



**SFUSD**

**SAN FRANCISCO  
PUBLIC SCHOOLS**

**NEW HIRE PERSONNEL PACKET**

**2013-2014**

**Forms to Complete and Return to SFUSD  
Recruitment Unit**



### **New Hire Packet Contents**

Welcome to San Francisco Unified School District! We are pleased that you have chosen to join our professional learning community.

In order to complete you're hiring please read, complete, and return the following documents to Human Resources. Should you have any questions, please direct them to Human Resources staff when you meet with them to complete your hiring.

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SALARY DEPARTMENT In order to place you on the appropriate salary step, we will need verification of your previous work experience and verification of units earned during your coursework. If you have previously worked in other school districts, please have the Verification of Previous Experience Form signed by your previous employer(s) and then submit to the salary office. Additionally, we will need copies of official transcripts to verify academic units earned.

Please Note: It is the employees' responsibility to provide all required forms and transcripts related to salary step increases.

**Personal Information**

Employee: \_\_\_\_\_

SS#: \_\_\_\_\_  
(Last) (First) (MI)

DOB: \_\_\_\_\_ Marital Status: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: \_\_\_\_\_

Email: \_\_\_\_\_

**Federal Law requires that you must answer both questions about Ethnicity and Race:**

**ETHNICITY: Mark the ethnicity that closely identifies you. Please check one:**

- Hispanic /Latino (A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race)
- Not Hispanic or Latino

**RACE:** (Please check up to five racial categories only). Circle the primary race. The above part of the question is about ethnicity, not race. No matter what you selected above, please continue to answer the following by marking one or more boxes to indicate what you consider your race to be:

- |   |  |
|---|--|
| <input type="checkbox"/> American Indian or Alaskan Native (100)<br>(Person having origins in any of the original people of North and South America (including Central America) | <input type="checkbox"/> Samoan (303)  |
| <input type="checkbox"/> Chinese (201)  | <input type="checkbox"/> Tahitian (304)  |
| <input type="checkbox"/> Cambodian (207)  | <input type="checkbox"/> Other Pacific Islander (399)  |
| <input type="checkbox"/> Hmong (208)  | <input type="checkbox"/> Filipino  |
| <input type="checkbox"/> Other Asian (209)  | <input type="checkbox"/> African American or Black (600)   |
| <input type="checkbox"/> Hawaiian (301)   | <input type="checkbox"/> White (700)<br>(Persons having origins in any of the original peoples of Europe, North Africa or Middle East) |
| <input type="checkbox"/> Guamanian (302)  | <input type="checkbox"/> Two or more races   |

**Please complete, sign and return to Human Resources.**



**Emergency Contact Information**

Name/Relationship: \_\_\_\_\_

Home Telephone: \_\_\_\_\_

Business/Other: \_\_\_\_\_

Name/Relationship: \_\_\_\_\_

Home Telephone: \_\_\_\_\_

Business/Other: \_\_\_\_\_

**Please complete, sign and return to Human Resources.**

### **Tobacco and Drug-Free Workplace Notice**

It is unlawful to manufacture, distribute, dispense, possess, or use a controlled substance in the workplace. Any employee violating this prohibition shall be subject to discipline up to and including termination of employment and/or will be required to complete a drug abuse assistance or rehabilitation program.

Each employee engaged in activities funded by Federal grant must notify the department head of any criminal drug state conviction for a violation occurring in the workplace no later than five days after such conviction.

As a prospective employee of the San Francisco Unified School District, you are mandated to comply with the drug abuse-reporting requirement as stated above.

Please print:

I, \_\_\_\_\_ have read and understood the  
*(First Name) (MI) (Last Name)*

requirements of the Drug Free Workplace Notice as outlined above and will comply with these provisions.

Signature \_\_\_\_\_

Date \_\_\_\_\_

**Please complete, sign and return to Human Resources.**

**Statement Acknowledging Requirements To Report Suspected Child Abuse**

The California Penal Code prohibits sexual molestation, sexual assault, the infliction of cruel or inhumane corporal punishment, and unjustifiable physical pain or mental suffering on a child. In addition, the Penal Code prohibits allowing or causing a child to be placed in a situation that endangers a child's health or person.

Section 11166 of the Penal Code requires any child care custodian, health practitioner, or employee of a child protective agency who has knowledge of or observes a child in his or her professional capacity or within the scope of his or her employment whom he or she knows or reasonably suspects has been the victim of child abuse report the known or suspected instance of child abuse to a child protective agency. The report must be sent to the child protective agency within 36 hours of receiving the information concerning the incident.

"Child Care Custodian" includes all persons who interact directly on a regular basis with pupils, including teachers, administrators, pupil service employees, paraprofessionals and volunteers. "Health practitioner" includes nurses, physicians, psychologists, and family and child counselors.

As a prospective employee of the San Francisco Unified School District, your employment position falls within the definition of Section 11166 of the California Penal Code. Therefore, you are mandated to comply with the child abuse reporting requirement as stated above.

I, \_\_\_\_\_ have read and understood the  
(First Name) (MI) (Last Name)

requirements of the Section 11166 of the California Penal Code as outlined above and will comply with those provisions.

Signature \_\_\_\_\_

Date \_\_\_\_\_

**Please complete, sign and return to Human Resources.**

### Infectious Diseases Information Form

This form disseminates information about precautions to prevent the spread of infectious diseases at school. In the school setting, it is not possible to know who may be a carrier of an infectious disease and what germs may be present. Persons with infections do not always have **outward signs** and often are not themselves aware of being infected. However, you can take **Universal Precautions** while you are at the school and in other situations that will help protect you from **ALL** infectious diseases. *Universal Precautions* include the actions below:

1. Wash your hands with soap and running water at regular times during your workday. Common infectious diseases (excluding HIV infection, AIDS and Hepatitis B) may be contracted from dirt and waste encountered in the workplace.
2. Avoid punctures with objects that may contain the blood of others.
3. Handle discharges from another person's body (particularly body fluids containing blood) with gloves and wash hands thoroughly with soap and running water when you are finished.
4. Carefully dispose of trash that contains body wastes and sharp objects. Use special container with plastic liners for disposal of refuse that contains blood or for any body spills that may contain blood. For disposal of sharp objects, use containers that cannot be broken or penetrated. **DO NOT BEND, BREAK OR RECAP NEEDLES.**
5. Promptly remove another person's blood and body wastes from your skin by washing with soap and running water.
6. Clean surfaces that have blood or body wastes containing blood on them with an Environmental Protection Agency (EPA) approved disinfectant or a 1:10 solution of household bleach and water. (The solution should be prepared fresh daily to ensure proper strength.)
7. Have a vaccination for protection from Hepatitis B if you are in contact with developmentally delayed students. The cost of having a vaccination series may be covered by your employee health insurance benefits. If you have any questions, call the School Health Program at 242-2615.
8. If you are responsible for administering First Aid to others or may be placed in a position where you may give First Aid, obtain a current instruction in First Aid and CPR. Current instruction will include modification of First Aid needed to protect the rescuer from infection.

*Universal Precautions will protect you from HIV infections, Hepatitis B, and many other infectious diseases. You do not need to know which people around you are infected with HIV or any other diseases they may be carrying because you are always prepared. Taking Universal Precautions will result in fewer illnesses for you and others around you.*

**MAINTAIN CONFIDENTIALITY** of all medical information concerning students and co-workers, especially if they individual has either HIV infection or AIDS. Disclosure without permission is prohibited by law and is punishable by a fine in California.

**PRECAUTIONS YOU CAN TAKE TO PROTECT YOURSELF FROM HIV INFECTION AND HEPATITIS B IN NON-WORKING SECTIONS.**

HIV infection and Hepatitis B are most commonly spread through sexual intercourse and by sharing needles with others to inject drugs. By abstaining from these activities, the major risk of exposure to these viruses is eliminated Sexual intercourse is safe if both partners are uninfected and mutually monogamous. The proper use of condoms with water-based lubricants containing spermicide can greatly reduce the risk of exposure to HIV infection and Hepatitis B from a partner who is infected. If needles are shared to inject drugs, cleaning all equipment with household bleach and rinsing with running water can reduce the risk of infection.

I have read and understand the above information.

Name: \_\_\_\_\_

*(First Name)*

*(MI)*

*(Last Name)*

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**Please complete, sign and return to Human Resources.**



### Disaster Service Worker Notice

Government Code Section 3100 et. seq. designates all public employees as “**Disaster Service Workers.**” The term “public employees” includes all persons employed by the state or any county, city, city and county, state agency or public district, excluding aliens legally employed. As an employee of the San Francisco Unified School District you are, therefore, designated as a **Disaster Service Worker.**

The purpose of this memo is to explain what it means to be a **Disaster Service Worker.** Simply put, being a **Disaster Service Worker** means that at any time during a catastrophic event – natural or manmade – which places life or property in jeopardy, you could be assigned to any disaster service activity that promotes the protection of public health and safety.

Your assignment might require you to serve at a location, at times and/or under conditions that significantly differ from your normal work assignment. As a **Disaster Service Worker** you have an obligation to serve the public in a time of need in whatever role you are directed to perform by a superior or by law.

Upon the declaration of an emergency during working hours, most employees will be assigned to their usual supervisors and will take directions from those persons. The exceptions will be those individuals who have been requested to perform special duties as members of the Emergency Response Teams, described in their Site Plan. All employees will be expected to remain at work until released. Your supervisor will be speaking to you, if he/she has not already, regarding a Personnel Release Schedule, which will help identify who on your staff may need, if possible, to be released at the first opportunity.

If an emergency occurs during non-working hours, or continues after employees have been instructed to go home during working hours, employees are not relieved of their obligations as legally designated **Disaster Services Workers.**

At the direction of the SFUSD Emergency Operating Center (EOC) Director as designated by the Superintendent, and, in some cases emergency services officials, employees may be required to perform disaster-related tasks at other school sites near to their homes, or in the community. Please monitor the Emergency Broadcast System and news stations during events. SFUSD Public Engagement and Information will be working to get information to you through that system. Radio stations to monitor include KALW – FM 91.7, KGO - AM 810, KCBS – AM 740, KRQR – FM 97.3, AND KNBR – AM 680.

It is impossible to specify, in advance of an actual disaster, the exact tasks that could be required of an employee as a disaster services worker. The nature, severity, and outcome of a possible disaster are too variable to allow prediction of the exact tasks that an employee could be asked to perform. However, all employees can be assured that the tasks required would be within reason and their ability to perform, and that their safety and well-being, as they fulfill their obligations, would be paramount.

I verify that I have read and understood the above notice.

_____	_____
Signature	Date
_____	_____
Name (please print)	Job Title



**Technology Acceptable Use and Security Policy**

**PLEASE SIGN BELOW IF YOU AGREE TO THE FOLLOWING STATEMENTS:**

- I have read, understand, and agree to the SFUSD Acceptable Use Policy. I agree to follow all of the rules contained in this 10 paged document. I understand that if I violate the rules, my account can be terminated, my access to computers revoked, and I may face disciplinary measures up to and including termination.
- I understand that internet sites are filtered and that my District email accounts and internet use, as well as any other uses of the system or files on the system, may be monitored by the District as described above.
- I hereby release the SFUSD, its personnel and any institutions with which it is affiliated, from any and all claims and damages of any nature arising from my use of, or inability to use, the SFUSD’s network and computer systems, including but not limited to claims that may arise from the unauthorized use of the system.

**Staff working with students:**

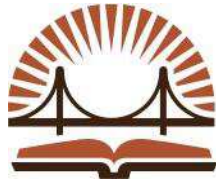
- I agree to enforce the Acceptable Use Policy with students under my supervision.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Printed Name: \_\_\_\_\_ Emplid: \_\_\_\_\_

Current (Anticipated) Work Location \_\_\_\_\_

**Please complete, sign and return to Human Resources.**



### WHAT IS WORKERS' COMPENSATION?

If you get hurt on the job, your employer is required by law to pay for workers' compensation benefits. You could get hurt by:

One event at work. Examples: hurting your back in a fall, getting burned by a chemical that splashes on your skin, getting hurt in a car accident while making deliveries.

—or—

Repeated exposures at work. Examples: hurting your wrist from using vibrating tools, losing your hearing because of constant loud noise.

—or—

Workplace crime. Examples: you get hurt in a store robbery, physically attacked by an unhappy customer.

### Discrimination is illegal

It is illegal under Labor Code section 132a for your employer to punish or fire you because you:

- File a workers' compensation claim
- Intend to file a workers' compensation claim
- Settle a workers' compensation claim
- Testify or intend to testify for another injured worker.

If it is found that your employer discriminated against you, he or she may be ordered to return you to your job. Your employer may also be made to pay for lost wages, increased workers' compensation benefits, and costs and expenses set by state law.

### WHAT ARE THE BENEFITS?

- **Medical care:** Paid for by your employer to help you recover from an injury or illness caused by work. Doctor visits, hospital services, physical therapy, lab tests and x-rays are some of the medical services that may be provided. These services should be necessary to treat your injury. There are limits on some services such as physical and occupational therapy and chiropractic care.
- **Temporary disability benefits:** Payments if you lose wages because your injury prevents you from doing your usual job while recovering. The amount you may get is up to two-thirds of your wages. There are minimum and maximum payment limits set by state law. You will be paid every two weeks if you are eligible. For most injuries, payments may not exceed 104 weeks

within five years from your date of injury. Temporary disability (TD) stops when you return to work, or when the doctor releases you for work, or says your injury has improved as much as it's going to.

- **Permanent disability benefits:** Payments if you don't recover completely. You will be paid every two weeks if you are eligible. There are minimum and maximum weekly payment rates established by state law. The amount of payment is based on:
  - Your doctor's medical reports
  - Your age
  - Your occupation
  
- **Supplemental job displacement benefits:** This is a voucher for up to \$6,000 that you can use for retraining or skill enhancement at an approved school, books, tools, licenses or certification fees, or other resources to help you find a new job. You are eligible for this voucher if:
  - You have a permanent disability.
  - Your employer does not offer regular, modified, or alternative work, within 60 days after the claims administrator receives a doctor's report saying you have made a maximum medical recovery.
  
- **Death benefits:** Payments to your spouse, children or other dependents if you die from a job injury or illness. The amount of payment is based on the number of dependents. The benefit is paid every two weeks at a rate of at least \$224 per week. In addition, workers' compensation provides a burial allowance.

### **OTHER BENEFITS**

You may file a claim with the Employment Development Department (EDD) to get state disability benefits when workers' compensation benefits are delayed, denied, or have ended. There are time restrictions so for more information contact the local office of EDD or go to their web site [www.edd.ca.gov](http://www.edd.ca.gov).

If your injury results in a permanent disability (PD) and the state determines that your PD benefit is disproportionately low compared to your earning loss, you may qualify for additional money from the Department of Industrial Relation's special earnings loss supplement program also known as the return to work program. If you have questions or think you qualify, contact the Information & Assistance Unit by going to [www.dwc.ca.gov](http://www.dwc.ca.gov) and looking under "Workers' Compensation programs and units" for the "Information & Assistance Unit" link or visit the DIR web site at [www.dir.ca.gov](http://www.dir.ca.gov).

Any person who makes or causes to be made any knowingly false statement in order to obtain or deny workers' compensation benefits or payments is guilty of a felony. If convicted, the person will have to pay fines up to \$150,000 and/or serve up to five years in jail.

### WHAT SHOULD I DO IF I HAVE AN INJURY?

#### **Report your injury to your employer**

Tell your supervisor right away no matter how slight the injury may be. Don't delay – there are time limits. You could lose your right to benefits if your employer does not learn of your injury within 30 days. If your injury or illness is one that develops over time, report it as soon as you learn it was caused by your job.

If you cannot report to the employer or don't hear from the claims administrator after you have reported your injury, contact the claims administrator yourself.

**Tristar Risk Management**  
**PO Box 2805**  
**Clinton, IA 52733**  
**(925) 349-7626**

You may be able to find the name of your employer's workers' compensation insurer at [www.caworkcompcoverage.com](http://www.caworkcompcoverage.com). If no coverage exists or coverage has expired, contact the Division of Labor Standards Enforcement at [www.dir.ca.gov/DLSE](http://www.dir.ca.gov/DLSE) as all employees must be covered by law.

#### **Get emergency treatment if needed**

If it's a medical emergency, go to an emergency room right away. Tell the medical provider who treats you that your injury is job related. Your employer may tell you where to go for follow up treatment.

**Emergency telephone number:** Call 911 for an ambulance, fire department or police. For non-emergency medical care, contact your employer, the workers' compensation claims administrator or go to this facility:

**St. Francis Memorial Hospital**  
**1199 Bush Street**  
**San Francisco, CA 94109**

#### **Fill out DWC 1 claim form and give it to your employer**

Your employer must give you a [DWC 1 claim form](#) within one working day after learning about your injury or illness. Complete the employee portion, sign and give it back to your employer. Your employer will then file your claim with the claims administrator. Your employer must authorize treatment within one working day of receiving the DWC 1 claim form.

If the injury is from repeated exposures, you have one year from when you realized your injury was job related to file a claim.

In either case, you may receive up to \$10,000 in employer-paid medical care until your claim is either accepted or denied. The claims administrator has up to 90 days to decide whether to accept or deny your claim. Otherwise your case is presumed payable.

Your employer or the claims administrator will send you “benefit notices” that will advise you of the status of your claim.

## **MORE ABOUT MEDICAL CARE**

### **What is a Primary Treating Physician (PTP)?**

This is the doctor with overall responsibility for treating your injury or illness. He or she may be:

- The doctor you name in writing *before* you get hurt on the job
- A doctor from the medical provider network (MPN)
- The doctor chosen by your employer during the first 30 days of injury if your employer does not have an MPN or
- The doctor you chose after the first 30 days if your employer does not have an MPN.

### **What is a Medical Provider Network (MPN)?**

An MPN is a select group of health care providers who treat injured workers. Check with your employer to see if they are using an MPN.

If you have not named a doctor before you get hurt and your employer is using an MPN, you will see an MPN doctor. After your first visit, you are free to choose another doctor from the MPN list.

### **What is Predesignation?**

Predesignation is when you name your regular doctor to treat you if you get hurt on the job. The doctor must be a medical doctor (M.D.), doctor of osteopathic medicine (D.O.) or a medical group with an M.D. or D.O. You must name your doctor in writing *before* you get hurt or become ill.

You may predesignate a doctor if you have health care coverage for non-work injuries and illnesses. The doctor must have:

- Treated you
- Maintained your medical history and records before your injury and
- Agreed to treat you for a work-related injury or illness before you get hurt or become ill.

You may use the “predesignation of personal physician” form included with this pamphlet. After you fill in the form, be sure to give it to your employer.

If your employer does not have an approved MPN, you may name your chiropractor or acupuncturist to treat you for work related injuries. The notice of personal chiropractor or acupuncturist must be in writing *before* you get hurt. You may use the form included in this pamphlet. After you fill in the form,

be sure to give it to your employer. State law does not allow a chiropractor to continue as your treating physician after 24 visits.

#### **WHAT IF THERE IS A PROBLEM?**

If you have a concern, speak up. Talk to your employer or the claims administrator handling your claim and try to solve the problem. If this doesn't work, get help by trying the following:

**Contact the Division of Workers' Compensation (DWC) Information and Assistance (I&A) Unit**  
All 24 DWC offices throughout the state provide information and assistance on rights, benefits and obligations under California's workers' compensation laws. I&A officers help resolve disputes without formal proceedings. Their goal is to get you full and timely benefits. Their services are free.

To contact the nearest I&A Unit, go to [www.dwc.ca.gov](http://www.dwc.ca.gov) and under "Workers' Compensation programs and units", click on "Information & Assistance Unit." At this site you will find fact sheets, guides and information to help you.

The nearest I&A Unit is located at:

**455 Golden Gate Avenue  
San Francisco, CA 94102-7014  
(415) 713-5020**

**Consult with an attorney**

Most attorneys offer one free consultation. If you decide to hire an attorney, his or her fees may be taken out of some of your benefits. For names of workers' compensation attorneys, call the State Bar of California at (415) 538-2120 or go to their website at [www.californiaspecialist.org](http://www.californiaspecialist.org). You may get a list of attorneys from your local I&A Unit or look in the yellow pages.

#### Warning

Your employer may not pay workers' compensation benefits if you get hurt in a voluntary off-duty recreational, social or athletic activity that is not part of your work-related duties.

#### Additional rights

You may also have other rights under the Americans with Disabilities Act (ADA) or the Fair Employment and Housing Act (FEHA). For additional information, contact FEHA at (800) 884-1684 or the Equal Employment Opportunity Commission (EEOC) at (800) 669-4000.

The information contained in this pamphlet conforms to the informational requirements found in Labor Code sections 3551 and 3553 and California Code of Regulation, Title 8, sections 9880 and 9883. This document is approved by the Division of Workers' Compensation administrative director.

*Revised 12/20/12 and effective for dates of injuries on or after 1/1/13.*



## **PREDESIGNATION OF PERSONAL PHYSICIAN**

In the event you sustain an injury or illness related to your employment, you may be treated for such injury or illness by your personal medical doctor (M.D.), doctor of osteopathic medicine (D.O.) or medical group if:

- you have group health coverage;
- 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 or illness, and (2) your personal doctor's name and business address.

You may use this form to notify your employer if you wish to have your personal medical doctor or a doctor of osteopathic medicine treat you for a work-related injury or illness and the above requirements are met.



### **San Francisco Unified School District**

Human Resources Department

Employee Support Services

555 Franklin Street, Room 204 – San Francisco, CA 94102

(415) 241-6101, ext. 7 – FAX (415) 241-6375

[www.sfusd.edu](http://www.sfusd.edu)

**ACKNOWLEDGEMENT OF RECEIPT OF  
EMPLOYEE’S PRE-DESIGNATION OF  
PERSONAL PHYSICIAN FORM**

This is to acknowledge that the San Francisco Unified School District has given me a copy of the “Employee’s Pre-Designation of Personal Physician Form” that allows me to choose my own personal physician if I sustain a work-related injury and that I cannot designate a Chiropractor. I understand that this physician must have treated me previously and maintains my medical records.

I also understand that if I do not complete this form prior to sustaining a work-related injury, I am required to obtain medical treatment from a facility that has been approved by the district.

I also acknowledge that this form is not complete until my personal physician has signed the form, acknowledging that he/she agrees to accept and follow the Labor Code laws of the State of California and the Administrative Rules & Regulations as they relate to providing medical treatment for work-related injuries, and this form is returned to the District office.

---

*Print Employee’s Name*

---

*Date of Hire*

---

*Employee’s Signature*

---

*Date*

## NOTICE OF PERSONAL CHIROPRACTOR OR PERSONAL ACUPUNCTURIST

If your employer or your employer's insurer does not have a Medical Provider Network, you may be able to change your treating physician to your personal chiropractor or acupuncturist following a work-related injury or illness. In order to be eligible to make this change, you must give your employer the name and business address of a personal chiropractor or acupuncturist in writing prior to the injury or illness. Your claims administrator generally has the right to select your treating physician within the first 30 days after your employer knows of your injury or illness. After your claims administrator has initiated your treatment with another doctor during this period, you may then, upon request, have your treatment transferred to your personal chiropractor or acupuncturist.

You may use this form to notify your employer of your personal chiropractor or acupuncturist.

State law does not allow a chiropractor to continue as your treating physician after 24 visits.

### **Your Chiropractor or Acupuncturist's Information:**

---

**(name of chiropractor or acupuncturist)**

---

**(street address, city, state, zip code)**

---

**(telephone number)**

Employee Name **(please print)**:

---

Employee's address:

---

Employee's  
Signature \_\_\_\_\_

Date: \_\_\_\_\_







# San Francisco Unified School District

## Teacher Support Entry Information Form

Intern/ PAR NT Program/BTSA/Induction Program  
C & I 750 25<sup>th</sup> Ave SF, CA 94121



**Name:** \_\_\_\_\_ **Hire Date:** \_\_\_\_\_

**School:** \_\_\_\_\_ **Grade level/Subject:** \_\_\_\_\_

**Home Address:** \_\_\_\_\_ **Best Phone to Call:** \_\_\_\_\_

**Email Address:** \_\_\_\_\_

**SFUSD employment status as of date of hire:**

<input type="checkbox"/> Full time	<input type="checkbox"/> Part time	<input type="checkbox"/> Temporary	<input type="checkbox"/> Other: _____
------------------------------------	------------------------------------	------------------------------------	---------------------------------------

Colleges: Undergraduate	Credential Program	Other Post Graduate Work

**Credential Information (check all that apply):**

<input type="checkbox"/> Prelim Multiple Subject _____ <div style="text-align: right; font-size: small;">Date Awarded</div> <input type="checkbox"/> Prelim Single Subject(s) _____ <div style="text-align: right; font-size: small;">Subject/Date Awarded</div> <input type="checkbox"/> Clear Multiple Subject _____ <div style="text-align: right; font-size: small;">Date Awarded</div> <input type="checkbox"/> Clear Single Subject(s) _____ <div style="text-align: right; font-size: small;">Subject/Date Awarded</div> <input type="checkbox"/> Out of State Credential _____ <div style="text-align: right; font-size: small;">State/Subject/ Date Awarded</div> <input type="checkbox"/> Completed Intern, Alt. Certification program <div style="display: flex; justify-content: space-between; font-size: small; margin-top: 5px;"> <span>_____ District/Dates Interned</span> <span>_____ University</span> </div> <input type="checkbox"/> SFUSD UTR Graduate	<input type="checkbox"/> Special Ed. Level 1 <input type="checkbox"/> Special Ed. Prelim <input type="checkbox"/> Special Ed. Level 2 <input type="checkbox"/> Special Ed. Clear <div style="text-align: right; font-size: small;">Date Awarded _____</div> Sp Ed Type: _____ <div style="text-align: right; font-size: small;">Date Awarded _____</div> Authorizations: _____ <input type="checkbox"/> Intern, Alternative Certification Program Year 1 _____ Year 2 _____ other _____ University: _____ <input type="checkbox"/> Provisional Permit Year 1 _____ Year 2 _____ <input type="checkbox"/> Short-Term Staff Permit University selected: _____ <input type="checkbox"/> Substitute Permit – Type _____ <input type="checkbox"/> Program Waiver – Type _____
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**Previous Teaching Experience (Excluding student teaching experience):**

School Name	District	Grade/Subject	Dates

**Indicate New Teacher, BTSA or Induction Programs you have completed:**