CLASSIFIED HOURLY/SUBSTITUTE PACKET

In order to work in our district, please follow the instructions below:

1.) Fill out the attached employment packet.

2.) Have your fingerprints processed at a certified Live Scan facility. There is a Live Scan form enclosed. We do not pay for this service. If you have already had your fingerprints processed for our district, do NOT process them again.

3.) You will need a current TB test or TB Risk Assessment. TB tests/assessments are good for 4 years, so if you have taken a TB test/assessment in the past 4 years, your proof of a negative result is all we require. Otherwise, please visit your physician and request a TB test/risk assessment.

4.) If you are applying to be a **CUSTODIAN OR STAGEHAND POSITION (ALL OTHER SUBSTITUTES DO NOT NEED PHYSICALS):** Please make an appointment for a pre-employment physical and urinalysis. The District will cover the cost of the physical and urinalysis. Your physical will need to be done at Pomona Valley Health Center, there are two locations for your convenience. Please see physical form for location details.

5.) To work for Food Services you will need a **CALIFORNIA FOOD HANDLER CERTIFICATION.** To obtain a Food Handler's Card for California, please go to the link below. Click on "Take Online Course". Print the certificate and submit with your packet.
http://bit.ly/1QUSSAB

6.) To work as a Health Clerk please submit a valid CPR/First aid Training certificate with your packet. Additional training through the District will be required.

7.) Provide proof of Child Abuse Mandated Reporter Training per California Education Code 44691(b) (2). Print the certificate and submit with your packet.
https://ascip.docebosaas.com/learn/signin

8.) Please read and sign the **ANNUAL EMPLOYEE NOTIFICATION FORM.** To access the notifications visit: http://bit.ly/2wUYSmO.

After you have filled out the forms and taken care of the requirements above, please drop off your completed packet at the District Office anytime Monday-Friday 8:00am – 4:30pm.

For any questions, please contact:
Jackie Villegas (Villegas@bonita.k12.ca.us or 909-971-8200).

BONITA UNIFIED SCHOOL DISTRICT
CLASSIFIED SUBSTITUTE APPLICATION

Name: _____ **Date:** _____

All items below must be completed before you are eligible for hire.

FORMS TO COMPLETE

☐ Classified Employment Application	☐ SSA-1945: Alternative SS Form
☐ Sub Information Sheet	☐ I-9
☐ Employee Use of Technology	☐ Oath of Allegiance
☐ Contact Data	☐ Workers Comp Information
☐ Reasonable Assurance Letter	☐ Physician Pre-Designation *(optional)*
☐ Race/Ethnicity Data	☐ Warrant Designation
☐ Employee Notification	☐ Direct Deposit *(optional)*
☐ W-4 & DE-4	☐ Copies of Driver's License & Social Security Card

OTHER REQUIREMENTS

Pre-Employment Physical Clearance Date *(if applicable, only req'd for Stagehands & Custodians):* _____

TB Negative Test Read Date: _____ TB Expiration Date: _____

BUSD Fingerprint Clearance Date: _____

Child Abuse Mandated Reporter Training Certificate of Completion Date: _____

CPR Card (to work as Health Clerk/LVN) Expiration Date_____

Nursing Licence (to work as LVN) Expiration Date _____

New Sub Rates Effective 7/1/2023

Classified Sub Rates 23-24

Classified Sub Positions	23-24 Rates
Bus Driver	$20.99
Cafeteria Worker	$17.00
Campus Aide	$15.50
Clerical	$18.81
Custodian	$19.80
Grounds	$20.99
Health Clerk	$18.63
Locker Room Attendant	$19.80
Maintenance	$24.31
Media Center Assistant	$18.81
Paraeducator	$17.00
Paraeducator - P.E.	$17.00
Paraeducator - Bilingual Assistant	$17.00
Paraeducator - Specialized Services	$17.74
School Age Care Assistant	$17.00
Student Campus Supervisor	$18.36
Stock/Warehouse	$20.71
Utility Driver	$20.71

HUMAN RESOURCES DEVELOPMENT

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 CLASSIFIED EMPLOYMENT

PRINT LEGIBLY IN BLUE OR BLACK INK.

Applying for position(s): _____

_____ 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

SUB INFORMATION SHEET

Access # _____
Date: _____

Classified Substitutes

Name: _____ Home Phone: _____

Address: _____

Email: _____ Cell phone: _____

CHECK CLASSIFICATION(S) OF INTEREST (Please check **all possible** classifications.)

- ☐ Bus Driver *(Training & certification required)*
- ☐ Campus Aide
- ☐ Clerical
- ☐ Custodian *(Physical required)*
- ☐ Food Services *(Food Handlers Cert Required)*
- ☐ Grounds
- ☐ Health Clerk *(CPR & BUSD training required)*
- ☐ Locker Room Attendant
- ☐ Maintenance
- ☐ Media Center Assistant
- ☐ Paraeducator *(classroom aide)*
- ☐ Paraeducator – P.E.
- ☐ Paraeducator – Special Education
- ☐ Paraeducator – Bilingual Aide
- ☐ School Age Care Assistant
- ☐ Stagehand *(Physical required)*
- ☐ Student Campus Supervisor
- ☐ Utility Driver

Do you work in more than one district? Yes___ No___

What days of the week are you available? Mon.___ Tues.___ Wed.___ Thurs.___ Fri.___

Are you currently or have you ever been a member of PERS? Yes___ No___

If yes, through what district? _____

Retired? Yes___ No___

Bonita USD | E 4040 Personnel

Employee Use Of Technology

ACCEPTABLE USE AGREEMENT

AND RELEASE OF DISTRICT FROM LIABILITY (EMPLOYEES)

The Bonita Unified School District authorizes district employees to use technology owned or otherwise provided by the district as necessary to fulfill the requirements of their position. The use of district technology is a privilege permitted at the district's discretion and is subject to the conditions and restrictions set forth in applicable Board policies, administrative regulations, and this Acceptable Use Agreement. The district reserves the right to suspend access at any time, without notice, for any reason.

The district expects all employees to use technology responsibly in order to avoid potential problems and liability. The district may place reasonable restrictions on the sites, material, and/or information that employees may access through the system.

The district makes no guarantee that the functions or services provided by or through the district will be without defect. In addition, the district is not responsible for financial obligations arising from unauthorized use of the system.

Each employee who is authorized to use district technology shall sign this Acceptable Use Agreement as an indication that he/she has read and understands the agreement.

Definitions

District technology includes, but is not limited to, computers, the district's computer network including servers and wireless computer networking technology (wi-fi), the Internet, email, USB drives, wireless access points (routers), tablet computers, smartphones and smart devices, telephones, cellular telephones, personal digital assistants, pagers, MP3 players, wearable technology, any wireless communication device including emergency radios, and/or future technological innovations, whether accessed on or off site or through district-owned or personally owned equipment or devices.

Employee Obligations and Responsibilities

Employees are expected to use district technology safely, responsibly, and primarily for work-related purposes. Any incidental personal use of district technology shall not interfere with district business and operations, the work and productivity of any district employee, or the safety and security of district technology. The district is not responsible for any loss or damage incurred by an employee as a result of his/her personal use of district technology.

The employee in whose name district technology is issued is responsible for its proper use at all times. Employees shall not share their assigned online services account information, passwords, or other information used for identification and authorization purposes, and shall use the system only under the account to which they have been assigned. Employees shall not gain unauthorized access to the files or equipment of others, access electronic resources by using another person's name or electronic

identification, or send anonymous electronic communications. Furthermore, employees shall not attempt to access any data, documents, emails, or programs in the district's system for which they do not have authorization.

Employees are prohibited from using district technology for improper purposes, including, but not limited to, use of district technology to:

1. Access, post, display, or otherwise use material that is discriminatory, defamatory, obscene, sexually explicit, harassing, intimidating, threatening, or disruptive

2. Disclose or in any way cause to be disclosed confidential or sensitive district, employee, or student information without prior authorization from a supervisor

3. Engage in personal commercial or other for-profit activities without permission of the Superintendent or designee

4. Engage in unlawful use of district technology for political lobbying

5. Infringe on copyright, license, trademark, patent, or other intellectual property rights

6. Intentionally disrupt or harm district technology or other district operations (such as destroying district equipment, placing a virus on district computers, adding or removing a computer program without permission, changing settings on shared computers)

7. Install unauthorized software

8. Engage in or promote unethical practices or violate any law or Board policy, administrative regulation, or district practice

Privacy

Since the use of district technology is intended for use in conducting district business, no employee should have any expectation of privacy in any use of district technology.

The district reserves the right to monitor and record all use of district technology, including, but not limited to, access to the Internet or social media, communications sent or received from district technology, or other uses within the jurisdiction of the district. Such monitoring/recording may occur at any time without prior notice for any legal purposes including, but not limited to, record retention and distribution and/or investigation of improper, illegal, or prohibited activity. Employees should be aware that, in most instances, their use of district technology (such as web searches or emails) cannot be erased or deleted.

All passwords created for or used on any district technology are the sole property of the district. The creation or use of a password by an employee on district technology does not create a reasonable expectation of privacy.

Personally Owned Devices

If an employee uses a personally owned device to access district technology or conduct district

business, he/she shall abide by all applicable Board policies, administrative regulations, and this Acceptable Use Agreement. Any such use of a personally owned device may subject the contents of the device and any communications sent or received on the device to disclosure pursuant to a lawful subpoena or public records request.

Records

Any electronically stored information generated or received by an employee which constitutes a district or student record shall be classified, retained, and destroyed in accordance with BP/AR 3580 - District Records, BP/AR 5125 - Student Records, or other applicable policies and regulations addressing the retention of district or student records.

Reporting

If an employee becomes aware of any security problem (such as any compromise of the confidentiality of any login or account information) or misuse of district technology, he/she shall immediately report such information to the Superintendent or designee.

Consequences for Violation

Violations of the law, Board policy, or this Acceptable Use Agreement may result in revocation of an employee's access to district technology and/or discipline, up to and including termination. In addition, violations of the law, Board policy, or this agreement may be reported to law enforcement agencies as appropriate.

Employee Acknowledgment

I have received, read, understand, and agree to abide by this Acceptable Use Agreement, BP 4040 - Employee Use of Technology, and other applicable laws and district policies and regulations governing the use of district technology. I understand that there is no expectation of privacy when using district technology or when my personal electronic devices use district technology. I further understand that any violation may result in revocation of user privileges, disciplinary action, and/or appropriate legal action.

I hereby release the district and its personnel from any and all claims and damages arising from my use of district technology or from the failure of any technology protection measures employed by the district.

Name: _____ Position: _____

(Please print)

School/Work Site: _____

Signature: _____ Date: _____

Exhibit BONITA UNIFIED SCHOOL DISTRICT

version: June 22, 2016 San Dimas, California

BONITA UNIFIED SCHOOL DISTRICT

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

CONTACT DATA

(Please print legibly)

Date _____

Social Security Number _____ - _____ - _____

Date of Birth _____

Prefix _____ Suffix _____
(Mr., Mrs., Miss) (Jr., Sr.)

Last Name _____
(Legal Name – must match social security card)

First Name _____ MI _____

Other Names Used _____

Physical Street Address _____

City _____ State _____ Zip Code _____

Mailing Address (if different than above) _____
_____

Home Phone Number _____

Cell Phone Number _____

Email Address _____

Name of Emergency Contact _____

Relationship _____

Emergency Contact Phone Number _____

Memorandum

BONITA UNIFIED SCHOOL DISTRICT
Human Resources Development

Re: NOTIFICATION OF REASONABLE ASSURANCE

The Bonita Unified School District hereby notifies you that you have reasonable assurance of returning to work in the next school year, after the summer recess period. You also have reasonable assurance of returning to work in your usual capacity at the close of all holiday and recess periods during the year. During the recess periods there will be no need for your services, unless you are notified.

We are required by the Unemployment Insurance (UI) Code to inform you that you may file a UI claim. If you choose to file a claim, your entitlement to benefits will be determined by the Employment Development Department (EDD) and not by this school district or its unemployment claims administrator, TALX. If you are not offered an opportunity to perform services in the next academic year/term, you may be entitled to UI benefits retroactive to the date you filed an initial claim, if you file a claim for retroactive benefits within 30 days after the start of the next academic year/term, if you filed a claim for each week benefits are claimed, and if you are otherwise eligible.

The official mailing address provided below should be given to the EDD when filing a claim for UI benefits:

Bonita Unified School District
c/o TALX
P.O. Box 23020
Oakland, CA 94623-2302

This letter is the only official and authorized notification you should rely on when determining your employment status for the next academic year or term.

_____ _____
Signature Date

BONITA UNIFIED SCHOOL DISTRICT
RACE & ETHNICITY DATA COLLECTION

Schools and Districts are now required to collect this data per California Government Code 8310.5. Final guidance issued in the Federal Register on October 19, 2007 (72 Fed. Reg. 59267) on the collection and reporting of racial and ethnic data by educational institutions and other grantees now allows individuals to self-identify their ethnicity and race, and select more than one race and/or ethnicity. This change permits individuals to more accurately reflect their racial and ethnic background by not limiting responses to only one racial or ethnic category.

Name: _____

Last *First* *Middle*

Section A
ETHNICITY (Select only one):

_____ No, not Hispanic or Latino

_____ Yes, Hispanic or Latino

Section A of this questionnaire is about ethnicity, not race. No matter your selection above, please continue to Section B and mark one or more choices to indicate what you consider your race to be.

Section B
RACE (Select one or more):

_____ American Indian/Alaskan Native
_____ Asian Indian
_____ Black/African American
_____ Cambodian
_____ Chinese
_____ Filipino
_____ Guamanian
_____ Hawaiian
_____ Hmong
_____ Japanese
_____ Korean
_____ Laotian
_____ Other Asian
_____ Other Pacific Islander
_____ Samoan
_____ Tahitian
_____ Vietnamese
_____ White

Memorandum

BONITA UNIFIED SCHOOL DISTRICT
Human Resources Development

TO: **All Employees**
FROM: **Assistant Superintendent, Human Resources Development**
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
- Employee Letter – Pesticides
- 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 .1l (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
- CDE Training Module on Bullying
- 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

Form **W-4**

Department of the Treasury
Internal Revenue Service

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.

OMB No. 1545-0074

2024

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) ☐ **Single** or **Married filing separately**
☐ **Married filing jointly** or **Qualifying surviving spouse**
☐ **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, and when to use the estimator at *www.irs.gov/W4App*.

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) Use the estimator at *www.irs.gov/W4App* for most accurate withholding for this step (and Steps 3–4). If you or your spouse have self-employment income, use this option; **or**

(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 . . . . . ☐

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)

General Instructions

Section references are to the Internal Revenue Code.

Future Developments

For the latest information about developments related to Form W-4, such as legislation enacted after it was published, go to *www.irs.gov/FormW4*.

Purpose of Form

Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay. If too little is withheld, you will generally owe tax when you file your tax return and may owe a penalty. If too much is withheld, you will generally be due a refund. Complete a new Form W-4 when changes to your personal or financial situation would change the entries on the form. For more information on withholding and when you must furnish a new Form W-4, see Pub. 505, Tax Withholding and Estimated Tax.

Exemption from withholding. You may claim exemption from withholding for 2024 if you meet both of the following conditions: you had no federal income tax liability in 2023 **and** you expect to have no federal income tax liability in 2024. You had no federal income tax liability in 2023 if (1) your total tax on line 24 on your 2023 Form 1040 or 1040-SR is zero (or less than the sum of lines 27, 28, and 29), or (2) you were not required to file a return because your income was below the filing threshold for your correct filing status. If you claim exemption, you will have no income tax withheld from your paycheck and may owe taxes and penalties when you file your 2024 tax return. To claim exemption from withholding, certify that you meet both of the conditions above by writing "Exempt" on Form W-4 in the space below Step 4(c). Then, complete Steps 1(a), 1(b), and 5. Do not complete any other steps. You will need to submit a new Form W-4 by February 15, 2025.

Your privacy. Steps 2(c) and 4(a) ask for information regarding income you received from sources other than the job associated with this Form W-4. If you have concerns with providing the information asked for in Step 2(c), you may choose Step 2(b) as an alternative; if you have concerns with providing the information asked for in Step 4(a), you may enter an additional amount you want withheld per pay period in Step 4(c) as an alternative.

When to use the estimator. Consider using the estimator at *www.irs.gov/W4App* if you:

1. Expect to work only part of the year;

2. Receive dividends, capital gains, social security, bonuses, or business income, or are subject to the Additional Medicare Tax or Net Investment Income Tax; or

3. Prefer the most accurate withholding for multiple job situations.

Self-employment. Generally, you will owe both income and self-employment taxes on any self-employment income you receive separate from the wages you receive as an employee. If you want to pay these taxes through withholding from your wages, use the estimator at *www.irs.gov/W4App* to figure the amount to have withheld.

Nonresident alien. If you're a nonresident alien, see Notice 1392, Supplemental Form W-4 Instructions for Nonresident Aliens, before completing this form.

Specific Instructions

Step 1(c). Check your anticipated filing status. This will determine the standard deduction and tax rates used to compute your withholding.

Step 2. Use this step if you (1) have more than one job at the same time, or (2) are married filing jointly and you and your spouse both work.

Option **(a)** most accurately calculates the additional tax you need to have withheld, while option **(b)** does so with a little less accuracy.

Instead, if you (and your spouse) have a total of only two jobs, you may check the box in option **(c)**. The box must also be checked on the Form W-4 for the other job. If the box is checked, the standard deduction and tax brackets will be cut in half for each job to calculate withholding. This option is accurate for jobs with similar pay; otherwise, more tax than necessary may be withheld, and this extra amount will be larger the greater the difference in pay is between the two jobs.

Multiple jobs. *Complete Steps 3 through 4(b) on only one Form W-4. Withholding will be most accurate if you do this on the Form W-4 for the highest paying job.*

Step 3. This step provides instructions for determining the amount of the child tax credit and the credit for other dependents that you may be able to claim when you file your tax return. To qualify for the child tax credit, the child must be under age 17 as of December 31, must be your dependent who generally lives with you for more than half the year, and must have the required social security number. You may be able to claim a credit for other dependents for whom a child tax credit can't be claimed, such as an older child or a qualifying relative. For additional eligibility requirements for these credits, see Pub. 501, Dependents, Standard Deduction, and Filing Information. You can also include **other tax credits** for which you are eligible in this step, such as the foreign tax credit and the education tax credits. To do so, add an estimate of the amount for the year to your credits for dependents and enter the total amount in Step 3. Including these credits will increase your paycheck and reduce the amount of any refund you may receive when you file your tax return.

Step 4 (optional).

Step 4(a). Enter in this step the total of your other estimated income for the year, if any. You shouldn't include income from any jobs or self-employment. If you complete Step 4(a), you likely won't have to make estimated tax payments for that income. If you prefer to pay estimated tax rather than having tax on other income withheld from your paycheck, see Form 1040-ES, Estimated Tax for Individuals.

Step 4(b). Enter in this step the amount from the Deductions Worksheet, line 5, if you expect to claim deductions other than the basic standard deduction on your 2024 tax return and want to reduce your withholding to account for these deductions. This includes both itemized deductions and other deductions such as for student loan interest and IRAs.

Step 4(c). Enter in this step any additional tax you want withheld from your pay **each pay period**, including any amounts from the Multiple Jobs Worksheet, line 4. Entering an amount here will reduce your paycheck and will either increase your refund or reduce any amount of tax that you owe.

Step 2(b)—Multiple Jobs Worksheet *(Keep for your records.)*

If you choose the option in Step 2(b) on Form W-4, complete this worksheet (which calculates the total extra tax for all jobs) on **only ONE** Form W-4. Withholding will be most accurate if you complete the worksheet and enter the result on the Form W-4 for the highest paying job. To be accurate, submit a new Form W-4 for all other jobs if you have not updated your withholding since 2019.

Note: If more than one job has annual wages of more than $120,000 or there are more than three jobs, see Pub. 505 for additional tables; or, you can use the online withholding estimator at *www.irs.gov/W4App*.

1 **Two jobs.** If you have two jobs or you're married filing jointly and you and your spouse each have one job, find the amount from the appropriate table on page 4. Using the "Higher Paying Job" row and the "Lower Paying Job" column, find the value at the intersection of the two household salaries and enter that value on line 1. Then, **skip** to line 3 . . . . . **1** $

2 **Three jobs.** If you and/or your spouse have three jobs at the same time, complete lines 2a, 2b, and 2c below. Otherwise, skip to line 3.

a Find the amount from the appropriate table on page 4 using the annual wages from the highest paying job in the "Higher Paying Job" row and the annual wages for your next highest paying job in the "Lower Paying Job" column. Find the value at the intersection of the two household salaries and enter that value on line 2a . . . . . **2a** $

b Add the annual wages of the two highest paying jobs from line 2a together and use the total as the wages in the "Higher Paying Job" row and use the annual wages for your third job in the "Lower Paying Job" column to find the amount from the appropriate table on page 4 and enter this amount on line 2b . . . . . **2b** $

c Add the amounts from lines 2a and 2b and enter the result on line 2c . . . . . **2c** $

3 Enter the number of pay periods per year for the highest paying job. For example, if that job pays weekly, enter 52; if it pays every other week, enter 26; if it pays monthly, enter 12, etc. **3**

4 **Divide** the annual amount on line 1 or line 2c by the number of pay periods on line 3. Enter this amount here and in **Step 4(c)** of Form W-4 for the highest paying job (along with any other additional amount you want withheld) . . . . . **4** $

Step 4(b)—Deductions Worksheet *(Keep for your records.)*

1 Enter an estimate of your 2024 itemized deductions (from Schedule A (Form 1040)). Such deductions may include qualifying home mortgage interest, charitable contributions, state and local taxes (up to $10,000), and medical expenses in excess of 7.5% of your income . . . . . **1** $

2 Enter:
- $29,200 if you're married filing jointly or a qualifying surviving spouse
- $21,900 if you're head of household
- $14,600 if you're single or married filing separately

. . . . . **2** $

3 If line 1 is greater than line 2, subtract line 2 from line 1 and enter the result here. If line 2 is greater than line 1, enter "-0-" . . . . . **3** $

4 Enter an estimate of your student loan interest, deductible IRA contributions, and certain other adjustments (from Part II of Schedule 1 (Form 1040)). See Pub. 505 for more information . . . . **4** $

5 **Add** lines 3 and 4. Enter the result here and in **Step 4(b)** of Form W-4 . . . . . **5** $

Privacy Act and Paperwork Reduction Act Notice. We ask for the information on this form to carry out the Internal Revenue laws of the United States. Internal Revenue Code sections 3402(f)(2) and 6109 and their regulations require you to provide this information; your employer uses it to determine your federal income tax withholding. Failure to provide a properly completed form will result in your being treated as a single person with no other entries on the form; providing fraudulent information may subject you to penalties. Routine uses of this information include giving it to the Department of Justice for civil and criminal litigation; to cities, states, the District of Columbia, and U.S. commonwealths and territories for use in administering their tax laws; and to the Department of Health and Human Services for use in the National Directory of New Hires. We may also disclose this information to other countries under a tax treaty, to federal and state agencies to enforce federal nontax criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism.

You are not required to provide the information requested on a form that is subject to the Paperwork Reduction Act unless the form displays a valid OMB control number. Books or records relating to a form or its instructions must be retained as long as their contents may become material in the administration of any Internal Revenue law. Generally, tax returns and return information are confidential, as required by Code section 6103.

The average time and expenses required to complete and file this form will vary depending on individual circumstances. For estimated averages, see the instructions for your income tax return.

If you have suggestions for making this form simpler, we would be happy to hear from you. See the instructions for your income tax return.

Married Filing Jointly or Qualifying Surviving Spouse

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	$0 - 9,999	$10,000 - 19,999	$20,000 - 29,999	$30,000 - 39,999	$40,000 - 49,999	$50,000 - 59,999	$60,000 - 69,999	$70,000 - 79,999	$80,000 - 89,999	$90,000 - 99,999	$100,000 - 109,999	$110,000 - 120,000
$0 - 9,999	$0	$0	$780	$850	$940	$1,020	$1,020	$1,020	$1,020	$1,020	$1,020	$1,370
$10,000 - 19,999	0	780	1,780	1,940	2,140	2,220	2,220	2,220	2,220	2,220	2,570	3,570
$20,000 - 29,999	780	1,780	2,870	3,140	3,340	3,420	3,420	3,420	3,420	3,770	4,770	5,770
$30,000 - 39,999	850	1,940	3,140	3,410	3,610	3,690	3,690	3,690	4,040	5,040	6,040	7,040
$40,000 - 49,999	940	2,140	3,340	3,610	3,810	3,890	3,890	4,240	5,240	6,240	7,240	8,240
$50,000 - 59,999	1,020	2,220	3,420	3,690	3,890	3,970	4,320	5,320	6,320	7,320	8,320	9,320
$60,000 - 69,999	1,020	2,220	3,420	3,690	3,890	4,320	5,320	6,320	7,320	8,320	9,320	10,320
$70,000 - 79,999	1,020	2,220	3,420	3,690	4,240	5,320	6,320	7,320	8,320	9,320	10,320	11,320
$80,000 - 99,999	1,020	2,220	3,620	4,890	6,090	7,170	8,170	9,170	10,170	11,170	12,170	13,170
$100,000 - 149,999	1,870	4,070	6,270	7,540	8,740	9,820	10,820	11,820	12,830	14,030	15,230	16,430
$150,000 - 239,999	1,960	4,360	6,760	8,230	9,630	10,910	12,110	13,310	14,510	15,710	16,910	18,110
$240,000 - 259,999	2,040	4,440	6,840	8,310	9,710	10,990	12,190	13,390	14,590	15,790	16,990	18,190
$260,000 - 279,999	2,040	4,440	6,840	8,310	9,710	10,990	12,190	13,390	14,590	15,790	16,990	18,190
$280,000 - 299,999	2,040	4,440	6,840	8,310	9,710	10,990	12,190	13,390	14,590	15,790	16,990	18,380
$300,000 - 319,999	2,040	4,440	6,840	8,310	9,710	10,990	12,190	13,390	14,590	15,980	17,980	19,980
$320,000 - 364,999	2,040	4,440	6,840	8,310	9,710	11,280	13,280	15,280	17,280	19,280	21,280	23,280
$365,000 - 524,999	2,720	6,010	9,510	12,080	14,580	16,950	19,250	21,550	23,850	26,150	28,450	30,750
$525,000 and over	3,140	6,840	10,540	13,310	16,010	18,590	21,090	23,590	26,090	28,590	31,090	33,590

Single or Married Filing Separately

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	$0 - 9,999	$10,000 - 19,999	$20,000 - 29,999	$30,000 - 39,999	$40,000 - 49,999	$50,000 - 59,999	$60,000 - 69,999	$70,000 - 79,999	$80,000 - 89,999	$90,000 - 99,999	$100,000 - 109,999	$110,000 - 120,000
$0 - 9,999	$240	$870	$1,020	$1,020	$1,020	$1,540	$1,870	$1,870	$1,870	$1,870	$1,910	$2,040
$10,000 - 19,999	870	1,680	1,830	1,830	2,350	3,350	3,680	3,680	3,680	3,720	3,920	4,050
$20,000 - 29,999	1,020	1,830	1,980	2,510	3,510	4,510	4,830	4,830	4,870	5,070	5,270	5,400
$30,000 - 39,999	1,020	1,830	2,510	3,510	4,510	5,510	5,830	5,870	6,070	6,270	6,470	6,600
$40,000 - 59,999	1,390	3,200	4,360	5,360	6,360	7,370	7,890	8,090	8,290	8,490	8,690	8,820
$60,000 - 79,999	1,870	3,680	4,830	5,840	7,040	8,240	8,770	8,970	9,170	9,370	9,570	9,700
$80,000 - 99,999	1,870	3,690	5,040	6,240	7,440	8,640	9,170	9,370	9,570	9,770	9,970	10,810
$100,000 - 124,999	2,040	4,050	5,400	6,600	7,800	9,000	9,530	9,730	10,180	11,180	12,180	13,120
$125,000 - 149,999	2,040	4,050	5,400	6,600	7,800	9,000	10,180	11,180	12,180	13,180	14,180	15,310
$150,000 - 174,999	2,040	4,050	5,400	6,860	8,860	10,860	12,180	13,180	14,230	15,530	16,830	18,060
$175,000 - 199,999	2,040	4,710	6,860	8,860	10,860	12,860	14,380	15,680	16,980	18,280	19,580	20,810
$200,000 - 249,999	2,720	5,610	8,060	10,360	12,660	14,960	16,590	17,890	19,190	20,490	21,790	23,020
$250,000 - 399,999	2,970	6,080	8,540	10,840	13,140	15,440	17,060	18,360	19,660	20,960	22,260	23,500
$400,000 - 449,999	2,970	6,080	8,540	10,840	13,140	15,440	17,060	18,360	19,660	20,960	22,260	23,500
$450,000 and over	3,140	6,450	9,110	11,610	14,110	16,610	18,430	19,930	21,430	22,930	24,430	25,870

Head of Household

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	$0 - 9,999	$10,000 - 19,999	$20,000 - 29,999	$30,000 - 39,999	$40,000 - 49,999	$50,000 - 59,999	$60,000 - 69,999	$70,000 - 79,999	$80,000 - 89,999	$90,000 - 99,999	$100,000 - 109,999	$110,000 - 120,000
$0 - 9,999	$0	$510	$850	$1,020	$1,020	$1,020	$1,020	$1,220	$1,870	$1,870	$1,870	$1,960
$10,000 - 19,999	510	1,510	2,020	2,220	2,220	2,220	2,420	3,420	4,070	4,070	4,160	4,360
$20,000 - 29,999	850	2,020	2,560	2,760	2,760	2,960	3,960	4,960	5,610	5,700	5,900	6,100
$30,000 - 39,999	1,020	2,220	2,760	2,960	3,160	4,160	5,160	6,160	6,900	7,100	7,300	7,500
$40,000 - 59,999	1,020	2,220	2,810	4,010	5,010	6,010	7,070	8,270	9,120	9,320	9,520	9,720
$60,000 - 79,999	1,070	3,270	4,810	6,010	7,070	8,270	9,470	10,670	11,520	11,720	11,920	12,120
$80,000 - 99,999	1,870	4,070	5,670	7,070	8,270	9,470	10,670	11,870	12,720	12,920	13,120	13,450
$100,000 - 124,999	2,020	4,420	6,160	7,560	8,760	9,960	11,160	12,360	13,210	13,880	14,880	15,880
$125,000 - 149,999	2,040	4,440	6,180	7,580	8,780	9,980	11,250	13,250	14,900	15,900	16,900	17,900
$150,000 - 174,999	2,040	4,440	6,180	7,580	9,250	11,250	13,250	15,250	16,900	18,030	19,330	20,630
$175,000 - 199,999	2,040	4,510	7,050	9,250	11,250	13,250	15,250	17,530	19,480	20,780	22,080	23,380
$200,000 - 249,999	2,720	5,920	8,620	11,120	13,420	15,720	18,020	20,320	22,270	23,570	24,870	26,170
$250,000 - 449,999	2,970	6,470	9,310	11,810	14,110	16,410	18,710	21,010	22,960	24,260	25,560	26,860
$450,000 and over	3,140	6,840	9,880	12,580	15,080	17,580	20,080	22,580	24,730	26,230	27,730	29,230

Employment Development Department
State of California

Employee's Withholding Allowance Certificate

Complete this form so that your employer can withhold the correct California state income tax from your paycheck.

Enter Personal Information	
First, Middle, Last Name	Social Security Number
Address City State ZIP Code	Filing Status Single or Married (with two or more incomes) Married (one income) Head of Household

1. Use Worksheet A for Regular Withholding allowances. Use other worksheets on the following pages as applicable.
   1a. Number of Regular Withholding Allowances (**Worksheet A**)
   1b. Number of allowances from the Estimated Deductions (**Worksheet B**, if applicable.)
   1c. Total Number of Allowances you are claiming
2. Additional amount, if any, you want withheld each pay period (if employer agrees), **(Worksheet C)**
   OR

Exemption from Withholding

3. I claim exemption from withholding for 2024, and I certify I meet both of the conditions for exemption. (Check box here)
   OR
4. I certify under penalty of perjury that I am **not subject** to California withholding. I meet the conditions set forth under the Service Member Civil Relief Act, as amended by the Military Spouses Residency Relief Act and the Veterans Benefits and Transition Act of 2018. (Check box here)

Under the penalties of perjury, I certify that the number of withholding allowances claimed on this certificate does not exceed the number to which I am entitled or, if claiming exemption from withholding, that I am entitled to claim the exempt status.

Employee's Signature _____ Date _____

Employer's Section: Employer's Name and Address	California Employer Payroll Tax Account Number

Purpose: The *Employee's Withholding Allowance Certificate* (DE 4) is for **California Personal Income Tax (PIT)** withholding purposes only. The DE 4 is used to compute the amount of taxes to be withheld from your wages, by your employer, to accurately reflect your state tax withholding obligation.

Beginning January 1, 2020, *Employee's Withholding Allowance Certificate* (Form W-4) from the Internal Revenue Service (IRS) will be used for federal income tax withholding **only**. You must file the state form DE 4 to determine the appropriate California PIT withholding.

If you do not provide your employer with a DE 4, the employer must use Single with Zero withholding allowance.

Check Your Withholding: After your DE 4 takes effect, compare the state income tax withheld with your estimated total annual tax. For state withholding, use the worksheets on this form.

Exemption From Withholding: If you wish to claim exempt, complete the federal Form W-4 and the state DE 4. You may claim exempt from withholding California income tax if you meet both of the following conditions for exemption:

1. You did not owe any federal/state income tax last year, and
2. You do not expect to owe any federal/state income tax this year. The exemption is good for one year.

If you continue to qualify for the exempt filing status, a new DE 4 designating **exempt** must be submitted by February 15 each year to continue your exemption. If you are not having federal/state income tax withheld this year but expect to have a tax liability next year, you are required to give your employer a new DE 4 by December 1.

Member Service Civil Relief Act: Under this act, as provided by the Military Spouses Residency Relief Act and the Veterans Benefits and Transition Act of 2018, you may be exempt from California income tax withholding on your wages if

(i) Your spouse is a member of the armed forces present in California in compliance with military orders;

(ii) You are present in California solely to be with your spouse; and

(iii) You maintain your domicile in another state.

If you claim exemption under **this** act, **check the box on Line 4**. You may be required to provide proof of exemption upon request.

The *California Employer's Guide* (DE 44) (edd.ca.gov/pdf_pub_ctr/de44.pdf) provides the income tax withholding tables. This publication may be found by visiting Payroll Taxes - Forms and Publications (edd.ca.gov/Payroll_Taxes/Forms_and_Publications.htm). To assist you in calculating your tax liability, please visit the Franchise Tax Board (FTB) (ftb.ca.gov).

If you need information on your last *California Resident Income Tax Return* (FTB Form 540), visit the FTB (ftb.ca.gov).

Notification: The burden of proof rests with the employee to show the correct California income tax withholding. Pursuant to section 4340-1(e) of Title 22, California Code of Regulations (CCR) (govt.westlaw.com/calregs/Search/Index), the FTB or the EDD may, by special direction in writing, require an employer to submit a Form W-4 or DE 4 when such forms are necessary for the administration of the withholding tax programs.

Penalty: You may be fined $500 if you file, with no reasonable basis, a DE 4 that results in less tax being withheld than is properly allowable. In addition, criminal penalties apply for willfully supplying false or fraudulent information or failing to supply information requiring an increase in withholding. This is provided by section 13101 of the California Unemployment Insurance Code (leginfo.legislature.ca.gov/faces/codes.xhtml) and section 19176 of the Revenue and Taxation Code (leginfo.legislature.ca.gov/faces/codes.xhtml).

Worksheets

Instructions — 1 — Allowances*

When determining your withholding allowances, you must consider your personal situation:
— Do you claim allowances for dependents or blindness?
— Will you itemize your deductions?
— Do you have more than one income coming into the household?

Two-Earners/Multiple Incomes: When earnings are derived from more than one source, under-withholding may occur. If you have a working spouse or more than one job, it is best to check the box "SINGLE or MARRIED (with two or more incomes)." Figure the total number of allowances you are entitled to claim on all jobs using only one DE 4 form. Claim allowances with **one** employer.

Do **not** claim the same allowances with more than one employer. Your withholding will usually be most accurate when all allowances are claimed on the DE 4 filed for the highest paying job and zero allowances are claimed for the others.

Married But Not Living With Your Spouse: You may check the "Head of Household" marital status box if you meet all of the following tests:
(1) Your spouse will not live with you **at any time** during the year;
(2) You will furnish over half of the cost of maintaining a home for the entire year for yourself and your child or stepchild who qualifies as your dependent; **and**
(3) You will file a separate return for the year.

Head of Household: To qualify, you must be unmarried or legally separated from your spouse and pay more than 50% of the costs of maintaining a home for the **entire** year for yourself and your dependent(s) or other qualifying individuals. Cost of maintaining the home includes such items as rent, property insurance, property taxes, mortgage interest, repairs, utilities, and cost of food. It does not include the individual's personal expenses or any amount which represents value of services performed by a member of the household of the taxpayer.

Worksheet A **Regular Withholding Allowances**

(A)	Allowance for yourself — enter 1	(A)
(B)	Allowance for your spouse (if not separately claimed by your spouse) — enter 1	(B)
(C)	Allowance for blindness — yourself — enter 1	(C)
(D)	Allowance for blindness — your spouse (if not separately claimed by your spouse) — enter 1	(D)
(E)	Allowance(s) for dependent(s) — do not include yourself or your spouse	(E)
(F)	Total — add lines (A) through (E) above and enter on line 1a of the DE 4	(F)

Instructions — 2 — (Optional) Additional Withholding Allowances

If you expect to itemize deductions on your California income tax return, you can claim additional withholding allowances. Use Worksheet B to determine whether your expected estimated deductions may entitle you to claim **one or more additional** withholding allowances. Use last year's FTB Form 540 as a model to calculate this year's withholding amounts.

Do not include deferred compensation, qualified pension payments, or flexible benefits, etc., that are deducted from your gross pay but are not taxed on this worksheet.

You may reduce the amount of tax withheld from your wages by claiming one additional withholding allowance for each $1,000, or fraction of $1,000, by which you expect your estimated deductions for the year to exceed your allowable standard deduction.

Worksheet B **Estimated Deductions**

Use this worksheet **only** if you plan to itemize deductions, claim certain adjustments to income, or have a large amount of nonwage income not subject to withholding.

1.	Enter an estimate of your itemized deductions for California taxes for this tax year as listed in the schedules in the FTB Form 540		1.
2.	Enter $10,726 if married filing joint with two or more allowances, unmarried head of household, or qualifying widow(er) with dependent(s) or $5,363 if single or married filing separately, dual income married, or married with multiple employers	–	2.
3.	Subtract line 2 from line 1, enter difference	=	3.
4.	Enter an estimate of your adjustments to income (alimony payments, IRA deposits)	+	4.
5.	Add line 4 to line 3, enter sum	=	5.
6.	Enter an estimate of your nonwage income (dividends, interest income, alimony receipts)	–	6.
7.	If line 5 is greater than line 6 (if less, see below [go to line 9]); Subtract line 6 from line 5, enter difference	=	7.
8.	Divide the amount on line 7 by $1,000, round any fraction to the nearest whole number enter this number on line 1b of the DE 4. Complete Worksheet C, if needed, otherwise **stop here**.		8.
9.	If line 6 is greater than line 5; Enter amount from line 6 (nonwage income)		9.
10.	Enter amount from line 5 (deductions)		10.
11.	Subtract line 10 from line 9, enter difference. Then, complete Worksheet C.		11.

*Wages paid to registered domestic partners will be treated the same for state income tax purposes as wages paid to spouses for California PIT withholding and PIT wages. This law does not impact federal income tax law. A registered domestic partner means an individual partner in a domestic partner relationship within the meaning of section 297 of the Family Code. For more information, please call our Taxpayer Assistance Center at 1-888-745-3886.

Worksheet C **Additional Tax Withholding and Estimated Tax**

1.	Enter estimate of total wages for tax year 2024.	1.
2.	Enter estimate of nonwage income (line 6 of Worksheet B).	2.
3.	Add line 1 and line 2. Enter sum.	3.
4.	Enter itemized deductions or standard deduction (line 1 or 2 of Worksheet B, whichever is largest).	4.
5.	Enter adjustments to income (line 4 of Worksheet B).	5.
6.	Add line 4 and line 5. Enter sum.	6.
7.	Subtract line 6 from line 3. Enter difference.	7.
8.	Figure your tax liability for the amount on line 7 by using the 2024 tax rate schedules below.	8.
9.	Enter personal exemptions (line F of Worksheet A x $158.40).	9.
10.	Subtract line 9 from line 8. Enter difference.	10.
11.	Enter any tax credits. (See FTB Form 540).	11.
12.	Subtract line 11 from line 10. Enter difference. This is your total tax liability.	12.
13.	Calculate the tax withheld and estimated to be withheld during 2024. Contact your employer to request the amount that will be withheld on your wages based on the marital status and number of withholding allowances you will claim for 2024. Multiply the estimated amount to be withheld by the number of pay periods left in the year. Add the total to the amount already withheld for 2024.	13.
14.	Subtract line 13 from line 12. Enter difference. If this is less than zero, you do not need to have additional taxes withheld.	14.
15.	Divide line 14 by the number of pay periods remaining in the year. Enter this figure on line 2 of the DE 4.	15.

Note: Your employer is not required to withhold the additional amount requested on line 2 of your DE 4. If your employer does not agree to withhold the additional amount, you may increase your withholdings as much as possible by using the “single” status with “zero” allowances. If the amount withheld still results in an underpayment of state income taxes, you may need to file quarterly estimates on Form 540-ES with the FTB to avoid a penalty.

These Tables Are for Calculating Worksheet C and for 2024 Only

Single Persons, Dual Income Married or Married With Multiple Employers

IF THE TAXABLE INCOME IS		COMPUTED TAX IS		
OVER	BUT NOT OVER	OF AMOUNT OVER...		PLUS
$0	$10,412	1.100%	$0	$0.00
$10,412	$24,684	2.200%	$10,412	$114.53
$24,684	$38,959	4.400%	$24,684	$428.51
$38,959	$54,081	6.600%	$38,959	$1,056.61
$54,081	$68,350	8.800%	$54,081	$2,054.66
$68,350	$349,137	10.230%	$68,350	$3,310.33
$349,137	$418,961	11.330%	$349,137	$32,034.84
$418,961	$698,271	12.430%	$418,961	$39,945.90
$698,271	$1,000,000	13.530%	$698,271	$74,664.13
$1,000,000	and over	14.630%	$1,000,000	$115,488.06

Unmarried/Head of Household

IF THE TAXABLE INCOME IS		COMPUTED TAX IS		
OVER	BUT NOT OVER	OF AMOUNT OVER...		PLUS
$0	$20,839	1.100%	$0	$0.00
$20,839	$49,371	2.200%	$20,839	$229.23
$49,371	$63,644	4.400%	$49,371	$856.93
$63,644	$78,765	6.600%	$63,644	$1,484.94
$78,765	$93,037	8.800%	$78,765	$2,482.93
$93,037	$474,824	10.230%	$93,037	$3,738.87
$474,824	$569,790	11.330%	$474,824	$42,795.68
$569,790	$949,649	12.430%	$569,790	$53,555.33
$949,649	$1,000,000	13.530%	$949,649	$100,771.80
$1,000,000	and over	14.630%	$1,000,000	$107,584.29

Married Persons

IF THE TAXABLE INCOME IS		COMPUTED TAX IS		
OVER	BUT NOT OVER	OF AMOUNT OVER...		PLUS
$0	$20,824	1.100%	$0	$0.00
$20,824	$49,368	2.200%	$20,824	$229.06
$49,368	$77,918	4.400%	$49,368	$857.03
$77,918	$108,162	6.600%	$77,918	$2,113.23
$108,162	$136,700	8.800%	$108,162	$4,109.33
$136,700	$698,274	10.230%	$136,700	$6,620.67
$698,274	$837,922	11.330%	$698,274	$64,069.69
$837,922	$1,000,000	12.430%	$837,922	$79,891.81
$1,000,000	$1,396,542	13.530%	$1,000,000	$100,038.11
$1,396,542	and over	14.630%	$1,396,542	$153,690.24

If you need information on your last California Resident Income Tax Return, FTB Form 540, visit (FTB) (ftb.ca.gov).

The DE 4 information is collected for purposes of administering the PIT law and under the authority of Title 22, CCR, section 4340-1, and the California Revenue and Taxation Code, including section 18624. The Information Practices Act of 1977 requires that individuals be notified of how information they provide may be used. Further information is contained in the instructions that came with your last California resident income tax return.

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** _____

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):

☐ 1. A citizen of the United States

☐ 2. A noncitizen national of the United States *(See instructions)*

☐ 3. A lawful permanent resident (Alien Registration Number/USCIS Number): _____

☐ 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. *(See instructions)*

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.

1. Alien Registration Number/USCIS Number: _____
OR
2. Form I-94 Admission Number: _____
OR
3. Foreign Passport Number: _____
Country of Issuance: _____

QR Code - Section 1
Do Not Write In This Space

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

STOP *Employer Completes Next Page* STOP

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				
Issuing Authority				
Document Number				
Expiration Date *(if any)(mm/dd/yyyy)*				
Document Title				
Issuing Authority				
Document Number				
Expiration Date *(if any)(mm/dd/yyyy)*				

Additional Information

QR Code - Sections 2 & 3
Do Not Write In This Space

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
		Personnel Technician

Last Name of Employer or Authorized Representative	First Name of Employer or Authorized Representative	Employer's Business or Organization Name
Villegas	Jackie	Bonita Unified School District

Employer's Business or Organization Address (Street Number and Name)	City or Town	State	ZIP Code
115 W. Allen Ave	San Dimas	Ca	

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 report of birth issued by the Department of State (Forms DS-1350, FS-545, FS-240)
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.** Original or certified copy of birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal
4. Employment Authorization Document that contains a photograph (Form I-766)		**4.** Voter's registration card		**4.** Native American tribal document
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.** U.S. Citizen ID Card (Form I-197)
		6. Military dependent's ID card		**6.** Identification Card for Use of Resident Citizen in the United States (Form I-179)
		7. U.S. Coast Guard Merchant Mariner Card		**7.** Employment authorization document issued by the Department of Homeland Security
		8. Native American tribal document		
		9. Driver's license issued by a Canadian government authority		
		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		
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				

Examples of many of these documents appear in Part 13 of the Handbook for Employers (M-274).

Refer to the instructions for more information about acceptable receipts.

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

BONITA UNIFIED SCHOOL DISTRICT

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

Signature: _____

Date: _____

BONITA UNIFIED SCHOOL DISTRICT

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

PERSONAL PHYSICIAN PRE-DESIGNATION FORM (OPTIONAL)

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: _____

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)

Payroll Unit

Direct Deposit Authorization

PLEASE CHECK

☐ New ☐ Change ☐ Cancel

PRINT LAST NAME, FIRST NAME, MIDDLE INITIAL	SOCIAL SECURITY NUMBER
NAME OF SCHOOL DISTRICT (IF EMPLOYED WITHIN THE OFFICE, PUT YOUR ROOM NUMBER HERE)	WORK TELEPHONE NUMBER ( )
NAME OF BANK/CREDIT UNION/SAVINGS & LOAN ☐ Checking ☐ Savings	BRANCH TELEPHONE NUMBER ( )
ACCOUNT NUMBER	ADDRESS OF BANK/CREDIT UNION/SAVINGS & LOAN (NUMBER,STREET,CITY AND ZIP CODE)

I hereby authorize the district and the Los Angeles County Office of Education (LACOE) and/or its agents to initiate electronic deposits and, as necessary, debit corrections to previous deposits to my account.

I understand:

- Direct deposit status is not activated until 10 days following a $0 test transaction for new or change authorization.
- I must submit a new *Employee's Direct Deposit Authorization*, if I change my account (name, institution, branch, type account, etc.).
- Direct deposit status will be temporarily suspended if wages are garnished.
- Direct deposit will also be suspended if a a certificated employee's credential expires.
- Direct deposit status may be suspended or rescinded by the district or LACOE and payment made by county warrant, if necesasry, to meet payroll deadlines or under extreme conditions.

I agree to hold harmless and indemnify the district and Los Angeles County Office of Education and its officers, employees, and agents from any claim or demand of whatever nature, including those based upon negligence of LACOE and its officers, employees, and agents for failure or delay in making deposits and/or corrections to deposits as herein authorized.

This authorization replaces any previously made by me and is to remain in effect until changed or canceled by submission of a new *Employee's Direct Deposit Authorization*.

ATTACH BELOW A VOIDED CHECK SHOWING THE INSTITUTION ROUTING NUMBER AND ACCOUNT NUMBER.	SIGNATURE OF EMPLOYEE **X**	DATE SIGNED

ATTACH VOIDED CHECK HERE

FOR COUNTY OFFICE USE ONLY

Refer to the Direct Deposit Reference Guide

FINANCIAL INSTITUTION ROUTING NO.

EMPLOYEE'S DEPOSIT ACCOUNT NO.

INPUT BY (PRINT NAME)

GR 9/2007

Attachment No. 2
Inf. Bul. No. 92
SFS-A20-2010-2011

Child Abuse Mandated Reporter Training

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

To complete the trainings go to *ASCIP Online Learning Center*. To access the link please go to https://do.bonita.k12.ca.us/index.html then to the Human Resources page.

If this is your first time on the ASCIP Online Learning Center please click on Register in the top right, next to the Log In box. When you register you can use your **PERSONAL EMAIL**. Once you've registered save your login information for future trainings.

To find courses click Catalog, click search and type in **AB1432 for the Mandated Reporter training**. Once you have completed the courses you will need to save or print your certificate of completion to submit with your packet. Click my Training, click Transcript, click the certificate icon on the right hand side for the correct training, save or print, and submit.

STATE OF CALIFORNIA
BCIA 8016A
(orig. 04/2001; rev. 01/2011)

DEPARTMENT OF JUSTICE

REQUEST FOR LIVE SCAN SERVICE
(Public Schools or Joint Powers Agencies)

Print Form Reset Form

Applicant Submission

ORI: A3279 (Code assigned by DOJ) Type of Applicant: ☒ Classified School Employee ☐ Credentialed School Employee

The following selections are for Public Schools only:

☒ License, Certification, Permit ☐ Peace Officer ☐ Law Enforcement Officer ☐ Volunteer

Type of License/Certification/Permit OR Working Title: Classified Substitute Employee
(Maximum 30 characters - if assigned by DOJ, use exact title assigned)

Contributing Agency Information:

Bonita Unified School District — Agency Authorized to Receive Criminal Record Information
01551 — Mail Code (five-digit code assigned by DOJ)
115 W. Allen Ave. — Street Address or P.O. Box
Jacqueline Villegas — Contact Name (mandatory for all school submissions)
San Dimas — City; CA — State; 91773 — ZIP Code
(909) 971-8200 — Contact Telephone Number

Applicant Information:

Last Name; First Name; Middle Initial; Suffix
Other Name (AKA or Alias) Last; First; Suffix
Date of Birth; Sex ☐ Male ☐ Female; Driver's License Number
Height; Weight; Eye Color; Hair Color
Billing Number (Agency Billing Number)
Place of Birth (State or Country); Social Security Number
Misc. Number (Other Identification Number)
Home Address — Street Address or P.O. Box; City; State; ZIP Code

Your Number: (OCA Number (Agency Identifying Number))

Level of Service: ☒ DOJ ☐ FBI

If re-submission, list original ATI number:
(Must provide proof of rejection)

Original ATI Number

Live Scan Transaction Completed By:

Name of Operator; Date
Transmitting Agency; LSID; ATI Number; Amount Collected/Billed

ORIGINAL - Live Scan Operator SECOND COPY - Applicant THIRD COPY (if needed) - Requesting Agency

Live Scan Fingerprinting

Post Masters Plus Of La Verne

1 Advanced Live Scan
1407 Foothill Blvd
La Verne, CA 91750
(909) 596-0039

Hours
Monday - Friday: 9:00 a.m. - 6:00 p.m.
Saturday: 10:00 a.m. - 5:00 p.m.

NO APPOINTMENT NECESSARY

Accept cash and credit.

This location is only a suggestion.

You can have your fingerprints processed at any LiveScan facility.

PVHC 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

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

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

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: Jane Lamb

Date: _____

Occupation: _____

Date of injury or appointment: _____

☐ Work Related Injury
☐ Bill W/C carrier
☐ Bill employer

Drug Screens
☐ Pre-placement ☐ DOT/DMV/Federal
☐ Non-regulated ☐ 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

Other: _____

Comments: _____

_____

Is employee a temp or leased? ☐ Yes ☐ No

Leasing company name & phone:

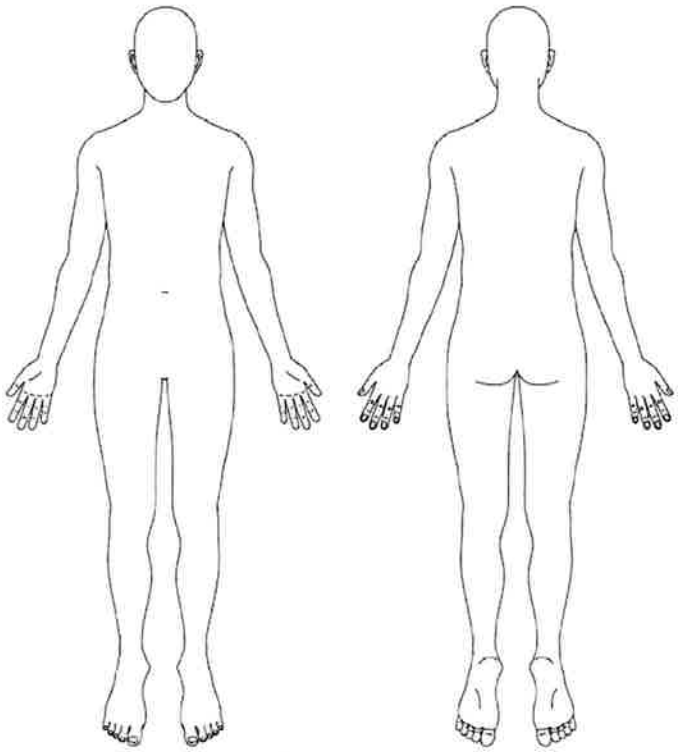
_____

Phone authorization by: _____
PVHC Associate

Date & time: _____

2/12/18 MSB

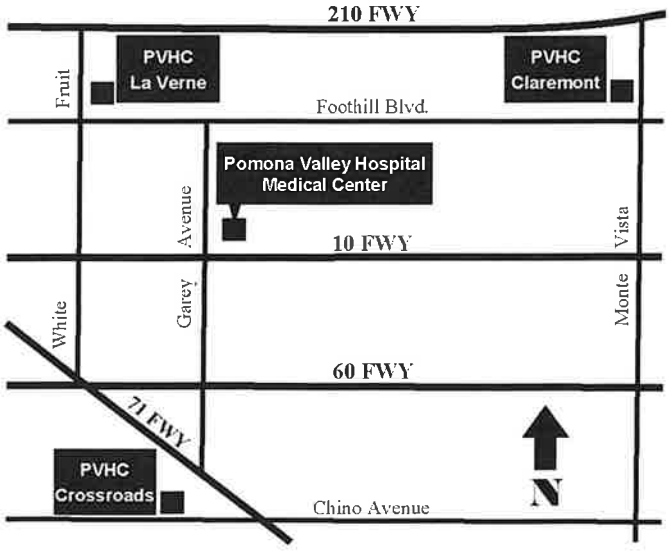
Please circle where the employee was injured on the diagram below.



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

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.



California Public Employees' Retirement System
P.O. Box 942709 Sacramento, CA 94229-2709
888 CalPERS (or **888**-225-7377)
TTY: (877) 249-7442 | Fax: (916) 795-4166
www.calpers.ca.gov

Reciprocal Self-Certification Form

*Complete the following information and return this form to your personnel office **within 10 business days.** To ensure this form is completed correctly, please reference the enclosed List of Qualifying Public Retirement Systems and instructions.*

Section 1. Member Information

Member Name: (Last) (First) (Middle)

Date of Birth: | CalPERS ID:

Membership Status in Qualifying Public Retirement Systems:

☐ I have not been a member of a qualifying public retirement system in California. (skip to section 3)

☐ I have membership in a defined benefit plan under a qualifying public retirement system in California other than CalPERS. (complete section 2 with membership information for each qualifying public retirement system)

Section 2. Qualifying Reciprocal Membership Information

Name of Most Recent Public Retirement System:	Membership Date: / /	Separation Date*: / /	☐Retired* or ☐Refunded* Date: / /
Name of Prior Public Retirement System:	Membership Date: / /	Separation Date*: / /	☐Retired* or ☐Refunded* Date: / /
Name of Prior Public Retirement System:	Membership Date: / /	Separation Date*: / /	☐Retired* or ☐Refunded* Date: / /

**Please provide dates, if applicable. Not all sections may be applicable for each Public Retirement System.*

Section 3. Sign and Certify

I understand that by accepting employment in a qualified public retirement system, I am subject to the applicable laws and regulations of that system. **I also understand that completing this form is not a request to establish reciprocity.**

I hereby certify that the foregoing information has been verified with the qualifying public retirement system as true and correct and any information found to be incorrect may require corrections to my CalPERS account including, but not limited to, my retirement enrollment level and adjustments to my member contributions. CalPERS may make any necessary corrections to my account to ensure I am properly enrolled and eligible to receive the correct retirement benefits.

Member Signature: *Date:*

Section 4. To Be Completed by Employer Only

Name of CalPERS Agency:

CalPERS Business Partner ID: | Member's Enrollment Eligibility Date:

Designee of Employer: (print name) | Designees' Title:

Designee Signature: *Date:*

The employer must retain this form in the member's file for auditing purposes.

For more direction regarding how to process the Reciprocal Self-Certification Form, please refer to our employer reference guides.

457(b) FICA Alternative Plan

Bonita Unified School District

Visit NBSbenefits.com/403b for additional information.

Highlights

Congratulations! You are eligible to participate in the 457(b) FICA Alternative Plan provided by the **Bonita Unified School District.** Contributing to a 457 plan will give you peace of mind through financial security during your retirement. A 457 plan allows you to contribute a portion of your compensation as a pre-tax basis in order to save for retirement.

The Employer has established a 457(b) FICA Alternative Plan to help employees accumulate money for their long-term financial needs.

WHAT IS A 457(b) FICA ALTERNATIVE PLAN?

457(b) refers to a section of the IRS Code that allows you to save part of your earnings on a PRE-TAX basis. This lowers your current taxable income and helps your long term savings grow faster. The 457(b) FICA Alternative Plan is a savings program for employees who are not eligible to participate in the State Employees' Retirement System. These individuals are normally part-time, seasonal, and temporary employees.

HOW MUCH CAN YOU SAVE?

As a participant of the Employer 457(b) FICA Alternative Plan you are eligible to have 3.75% automatically deducted from your paycheck and invested for you. The remainder of the 7.5% is paid by your employer.

INITIAL ELIGIBILITY

Part-time Employees who work less than 20 hours per week.
Temporary Employees who work full-time or part-time under a contract which is not expected to exceed 2 years.
Seasonal Employees who work full-time for less than 5 months during the Plan Year

HOW TO JOIN THE PLAN

You do not need to enroll. Enrollment is automatic; 3.75% of your gross pay automatically is deducted from your paycheck and invested with Life Insurance Company of the Southwest for you. The remainder of the 7.5% is paid by your employer.

INVESTMENT CHOICES

The funds will be invested in a group annuity with the Life Insurance Company of the Southwest (LSW). The funds will be invested in a fixed group contract, which has a guaranteed positive rate of return.

VESTING

You always own 100% of the contribution made to the Employer 457(b) FICA Alternative Plan and the earnings.

DISTRIBUTIONS FROM THE PLAN

You or your beneficiary will be able to withdraw your vested balance when one of the following occurs:

1. Retirement
2. Total Disability
3. Death
4. Termination of Employment

NOTE: The lesser of the interest credited to your account or $10.00 will be deducted from your account for any distribution, transfer, or a direct rollover.

NOTES:

Updated: 1/21/2019

NBS Retirement Service Center

8523 S. Redwood Rd.
West Jordan, UT 84088
800.274.0503 ext. 5
Fax - 1.800. 597.8206

Contact NBS if you have questions about the retirement plan

Bonita Unified School District457(b) FICA Alternative Plan
Bonita Unified School District

Plan Contact Person:
Sula Ferrer

115 West Allen Avenue

San Dimas, CA 91773

(909) 971-8340 ext. 5404

Second Opinion, Third Opinion and 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 Independent Medical Review (IMR) process at the time you select a third opinion physician. Information about the IMR process can be found in the MPN Employee Handbook.

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 Independent Medical Review (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 Independent Medical Review process and the form to request an Independent Medical Review.

If the second opinion, third opinion or IMR agrees with your treating doctor, you will need to continue to receive medical treatment with a network physician if MPN contains a physician who can provide the recommended treatment. If the 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 provider, 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 that are available to employees covered by the WellComp Network.

Primary treating and specialty services including consultations and referrals

Examples of primary treating or specialty providers include: general medical practitioners, chiropractors, dentists, orthopedists, surgeons, psychologists, internists, psychiatrists, cardiologists, neurologists.

Inpatient Hospital and Outpatient Surgery Center services

Examples of inpatient hospital and outpatient surgery center providers 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 of ancillary care providers 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

WellComp Managed Care Services™

WellComp Provider Directory

For more information about the MPN including access to a roster of all treating physicians 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):

WellComp Information

For questions about the use of MPN's or complaints The MPN contact is: Gale Chmidling, MPN Manager (800)544-8150

WellComp has individuals available to answer questions, provide website assistance, and generate provider listings. Medical Access Assistants are available to assist with finding an MPN physicians of your choice, including scheduling and confirming physician appointments. Assistants are available 7am to 8pm Pacific Standard Time, Monday through Saturday at the contact information below:

WellComp
Patient Services Department
P.O. Box 59914
Riverside, CA 92517
Toll Free (800) 544-8150
fax: (888) 620-6921 or
e-mail: info@WellComp.com

Rev 12/14

WellComp Managed Care Services™

Employee Notification

This pamphlet contains important information on accessing the WellComp Medical Provider Network:

- ✓ 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

MPN Identification Number: _____

This pamphlet is available in Spanish. For a free copy, please contact WellComp Medical Provider Network.

Este folleto esta disponible en el Español. Para una copia gratis, favor de llamar a WellComp Medical Provider Network

Welcome to WellComp

Your employer has elected to provide you with the choice of a broad scope of medical services for work-related injuries and illnesses by implementing a Medical Provider Network (MPN), called WellComp. WellComp delivers quality medical care through your choice of a provider who is part of an exclusive network of healthcare providers, each of whom possess a deep understanding of the California workers' compensation system and the impact their decisions have on you. Your employer has received the approval from the State of California to cover your workers' compensation medical care needs through the WellComp Network. You are automatically covered by the WellComp Network if your date of injury or illness is on or after your employer's MPN implementation date and if you have not properly pre-designated a personal physician prior to your injury or illness.

In the event that you have an injury or illness, you may carry this pamphlet with you to present to your medical service provider for access to care.

This pamphlet is not required to receive medical services

Initial Care

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

In the event that 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.

Access to Medical Care

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 provider 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.

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

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

1. Your primary treating provider 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.
2. You may select an appropriate specialist by accessing the WellComp Directory.
3. You may contact your Medical Access Assistants in the WellComp Patient Services who can help coordinate necessary arrangements.

If your primary treating provider 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.

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.AC.) 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.AC. 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.AC. You may use this form to notify your employer of your personal D.C. or L.AC., or your employer may have their own form. The D.C. or L.AC. must be your regular D.C. or L.AC. 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.AC. 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.AC.)

_____
(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** _____

909-971-8200 x.5201

Information & Assistance Office:_____

_____

_____

Employer MUST complete this information

sedgwick®
caring counts

The Facts About Workers' Compensation

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

Approved by Division of Workers' Compensation

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 in 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 t hey 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 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.

Memorandum

BONITA UNIFIED SCHOOL DISTRICT
Human Resources Development

TO: **CLASSIFIED SUBSTITUTES**

FROM: **Human Resources**

SUBJECT: **Education Code 45103**

Education Code 45103(b) allows a substitute/temporary employee to work 195 days from July 1st through June 30th. The 195 days is inclusive of school holidays, sick leave, vacation and other leaves of absence, irrespective of the number of hours worked per day. Because the 195 days is inclusive of school holidays, sick leave, and vacation the District cannot allow you to work more than **150 days** during these dates.

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

Memorandum

BONITA UNIFIED SCHOOL DISTRICT

Human Resources Development

RE: AB1522 HEALTHY FAMILIES ACT OF 2014

Effective July 1, 2015, AB 1522 Healthy Workplaces, Healthy Families Act provides sick leave to California employees who work 30 days or more per year and who do not currently earn sick leave.

- This affects non-permanent part time employees (i.e. substitutes, student workers, temporary hourly and seasonal employees) whose positions are not represented by a collective bargaining unit.
- Sick leave will be accrued at the rate of one hour for every 30 hours worked, retroactive to the first day worked, or July 1, 2015, whichever is later.
- An employee is eligible to begin accruing sick leave after having worked at least 30 days in a fiscal year (July-June). Sick leave earned cannot be used until the 90th day of employment.
- Unused sick leave carries over year to year. The maximum that can be accrued in any year is 48 hours or 6 days.
- The use of sick leave is limited to 24 hours (3 days) per year of employment.

Employees who qualify for the Healthy Workplace, Healthy Families Act (provided they work the required number of hours) include, but are not limited to:

- Certificated Substitute Teachers
- Classified Substitutes
- Noon Duty Assistants
- Intervention Specialists/Hourly Teachers
- Home Hospital Teachers
- Walk-on Coaches/Advisors
- Retirees who return to work
- Student Workers
- ASB extra-duty assignments if non-District employees
- Stage Crews

Using Sick Leave

Once an employee has worked 30 days, any accrued sick leave earned will appear on his/her check stub. This information will inform the employee of sick hours available for applicable use.

Sick leave can be used for the diagnosis, care or treatment of an existing health condition, as well as preventative care for the employee or family member. A "family member" is defined in AB1522 as:

- Child (biological, adoptive, foster, step, legal ward) regardless of age or dependency statutes
- Parent (biological, adoptive, foster, step, legal guardian)
- Spouse or registered domestic partner
- Grandparent
- Grandchild
- Sibling

In addition, sick leave can be used for an employee who is a victim of domestic violence, sexual assault, or stalking.

Other Provisions

There is no requirement to pay out unused sick leave upon separation of employment. If an employee returns to the employer within one year, the sick leave balance is restored. The employee is eligible to use the sick leave balance and also begins accruing additional sick leave upon rehire. Additional FAQs can be found www.dir.ca.gov.

BONITA UNIFIED SCHOOL DISTRICT

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

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.

PART-TIME, SEASONAL AND TEMPORARY CLASSIFED EMPLOYEE

The District is implementing a change in federal law which requires all part-time, seasonal and temporary employees, not previously covered by Social Security, to participate in a retirement plan. The District and California School Employees Association, Local Chapter 21 met, shared materials and information regarding various alternative plans and mutually agreed to recommend the LARISA Social Security Alternative Plan. This retirement plan is an alternative to Social Security. The employee shall contribute 3.75% per pay period and the employer will contribute an equal amount. Additional details are outlined on the attached sheet. The employees covered by this alternative will commence with a mandatory deduction from all earned salary effective January 1, 1992. If you have not previously signed the forms for the mandatory retirement reduction you will be instructed to do so when you pick up your pay warrant. Additional information will be available at that time. Please call if you would like additional consultation on this matter.

SUBSTITUTE CERTIFICATE EMPLOYEES

State Teacher's Retirement System (STRS)

This is the other choice you have. The employee's contribution in this plan is 8% and your participation will count toward retirement. The funds deposited into your account from your 8% deduction belong to you and may be withdrawn if you terminate your employment as a substitute teacher with all public school districts in the state of California. If this is the plan you elect it is necessary to complete the application for STRS and this form is available in the Personnel Office. This needs to be done as soon as possible. Once you sign up for STRS in one district you become a member of the STRS system. There is no need to sign up in other districts.