount through Covered California. Covered California will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

- If you decide to shop for coverage in Covered California, they will guide you through the process.



Coach Education
www.nfhslearn.com

The NFHS proudly offers **Concussions in Sports - What You Need to Know**, a free online course designed to educate coaches, officials, parents and students on the importance of proper concussion recognition and management in high school sports. The course meets new legislation, Assembly Bill 1451, requiring California Interscholastic Federation (CIF) high school coaches receive training every two years on recognizing the signs of concussions.

Concussion Course

Course Directions: Log into www.nfhslearn.com and search under courses and free courses. Click on the **Concussion in Sports – What you need to know** course. You must log in and create an account. If you already created an account with the coaching course, the account log in is the same.

Course Overview: Sports-related concussion in high school sports can be serious or even life-threatening situations if not managed correctly. National Federation of State High School Associations (NFHS) and Centers for Disease Control and Prevention (CDC) have teamed up to provide information and resources to help educate coaches, officials, parents and students on the importance of proper concussion recognition and management in high school sports. In this course you will understand the impact sports-related concussion can have on your players, how to recognize a suspected concussion, the proper protocols to manage a suspected concussion, and steps to help your player return to play safely after experiencing a concussion.

Course Outline:

Unit 1: Concussion Overview
Unit 2: The Problem
Unit 3: Your Responsibility
Unit 4: Review

Course Certificate:

Course completion will be verified with a certificate after completion. Please print and return the certificate with coaching materials.

NON-DISCRIMINATION INFORMATION

It is the policy of the Bonita Unified School District to comply with the following:

TITLE VI COMPLIANCE - TITLE VI OF THE CIVIL RIGHTS ACT OF 1964

“No person...shall, on the ground of race, color or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity receiving Federal financial assistance from the department of Education.”

TITLE IX COMPLIANCE - TITLE IX OF THE EDUCATION AMENDMENTS OF 1972

“No person... shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any education program or activity receiving Federal financial assistance.”

SECTION 504 COMPLIANCE - SECTION 504 OF THE REHABILITATION ACT OF 1973

“No otherwise qualified individual with a disability...shall, solely by reason of his or her disability, be excluded from the participation, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance.”

TITLE II OF THE ADA COMPLIANCE - TITLE II OF THE AMERICAN WITH DISABILITIES ACT (ADA) OF 1990

“No qualified individual with a disability shall, by reason of such disability, be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity, or be subjected to discrimination of any such entity.”

STATE LAW/DISTRICT POLICIES COMPLIANCE

State laws and District policies further provide that the District does not discriminate on the basis of religion ancestry, marital status, sexual orientation, medical condition (cancer related), political belief or affiliation, or in retaliation.

Students, parents, employees/applicants and/or community members who feel they have a grievance against the Bonita Unified School District, which concerns a matter of unlawful discrimination, should contact:

Assistant Superintendent Human Resources
BONITA UNIFIED SCHOOL DISTRICT
115 WEST ALLEN AVENUE
SAN DIMAS, CALIFORNIA 91773
TELEPHONE: (909) 971-8200 FAX: (909) 971-8349

ELEMENTARY SCHOOLS

- Allen Avenue 909-971-8202, ext 4211
- Ekstrand 909-971-8203, ext 4311
- Gladstone 909-971-8204, ext 4411
- Grace Miller 909-971-8206, ext 4611
- La Verne Heights 909-971-8205, ext 4511
- Oak Mesa 909-971-8209, ext 4911
- Roynon 909-971-8207, ext 4711
- Shull 909-971-8208, ext 4811

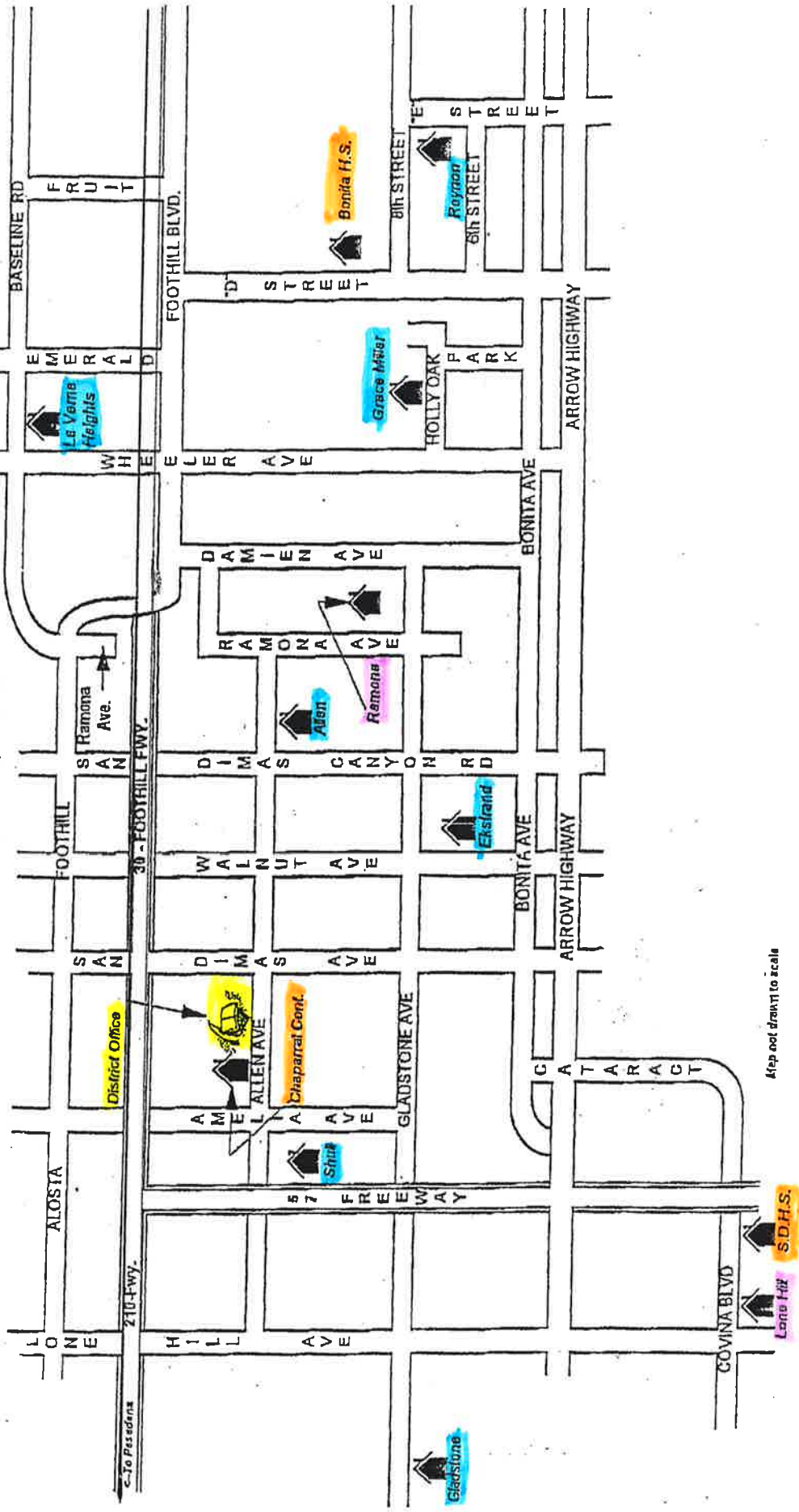
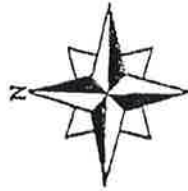
MIDDLE SCHOOLS

- Lonehill MS 909-971-8270, ext 7011
- Ramona MS 909-971-8260, ext 6011

HIGH SCHOOLS

- Bonita HS 909-971-8220, ext 2011
- San Dimas HS 909-971-8230, ext 3011
- Ed Jones Ed. Center 909-971-8240, ext 4011
- Chaparral HS 909-971-8242, ext 4111
- Vista School 909-971-8242, ext 4111
- 3102 North "D" Street, La Verne, CA 91750
- 800 West Covina Blvd, San Dimas, CA 91750
- 121 West Allen Ave, San Dimas, CA 91773
- 121 West Allen Ave., San Dimas, CA 91773

BONITA UNIFIED SCHOOL DISTRICT
 115 W. Allen Avenue
 San Dimas, CA 91773
 909-971-8200
 www.bonita.k12.ca.us



Map not drawn to scale

Lone Hill S.D.H.S.