BONITA UNIFIED SCHOOL DISTRICT
CERTIFICATED SUBSTITUTE REQUIREMENTS

Name:_____ Date:_____

How did you hear about this substitute position?:_____

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

FORMS TO COMPLETE:

- ☐ Application
- ☐ Data Collection
- ☐ 41-4: Credential Application *only for non-credentialed subs*
- ☐ Warrant Designation
- ☐ W-4
- ☐ SSA-1945: Alternative SS Form
- ☐ Staff Acceptable Use Agreement
- ☐ Workers Comp Information
- ☐ I-9
- ☐ Contact Data
- ☐ Pre-Designation (optional)
- ☐ Understanding of Responsibility
- ☐ Oath
- ☐ Reasonable Assurance
- ☐ STRS - Election Form
- ☐ Sub Info Sheet

DOCUMENTATION:

- ☐ Driver's License / Photo ID
- ☐ Social Security ID
- ☐ Original CBEST and Transcript or Diploma *for non-credentialed subs*

OTHER REQUIREMENTS:

- ☐ Fingerprint Clearance Date (STATE): _____ *for non-credentialed subs*
- ☐ Fingerprint Clearance Date (DISTRICT):_____
- ☐ TB Test Date:_____
- ☐ Child Abuse Mandated Reporter Training Completion Certificate

COMPLETE THIS PACKET AND RETURN TO HUMAN RESOURCES DEVELOPMENT

First date worked:_____ Site:_____

CREDENTIAL:_____ EXPIRES:_____

Office Use Only:
SFE
Email SFE Date
HRS

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 CERTIFICATED EMPLOYMENT

PRINT LEGIBLY IN BLUE OR BLACK INK.

Date available: _____

Name: _____
Last First Middle

Address: _____
Number Street

_____
City State Zip

Social Security #: _____ Telephone #: _____

Email Address: _____

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

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

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

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

Education: Circle highest year completed or appropriate certificate.

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

Applicant must complete both sides of application

The Bonita Unified School District is an equal opportunity employer and does not discriminate on the basis of any class protected by law.

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

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

APPLICATION FOR CREDENTIAL AUTHORIZING PUBLIC SCHOOL SERVICE

(For Privacy Act Notification see Application Instructions)

Appeal:_____

Route to: _____

Mail application and payment (check or money order) to:
Commission on Teacher Credentialing
Certification Division
1900 Capitol Avenue
Sacramento, California 95811-4213

Commission Use Only: Fee Information		
APP	FP	Other

CTC Use Only

IHE/County/District Use Only

Issuance Date:_____

Email Address:_____

1. PERSONAL INFORMATION (type or print)

Social Security or Individual Tax ID Number:

Date of Birth: (mm/dd/yyyy)

Applicant's Name:

First | Middle | Last

Former/Maiden Name(s):

County or District of Employment:

Address:

City:

State:

Zip:

Home Phone:

Work Phone:

Message Phone:

Email Address:

2. CREDENTIAL TYPE (choose only one type below) OPTIONS:

Substitute Permits (PT)

Single Subject (Secondary Teaching)

Specify Subject (If you are requesting more than one subject, enter it in *Comments.*)

Specify World Language other than English (if applicable)

☐ **English Learner Authorization** **Term**

BILINGUAL AUTHORIZATION - Specify Language

Multiple Subject (Elementary Teaching)

☐ **English Learner Authorization** **Term**

BILINGUAL AUTHORIZATION - Specify Language

Education Specialist (Special Education)
(If you are requesting more than one specialty area, enter it in *Comments.*)

Specify Specialty Area

☐ **English Learner Authorization** **Term**

Other Specialist Credentials

☐ **Added Authorizations (AASE)**

English Learner Authorizations

BILINGUAL AUTHORIZATION - Specify Language

Services Credentials

Term

Specify Other Health Services

Child Development Permits (PK)

☐ **School-Age Emphasis**

Designated Subjects (PW)

Subject(s) **Term**

Supplementary Authorization(s) (PJ)

Subject Matter Authorization(s) (PJ)

CTC Use Only

3. CHILD DEVELOPMENT PERMIT RENEWAL SELF-VERIFICATION

As the holder of a Child Development Permit (any level except the Associate Teacher Permit) you must complete a specific number of planned and approved professional growth activities for each five-year renewal. These activities must be recorded on the *Professional Growth Plan and Record* form. As the holder of a Child Development Permit choosing to self-verify completion of these requirements, you may be subject to an audit. The Commission reserves the right to request submission of these forms for auditing purposes any time within one year following submission of this application. If the Commission determines through its audit that you did not complete the professional growth requirements, your permit will not be renewed and you may be subject to adverse action on other credentials you currently hold. You must retain your *Professional Growth Plan and Record* form for one year following the submission of this application.

DECLARATION:

I certify (or declare) that I have read the above and completed the following for this renewal of my clear credential:

I have completed _____ hours of professional growth activities

My Professional Growth Advisor is _____ _____

Advisor's Name **Advisor's Phone Number**

4. PROFESSIONAL FITNESS QUESTIONS

Answers to the following questions are required**. If you answer yes to any question, you must complete the corresponding *Professional Fitness Explanation Form*.**

Before granting your application, the Commission will review, at a minimum:

- Federal Bureau of Investigation criminal history (rap sheet)
- California Department of Justice criminal history (rap sheet)
- International database of teacher misconduct maintained by the National Association of State Directors of Teacher Education and Certification (NASDTEC)
- Previous reviews by the Commission
- Complaints from others
- Notifications from school districts
- Teacher preparation test score violations

You must disclose misconduct, even if:

- It happened a long time ago
- It happened in another state, federal court, military or jurisdiction outside the United States
- You did not go to court and your attorney went for you
- You did not go to jail or the sentence was only a fine or probation
- You received a certificate of rehabilitation
- Your conviction was later dismissed (even if under Penal Code section 1203.4), expunged, set aside or the sentence was suspended

Warning: You will be required to sign your application under penalty of perjury; by doing so you are also stating:

- That the information you provide is true and correct;
- That you understand any and all instructions related to your application;
- The Commission may reject your application if it is incomplete and it will be delayed;
- Failure to disclose any information requested is falsification of your application and the Commission may reject or deny your application or take disciplinary action against your credential

a. Have you ever been:

- dismissed or,
- non-reelected or,
- suspended without pay for more than ten days, or
- retired or,
- resigned from, or otherwise left school employment

because of **allegations of misconduct** or while **allegations of misconduct** were pending?

☐ Yes ☐ No

b. Have you ever been convicted of any felony or misdemeanor in California or any other place?

You must disclose:

- all criminal convictions
- misdemeanors and felonies
- convictions based on a plea of no contest or nolo contendere
- convictions dismissed pursuant to Penal Code Section 1203.4
- driving under the influence (DUI) or reckless driving convictions
- no matter how much time has passed

You do not have to disclose:

- misdemeanor marijuana-related convictions that occurred more than two years prior to this application, except convictions involving concentrated cannabis, which must be disclosed regardless of the date of such a conviction.
- infractions (DUI or reckless driving convictions are not infractions)

☐ Yes ☐ No

c. Are you currently the subject of any inquiry or investigation by any law enforcement agency or any licensing agency in California or any other state?

☐ Yes ☐ No

d. Are any criminal charges currently pending against you?

☐ Yes ☐ No

e. Have you ever had any credential, including but not limited to, any Certificate of Clearance, permit, credential, license or other document authorizing public school service, revoked, denied, suspended, publicly reproved, and/or otherwise subjected to any other disciplinary action (including an action that was stayed) in California or any other state or place?

☐ Yes ☐ No

f. Have you ever had any professional or vocational (not teaching or educational) license revoked, denied, suspended, and/or otherwise subjected to any other disciplinary action (including an action that was stayed) in California or any other state or place?

☐ Yes ☐ No

5. CHILD ABUSE AND NEGLECT MANDATED REPORTING

As a document holder authorized to work with children, it is part of my professional and ethical duty to report every instance of child abuse or neglect known or suspected to have occurred to a child with whom I have professional contact.

I understand that I must report immediately, or as soon as practicably possible, by telephone to a law enforcement agency or a child protective agency, and will send a written report and any evidence relating to the incident within 36 hours of becoming aware of the abuse or neglect of the child.

I understand that reporting the information regarding a case of possible child abuse or neglect to an employer, supervisor, school principal, school counselor, coworker, or other person is not a substitute for making a mandated report to a law enforcement agency or a child protective agency.

I understand that the reporting duties are individual and no supervisor or administrator may impede or inhibit my reporting duties.

I understand that once I submit a report, I am not required to disclose my identity to my employer.

I understand that my failure to report an instance of suspected child abuse or neglect as required by the Child Abuse and Neglect Reporting Act under Section 11166 of the Penal Code is a misdemeanor punishable by up to six months in jail or by a fine of one thousand dollars ($1,000), or by both that imprisonment and fine.

I acknowledge and certify that as a document holder, I will fulfill all the duties required of a mandated reporter.

☐ **I agree**

Before submitting, please review the application for completeness:

1) *Personal information with correct SSN, date of birth, and email address filled in on page 1*
2) *Type of credential clearly marked on page 1 (use box below for additional subject/authorization requests)*
3) *All Professional Fitness Questions marked Yes or No on pages 3 and 4*
4) *Read and agreed to your responsibilities as a mandated reporter*
5) *Payment (check or money order attached to the front of this form). See Credential Leaflet CL-659 for fee schedule.*

Checks or money orders may be made payable to the Commission on Teacher Credentialing. The Commission *does not* accept cash payments. All application fees are non-refundable.

Applications submitted that are incomplete or without the appropriate fee included will not be processed and will be returned.

6. OATH AND AFFIDAVIT

I solemnly swear (or affirm) that I will support the Constitution of the United States of America, the Constitution of the State of California, and the laws of the United States and the State of California. I hereby certify (or declare) under penalty of perjury under the laws of the State of California that all the foregoing statements in this application are true and correct.

Date _____ **City** _____ **County** _____ **State** _____
(where you sign the form)

SIGNATURE OF APPLICANT _____

7. EMPLOYING AGENCY INFORMATION

This section must be completed for all credential, certificate, and permit types where service is restricted to an employing agency.

County CDS Code _____ **School District CDS Code** _____

Charter School/Non-Public School or Agency/Statewide Agency Name _____

Applications for One-Year Nonrenewable Credentials, Provisional Internship Permits, Short-Term Staff Permits, Limited Assignment Permits, and Emergency Permits (except 30-Day or Prospective Substitute Teaching Permits), must be filed through the employing agency. Employers must have an annual Declaration of Need for Fully Qualified Educators on file with the Commission prior to the submission of any applications for Limited Assignment or Emergency Permits.

Comments/Additional Subject Requests:

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)

Form W-4 (2015)

Purpose. Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay. Consider completing a new Form W-4 each year and when your personal or financial situation changes.

Exemption from withholding. If you are exempt, complete **only** lines 1, 2, 3, 4, and 7 and sign the form to validate it. Your exemption for 2015 expires February 16, 2016. See Pub. 505, Tax Withholding and Estimated Tax.

Note. If another person can claim you as a dependent on his or her tax return, you cannot claim exemption from withholding if your income exceeds $1,050 and includes more than $350 of unearned income (for example, interest and dividends).

Exceptions. An employee may be able to claim exemption from withholding even if the employee is a dependent, if the employee:

- Is age 65 or older,
- Is blind, or
- Will claim adjustments to income; tax credits; or itemized deductions, on his or her tax return.

The exceptions do not apply to supplemental wages greater than $1,000,000.

Basic instructions. If you are not exempt, complete the **Personal Allowances Worksheet** below. The worksheets on page 2 further adjust your withholding allowances based on itemized deductions, certain credits, adjustments to income, or two-earners/multiple jobs situations.

Complete all worksheets that apply. However, you may claim fewer (or zero) allowances. For regular wages, withholding must be based on allowances you claimed and may not be a flat amount or percentage of wages.

Head of household. Generally, you can claim head of household filing status on your tax return only if you are unmarried and pay more than 50% of the costs of keeping up a home for yourself and your dependent(s) or other qualifying individuals. See Pub. 501, Exemptions, Standard Deduction, and Filing Information, for information.

Tax credits. You can take projected tax credits into account in figuring your allowable number of withholding allowances. Credits for child or dependent care expenses and the child tax credit may be claimed using the **Personal Allowances Worksheet** below. See Pub. 505 for information on converting your other credits into withholding allowances.

Nonwage income. If you have a large amount of nonwage income, such as interest or dividends, consider making estimated tax payments using Form 1040-ES, Estimated Tax for Individuals. Otherwise, you may owe additional tax. If you have pension or annuity income, see Pub. 505 to find out if you should adjust your withholding on Form W-4 or W-4P.

Two earners or multiple jobs. If you have a working spouse or more than one job, figure the total number of allowances you are entitled to claim on all jobs using worksheets from only one Form W-4. Your withholding usually will be most accurate when all allowances are claimed on the Form W-4 for the highest paying job and zero allowances are claimed on the others. See Pub. 505 for details.

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

Check your withholding. After your Form W-4 takes effect, use Pub. 505 to see how the amount you are having withheld compares to your projected total tax for 2015. See Pub. 505, especially if your earnings exceed $130,000 (Single) or $180,000 (Married).

Future developments. Information about any future developments affecting Form W-4 (such as legislation enacted after we release it) will be posted at *www.irs.gov/w4*.

Personal Allowances Worksheet (Keep for your records.)

A	Enter "1" for **yourself** if no one else can claim you as a dependent	A ____
B	Enter "1" if: • You are single and have only one job; or • You are married, have only one job, and your spouse does not work; or • Your wages from a second job or your spouse's wages (or the total of both) are $1,500 or less.	B ____
C	Enter "1" for your **spouse.** But, you may choose to enter "-0-" if you are married and have either a working spouse or more than one job. (Entering "-0-" may help you avoid having too little tax withheld.)	C ____
D	Enter number of **dependents** (other than your spouse or yourself) you will claim on your tax return	D ____
E	Enter "1" if you will file as **head of household** on your tax return (see conditions under **Head of household** above)	E ____
F	Enter "1" if you have at least $2,000 of **child or dependent care expenses** for which you plan to claim a credit (**Note.** Do **not** include child support payments. See Pub. 503, Child and Dependent Care Expenses, for details.)	F ____
G	**Child Tax Credit** (including additional child tax credit). See Pub. 972, Child Tax Credit, for more information. • If your total income will be less than $65,000 ($100,000 if married), enter "2" for each eligible child; then **less** "1" if you have two to four eligible children or **less** "2" if you have five or more eligible children. • If your total income will be between $65,000 and $84,000 ($100,000 and $119,000 if married), enter "1" for each eligible child	G ____
H	Add lines A through G and enter total here. (**Note.** This may be different from the number of exemptions you claim on your tax return.) ▶	H ____

For accuracy, complete all worksheets that apply.

- If you plan to **itemize** or **claim adjustments to income** and want to reduce your withholding, see the **Deductions and Adjustments Worksheet** on page 2.
- If you are **single and have more than one job** or are **married and you and your spouse both work** and the combined earnings from all jobs exceed $50,000 ($20,000 if married), see the **Two-Earners/Multiple Jobs Worksheet** on page 2 to avoid having too little tax withheld.
- If **neither** of the above situations applies, **stop here** and enter the number from line H on line 5 of Form W-4 below.

---------- **Separate here and give Form W-4 to your employer. Keep the top part for your records.** ----------

Form **W-4**
Department of the Treasury
Internal Revenue Service

Employee's Withholding Allowance Certificate

▶ **Whether you are entitled to claim a certain number of allowances or exemption from withholding is subject to review by the IRS. Your employer may be required to send a copy of this form to the IRS.**

OMB No. 1545-0074

2015

1	Your first name and middle initial	Last name	2 **Your social security number**
	Home address (number and street or rural route)	3 ☐ Single ☐ Married ☐ Married, but withhold at higher Single rate. **Note.** If married, but legally separated, or spouse is a nonresident alien, check the "Single" box.	
	City or town, state, and ZIP code	4 **If your last name differs from that shown on your social security card, check here. You must call 1-800-772-1213 for a replacement card.** ▶ ☐	
5	Total number of allowances you are claiming (from line **H** above **or** from the applicable worksheet on page 2)	5	
6	Additional amount, if any, you want withheld from each paycheck	6	$
7	I claim exemption from withholding for 2015, and I certify that I meet **both** of the following conditions for exemption. • Last year I had a right to a refund of **all** federal income tax withheld because I had **no** tax liability, **and** • This year I expect a refund of **all** federal income tax withheld because I expect to have **no** tax liability. If you meet both conditions, write "Exempt" here ▶	7	

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

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

8	Employer's name and address (Employer: Complete lines 8 and 10 only if sending to the IRS.)	9 Office code (optional)	10 Employer identification number (EIN)

Deductions and Adjustments Worksheet

Note. Use this worksheet *only* if you plan to itemize deductions or claim certain credits or adjustments to income.

1	Enter an estimate of your 2015 itemized deductions. These include qualifying home mortgage interest, charitable contributions, state and local taxes, medical expenses in excess of 10% (7.5% if either you or your spouse was born before January 2, 1951) of your income, and miscellaneous deductions. For 2015, you may have to reduce your itemized deductions if your income is over $309,900 and you are married filing jointly or are a qualifying widow(er); $284,050 if you are head of household; $258,250 if you are single and not head of household or a qualifying widow(er); or $154,950 if you are married filing separately. See Pub. 505 for details	1	$
2	Enter: { $12,600 if married filing jointly or qualifying widow(er); $9,250 if head of household; $6,300 if single or married filing separately }	2	$
3	**Subtract** line 2 from line 1. If zero or less, enter "-0-"	3	$
4	Enter an estimate of your 2015 adjustments to income and any additional standard deduction (see Pub. 505)	4	$
5	**Add** lines 3 and 4 and enter the total. (Include any amount for credits from the *Converting Credits to Withholding Allowances for 2015 Form W-4* worksheet in Pub. 505.)	5	$
6	Enter an estimate of your 2015 nonwage income (such as dividends or interest)	6	$
7	**Subtract** line 6 from line 5. If zero or less, enter "-0-"	7	$
8	**Divide** the amount on line 7 by $4,000 and enter the result here. Drop any fraction	8	
9	Enter the number from the **Personal Allowances Worksheet,** line H, page 1	9	
10	**Add** lines 8 and 9 and enter the total here. If you plan to use the **Two-Earners/Multiple Jobs Worksheet,** also enter this total on line 1 below. Otherwise, **stop here** and enter this total on Form W-4, line 5, page 1	10	

Two-Earners/Multiple Jobs Worksheet (See *Two earners or multiple jobs* on page 1.)

Note. Use this worksheet *only* if the instructions under line H on page 1 direct you here.

1	Enter the number from line H, page 1 (or from line 10 above if you used the **Deductions and Adjustments Worksheet**)	1	
2	Find the number in **Table 1** below that applies to the **LOWEST** paying job and enter it here. **However,** if you are married filing jointly and wages from the highest paying job are $65,000 or less, do not enter more than "3"	2	
3	If line 1 is **more than or equal to** line 2, subtract line 2 from line 1. Enter the result here (if zero, enter "-0-") and on Form W-4, line 5, page 1. **Do not** use the rest of this worksheet	3	

Note. If line 1 is **less than** line 2, enter "-0-" on Form W-4, line 5, page 1. Complete lines 4 through 9 below to figure the additional withholding amount necessary to avoid a year-end tax bill.

4	Enter the number from line 2 of this worksheet	4		
5	Enter the number from line 1 of this worksheet	5		
6	**Subtract** line 5 from line 4		6	
7	Find the amount in **Table 2** below that applies to the **HIGHEST** paying job and enter it here		7	$
8	**Multiply** line 7 by line 6 and enter the result here. This is the additional annual withholding needed		8	$
9	Divide line 8 by the number of pay periods remaining in 2015. For example, divide by 25 if you are paid every two weeks and you complete this form on a date in January when there are 25 pay periods remaining in 2015. Enter the result here and on Form W-4, line 6, page 1. This is the additional amount to be withheld from each paycheck		9	$

Table 1

Married Filing Jointly		All Others	
If wages from **LOWEST** paying job are—	Enter on line 2 above	If wages from **LOWEST** paying job are—	Enter on line 2 above
$0 - $6,000	0	$0 - $8,000	0
6,001 - 13,000	1	8,001 - 17,000	1
13,001 - 24,000	2	17,001 - 26,000	2
24,001 - 26,000	3	26,001 - 34,000	3
26,001 - 34,000	4	34,001 - 44,000	4
34,001 - 44,000	5	44,001 - 75,000	5
44,001 - 50,000	6	75,001 - 85,000	6
50,001 - 65,000	7	85,001 - 110,000	7
65,001 - 75,000	8	110,001 - 125,000	8
75,001 - 80,000	9	125,001 - 140,000	9
80,001 - 100,000	10	140,001 and over	10
100,001 - 115,000	11		
115,001 - 130,000	12		
130,001 - 140,000	13		
140,001 - 150,000	14		
150,001 and over	15		

Table 2

Married Filing Jointly		All Others	
If wages from **HIGHEST** paying job are—	Enter on line 7 above	If wages from **HIGHEST** paying job are—	Enter on line 7 above
$0 - $75,000	$600	$0 - $38,000	$600
75,001 - 135,000	1,000	38,001 - 83,000	1,000
135,001 - 205,000	1,120	83,001 - 180,000	1,120
205,001 - 360,000	1,320	180,001 - 395,000	1,320
360,001 - 405,000	1,400	395,001 and over	1,580
405,001 and over	1,580		

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 who claims no withholding allowances; 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 possessions 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.

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** _____

SIGN AND RETURN TO HUMAN RESOURCES DEVELOPMENT

BONITA UNIFIED SCHOOL DISTRICT
STAFF ACCEPTABLE USE AGREEMENT

NAME: _____
Print Name

School: _____ School Year: _____

I have read and understand the provisions set forth by Bonita Unified School District in the Staff Acceptable Use Regulation and show my acceptance by initialing the provisions listed below. All staff using the District Electronic Information Resources must have their signature on this regulation to access those resources.

PROVISIONS:

1.	Personal Responsibility	initial:_____
2.	Privilege	initial:_____
3.	Acceptable Use	initial:_____
4.	Unacceptable Use	initial:_____
5.	Personal Information And Confidentiality	initial:_____
6.	Software Copyright Policy	initial:_____
7.	Web Page/Information Policy	initial:_____
8.	Disciplinary Action	initial:_____
9.	Network Etiquette and Privacy	initial:_____

I understand and will abide by the provisions and conditions of this regulation. I understand that any violations of the above provisions may result in, the revoking of my privileges for use of the District Electronic Information Resources, legal actions, employee progressive discipline as set forth in the collective bargaining agreements or board policy and regulation as applicable, and possible termination of my employment. I also agree to report any misuse of the District Electronic Information Resources to my supervisor, system administrator or other designated person in charge.

_____

SIGNATURE

Date _____

BONITA UNIFIED SCHOOL DISTRICT

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

Print Name: _____

Signature: _____

Date: _____

Employment Eligibility Verification

Department of Homeland Security
U.S. Citizenship and Immigration Services

USCIS
Form I-9
OMB No. 1615-0047
Expires 03/31/2016

►START HERE. Read instructions carefully before completing this form. The instructions must be available during completion of this form.
ANTI-DISCRIMINATION NOTICE: It is illegal to discriminate against work-authorized individuals. Employers **CANNOT** specify which document(s) they will accept from an employee. The refusal to hire 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 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	E-mail Address	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):

☐ A citizen of the United States

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

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

☐ An alien authorized to work until (expiration date, if applicable, mm/dd/yyyy) _____. Some aliens may write "N/A" in this field. *(See instructions)*

*For aliens authorized to work, provide your Alien Registration Number/USCIS Number **OR** Form I-94 Admission Number:*

1. Alien Registration Number/USCIS Number: _____

OR

2. Form I-94 Admission Number: _____

If you obtained your admission number from CBP in connection with your arrival in the United States, include the following:

Foreign Passport Number: _____

Country of Issuance: _____

Some aliens may write "N/A" on the Foreign Passport Number and Country of Issuance fields. (*See instructions*)

3-D Barcode
Do Not Write in This Space

Signature of Employee:	Date *(mm/dd/yyyy):*

Preparer and/or Translator Certification *(To be completed and signed if Section 1 is prepared by a person other than the employee.)*

I attest, under penalty of perjury, that I have assisted in the completion of this form and that to the best of my knowledge the information is true and correct.

Signature of Preparer or Translator:			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

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 examine a combination of one document from List B and one document from List C as listed on the "Lists of Acceptable Documents" on the next page of this form. For each document you review, record the following information: document title, issuing authority, document number, and expiration date, if any.)

Employee Last Name, First Name and Middle Initial from Section 1:

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)*:				

3-D Barcode
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	Date *(mm/dd/yyyy)*	Title of Employer or Authorized Representative
		Credential Technician

Last Name *(Family Name)*	First Name *(Given Name)*	Employer's Business or Organization Name
Bruyninckx	Jane	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	91773

Section 3. Reverification and Rehires *(To be completed and signed by employer or authorized representative.)*

A. New Name *(if applicable)* Last Name *(Family Name)* First Name *(Given Name)* Middle Initial	B. Date of Rehire *(if applicable) (mm/dd/yyyy)*:

C. If employee's previous grant of employment authorization has expired, provide the information for the document from List A or List C the employee presented that establishes current 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:	Date *(mm/dd/yyyy)*:	Print Name of Employer or Authorized Representative:

LISTS OF ACCEPTABLE DOCUMENTS
All documents must be UNEXPIRED

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

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

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

Refer to Section 2 of the instructions, titled "Employer or Authorized Representative Review and Verification," 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

CONTACT DATA

(Print Legibly)

Social Security Number _____ - _____ - _____

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

Last Name _____ First Name _____ MI _____

Current Address _____

City _____ State _____ Zip Code _____

Home Phone Number _____

Cell Phone Number _____

Email Address _____

Name of Emergency Contact _____

Relationship _____

Emergency Contact Phone Number _____

Office Use Only:

Access ID # _____

BONITA UNIFIED SCHOOL DISTRICT

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

PERSONAL PHYSICIAN PRE-DESIGNATION FORM

Date Employee was provided Pre-Designation Form: _____

Employee: _____

Department: _____

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

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

Name of Physician: _____

Specialty: _____

Address: _____

Telephone: _____

Employee Name: (print) _____

Employee Signature: _____

Date of Request: _____

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

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

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

Date: _____

Physician: _____

Employee: _____

CERTIFICATION

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

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

Physician's Signature: _____

Print Name: _____

Date: _____

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

Physician's Signature: _____

Print Name: _____

Date: _____

BONITA UNIFIED SCHOOL DISTRICT

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

Acknowledgement of Receipt and Review of Materials, Attendance at Training and Understanding of Responsibility

Employees who are mandated reporters, as defined by law and District regulation, are obligated to report all known or suspected incidents of child abuse and neglect. Mandated reporters shall not investigate any suspected incidents but rather shall cooperate with agencies responsible for investigating and prosecuting cases of child abuse and neglect. In the Bonita Unified School District all employees are required to report suspected child abuse.

It is a violation of Board Policy for any employee, volunteer, student, or third party to harass, or be harassed by, an employee, volunteer, student, or third party who interacts with your school workplace. A third party participant in your school workplace includes anyone who participates regularly, or on occasion, on your workplace, interacting with your employees, volunteers, or students, such as, but not limited to: members of the public, vendors, family members of employees or volunteers, Board members, clients, job applicants, or independent contractors.

- I have read and understand the requirements above.
- I have received a copy of Board Policy 4119.11, Harassment; Board Policy 4020-4020.21, Drug and Alcohol Free Workplace and Notice To Employees; Board Policy and Regulations 4040, Staff Acceptable Use.
- I have read and understand the Board Policy: 4119.11, 4020 and 4040.

Employee Name (Print):_____

Signature:_____ Date:_____

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

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

Permissive Membership

ES 0350 (Rev. 6/11)

PERMISSIVE ELECTION AND ACKNOWLEDGEMENT OF RECEIPT OF CALSTRS DEFINED BENEFIT PLAN MEMBERSHIP INFORMATION

California State Teachers' Retirement System
P.O. Box 15275, MS 17
Sacramento, CA 95851-0275
800-228-5453
CalSTRS.com

An employee who performs creditable service (Education Code Section 22119.5), and who is excluded from mandatory membership pursuant to Section 22601.5, 22602, or 22604, may elect membership in the California State Teachers' Retirement System (CalSTRS) Defined Benefit Program at any time while employed to perform creditable service. If you elect membership below, then your election becomes irrevocable until you terminate employment. This form containing your election must be on file with CalSTRS before your employer submits contributions into the program.

EMPLOYEE CERTIFICATION

NAME (LAST, FIRST, INITIAL) | CLIENT ID OR SOCIAL SECURITY NUMBER

MAILING ADDRESS | POSITION TITLE

CITY | STATE | ZIP CODE | HOME TELEPHONE ( )

E-MAIL ADDRESS

With my signature below, I certify that I have received information from my employer on my eligibility to elect membership in CalSTRS Defined Benefit Program and that I am making the following election. I fully understand this election is irrevocable and applies to all future creditable service until I terminate employment.

I understand it is a crime to fail to disclose a material fact or to make any knowingly false material statements for the purpose of altering a benefit administered by CalSTRS and it may result in penalties, including restitution, up to one year in jail and a fine of up to $5,000 (Education Code Section 22010).

I elect membership ☐ **I decline membership at this time** ☐

SIGNATURE | **DATE**

TO BE COMPLETED BY EMPLOYER

With my signature below, I certify that the above-named employee has been provided with the membership criteria for the CalSTRS Defined Benefit Program, and if applicable, was informed within 30 days of hire that they may elect membership in the Program at any time while employed. (Education Code section 22455.5).

OFFICIAL'S SIGNATURE | **TITLE**

COUNTY (or Other Employing Agency) | **DISTRICT**

EMPLOYEE #	**SEX** **MALE** **FEMALE**	**BIRTHDAY** (MO/DAY/YEAR)	**MEMBERSHIP DATE** (MO/DAY/YEAR)	**ASSIGNMENT** **FT**	**PT**	**SUB**

ES0350

SUB INFORMATION SHEET Access #_____

Certificated Substitutes Date: _____

Name: _____ Home phone: _____

Address: _____

Email address: _____ Cell phone: _____

Credentials or Certifications you currently hold: _____

Permit/Credential expires: _____

Subject preference(s): _____ Grade(s): ☐ K-3 ☐ 4-5 ☐ 6-8 ☐ HS

SCHOOL LOCATION(S) OF INTEREST (Please check **all possible** job locations.)

☐ All schools
☐ Bonita High School
☐ Chaparral High School
☐ San Dimas High School
☐ Lone Hill Middle School
☐ Ramona Middle School
☐ Allen Ave. Elementary
☐ Ekstrand Elementary
☐ Gladstone Elementary
☐ La Verne Hts. Elementary
☐ Grace Miller Elementary
☐ Oak Mesa Elementary
☐ Roynon Elementary
☐ Shull Elementary

CHECK GRADE(S) OF INTEREST (Please check **all possible** grades.)

☐ 9-12 (High School)
☐ 6-8 (Middle School)
☐ Kindergarten
☐ 1st Grade
☐ 2nd Grade
☐ 1/2 Combo
☐ 3rd Grade
☐ 2/3 Combo
☐ 4th Grade
☐ 3/4 Combo
☐ 5th Grade
☐ 4/5 Combo

Special Education

☐ Pre-school SDC
☐ RSP (Resource Specialist)
☐ SDC K-3
☐ SDC 4-5
☐ ASRD Pre-school (Autistic)
☐ ASRD K-1 (Autistic)

Will you substitute in a/an:

☐ Physical Education class
☐ Industrial Arts class
☐ Special Education class

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 STRS? ☐ Yes ☐ No

If yes, through what district? _____ Retired? ☐ Yes ☐ No Refund _____

REQUEST FOR LIVE SCAN SERVICE

FORM 41-LS Rev. 06/13

Applicant Submission

ORI: **A0281** (Code assigned by DOJ) Type of Application: **License/Certification/Permit**

Job Title or Type of License, Certification or Permit: **TEACHER CRED 44340 EC**

Agency Address Set Contributing Agency:

CASM TEACHER CREDENTIALING
Agency authorized to receive criminal history information

03294
Mail Code (five-digit code assigned by DOJ)

1900 Capitol Avenue
Street No. Street or PO Box

Contact Name (Mandatory for all school submissions)

Sacramento City **CA** State **95811-4213** Zip Code

Contact Telephone No.

Name of Applicant: (Please print) Last First MI

Alias: Last First

Driver's License No:

Date of Birth: Sex: ☐ Male ☐ Female

Misc. No. BIL - Agency Billing Number

Height: Weight:

Misc. Number:

Home Address:

Eye Color: Hair Color:

Street No. Street or PO Box

Place of Birth:

City, State and Zip Code

Social Security Number (full):

Your Number: OCA No. (Applicant Social Security No.)

Level of Service: ☒ DOJ ☒ FBI

If resubmission, list Original ATI Number:

Employer: (Additional response for agencies specified by statute)

Employer Name

Street No. Street or PO Box

Mail Code (five digit code assigned by DOJ)

City State Zip Code

( ) Agency Telephone No. (optional)

Live Scan Transaction Completed By: Name of Operator LSID Date

Transmitting Agency ATI No. Amount Collected/Billed

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

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)

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: _____
(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

Jane Bruyninckx
Contact Name (mandatory for all school submissions)

San Dimas CA 91773
City State 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

Child Abuse Mandated Reporter Training

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

To complete the Child Abuse Mandated Reporter Training:

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

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

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

<u>You do not need to print the following pages.</u>

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

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.

BONITA UNIFIED SCHOOL DISTRICT

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

TB MANTOUX (PPD)

A Mantoux Tuberculosis (TB) test is necessary before being hired by Bonita Unified School District. If you have taken at TB Test within the last 4 years, proof of a negative result is all we require. TB TINE tests will not be accepted.

If your TB result is positive, you will need to get a chest x-ray from your medical provider to verify you are free of communicable disease.

If you don't have a medical provider, please contact your local community health center or one of the centers below to make an appointment for a TB test.

EAST VALLEY COMMUNITY HEALTH CENTERS

POMONA

680 FAIRPLEX DRIVE
POMONA, CA 91768

(909) 620-8088
FAX (909) 623-4861

CLINIC APPOINTMENTS
(909) 620-8088 X3100

WEST COVINA

420 SOUTH GLENDORA AVENUE
WEST COVINA, CA 91790

(626) 919-4333
FAX (626) 919-2084

CLINIC APPOINTMENTS
(626) 919-5724 X2110

SUBSTITUTE TEACHER INFORMATION

Substitute teachers are employed on an "on call" basis, depending upon their availability. The names of the approved substitute teachers are placed on a substitute list from which assignments are given. However, placement on this list does not assure employment.

Termination of the substitute teacher list is at the end of June each year. The Human Resource Department will send an offer of re-employment for the following school year during the summer months.

Substitutes are assigned through the Human Resource Department. If you receive an inquiry from a teacher regarding availability, please understand you may be assigned to a particular class at the teacher's request; however, this must be processed through the Personnel Office. Should an emergency prevent a substitute from fulfilling the duty after assignment and acceptance, the Human Resource Department must be notified so that another substitute may be called, phone: 909- 971-8200 ext. 5403.

If the regular teacher's absence has been pre-planned, with approval by the principal, the substitute will be scheduled in advance. However, if the regular teacher's absence is the result of an emergency, the substitute generally will be telephoned the evening before or between 5:30 a.m. – 7:00 a.m. of the day services are required.

Try to arrive at school at least 30 minutes before class begins. Report to the school office where you will be informed about the time sheet, keys and other pertinent information. Learn the correct attendance procedures. Take roll accurately and turn in the required attendance forms.

Lesson plans should be available when you report to the office or in the classroom. In your report to the classroom teacher, please indicate any deviations which were necessary or any noteworthy problems (plans, discipline, etc.) which occurred.

SALARY INFORMATION

Substitute teachers are paid on the 10th of the month for work performed up to the 30th of the preceding month. Checks can be picked up at the District Office after 12:00 p.m. from the receptionist on the 10th (if the 10th falls on a weekend, the checks will be available on the Friday before). Substitute teachers are paid $100 for a full 7.25 hours a day (which includes lunch), $50 for a half day. Substitute teachers are to stay for the full day, if the assignment is over 3.5 hours. Please check with the office if school is out early for whatever reason to see what you can do: correct papers, etc.

Memorandum

BONITA UNIFIED SCHOOL DISTRICT
Human Resources Development

TO: Applicants

FROM: Human Resources Development

RE: Federal Earned Income Tax Credit

Based on your annual earnings, you may be eligible to receive the Earned Income Tax Credit from the federal government. The Earned Income Tax Credit is a refundable federal income tax credit for low-income working individuals and families.

The Earned Income Tax Credit has no effect on certain welfare benefits. In most cases, Earned Income Tax Credit payments will not be used to determine eligibility for Medicaid, supplemental security income, food stamps, low-income housing or most temporary assistance for needy families' payments. Even if you do not owe federal taxes, you must file a tax return to receive the Earned Income Tax Credit.

Be sure to fill out the Earned Income Tax Credit form in the federal income tax return booklet. For information regarding your eligibility to receive the Earned Income Tax Credit, including information on how to obtain the Internal Revenue Service (IRS) Notice 797 or Form W-5 or any other necessary forms and instructions, contact the IRS by calling 1-800-829-3676 or through their website at www.irs.gov.

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.

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

BONITA UNIFIED
School District

Students

HARASSMENT

The Governing Board prohibits sexual harassment of District employees and job applicants. The Board also prohibits retaliatory behavior or action against District employees or other persons, who complain, testify or otherwise participate in the complaint process established pursuant to this policy and the administrative regulation.

The Superintendent or designee shall take all actions necessary to ensure the prevention, investigation and correction of sexual harassment, including but not limited to:

1. Providing periodic training to all staff regarding the District's sexual harassment policy, particularly the procedures for filing complaints and employees' duty to use the District's complaint procedures in order to avoid harm.

2. Publicizing and disseminating the District's sexual harassment policy to staff.

3. Ensuring prompt, thorough and fair investigation of complaints.

4. Taking timely and appropriate corrective/remedial actions after completion of investigation. This may require interim separation of the complainant and the alleged harasser, and subsequent monitoring of developments.

Any District employee or job applicant who feels that he/she has been sexually harassed, or who has knowledge of any incident of sexual harassment by or against another employee, a job applicant or a student, shall immediately contact his/her supervisor, the principal, District administrator or Superintendent to obtain procedures for filing a complaint. Complaints of sexual harassment shall be filed in accordance with AR 4031 – Complaints Concerning Discrimination in Employment.

An employee may bypass his/her supervisor in filing a complaint where the supervisor is the subject of the complaint.

All complaints and allegations of sexual harassment shall be kept confidential to the extent necessary to carry out the investigation or take other subsequent necessary action.

Any District employee who engages or participates in sexual harassment, or who aids, abets, incites, compels or coerces another to commit sexual harassment against a District employee, job applicant or student, is a violation of this policy and is subject to disciplinary action, up to and including dismissal.

Legal Reference:
EDUCATION CODE

Date Adopted: 03/30/93
Date Revised: 09/10/03

200-262.4 Prohibition of discrimination on the basis of sex

GOVERNMENT CODE
12900-12996 Fair Employment and Housing Act

LABOR CODE
1101 Political Activities of Employees
1102.1 Discrimination: sexual orientation

CODE OF REGULATIONS, TITLE 5
4900-4965 Nondiscrimination in elementary and secondary education programs receiving state financial assistance

UNITED STATES CODE, TITLE 42
2000d-2000d-7 Title VI, Civil Rights Act of 1964
2000e-2000e-17 Title VII, Civil Rights Act of 1964 as amended
2000h-2-2000h-6 Title IX, 1972 Education Act Amendments

CODE OF FEDERAL REGULATIONS, TITLE 34
106.9 Dissemination of Policy

COURT DECISIONS
Faragher v. City of Boca Raton, (1998) 118 S.Ct. 2275
Burlington Industries v. Ellreth, (1998) 118 S.Ct. 2257
Gebser v. Lago Vista Independent School District, (1998) 118 S.Ct. 1989
Oncale v. Sundowner Offshore Serv. Inc., (1998) 118 S.Ct. 998
Juarez v. Ameritech Mobile Systems, (N.D. Ill.) 746 F.Supp. 798
Dornhecker v. Malibu Grand Prix Corp., (5th Cir, 1987) 828 F.2d. 307
Meritor Savings Bank, FSB v. Vinson et al., (1986) 447 U.S. 57

Management Resources:

OFFICE OF CIVIL RIGHTS AND NATIONAL ASSOCIATION OF ATTORNEYS GENERAL
Protecting Students from Harassment and Hate Crime, January, 1999

WEB SITES
EEOC: http://www.eeoc.gov
OCR: http://www.ed.gov/offices/OCR

BONITA UNIFIED
School District

Personnel

DRUG AND ALCOHOL-FREE WORKPLACE

The Governing Board believes that the maintenance of a drug and alcohol-free workplace is essential to school and District operations.

No employee shall unlawfully manufacture, distribute, dispense, possess, use or be under the influence of any alcoholic beverage, drug or controlled substance as defined in 21 USC at any school District workplace. These prohibitions apply before, during and after school hours. A school district workplace is any place where school District work is performed, any school-owned or school-approved vehicle used to transport students to and from school or school activities; any off-school sites when accommodating a school-sponsored or school-approved activity or function where students are under District jurisdiction; or during any period of time when an employee is supervising students on behalf of the District or otherwise engaged in District business.

The Superintendent or designee shall notify employees of these prohibitions. (Government Code 8355; 41 USC 702)

An employee shall abide by the terms of this policy and notify the District, within five days, of any criminal drug or alcohol statute conviction, which he/she receives for a violation occurring in the workplace. (41 USC 701)

The Superintendent or designee shall notify the appropriate federal granting or contracting agencies within 10 days after receiving notification, from an employee or otherwise, of any conviction for a violation occurring in the workplace. (41 USC 701)

The Board shall not employ or retain in employment persons convicted of as controlled substance offense as defined in Education Code 44011. If any such conviction is reversed and the person acquitted in a new trial or the charges dismissed, his/her employment is no longer prohibited. A plea or verdict of guilty, a finding of guilt by a court in a trial without a jury, or a conviction following a plea of nolo contendere shall be deemed to be a conviction. (Education Code 44836, 45123)

The Board may take appropriate disciplinary action, up to and including termination, or require the employee to satisfactorily participate in and complete a drug assistance or rehabilitation program approved by a federal, state or local health, law enforcement or other appropriate agency.

The Superintendent or designee shall establish a drug and alcohol-free awareness program to inform employees about: (Government Code 8355)

1. The dangers of drug and alcohol abuse in the workplace
2. The District policy of maintaining drug and alcohol-free workplaces

3. Any available drug and alcohol counseling, rehabilitation, and employee assistance programs
4. The penalties that may be imposed on employees for drug and alcohol abuse violations

Legal Reference:

EDUCATION CODE	
44011	Controlled substance offense
44425	Conviction of controlled substance offenses as grounds for revocation of credential
44836	Employment of certificated persons convicted of controlled substance offenses
44940	Compulsory leave of absence for certificated persons
44940.5	Procedures when employees are placed on compulsory leave of absence
45123	Employment of classified employee after conviction of controlled substance offense
45304	Compulsory leave of absence for classified persons
GOVERNMENT CODE	
8350-8357.1	Drug-free workplace
UNITED STATES CODE, TITLE 20	
7111-7117.1	Safe and Drug Free Schools and Communities Act
UNITED STATES CODE, TITLE 21	
812	Schedule of controlled substances
CODE OF FEDERAL REGULATIONS, TITLE 21	
1308.01-1308.49	Schedule of controlled substances

BONITA UNIFIED
School District

Personnel

EMPLOYEE USE OF TECHNOLOGY

The Governing Board recognizes that technological resources can enhance employee performance by improving access to and exchange of information, offering effective tools to assist in providing a quality instructional program, and facilitating District and school operations. The Board expects all employees to learn to use the available technological resources that will assist them in the performance of their job responsibilities. As needed, employees shall receive training in the appropriate use of these resources.

Employees shall be responsible for the appropriate use of technology and shall use the District's technological resources only for purposes related to their employment. Such use is a privilege which may be revoked at any time.

Employees should be aware that computer files and communications over electronic networks, including e-mail and voice mail, are not private. These technologies shall not be used to transmit confidential information about students, employees or District operations without authority.

The Superintendent or designee shall ensure that all District computers with internet access have a technology protection measure that prevents access to visual depictions that are obscene or child pornography, and that the operation of such measures is enforced. The Superintendent or designee may disable the technology protection measure during use by an adult to enable access for bona fide research or other lawful purpose (20 USC 7001; 47 USC 254).

To ensure proper use of the system, the Superintendent or designee may monitor the District's technological resources, including e-mail and voice mail systems, at any time without advance notice or consent. If passwords are used, they must be known to the Superintendent or designee so that he/she may have system access.

The Superintendent or designee shall establish administrative regulations which outline employee obligations and responsibilities related to the use of District technology. He/she also may establish guidelines and limits on the use of technological resources. The Superintendent may grant exceptions to these guidelines and limits on an individual basis. Inappropriate use shall result in a cancellation of the employee's user privileges, disciplinary action and/or legal action in accordance with law, Board policy and administrative regulations.

The Superintendent or designee shall provide copies of related policies, regulations and guidelines to all employees who use the District's technological resources. Employees shall be asked to acknowledge in writing that they have read and understood these policies, regulations and guidelines.

In the event that the use of an electronic resource affects the working conditions of one or more employees, the Superintendent or designee shall notify the employee's exclusive representative, if applicable.

BONITA UNIFIED
School District

Personnel

Legal Reference:

EDUCATION CODE

51870-51874	Education technology

GOVERNMENT CODE

3543.1	Rights of employee organizations

PENAL CODE

502	Computer crimes, remedies
632	Eavesdropping on or recording confidential communications

UNITED STATES CODE, TITLE 20

6801-6979	Technology for Education Act
7001	Internet safety policy and technology protection measures, Title III funds

UNITED STATED CODE, TITLE 47

254	Universal service discounts (E-rate)

CODE OF FEDERAL REGULATIONS, TITLE 47

54520	Internet safety policy and technology protection measures, E-rate discounts

Management Resources:

CDE PUBLICATIONS

K-12 Network Technology Planning Guide: Building the Future, 1994

CDE PROGRAM ADVISORIES

1223.94	Acceptable Use of Electronic Information Resources

WEB SITES

CDE: http://www.cde.ca.gov
CSBA: http://www.csba.org
Federal Communications Commission: http://www.fcc.gov
U.S. Department of Education: http://www.ed.gov
American Library Association: http://www.ala.org

Date Adopted: 07/17/04
Date Revised:

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

Access to Medical Care

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.

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: _____

Employee Signature: _____ Date _____

Note to Employee: Unless you agree in writing, neither your employer or York 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 York 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).

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. York 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 York 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.

_____
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: _____

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, X5201

_____

Information & Assistance Office: _____

_____

_____

Employer MUST complete this information

YORK™

The Facts About Workers' Compensation

For dates of injury on or after January 1, 2013

York Risk Services Group, Inc.
P.O. Box 619079
Roseville, CA 95661
Phone (866) 221-2402
Fax (866) 548-2637

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. York Risk Services Group (York) is your employer's claims administrator. Your employer or York 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 York 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 York 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 York. York 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 York 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 York Risk Services Group.

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, York 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 York 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 York. 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 they vary by injury date. If you are entitled to PD, York 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, York 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.

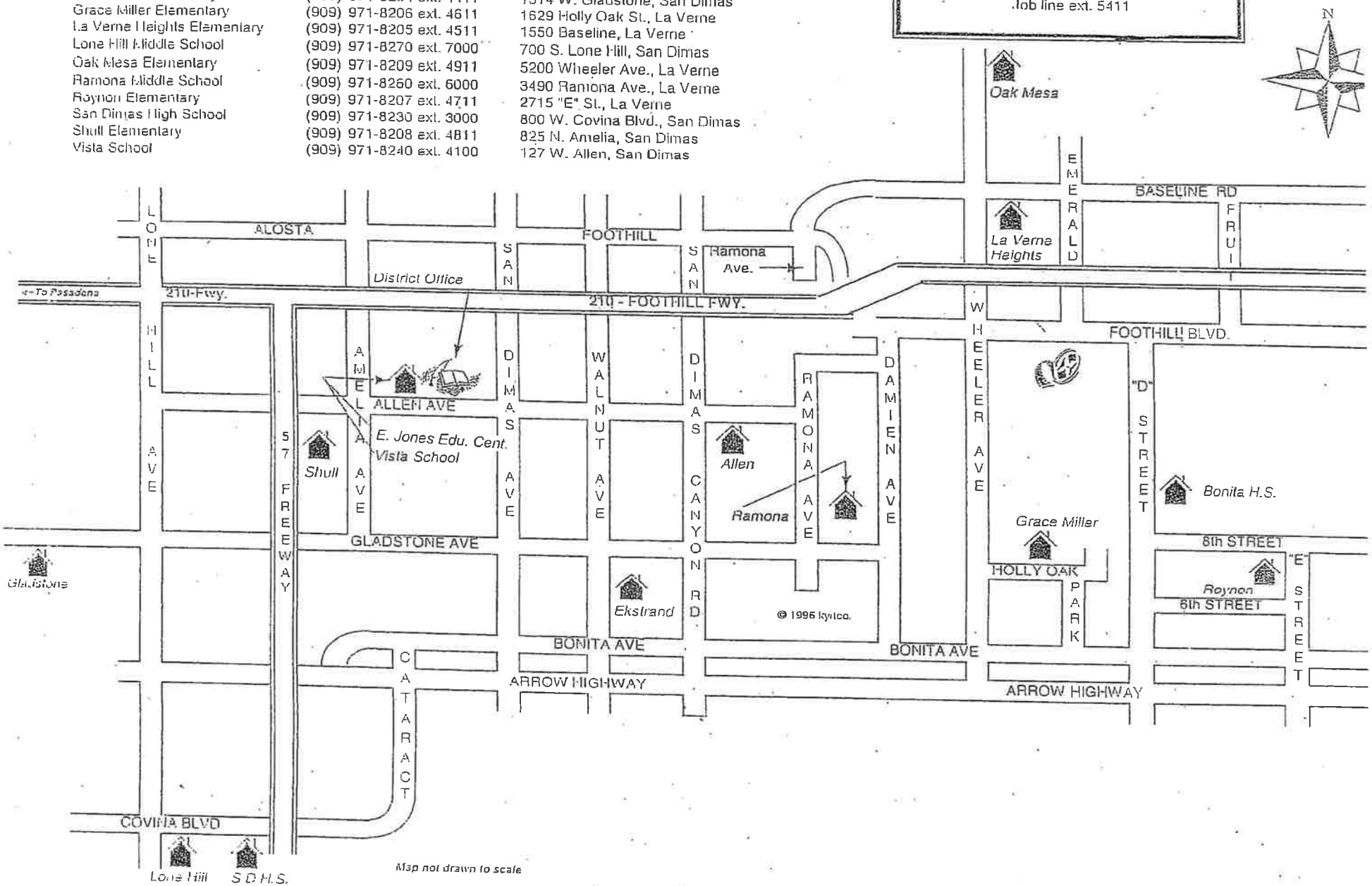
If You Still Have Questions...ask your supervisor or employer representative. Or contact York at the number indicated on workers' compensation posters at work and on this brochure. You can also contact the State Division of Workers' Compensation (DWC) and speak with an Information and Assistance Officer. 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.

Allen Avenue Elementary	(909) 971-8202 ext. 4211	740 Allen Ave., San Dimas
Bonita High School	(909) 971-8220 ext. 6500	3102 "D" St., La Verne
Ed Jones Edu. Center	(909) 971-8240 ext. 4000	121 W. Allen Ave., San Dimas
Ekstrand Elementary	(909) 971-8203 ext. 4311	400 Walnut Ave., San Dimas
Gladstone Elementary	(909) 971-8204 ext. 4411	1314 W. Gladstone, San Dimas
Grace Miller Elementary	(909) 971-8206 ext. 4611	1629 Holly Oak St., La Verne
La Verne Heights Elementary	(909) 971-8205 ext. 4511	1550 Baseline, La Verne
Lone Hill Middle School	(909) 971-8270 ext. 7000	700 S. Lone Hill, San Dimas
Oak Mesa Elementary	(909) 971-8209 ext. 4911	5200 Wheeler Ave., La Verne
Ramona Middle School	(909) 971-8260 ext. 6000	3490 Ramona Ave., La Verne
Roynon Elementary	(909) 971-8207 ext. 4711	2715 "E" St., La Verne
San Dimas High School	(909) 971-8230 ext. 3000	800 W. Covina Blvd., San Dimas
Shull Elementary	(909) 971-8208 ext. 4811	825 N. Amelia, San Dimas
Vista School	(909) 971-8240 ext. 4100	127 W. Allen, San Dimas

Bonita Unified School District
115 W. Allen Avenue
San Dimas, California 91773
(909) 971-8200
Job line ext. 5411



Map not drawn to scale