Welcome from the Office of Human Resources!

New Hire Forms for Administrative Employees

As a condition of employment, applicants are required to submit the following documents and information as soon as possible to the hiring administrator or respective hiring department in order to meet Board deadlines and confirm start date.

1. Personnel Action Form (PAF) – *to be completed by the Hiring Administrator only*
2. Oath of Allegiance - Please have the Administrator who is involved in your hiring, or designee, administer the Oath or Affirmation of Allegiance. (See Board Policy 2230)
3. Tuberculosis Certificate Information Form – Please complete form and attach a copy of a current tuberculosis certificate, no older than four (4) years.
4. W-4 Form - Employee's Withholding Allowance Certificate – If your State withholding allowances will be different, please complete a State Tax Withholding form.
5. Personal Information Form - This information is used in preparing state and federal mandatory reports. The form will remain in a confidential Payroll file.
6. Confidential Personal Information Form - This information is used in preparing mandatory state and federal statistical reports. The form will remain confidential in the Office of Human Resources.
7. Salary Warrant Delivery Request - Please check the method you would prefer to receive your monthly salary warrant.
8. Direct Deposit Form
9. Fingerprint Live Scan Form – Complete live scan form and read State of California instructions. Return copy to the Office of Human Resources. If you are out of state, please contact noted Human Resources person below.
10. Department of Homeland Security's Employment Eligibility Verification (I-9) Form – Complete the linked form with Hiring Administrator or designee showing original identification for proof of eligibility to work in the United States.
11. Request for Sick Leave Transfer
12. CALSTRS Retirement System Election
13. CalPERS Member Reciprocal Self-Certification Form

When the Office of Human Resources receives the completed application packet, they will process for Board of Trustees approval and confirm start date with hiring administrator or designee.

The following notices are being provided to you as mandated by State and/or Federal law. Please retain for reference:

- Federal Privacy Act Information
- Equal Opportunity Compliance Notice
- Sexual Harassment Policy
- Family Leave Act
- Chabot-Las Positas Community College District Retirement Savings Plans
- Statement Concerning Your Employment in a Job Not Covered by Social Security (Academic Administrators only)
- Health Reimbursement Account (HRA)
- New Health Insurance Marketplace Coverage Options and Your Health Coverage
- Workers' Compensation Information for New Hires

If you have any questions, please contact the Office of Human Resources, Lydia Penaflor at (925) 485-5240.

CHABOT-LAS POSITAS COMMUNITY COLLEGE DISTRICT

Office of Human Resources

Personnel / Position Action Form (PAF) Form

SECTION 1 – Action Required

Employee Information:

- □ New Hire
- □ Re-Hire
- □ Board Correction
- □ Continuation of Contract
- □ Faculty Hourly
- □ Faculty Special Assignment **(F hrs)**
- □ Leave of Absence: Type_____
  (see attached instructions for leave type)
  From: _____/_____/_____
  To: _____/_____/_____
- □ Pre-retirement: Reduction in load
- □ Promotion
- □ Separation
  - ☐ Resignation
  - ☐ Retirement
  - ☐ Other (see attached instructions)
- □ Step Placement
- □ Stipend
- □ Transfer
  - ☐ Involuntary
  - ☐ Voluntary
- □ Work Out of Class

Position Information:

- □ New Position
- □ Position Eliminated
- □ Position FTE Reduced/Increased
- □ Change in Labor Distribution
- □ Other:_____

SECTION 2 – Location

□ **Chabot** □ **Las Positas** **District:** □ **Hayward** □ **Livermore** □ **Dublin**

SECTION 3 – Personal Data

Employee SSN # or W: | Date of Birth: / /

Legal Name: (as shown on Social Security Card)

_____
(Last) (First) (Middle)

Residential address:

_____
(Street & Number) (City) (State/Zip)

Phone #: (_____)_____ Alternate phone #: (_____)_____

SECTION 4 – Proposed Position Classification

FACULTY

- □ Full-time Tenure Track
  - ☐ 1st year contract
  - ☐ 2nd year contract
  - ☐ 3rd / 4th year contract
- □ Full-time Tenured
- □ Part-time Adjunct
- □ Apprenticeship
- □ Temporary
  - ☐ Leave Replacement
  - ☐ Substitute:
    name of person being replaced:
    _____

CLASSIFIED

- □ Regular
  - ☐ Full-Time (50% or more)
  - ☐ Part-Time (below 50%)
- □ Confidential
- □ Supervisory

MANAGEMENT

- □ Academic
- □ Classified
- □ Interim

Contract Term ____ year(s)

***OTHER**

- ☐ Short Term On-Call
- ☐ Professional Expert
- ☐ Volunteer
- ☐ Substitute:
  name of person being replaced:
  _____

SECTION 5 – Current Status (if currently working)

Job Title:	**Job Code:**	**Dept:**
Faculty Assignments: □ Fall □ Spring □ Summer		**Discipline:**

Begin Date	**End Date**	**Range/Step**	**Salary**
_____/_____/_____	_____/_____/_____	_____/_____	$_____ □ Weekly □ Monthly □ Hourly □ Flat Rate □ Max

FTE	**Months**	**Days/Week**	**Hours**
_____%	◯ 9 ◯ 10 ◯ 11 ◯ 12	□ Mon □ Tues □ Wed □ Thurs □ Fri □ Sat □ Sun	_____ □ Weekly □ Monthly □ Maximum

SECTION 6 – Proposed Status

Is this an additional assignment with current status? ☐ Yes ☐ No	**Job Title:**	**Job Code:**	**Dept:**
	Faculty Assignments: □ Fall □ Spring □ Summer		**Discipline:**

Begin Date	**End Date**	**Range/Step**	**Salary**
_____/_____/_____	_____/_____/_____	_____/_____	$_____ □ Weekly □ Monthly □ Hourly □ Flat Rate □ Max

FTE	**Months**	**Days/Week**	**Hours**
_____%	◯ 9 ◯ 10 ◯ 11 ◯ 12	□ Mon □ Tues □ Wed □ Thurs □ Fri □ Sat □ Sun	_____ □ Weekly □ Monthly □ Maximum

***Labor Dist. #1:** _____-_____-_____-_____ _____% (Fund Org Acct Program)	***Labor Dist. #3:** _____-_____-_____-_____ _____% (Fund Org Acct Program)
***Labor Dist. #2:** _____-_____-_____-_____ _____% (Fund Org Acct Program)	***Labor Dist. #4:** _____-_____-_____-_____ _____% (Fund Org Acct Program)

SECTION 7 – Justification

***Detailed explanation of action **(required)**: Please provide a SPECIFIC EXPLANATION FOR personnel/position action and qualifications and educations.

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

SECTION 8 – Signatures for Approval

Name of Person who Prepared Requisition: (if different from Hiring Administrator)

_____Phone Ext: _____

Hiring Administrator: _____
Print Name

1)_____ ____/____/____
Hiring Dean/Administrator's Signature Date

Phone Extension:_____

2)_____ ____/____/____
Vice President's Signature Date

3) _____ ____/____/____
President's/Vice Chancellor Signature Date

FOR SIGNATURES AND OFFICE USE ONLY

FOR LABOR DISTRIBUTION CHANGES ONLY

***VP of Administrative Services Signature:** _____ Date:____/____/____

***Director of Business Services Signature:** _____ Date:____/____/____

****

FOR HUMAN RESOURCES ONLY

1)_____ ____/____/____
Human Resources Review Date

Item Number Presented to Board _____ **Date of Board Approval** ____/____/____ **Completed:** □ I-9 □ Fingerprints □ TB

2)_____ ____/____/____
Vice Chancellor, Human Resources or Designee Signature Date

HR: Inputted by: _____ Date: _____/_____/_____ Payroll: Inputted by: _____ Date: _____/_____/_____ Benefits: Inputted by: _____ Date: _____/_____/_____

OATH OF ALLEGIANCE FOR PERSONS EMPLOYED BY A SCHOOL DISTRICT IN THE STATE OF CALIFORNIA

(Required by Section 3 of Article XX Constitution of the State of California and by Chapter 8, Division 4, Title 1 of the Government Code)

(State of California as County of Alameda)

I, _____, do solemnly swear (or affirm) that I will support and
(type or print name)
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

_____
Title of position

Taken, subscribed and sworn to before me
This _____ day of _____ ,20 _____

_____
Signature of Administrator

_____
Title

This oath must be signed by a Chabot-Las Positas Community College District administrator involved in the hiring and payroll process of faculty, classified and student assistance employees of the District

REFERENCES: Governing Board Policy 2230 and Government Code Section 3104.

CHABOT - LAS POSITAS COMMUNITY COLLEGE DISTRICT

Tuberculosis (TB) Certificate Information

SECTION 1: PERSONAL INFORMATION

Name: _____
(Last) (First) (Middle)

SSN/W#: _____ Position Title: _____

Division/Office: _____ Employee Signature: _____

SECTION 2: TB CERTIFICATE

Have you submitted a clear/negative TB test or X-ray **(no later than 4 years old)** to the Office of Human Resources for work prior to this job?

☐ **Yes** (If you answered yes, please turn in this form to the Office of Human Resources)

☐ **No** (If you answered no, please proceed to SECTION 3)

SECTION 3: INSTRUCTIONS

1) Schedule an appointment with your personal physician or health care center. (List of available locations are listed on the next page for your convenience)

2) Take this form with you when you go in for your TB test.

3) Your test will require two visits: The first visit will be for taking your TB test and the second visit will be for a follow-up to have the test viewed for results. (You will have to wait 48 to 72 hours before returning for the second visit to review the results. Remember to schedule your initial visit only if you know you will be able to meet the second visit time requirement, otherwise you may be charged to re-test)

4) Once you have completed your examination successfully, your physician will give you a copy of the TB / X-ray certificate. Please check to see if the following information is listed on your certificate:
   - Hospital / Health Clinic Name
   - Date of TB examination or X-ray and final date of results
   - Results of the test is marked as either negative or positive

   (NOTE: if positive, a chest X-ray will be required for continuation of employment with the District. An X-ray may be scheduled at most hospitals and clinics)

5) Submit this TB form along with **a copy of your TB / X-ray certificate** to the Office of Human Resources after you have received a clear TB test from the physician.

6) Expense for the initial examination, including X-rays, if needed, is the responsibility of the employee with the exception of student assistants. Only TB examinations are covered for student assistants, not X-rays examinations. Expenses for renewal tests are paid by the District. Please see board policy: www.clpccd.org/board/documents/7033Policy.pdf.

7) Once your TB test has expired, after 4 years, a renewal letter will be sent out to notify you that an updated TB test is required for your personnel file. The letter will state a 3-month due date by which you must submit your test to the Office of Human Resources, 7600 Dublin Boulevard, 3rd Floor, Dublin CA 94568. (A current TB certificate must be on file with Human Resources at all times in order to continue active employment with Chabot-Las Positas Community College District).

CALIFORNIA EDUCATION CODE:

Education Code Section 87408.6 provides that each person employed by a school district shall undergo an examination at least once every four years to determine that he/she is free of active tuberculosis. This examination shall consist of an approved intradermal tuberculin test which, if positive, shall be followed by an x-ray of the lungs. After such examination, each employee shall file with the school district of employment a certificate showing the employee was examined and found free from active tuberculosis. The certificate signed by the examining physician and surgeon or a notice from a public health agency or unit of the Tuberculosis Association which indicates freedom from active tuberculosis will constitute evidence of compliance with this section.

TB TESTING LOCATIONS

HEALTH CENTERS:

Please be aware that the following are recommended centers; however, we are unable to guarantee available appointments. Expense for the initial examination, including X-Rays, if needed, is the responsibility of the employee with the exception of student assistants. Only TB examinations are covered for student assistants, not X-rays examinations. Expenses for renewal tests are paid by the District (re CLPCCD Board Policy 4015).

CHABOT COLLEGE HEALTH CENTER

LOCATED AT:

25555 Hesperian Boulevard
Building 200, Room 204
Hayward, CA 94545
(510) 723-7625
www.chabotcollege.edu/healthcenter
Charge for TB testing is $25.00 for new hires
Chest X-Rays are referred out as needed

IMMUNIZATION:
Please call for an appointment or business hours, as the schedule below changes according to seasons or holidays as needed:

Monday, Tuesday & Wednesday: 9:00 a.m. – 7:00 p.m.
Thursday: 9:00 a.m. – 5:00 p.m.
Friday: 9:00 a.m. – 1:00 p.m.
Closed for lunch: 1:00 p.m. – 2:00 p.m.
No TB testing on Thursday

LAS POSITAS COLLEGE HEALTH CENTER

LOCATED AT:

3000 Campus Hill Drive
Building 1700, Room 1701
Livermore, CA 94551
(925) 424-1830
www.laspositascollege.edu/healthcenter
Charge for TB testing is $25.00 for new hires
Chest X-Rays are referred out as needed

IMMUNIZATION:
Please call for an appointment or business hours, as the schedule below changes according to seasons or holidays as needed:

Monday, Tuesday, Thursday: 9:00 a.m. – 5:00 p.m.
Wednesday: 10:00 a.m. – 6:00p.m.
Friday: Closed
This site remains OPEN during lunchtime.
TB Testing performed on Mondays & Tuesdays only.

Please Note:

We no longer have an account set up with Pleasanton Urgent Care, nor are we continuing to refer our employees to them for TB tests and x-rays. If you still choose to use this clinic on your own, Pleasanton Urgent Care has undergone new management and is now called Redwood Medical Center and Urgent Care.

For questions contact Denise Marriott in the Human Resources Department at dmarriott@clpccd.org or by calling (925) 485-5236.

NOTE: SUBJECT TO CHANGE

Form W-4 (2016)

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 2016 expires February 15, 2017. 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 2016. 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 $70,000 ($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 $70,000 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

2016

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 2016, 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 2016 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, 1952) of your income, and miscellaneous deductions. For 2016, you may have to reduce your itemized deductions if your income is over $311,300 and you are married filing jointly or are a qualifying widow(er); $285,350 if you are head of household; $259,400 if you are single and not head of household or a qualifying widow(er); or $155,650 if you are married filing separately. See Pub. 505 for details . . .	1	$
2	Enter: { $12,600 if married filing jointly or qualifying widow(er); $9,300 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 2016 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 2016 Form W-4* worksheet in Pub. 505.)	5	$
6	Enter an estimate of your 2016 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 $4,050 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 2016. 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 2016. 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 - $9,000	0
6,001 - 14,000	1	9,001 - 17,000	1
14,001 - 25,000	2	17,001 - 26,000	2
25,001 - 27,000	3	26,001 - 34,000	3
27,001 - 35,000	4	34,001 - 44,000	4
35,001 - 44,000	5	44,001 - 75,000	5
44,001 - 55,000	6	75,001 - 85,000	6
55,001 - 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	$610	$0 - $38,000	$610
75,001 - 135,000	1,010	38,001 - 85,000	1,010
135,001 - 205,000	1,130	85,001 - 185,000	1,130
205,001 - 360,000	1,340	185,001 - 400,000	1,340
360,001 - 405,000	1,420	400,001 and over	1,600
405,001 and over	1,600		

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.

CHABOT-LAS POSITAS COMMUNITY COLLEGE DISTRICT
Office of Human Resources
Personal Information Form

Date _____

Name _____
Last First Middle

SSN # _____

Address: _____
(Mailing) City State Zip

_____
(Residence) City State Zip

Contact Information: ( ) _____ ( ) _____
(Home) (Cell)

_____
(Email)

Date of Birth: _____ Place of Birth: _____

Sex: Male ☐ Female ☐ U.S. Citizen: Yes ☐ No ☐

Marital Status: Single ☐ Married ☐ Divorced ☐ Other (specify) _____

If married, name of spouse: _____

Are you now a member of California State Teacher's Retirement System (CALSTRS)? Yes ☐ No ☐

If "yes," which Defined Benefit Plan? _____ **Cash Balance?** **$** _____

Are you currently employed as a teacher by another school district? Yes ☐ No ☐

If "yes", give name of District and indicate whether full-time or part-time:

_____ Full-time ☐
(District's Name) Part-time ☐

Are you now a member of the California Public Employees Retirement System (CALPERS)? Yes ☐ No ☐

If "yes", give name of current or former employer and indicate whether full time or part-time:

_____ Full-time ☐
Part-time ☐

If employment was terminated, give date: _____

CHABOT-LAS POSITAS COMMUNITY COLLEGE DISTRICT
Office of Human Resources
Confidential Personal Information Form

NAME: _____ **DATE:** _____
Last *First* *Middle Initial*

SEX: **M** ☐ **F** ☐ **SSN:** _____ **BIRTHDATE:** _____
month/day/year

POSITION TITLE: _____ **Code #:** _____

LOCATION: **Chabot:** ☐ **Las Positas:** ☐ **District:** ☐

RACE/ETHNICITY AND OTHER INFORMATION: **(Please Check One of the following)**

☐ **WHITE** (not of Hispanic origin): All persons having origins in any of the original people of Europe, North Africa, or the Middle East.

☐ **AFRICAN AMERICAN/BLACK** (not of Hispanic origin): All persons having origins in any of the Black racial groups of Africa.

☐ **AMERICAN INDIAN OR ALASKAN NATIVE:** All persons having origins in any of the cultural people of North America, and who maintain cultural identification through tribal affiliation or community recognition.

☐ **ASIAN/PACIFIC ISLANDER:** All persons having origins in any of the following (Check One):

☐ CHINA ☐ INDIA ☐ JAPAN ☐ OTHER ASIAN COUNTRY: _____

☐ LAOS ☐ VIETNAM ☐ KOREA

☐ PHILLIPINES ☐ CAMBODIA ☐ SAMOA ☐ OTHER PACIFIC ISLAND: _____

☐ GUAM ☐ HAWAII

☐ **HISPANIC:** All persons of Mexican, Puerto Rican, Cuban or South American culture or origin, regardless of race.

☐ **OTHER:** _____

☐ **DECLINE TO STATE**

Are you disabled? ☐ **Yes** ☐ **No**
An individual with a disability is a person who has (1) a physical or mental impairment that substantially limits one or more major life activities; or, (2) a record of such impairment; or, (3) is regarded as having such impairment.

PERSON TO NOTIFY IN CASE OF EMERGENCY: _____

RELATIONSHIP: _____

CONTACT INFORMATION: **Phone/Cell Number(s):** _____
Email Address(es): _____
Mailing Address: _____
_____

CHABOT-LAS POSITAS COMMUNITY COLLEGE DISTRICT

Salary Warrant Distribution Request

I understand my salary warrant will be coded for automatic delivery as authorized below and will continue until a written request to change has been received by Human Resources and Payroll.

My salary warrant should be distributed to the following location:

Chabot College:

- ☐ Faculty Mailbox [Code 17] (option available to faculty who have an assigned mailbox)
- ☐ Academic Services [Code 7]
- ☐ Admissions & Records [Code 13]
- ☐ Children's Center [Code 6]
- ☐ PE/Athletics [Code 10]
- ☐ Admin Services [Code 19]
- ☐ Bookstore [Code 15]
- ☐ Learning Resource Center [Code 14]
- ☐ Student [Code 16]

☐ **Las Positas College** [Code 20]

☐ **ITS** [Code 8]

☐ Student [Code 26]

☐ **District Office** [Code 30]

☐ **Home Address via U.S. Mail** [Code 18]

_____

_____

☐ **Direct Deposit** (Please complete a Direct Deposit Form)
Please be aware that your Direct Deposit pay warrant stub will be mailed.

I understand that my salary warrant will be mailed via U.S. Mail the next working day, if not picked up prior to 5 p.m. on pay day.

Print Name	W or SSN #
Position Title	Division/Office/Area Assigned
Signature	Date

CHABOT-LAS POSITAS COMMUNITY COLLEGE DISTRICT

Office of Human Resources

DIRECT DEPOSIT FORM

Direct deposit requests will be verified first through a pre-note process with the financial institution to confirm the account information that you have provided is valid. Once your request is pre-noted, your direct deposit will be effective the following month.

If you choose to split salary between more than one financial institution your direct deposit must equal 100% of your net pay.

1. Attach a voided check. If you do not have either, contact your financial institution for the following information:

Account #1
Financial Institution: _____ Amount/Balance $ _____
(Indicate the word "Balance")

Routing number: _____

Account number: _____ ☐ Checking ☐ Savings

Account #2
Financial Institution: _____ Amount/Balance $ _____
(Indicate the word "Balance")

Routing number: _____

Account number: _____ ☐ Checking ☐ Savings

Account #3
Financial Institution: _____ Amount/Balance $ _____
(Indicate the word "Balance")

Routing number: _____

Account number: _____ ☐ Checking ☐ Savings

2. A voucher of your salary warrant will be sent to your mailing address.
3. **SIGN BELOW and return this form to: District Office, Payroll, 7600 Dublin Boulevard, 3rd Floor Dublin CA 94568**

Print Name _____ SSN / W # _____

Position Title _____ Division/Office/Area Assigned _____

Signature _____ Date _____

Posted by payroll: _____

Revised 08/28/2008
(P:Forms:Payroll/direct deposit form updated)

CHABOT LAS POSITAS COMMUNITY COLLEGE DISTRICT
Office of Human Resources

INSTRUCTIONS FOR FINGERPRINTING - Administrator

The State of California Education Code, sections 87013 and 88024 mandates employees of a community college district shall be fingerprinted within ten (10) working days of employment.

Under California law a plea or verdict of guilty or finding of guilt by the court is deemed to be a conviction, irrespective of a subsequent order under Penal Code section 1203.4 and Education Code sections 87008(a), 87009, 87013, 87405, 88022, and 88024. Relief under Penal Code section 1203.4 does not remove the fact of conviction as they relate to applications or questionnaires to public entities such as the Chabot - Las Positas Community College District. As a result, you are required to reveal any past conviction on your employment application.

Fingerprinting may only be completed by State of California's Department of Justice (DOJ) qualified Live Scan Site to perform fingerprinting services. The listing is available on the State of California's Department of Justice website: http://ag.ca.gov/fingerprints/publications/contact.php. As the applicant is responsible for cost, it is strongly suggested that the applicant contact the Site you are interested in to verify a) cost of fingerprinting, b) cost of rolling fee, and c) hours of Live Scan operation. If you are out of state, please notify the Human Resources representative listed below.

STEPS TO FOLLOW:

1) Fingerprinting is to be accomplished as soon as possible to meet Board deadlines and confirm start date.
2) Complete the middle section of the three (3) "Request for Live Scan Service" forms by filling in your name, date of birth, sex, height, weight, eye and hair color, place of birth, driver's license number, and home address.
3) Take the three (3) Request for Live Scan Service forms and a valid photo ID to the DOJ-qualified Live Scan Site to have the fingerprinting service performed.
4) Have the Live Scan Fingerprint Processing Agent complete and acknowledge the service by filling in the appropriate section at the bottom of the three (3) Request for Live Scan Service forms.
5) The agency will process the Request for Live Scan Service Form. The Live Scan fingerprint processing and rolling fee is the responsibility of the applicant.
6) The Live Scan Fingerprint Processing Agent will return two completed Request for Live Scan Service forms back to you. Please return one copy of the Live Scan form to the address below and keep the other copy for your records.

Office of Human Resources
Chabot - Las Positas Community College District
Attention: Fingerprint Processing
7600 Dublin Boulevard, 3rd Floor
Dublin CA 94568

For additional information or questions please contact the Office of Human Resources, Lydia Penaflor, at 925.485.5240.

STATE OF CALIFORNIA
BCII 8016
(orig. 4/01; rev. 6/09)

DEPARTMENT OF JUSTICE

REQUEST FOR LIVE SCAN SERVICE

Applicant Submission

A0593
ORI (Code assigned by DOJ)

Administrative Employment
Authorized Applicant Type

☐ CC ☐ LPC ☐ DO Department working for:

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

Contributing Agency Information:

Chabot-Las Positas Community College District
Agency Authorized to Receive Criminal Record Information

00417
Mail Code (five-digit code assigned by DOJ)

7600 Dublin Boulevard, 3rd Floor
Street Address or P.O. Box

Lydia Penaflor
Contact Name (mandatory for all school submissions)

Dublin
City

CA
State

94568
ZIP Code

(925) 485-5240
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: A0593
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

Employer (Additional response for agencies specified by statute):

Chabot-Las Positas Community College District
Employer Name

00417
Mail Code (five digit code assigned by DOJ

7600 Dublin Boulevard, 3rd Floor
Street Address or P.O. Box

Dublin
City

CA
State

94568
ZIP Code

(925) 485-5240
Telephone Number (optional)

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

STATE OF CALIFORNIA
BCII 8016
(orig. 4/01; rev. 6/09)

DEPARTMENT OF JUSTICE

REQUEST FOR LIVE SCAN SERVICE

Applicant Submission

A0593
ORI (Code assigned by DOJ)

Administrative Employment
Authorized Applicant Type

☐ CC ☐ LPC ☐ DO Department working for:

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

Contributing Agency Information:

Chabot-Las Positas Community College District
Agency Authorized to Receive Criminal Record Information

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Mail Code (five-digit code assigned by DOJ)

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Street Address or P.O. Box

Lydia Penaflor
Contact Name (mandatory for all school submissions)

Dublin
City

CA
State

94568
ZIP Code

(925) 485-5240
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: A0593
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

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Chabot-Las Positas Community College District
Employer Name

00417
Mail Code (five digit code assigned by DOJ

7600 Dublin Boulevard, 3rd Floor
Street Address or P.O. Box

Dublin
City

CA
State

94568
ZIP Code

(925) 485-5240
Telephone Number (optional)

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

STATE OF CALIFORNIA
BCII 8016
(orig. 4/01; rev. 6/09)

DEPARTMENT OF JUSTICE

REQUEST FOR LIVE SCAN SERVICE

Applicant Submission

A0593
ORI (Code assigned by DOJ)

Administrative Employment
Authorized Applicant Type

☐ CC ☐ LPC ☐ DO Department working for:

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

Contributing Agency Information:

Chabot-Las Positas Community College District
Agency Authorized to Receive Criminal Record Information

00417
Mail Code (five-digit code assigned by DOJ)

7600 Dublin Boulevard, 3rd Floor
Street Address or P.O. Box

Lydia Penaflor
Contact Name (mandatory for all school submissions)

Dublin
City

CA
State

94568
ZIP Code

(925) 485-5240
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: A0593
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

Employer (Additional response for agencies specified by statute):

Chabot-Las Positas Community College District
Employer Name

00417
Mail Code (five digit code assigned by DOJ

7600 Dublin Boulevard, 3rd Floor
Street Address or P.O. Box

Dublin
City

CA
State

94568
ZIP Code

(925) 485-5240
Telephone Number (optional)

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

On March 8, 2013, the Department of Homeland Security released a new version of the Form I-9. Please click here to retrieve.

CHABOT-LAS POSITAS COMMUNITY COLLEGE DISTRICT
Office of Human Resources
Request for Sick Leave Transfer

Note to Employee: Complete top half of page and send to former employer, please do not send back incomplete as it will delay processing.

To: **PAYROLL DEPARTMENT**

Subject: Verification of Sick Leave

Re: _____ _____
Name of Employee SSN

_____
Former name in which records may be filed

This will authorize you to verify my sick leave at: _____
Name of previous school district or agency

_____
Address City State Zip

_____
Employee Signature

The following is to be filled out by past employer:

VERIFICATION OF UNUSED SICK LEAVE

Upon separation from service on _____ , the above-mentioned employee is entitled to _____ days or _____ hours of sick leave.

I certify that this is a true and correct statement.

_____ _____
Signature of Verifying Official Print Name of Verifying Official

_____ _____
Title School District or Agency

_____
Date

Send completed form to:
Chabot-Las Positas Community College District
ATTN: Payroll Department
7600 Dublin Boulevard, 3rd Floor
Dublin CA 94568
Office: 925.485.5228 Fax: 925.485.5286

CALSTRS
HOW WILL YOU SPEND YOUR FUTURE?

RETIREMENT SYSTEM ELECTION

Read the attached instructions and information for retirement system coverage before completing the Retirement System Election. Keep a copy of the instructions and information sheet for your records. Please use a black ink pen or download and print the form.

TELEPHONE NUMBERS:
TOLL FREE 1-800-228-5453

MAILING ADDRESS:
CalSTRS
MAIL STATION #16
P.O. BOX 15275
SACRAMENTO, CA 95851-0275

(ES 372 05/09)

INSTRUCTIONS AND INFORMATION FOR RETIREMENT SYSTEM ELECTION

The following instructions are to assist you and your employer in completing the Retirement System Election (Form # ES 372). The first section of the form must be completed by you with assistance from your employer. Please complete all entries above the Employer Certification section. By signing this document, you 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 up to one year in jail and a fine of up to $5,000. Ed. Code §22010

EMPLOYEE INSTRUCTIONS

I. Press firmly and print clearly with **DARK INK**, or type all information requested. Do not use light colors of ink, pencil, felt pen, or erasable ink.

II. If you should make a mistake on the Retirement System Election form, line through the error and initial.

III. Enter your full name, last four digits of your Social Security Number, effective date of the change in employment status and position type.

IV. **EFFECTIVE DATE** is the first date that service was or will be performed in the new position.

V. **RETIREMENT SYSTEM COVERAGE** If you are a member of CalSTRS and have accepted employment to perform service that requires membership in CalPERS, enter an "X" in the box next to the coverage you elect. If you are a member of CalPERS and have accepted employment to perform service that requires membership in CalSTRS, enter an "X" in the box next to the coverage you elect.

VI. **EMPLOYEE SIGNATURE** Sign and date the Retirement System Election form.

VII. **SUBMIT** the Retirement System Election form to your employer. Retain a copy for your records.

For further information, you may contact our office toll Free **1-800-228-5453**, or by writing us at the address on the cover page.

Should you find it necessary to contact us, your correspondence should include the last four digits of your Social Security number, full name, address, and daytime telephone number.

EMPLOYER INSTRUCTIONS

Please complete the EMPLOYER CERTIFICATION only after the employee has completed the required employee information. Employees must qualify for membership before they can elect.

CO/DIST CODE/STATE DEPARTMENT – Enter the appropriate county and district codes. Example: Kern County, Edison Elementary would be 15-012, CA Department of Education 59-174.

EMPLOYER CERTIFICATION – Print official's name, title and phone number, sign and date the Retirement System Election form.

SUBMIT the completed Retirement System Election form to the County Office of Education or if you represent a state department, send it directly to CalSTRS and send a copy to CalPERS.

COUNTY OFFICE OF EDUCATION

Review, sign and date the Retirement System Election form.

Mail the original Retirement System Election form to the retirement system elected by the employee and a copy to the retirement system that would normally cover the service. Provide copies for the employer, employee and employee's file.

INFORMATION

A member of the CalSTRS Defined Benefit Program who becomes employed by a school district, a community college district, a county superintendent of schools or limited state departments to perform service that requires membership by the California Public Employees' Retirement System (CalPERS) [Education Code section 22508(a)]may elect to receive credit under the CalSTRS Defined Benefit Program for such service by submitting a Retirement System Election form to CalSTRS, within 60 days of the effective date of employment in the position requiring membership in the other system. If the CalSTRS member does not elect to continue as a member of CalSTRS, all service subject to coverage by CalPERS will be reported to that retirement system. (Education Code 22508)

A member of CalPERS who was employed by a school employer, Board of Governors of California Community Colleges, or State Department of Education or has at least five years of CalPERS credited service and who accepts employment to perform creditable service that requires membership by the CalSTRS Defined Benefit Program [Government Code section 20309 (a)] may elect to receive credit under CalPERS for such service by submitting a Retirement System Election form to CalPERS, within 60 days of the effective date of employment in the position requiring membership in the other system. If the CalPERS member does not elect to continue as a member of CalPERS, all CalSTRS creditable service will be reported to CalSTRS. (Government Code 20309)

Retirement System Election

ES0372 (rev 11/13)

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

PLEASE READ THE ATTACHED INSTRUCTIONS BEFORE COMPLETING THIS FORM. PLEASE TYPE OR PRINT LEGIBLY IN DARK INK.

SECTION 1: MEMBER INFORMATION AND ELECTION (to be completed by employee)

NAME (LAST, FIRST, INITIAL) FULL SOCIAL SECURITY NUMBER

HIRE DATE EFFECTIVE DATE OF POSITION POSITION TITLE ☐ Credentialed ☐ Classified ☐ State Service

Employment in the California public school system is generally subject to coverage by either the California State Teachers' Retirement System (CalSTRS), or a different public retirement system including but not limited to the California Public Employees' Retirement System (CalPERS).

A member of CalSTRS who becomes employed by the same or a different school district, a community college district, a county superintendent of schools or limited state employment, as defined in Education Code Section 22508, to perform service that requires membership in a different public retirement system will have that service credited with that other public retirement system unless he/she files a written election (within 60 days from the date of hire in the new position) to have the service credited with CalSTRS.

A member of CalPERS who is employed by a school employer, Board of Governors of Community College Districts or State Department of Education or has at least five years of CalPERS credited service, as defined in Government Code Section 20309, and who subsequently becomes employed to perform creditable service that requires membership in CalSTRS, will have that service credited with CalSTRS unless he/she files a written election (within 60 days of the date of hire in the new position) to have the service credited with CalPERS.

I am a member of CalSTRS who has accepted employment to perform service that requires membership in a different public retirement system but am eligible to elect to continue retirement system coverage under CalSTRS.
I elect coverage in: (please choose one)

☐ CA State Teachers' Retirement System (CalSTRS)

☐ CA Public Employee's Retirement System (CalPERS) *

☐ Other: _____

OR

I am a member of CalPERS who has accepted employment to perform service that requires membership in CalSTRS but am eligible to elect to continue coverage under CalPERS.
I elect coverage in: (please choose one)

☐ CA State Teachers' Retirement System (CalSTRS)

☐ CA Public Employee's Retirement System (CalPERS) *

I fully understand that this election is irrevocable for this employer. 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 up to one year in jail and a fine of up to $5,000. (Education Code section 22010)

EMPLOYEE SIGNATURE DATE

SECTION 2: EMPLOYER CERTIFICATION (to be completed by employer and County Office of Education)

I certify that the employee meets the qualifications to make a retirement system election.

CO/DIST/STATE DEPT NAME CALSTRS REPORT UNIT CODE

SCHOOL/STATE OFFICIAL'S NAME TITLE PHONE NUMBER

SIGNATURE OF SCHOOL/STATE OFFICIAL DATE

COUNTY OFFICIAL'S NAME TITLE PHONE NUMBER

SIGNATURE OF COUNTY OFFICIAL

*CalPERS Employer Code:

ES0372

Retirement System Election – Information and Instructions

The following instructions are to assist you and your employer in completing the *Retirement System Election* form (ES372). Please read the instructions and information for retirement system coverage before completing the form.

Please type or print legibly in dark ink. Do not use light colors of ink, pencil, felt pen, or erasable ink. If you should make a mistake on the form, line through the error and initial.

INFORMATION

A member of the CalSTRS Defined Benefit Program who becomes employed by a school district, a community college district, a county superintendent of schools or limited state departments to perform service that requires membership in a different public retirement system, may elect to receive credit under the CalSTRS Defined Benefit Program for such service by submitting a *Retirement System Election* form (ES372) to CalSTRS, within 60 days of the effective date of employment in the position requiring membership in the other system. If the CalSTRS member does not elect to continue as a member of CalSTRS, all service subject to coverage by the other public retirement system will be reported to that retirement system. (Education Code section 22508)

A member of CalPERS who was employed by a school employer, Board of Governors of California Community Colleges, or State Department of Education or has at least five years of CalPERS credited service and who accepts employment to perform creditable service that requires membership by the CalSTRS Defined Benefit Program, may elect to receive credit under CalPERS for such service by submitting a *Retirement System Election* form (ES372) to CalPERS, within 60 days of the effective date of employment in the position requiring membership in the other system. If the CalPERS member does not elect to continue as a member of CalPERS, all CalSTRS creditable service will be reported to CalSTRS. (Government Code section 20309).

SECTION 1: MEMBER INFORMATION AND ELECTION

Section 1 of the form must be completed by the employee with assistance from the employer. Please complete all entries in Section 1. Keep a copy of the form for your records.

EMPLOYEE NAME and SOCIAL SECURITY NUMBER – Enter employee's full name, and full Social Security Number.

HIRE DATE – Enter the date the employee was hired in the position.

EFFECTIVE DATE OF POSITION - Enter the effective date of the new position. This is the first date that service was/will be performed by the employee in the new position.

POSITION TITLE – Enter employee's new position title and check the box next to the applicable position type.

RETIREMENT SYSTEM COVERAGE:
If you are a member of CalSTRS and have accepted employment to perform service that requires membership in a different public retirement system, enter an "X" in the box next to the coverage you elect.

If you are a member of CalPERS and have accepted employment to perform service that requires membership in CalSTRS, enter an "X" in the box next to the coverage you elect.

EMPLOYEE SIGNATURE – Sign and date the *Retirement System Election* form (ES372). By signing this document, you understand this election is irrevocable for this employer, and that 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 up to one year in jail and a fine of up to $5,000. (Education Code section 22010)

Submit the signed and dated *Retirement System Election* form (ES372) to your employer. Retain a copy for your records.

For further information, contact CalSTRS by calling 800-228-5453, or write to CalSTRS at P.O. Box 15275, MS 17, Sacramento, CA 95851-0275.

SECTION 2: EMPLOYER CERTIFICATION

Section 2 of the form must be completed by the employer and the County Office of Education. Please complete the employer certification only after the employee has completed Section 1. Employees must qualify for membership before they can elect.

EMPLOYER:

CO/DIST CODE/STATE DEPARTMENT – Enter the appropriate county and district codes. Example: Kern County, Edison Elementary would be 15-012, CA Department of Education 59-174.

EMPLOYER CERTIFICATION – Print school or state official's name, title and phone number, sign and date the *Retirement System Election* form (ES372).

Submit the completed *Retirement System Election* form (ES 372) to the County Office of Education or if you represent a state department, send it directly to CalSTRS and send a copy to the other public retirement system.

COUNTY OFFICE OF EDUCATION:

Review, sign and date the *Retirement System Election* form (ES372).

Mail the original *Retirement System Election* form (ES372) form to the retirement system elected by the employee and a copy to the retirement system that would normally cover the service. Provide copies for the employer, employee and employee's file.

California Public Employees' Retirement System
Customer Account Services Division
Retirement Account Services Section
P.O. Box 942709
Sacramento, CA 94229-2709
TTY: (877) 249-7442
888 CalPERS (or **888**-225-7377) phone • (916) 795-4166 fax
www.calpers.ca.gov

MEMBER RECIPROCAL SELF-CERTIFICATION FORM

*Complete the following information and return this form to your Human Resources Office **within 10 business days**:*

EMPLOYEE NAME: _____
(Last) *(First)* *(Middle)*

SOCIAL SECURITY NUMBER OR CalPERS ID NUMBER: _____

NAME OF MOST RECENT RECIPROCAL RETIREMENT SYSTEM: _____

PERMANENT SEPARATION DATE FROM MOST RECENT RECIPROCAL RETIREMENT SYSTEM: _____
_____

FIRST MEMBERSHIP DATE IN ANY PRIOR CALIFORNIA PUBLIC RETIREMENT SYSTEM THAT IS SUBJECT TO RECIPROCITY: _____

(Check the applicable statement)

☐ I have not been a member of another California Public Retirement System within the last six months.

☐ I was a member and am retired from the _____ Retirement System and subsequently became employed by a CalPERS-covered employer.

☐ I was a member of the _____ Retirement System and became employed by a CalPERS-covered employer within six months after separating from employment with the previous reciprocal retirement system.

I understand that by accepting employment in a specific retirement system, I am subject to the applicable laws and regulations of that system. I also understand that completing this form does not constitute a request to establish reciprocity. I must complete and return the "Election to Coordinate Retirement When Changing Retirement Systems," (PERS-MSD-255) Form to CalPERS.

I hereby certify that the foregoing information is true and correct and any information found to be incorrect may require corrections to my account in the California Public Employees' Retirement System including, but not limited to, my date of membership. CalPERS may make any necessary corrections to my account to ensure I am properly enrolled and eligible to receive the correct retirement benefits.

_____ _____
SIGNATURE OF EMPLOYEE **DATE**

TO BE COMPLETED BY EMPLOYER ONLY:

NAME OF CalPERS AGENCY:

_____

CalPERS BUSINESS PARTNER ID:

_____

CalPERS MEMBERSHIP ELIGIBILITY DATE WITH YOUR AGENCY:

_____

ORIGINAL HIRE DATE WITH YOUR AGENCY:

_____

DATE MEMBER RECIPROCAL SELF-CERTIFICATION FORM GIVEN TO EMPLOYEE: _____
DATE MEMBER RECIPROCAL SELF-CERTIFICATION FORM RECEIVED FROM EMPLOYEE: _____

_____ _____ _____
(*Please Print*) **DESIGNEE OF EMPLOYER** **TITLE** **DATE**

_____
DESIGNEE'S SIGNATURE

MEMBER RECIPROCAL SELF-CERTIFICATION FORM
Instructions

Reciprocity is an agreement among public retirement systems to allow members to separate from one public employer and enter into employment with another public employer within a specific time limit without losing some valuable retirement and related benefit rights.

The Public Employees' Pension Reform Act of 2013 (PEPRA), effective January 1, 2013, requires a CalPERS covered employer to determine the applicable PEPRA retirement benefit formula for new employees. CalPERS refers to all members that do not fit within the PEPRA definition of a "new member[1]" as "classic members" who are subject to the Public Employees' Retirement Law (PERL). PEPRA allows a member after January 1, 2013, to retain his/her classic member retirement benefit status if the member continues his/her membership in all previous California Public Retirement System(s) by leaving his/her service credit and contributions (if any) on deposit, and the member enters into employment that results in CalPERS membership within six months of separating from the most recent California Public Retirement System. Classic member status also requires the membership date to be on or before December 31, 2012, in a California Public Retirement System in which reciprocity is established.

EMPLOYER INSTRUCTIONS

1. Employers must provide the Member Reciprocal Self-Certification Form to all new employees upon eligibility for membership.
2. Employers must sign and date the Member Reciprocal Self-Certification Form on the date the form is given to the employee.
3. Upon receipt of the completed Member Reciprocal Self-Certification Form, the employer will enter the date the employee returns the form.
4. The employer will enroll the new employee into CalPERS membership through my|CalPERS based on the information provided on the Member Reciprocal Self-Certification Form. my|CalPERS will determine the proper retirement benefit formula. If an employer believes the retirement benefit formula is incorrect, employers may contact CalPERS at 1-**888**-225-7377.
5. It is the responsibility of the employer to retain the completed Member Reciprocal Self-Certification Form in the employee's employment records for auditing purposes.

[1] A new member is defined in PEPRA as any of the following:
- A new hire who is brought into CalPERS membership for the first time on or after January 1, 2013, who has no prior membership in any California Public Retirement System.
- A new hire who is brought into CalPERS membership for the first time on or after January 1, 2013, who has a break in service of greater than six months with another **California Public Retirement System that is subject to Reciprocity.**
- A member who first established CalPERS membership prior to January 1, 2013, who is rehired by a different CalPERS employer after a break in service of greater than six months.

EMPLOYEE INSTRUCTIONS

1. The Member Reciprocal Self-Certification Form will assist your employer in determining whether you are considered a new member or a classic member under PEPRA.

2. As the new employee, you must complete, sign and date the Member Reciprocal Self-Certification Form to self-certify your most recent service in a reciprocal California Public Retirement System, your first membership date in any previous California Public Retirement System and your permanent separation date from the most recent California Public Retirement System; or indicate that you are not a member of any California Public Retirement System that is subject to Reciprocity.

3. As the new employee, you must return the Member Reciprocal Self-Certification Form to your Personnel Office **within 10 business days** of employment.

4. The completion of the Member Reciprocal Self-Certification Form does not establish reciprocity and is not a request to establish reciprocity. In order to request that reciprocity be established, visit the CalPERS web-site at: www.calpers.ca.gov and download the publication: "When You Change Retirement Systems", PUB-16. **It is the responsibility of the employee to complete and send the "Election to Coordinate Retirement When Changing Retirement Systems," PERS-MSD-255 Form to CalPERS.**

Reciprocal 1937 Act Counties

Alameda
Contra Costa
Fresno
Imperial
Kern
Los Angeles
Marin
Mendocino
Merced
Orange
Sacramento
San Bernardino
San Diego
San Joaquin
San Mateo
Santa Barbara
Sonoma
Stanislaus
Tulare
Ventura

Non-Reciprocal & UCRS Retirement Systems

Non-reciprocal systems are not covered by reciprocity retirement laws, but participate in retirement agreements with other systems.

State Teachers' Retirement System
Legislators' Retirement System
Judges' Retirement System
Judges' Retirement System II
University of California Retirement System

Reciprocal Public Agencies

*City of Concord
*City of Costa Mesa (Safety employees only)
City of Fresno (Miscellaneous and Safety Retirement Systems)
City of Los Angeles (non-Safety only)
City of Oakland (non-Safety employees only)
City of Pasadena (Fire and Police Retirement System)
*City of Sacramento
*City of San Clemente (non-Safety employees only)
City of San Diego
*City and County of San Francisco
City of San Jose
Contra Costa Water District
County of San Luis Obispo
East Bay Municipal Utility District
East Bay Regional Park District (Safety employees only)
Los Angeles County Metropolitan Transportation Authority (Non-Contract Employees' Retirement Income Plan, formerly Southern California Rapid Transit District)

*Also CalPERS-covered agency

CHABOT-LAS POSITAS COMMUNITY COLLEGE DISTRICT

FEDERAL PRIVACY ACT INFORMATION

The Board of Administration, Public Employees' Retirement System, requires the disclosure of each member's Social Security account number on a mandatory basis to comply with Section 6033 and 6041, Title 26, of the United States Code, and Sections 1.603-1(a) and 1.6041.2(b) of the Federal Tax Regulations, requiring reporting the Internal Revenue Service of disbursements made by the System and to comply with its obligations under the Federal-State agreement imposed by Sections 404.1242, 404.1243, 404.1250, 404.1255, and 404.1256, Title 20, Code of Federal Regulations, requiring reporting to the Social Security Administration.

The Social Security account number is used for the following purpose and is included in the following documents:

1. Member identification on membership files, documents and correspondence.

2. Annual report to the Franchise Tax Board and to the Internal Revenue Service of interest on refunds where the interest paid to an individual is $600 or more.

3. Annual Statement of Member Contribution and Service Credit sent to employers for distribution to members.

4. Annual Listing of Member Contributions as of each June 30 sent to each employer.

5. All Refund Rolls submitted to the State Controller for processing.

6. Reports of benefit payments to the State Franchise Tax Board and to the Internal Revenue Service.

7. Annual return filed with the Internal Revenue Service.

8. Reports to the Internal Revenue Service of Federal income tax withheld from benefit payments.

9. Reports submitted to the Social Security Administration.

CHABOT-LAS POSITAS COMMUNITY COLLEGE DISTRICT

COMPLIANCE NOTICE

Chabot-Las Positas Community College District is an equal opportunity institution in its policies, procedures, and practices relating to access, admission, and employment in its programs, services and activities.

In compliance with Titles VI and VII of the Civil Rights Act of 1964, Title IX of the Education Amendments of 1972 Sections 503 and 504 of the Rehabilitation Act of 1973, the Age Discrimination in Employment Act of 1974, Americans with Disabilities Act, Fair Employment and Housing Authority, and other relevant legislation in regards to fair employment practices and equal opportunities, its own statements of philosophy and objectives, and with the regulations affecting community colleges in the State of California, Chabot-Las Positas Community College District does not discriminate on the basis of race, color, national origin, religion, sex, marital status, sexual preference, age, or disability. We encourage individuals of both sexes, ethnic minorities, Vietnam Era Veterans and the disabled to attend our institution and to file applications for employment.

INQUIRIES ON	**CONTACT**
1. Equal Opportunity, Student Policies and Procedures (for student matters).	Vice President, Student Services Chabot College, 25555 Hesperian Blvd., Hayward CA 94545 Telephone: (510) 723-6744 Vice President, Student Services Las Positas College, 3000 Campus Hill Drive, Livermore CA 94551 Telephone: (925) 424-1405
2. Equal Opportunity, Faculty/Staff Policies and Procedures (for faculty, classified staff and public employment).	Vice Chancellor, Human Resources; or Director of Employee and Labor Relations 7600 Dublin Boulevard, 3rd Floor, Dublin, CA 94568 Telephone: (925) 485-5261 or (925) 485-5513 Vice President, Student Services Chabot College, 25555 Hesperian Blvd., Hayward CA 94545 Telephone: (510) 723-6744; or Dean, Student Services – Enrollment Las Positas College, 3000 Campus Hill Drive, Livermore CA 94551 Telephone: (925) 424-1542; or Office of Civil Rights – U.S. Department of Education 50 Beale Street, Suite 7200, San Francisco CA 94105-1813 Telephone: (415) 486-5555; or Department of Fair Employment and Housing Telephone: (800) 884-1684; or The U.S. Equal Employment Opportunity Commission Telephone: (800) 669-4000
3. Non-Compliance with Section 504 Provisions (Policy of Non-Discrimination on the Basis of Disability) and (Coordinator of Section 504) The Americans with Disabilities Act.	Vice President, Student Services Chabot College, 25555 Hesperian Blvd., Hayward CA 94545 Telephone: (510) 723-6744 Vice President, Academic Services Las Positas College, 3000 Campus Hill Drive, Livermore CA 94551 Telephone: (925) 424-1103
4. Alleged Discrimination per Government Code 11135 (code which prohibits unlawful discrimination on the basis of ethnic group identification, religion, age, sex, color or disability, in programs or activities receiving state assistance) and Non-compliance with Title IX Provisions (Policy of Non-Discrimination on the Basis of Sex).	Vice Chancellor, Human Resources; or Director of Labor and Employee Relations (District Unlawful Discrimination Complaint Officer, Coordinator Title IX). Chabot-Las Positas Community College District 7600 Dublin Boulevard, 3rd Floor, Dublin, CA 94568 Telephone: (925) 485-5261 or (925) 485-5513

General Institution

BP 3430 PROHIBITION OF HARASSMENT

References:

Education Code Sections 212.5, 44100, 66252, and 66281.5;
Government Code Section 12950.1;
Title VII of the Civil Rights Act of 1964, 42 U.S. Code Annotated Section 2000e;
Title 5 Sections 59300 et seq.

All forms of harassment are contrary to basic standards of conduct between individuals and are prohibited by state and federal law, as well as this policy, and will not be tolerated. The District is committed to providing an academic and work environment that respects the dignity of individuals and groups. The District shall be free of sexual harassment and all forms of sexual intimidation and exploitation including acts of sexual violence. It shall also be free of other unlawful harassment, including that which is based on any of the following statuses: race, ethnicity, religious creed, color, national origin, ancestry, physical disability, mental disability, medical condition, genetic information, marital status, sex, gender, gender identity, gender expression, age, or sexual orientation of any person, or because he or she is perceived to have one or more of the foregoing characteristics.

The District seeks to foster an environment in which all employees and students feel free to report incidents of harassment without fear of retaliation or reprisal. Therefore, the District also strictly prohibits retaliation against any individual for filing a complaint of harassment or for participating in a harassment investigation. Such conduct is illegal and constitutes a violation of this policy. All allegations of retaliation will be swiftly and thoroughly investigated. If the District determines that retaliation has occurred, it will take all reasonable steps within its power to stop such conduct. Individuals who engage in retaliatory conduct are subject to disciplinary action, up to and including termination or expulsion.

Any student or employee who believes that he/she has been harassed or retaliated against in violation of this policy should immediately report such incidents by following the procedures described in AP 3435 titled Discrimination and Harassment Complaint Procedures. Supervisors are mandated to report all incidents of harassment and retaliation that come to their attention.

This policy applies to all aspects of the academic environment, including but not limited to classroom conditions, grades, academic standing, employment opportunities, scholarships, recommendations, disciplinary actions, and participation in any community

college activity. In addition, this policy applies to all terms and conditions of employment, including but not limited to hiring, placement, promotion, disciplinary action, layoff, recall, transfer, leave of absence, training opportunities and compensation.

To this end the Chancellor shall ensure that the institution undertakes education and training activities to counter discrimination and to prevent, minimize and/or eliminate any hostile environment that impairs access to equal education opportunity or impacts the terms and conditions of employment.

The Chancellor shall establish procedures that define harassment on campus. The Chancellor shall further establish procedures for employees, students, and other members of the campus community that provide for the investigation and resolution of complaints regarding harassment and discrimination, and procedures for students to resolve complaints of harassment and discrimination. All participants are protected from retaliatory acts by the District, its employees, students, and agents.

This policy and related written procedures (including the procedure for making complaints) shall be widely published and publicized to administrators, faculty, staff, and students, particularly when they are new to the institution. They shall be available for students and employees in all administrative offices.

Employees who violate the policy and procedures may be subject to disciplinary action up to and including termination. Students who violate this policy and related procedures may be subject to disciplinary measures up to and including expulsion.

Date Adopted: June 16, 2015

(This new policy replaces current CLPCCD Policies 4027 and 5517)

EMPLOYEE RIGHTS AND RESPONSIBILITIES UNDER THE FAMILY AND MEDICAL LEAVE ACT

Basic Leave Entitlement

FMLA requires covered employers to provide up to 12 weeks of unpaid, job-protected leave to eligible employees for the following reasons:

- for incapacity due to pregnancy, prenatal medical care or child birth;
- to care for the employee's child after birth, or placement for adoption or foster care;
- to care for the employee's spouse, son, daughter or parent, who has a serious health condition; or
- for a serious health condition that makes the employee unable to perform the employee's job.

Military Family Leave Entitlements

Eligible employees whose spouse, son, daughter or parent is on covered active duty or call to covered active duty status may use their 12-week leave entitlement to address certain qualifying exigencies. Qualifying exigencies may include attending certain military events, arranging for alternative childcare, addressing certain financial and legal arrangements, attending certain counseling sessions, and attending post-deployment reintegration briefings.

FMLA also includes a special leave entitlement that permits eligible employees to take up to 26 weeks of leave to care for a covered service-member during a single 12-month period. A covered servicemember is: (1) a current member of the Armed Forces, including a member of the National Guard or Reserves, who is undergoing medical treatment, recuperation or therapy, is otherwise in outpatient status, or is otherwise on the temporary disability retired list, for a serious injury or illness*; or (2) a veteran who was discharged or released under conditions other than dishonorable at any time during the five-year period prior to the first date the eligible employee takes FMLA leave to care for the covered veteran, and who is undergoing medical treatment, recuperation, or therapy for a serious injury or illness.*

***The FMLA definitions of "serious injury or illness" for current servicemembers and veterans are distinct from the FMLA definition of "serious health condition".**

Benefits and Protections

During FMLA leave, the employer must maintain the employee's health coverage under any "group health plan" on the same terms as if the employee had continued to work. Upon return from FMLA leave, most employees must be restored to their original or equivalent positions with equivalent pay, benefits, and other employment terms.

Use of FMLA leave cannot result in the loss of any employment benefit that accrued prior to the start of an employee's leave.

Eligibility Requirements

Employees are eligible if they have worked for a covered employer for at least 12 months, have 1,250 hours of service in the previous 12 months*, and if at least 50 employees are employed by the employer within 75 miles.

***Special hours of service eligibility requirements apply to airline flight crew employees.**

Definition of Serious Health Condition

A serious health condition is an illness, injury, impairment, or physical or mental condition that involves either an overnight stay in a medical care facility, or continuing treatment by a health care provider for a condition that either prevents the employee from performing the functions of the employee's job, or prevents the qualified family member from participating in school or other daily activities.

Subject to certain conditions, the continuing treatment requirement may be met by a period of incapacity of more than 3 consecutive calendar days combined with at least two visits to a health care provider or one visit and a regimen of continuing treatment, or incapacity due to pregnancy, or incapacity due to a chronic condition. Other conditions may meet the definition of continuing treatment.

Use of Leave

An employee does not need to use this leave entitlement in one block. Leave can be taken intermittently or on a reduced leave schedule when medically necessary. Employees must make reasonable efforts to schedule leave for planned medical treatment so as not to unduly disrupt the employer's operations. Leave due to qualifying exigencies may also be taken on an intermittent basis.

Substitution of Paid Leave for Unpaid Leave

Employees may choose or employers may require use of accrued paid leave while taking FMLA leave. In order to use paid leave for FMLA leave, employees must comply with the employer's normal paid leave policies.

Employee Responsibilities

Employees must provide 30 days advance notice of the need to take FMLA leave when the need is foreseeable. When 30 days notice is not possible, the employee must provide notice as soon as practicable and generally must comply with an employer's normal call-in procedures.

Employees must provide sufficient information for the employer to determine if the leave may qualify for FMLA protection and the anticipated timing and duration of the leave. Sufficient information may include that the employee is unable to perform job functions, the family member is unable to perform daily activities, the need for hospitalization or continuing treatment by a health care provider, or circumstances supporting the need for military family leave. Employees also must inform the employer if the requested leave is for a reason for which FMLA leave was previously taken or certified. Employees also may be required to provide a certification and periodic recertification supporting the need for leave.

Employer Responsibilities

Covered employers must inform employees requesting leave whether they are eligible under FMLA. If they are, the notice must specify any additional information required as well as the employees' rights and responsibilities. If they are not eligible, the employer must provide a reason for the ineligibility.

Covered employers must inform employees if leave will be designated as FMLA-protected and the amount of leave counted against the employee's leave entitlement. If the employer determines that the leave is not FMLA-protected, the employer must notify the employee.

Unlawful Acts by Employers

FMLA makes it unlawful for any employer to:

- interfere with, restrain, or deny the exercise of any right provided under FMLA; and
- discharge or discriminate against any person for opposing any practice made unlawful by FMLA or for involvement in any proceeding under or relating to FMLA.

Enforcement

An employee may file a complaint with the U.S. Department of Labor or may bring a private lawsuit against an employer.

FMLA does not affect any Federal or State law prohibiting discrimination, or supersede any State or local law or collective bargaining agreement which provides greater family or medical leave rights.

FMLA section 109 (29 U.S.C. § 2619) requires FMLA covered employers to post the text of this notice. Regulation 29 C.F.R. § 825.300(a) may require additional disclosures.

For additional information:
1-866-4US-WAGE (1-866-487-9243) TTY: 1-877-889-5627
WWW.WAGEHOUR.DOL.GOV

U.S. Department of Labor | Wage and Hour Division

WHD Publication 1420 · Revised February 2013

Chabot-Las Positas Community College District Retirement Savings Plan

We would like to make our employees aware of the retirement plans that we sponsor which include a 403(b) Tax Sheltered Annuity Plan (TSA/403(b) Plan) and a 457(b) Deferred Compensation Plan (DCP/457(b) Plan) (the Plans). Participation is voluntary, allowing you to make pre-tax salary deferral contributions via payroll deduction. One of the benefits of participating in the Plans is the ability to defer from current taxation salary that would otherwise be currently taxable and also defer income taxes on the earnings credited to your account.

The amounts you contribute to the TSA/403(b) Plan have an independent limit from the amounts that you contribute to the DCP/457(b) Plan. You may make pre-tax salary deferral contributions to the TSA/403(b) Plan, the DCP/457(b) Plan only, or you may make pre-tax contributions to both Plans simultaneously. See the chart below for the maximum contribution limits.

Year	403(b) TSA	457(b) DCP	Total
2016 Basic Limit	$18,000	$18,000	$36,000
Age 50+ Catch-up	$6,000	$6,000	$12,000
Total	**$24,000**	**$24,000**	**$48,000**

We are pleased to be able to offer the benefits of these voluntary pre-tax savings plans for you, because we recognize that many of you wish to defer current income taxes to your post retirement years, while accumulating additional savings for retirement.

Please note that if you also make contributions, or have contributions made for you, to a 401(a) or 401(k) plan you are limited by the overall 415(c)(1)(A) limit for all plans including 403(b), 401(a) and 401(k). If you are a participant in another retirement plan (excluding CalSTRS or CalPERS), please advise Envoy Plan Services, Inc.

If you wish to learn more about participating in the 403(b) Plan and the 457(b) Plan, please visit the website of our retirement plans administrator Envoy Plan Services, Inc. at www.envoyplanservices.com.

Getting Started

- Logon to **www.envoyplanservices.com**
- Click onto Client Center; then Click onto your State, County and Employer.
- You are now on your Employer's home page on the Envoy website.
  - **403(b) Plan Providers** – A complete list of Approved Providers currently available in the Plan is listed on the Employer's home page.
  - **Forms Tab** – A Forms tab is at the top of the home page. Clicking on this tab will provide you with Definitions, Enrollment Procedures, Plan Highlights, Salary Reduction Agreement (SRA), Transaction Request Form and Instructions. Please download applicable forms and read carefully!
  - **Frequently Asked Questions –** A list of frequently asked questions and the responses to the questions is provided for your reference.
  - **Educational Videos** are provided for your viewing.

IMPORTANT NOTE: IF YOU HAVE A 403(b) AND/OR 457(b) PLAN ACCOUNT WITH A PREVIOUS EMPLOYER, YOU MUST ESTABLISH A NEW ACCOUNT TO ENROLL IN THIS PLAN. YOUR SALARY DEFERRAL CONTRIBUTIONS IN THIS EMPLOYER'S 403(b) PLAN AND 457(b) PLAN CANNOT BE INVESTED IN THE 403(b) PLAN AND 457(b) PLAN OF A PREVIOUS EMPLOYER.

Step 1: Enrolling with a 403(b)

- Locate the provider of your choice from the list on your Employer's home page.
- Contact information is listed for each approved provider.
- Contact the provider directly to request enrollment forms and instructions.
- Work directly with the provider to complete their enrollment process. ***(Envoy Plan Services will not accept Provider enrollment forms)***.

Step 2: Enrolling with a 457(b) Provider

- Contact Josh Schefers the local representative for the 457(b) Plan
- Phone: 925-830-5025 or Email: jschefers@zukfinancial.com

Step 3: Establish Salary Reduction Agreement (SRA)

- After you have established your 403(b) or 457 account, you will need to submit a completed SRA to begin your payroll deduction contributions. **(New Participants: your initial SRA must be submitted via Paper.)**
  Paper: To obtain a paper SRA form logon to the website at www.envoyplanservices.com
  a. Click on Customer Service Center, then click on your state, then click on your county, then click on your employer's section, then click on the Forms tab, then click on Salary Reduction Agreement.
  b. Complete the SRA form (it is a fillable PDF file), print it, sign and date and fax it to Envoy's toll free fax number 877-513-2272.

  Online: If you are currently contributing to a 403(b) or 457 you can submit an SRA online.
  a. To submit an online SRA logon to Envoy's website at www.envoyplanservices.com and click on the Red Login Button at the top right of the page.
  b. Username: enter your Social Security Number (SSN)
  c. Password: Your default password will be the last 4 digits of your SSN
  d. If this is your initial login, go to the next page for instructions on how to change your password to a more personal and secure one. Otherwise, you will be directed to the Main Menu.
- The SRA must be received by Envoy no later than **the last business day of the month prior to the month that you want** your first payroll deduction or the date you would like the change(s) to be effective.

Transactions:

- Transactions for the Plan include: loans, transfers, rollovers, contract exchanges, and all distributions.
- All transactions must be sent to Envoy for approval prior to submission to your provider for processing.
- If you are transferring and closing your 403(b) or 457(b) account, YOU MUST submit a new SRA to stop or change your payroll deduction salary deferral contributions, or your payroll deductions will not stop.
- To submit a transaction request to Envoy for approval follow the steps below:

  Paper:
  a. Contact your provider and request their specific paperwork.
  b. Go to Envoy's website and obtain the Transaction Request Form and Instructions (located from Envoy's website home page under Forms and Tools)
  c. Complete and mail all of the paperwork to Envoy at the address below, or you can fax the paperwork toll free at 877-513-2272.

  Online:
  a. Logon to Envoy's website at www.envoyplanservices.com and click on the red Login Button at the top right of the page
  b. Username: enter your Social Security Number (SSN)
  c. Password: Your default password will be the last 4 digits of your SSN
  d. If this is your initial login, go to the next page for instructions on how to change your password to a more personal and secure one. Otherwise, you will be directed to the Main Menu.

ENVOY PLAN SERVICES, INC.
c/o MidAmerica
402 South Kentucky Avenue, Suite 500, Lakeland, FL 33801
(800) 248-8858 Toll Free Phone Number
(877) 513-2272 Toll Free Fax Number
Email us at: info@envoyplanservices.com
Website: www.EnvoyPlanServices.com

CHABOT
LAS POSITAS
COMMUNITY
COLLEGE
DISTRICT

DATE: May 16, 2015

TO: All New Employees

FROM: Payroll Manager

SUBJECT: **CalPERS Supplemental Income 457 Plan**

The CalPERS Supplemental Income 457 Plan is a voluntary plan that is separate from the District's retirement program. If you are interested in this supplemental plan, click here or to the CalPERS site at https://calpers.ingplans.com.

If you seek further information about this voluntary plan, please contact either the CLPCCD Payroll Department at 925.485.5282 or the CalPERS Plan Information Line at 1.800.260.0659.

Kit|P:/Forms/Payroll/CalPERS/Cover Memo 5/16/15

ACADEMIC ADMINISTRATORS ONLY

Social Security Administration

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** _____

Information about Social Security Form SSA-1945 Statement Concerning Your Employment in a Job Not Covered by Social Security

New legislation [Section 419(c) of Public Law 108-203, the Social Security Protection Act of 2004] requires State and local government employers to provide a statement to employees hired January 1, 2005 or later in a job not covered under Social Security. The statement explains how a pension from that job could affect future Social Security benefits to which they may become entitled.

Form SSA-1945, **Statement Concerning Your Employment in a Job Not Covered by Social Security,** is the document that employers should use to meet the requirements of the law. The SSA-1945 explains the potential effects of two provisions in the Social Security law for workers who also receive a pension based on their work in a job not covered by Social Security. The Windfall Elimination Provision can affect the amount of a worker's Social Security retirement or disability benefit. The Government Pension Offset Provision can affect a Social Security benefit received as a spouse, surviving spouse, or an ex-spouse.

Employers must:

- Give the statement to the employee prior to the start of employment;
- Get the employee's signature on the form; and
- Submit a copy of the signed form to the pension paying agency.

Social Security will not be setting any additional guidelines for the use of this form.

Copies of the SSA-1945 are available online at the Social Security website, www.socialsecurity.gov/online/ssa-1945.pdf. Paper copies can be requested by email at ofsm.oswm.rqct.orders@ssa.gov or by fax at 410-965-2037. The request must include the name, complete address and telephone number of the employer. Forms will not be sent to a post office box. Also, if appropriate, include the name of the person to whom the forms are to be delivered. The forms are available in packages of 25. Please refer to Inventory Control Number (ICN) 276950 when ordering.

Health Reimbursement Arrangement

Plan Highlights

for

Chabot-Las Positas Community College District

Effective Date: The effective date of the Plan is January 1, 2013.

Plan Year: The Plan Year ends on December 31.

Eligibility: Participation in this Plan is mandatory for all Employees of the class or classes as determined by the Employer:

- Regular Classified, Confidential and Supervisor Staff, and Regular Administrator Employees hired after January 1, 2013.

Contribution Types: All funds for the Plan shall come exclusively from the Employer and shall be a specified dollar amount as the Employer shall from time to time determine.

- $200 per month for 12 months for 9, 10, 11, and 12 month Employees. If .5 FTE or more, but less than 1.0 FTE, the District HRA contribution shall be prorated each month.

Contribution Frequency: Monthly

Investments: Funds are invested in a guaranteed fixed annuity with American United Life Insurance Company, *a OneAmerica Financial Partner*. The interest rate may change on a quarterly basis, but is guaranteed never to fall below the standard NAIC rate. The guarantee is based on the claims paying ability of AUL. All earnings in the account are tax-free!

Reimbursements: Participants may request reimbursements from their accounts upon retirement or separation from service, but only for medical expenses incurred subsequent to becoming eligible to participate in the Plan. Participants must exhaust any funds available in a flexible spending arrangement ("FSA") prior to receiving reimbursement from this Plan. Funds in a participant's account at the end of each year shall be rolled into the following year.

Vesting Schedule: Participants shall own their account balance in accordance with the following vesting schedule:

- After Five (5) years of service

Death Benefit: If a Participant dies prior to exhausting his vested account balance, the Participant's surviving spouse and/or dependents are eligible to be reimbursed under this Plan for their eligible medical expenses until the vested account balance is exhausted. In the event of the death of the Participant, the Participant's spouse, and all of the Participant's qualifying dependants, any funds remaining in the account shall be forfeited in accordance with the Plan's provisions. Forfeited funds shall reduce future Employer contributions.

Administrative Fees: Participants will be charged a reimbursement processing fee of $7.00 for each claim processed, up to a maximum annual reimbursement processing fee of $42.00.

Reports: Each quarter, Plan Participants will receive statements of account activity.

Agent: Dan Keenan, Keenan and Associates

Contact: To access account information, request forms, or for plan related questions, please contact MidAmerica toll-free at (800) 430-7999 or visit our website at www.midamerica.biz.

Please mail all forms to: MidAmerica Administrative & Retirement Solutions, Inc., Attn: HRAADMIN,
402 South Kentucky Avenue, Suite 500, Lakeland, FL 33801

Keenan
Financial Services

AUL
a OneAmerica®
financial partner

MidAmerica
Administrative & Retirement Solutions, Inc.

New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 11-30-2013)

PART A: General Information

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by your employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.[1]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution -as well as your employee contribution to employer-offered coverage- is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact:
Chabot-Las Positas Benefits Office
http://www.clpccd.org/HR/benefits.php.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit **HealthCare.gov** for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

[1] An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer name **Chabot-Las Positas Community College District**		4. Employer Identification Number (EIN) 94-1670563
5. Employer address **7600 Dublin Boulevard, 3rd Floor**		6. Employer phone number **(925) 485-5513**
7. City **Dublin**	8. State **CA**	9. ZIP code **94568**
10. Who can we contact about employee health coverage at this job? **David Betts**		
11. Phone number (if different from above) (925) 485-5513	12. Email address dbetts@clpccd.org	

Here is some basic information about health coverage offered by this employer:

- As your employer, we offer a health plan to:

☐ All employees.

☒ **Some employees.** Eligible employees are:

- Faculty as covered in the collective bargaining agreement, including:
  - Tenured and Tenure-track
  - Temporary Leave Replacement (TLR) and Temporary Sabbatical Replacement(TSR)
  - Part-time faculty meeting eligibility requirements outlined in the collective bargaining agreement
- Regular and Probationary classified employees who work 9 or more months/year, work at least 20 hours/week, and are Confidential/Supervisory employees or members of the SEIU collective bargaining unit
- Management and Executive employees.
- Elected Board of Trustee Members
- Retirees as covered under the collective bargaining agreements and board policy
- Employees who have been determined to work an average of 30 or more hours/week during the established measurement period

- With respect to dependents:

☒ **We do offer coverage.** Eligible dependents are:

- Qualified dependents, legal spouse/domestic partner of covered employees in the categories that are listed above.

☐ We do not offer coverage.

☒ If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

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

If you decide to shop for coverage in the Marketplace, HealthCare.gov will guide you through the process. Here's the employer information you'll enter when you visit HealthCare.gov to find out if you can get a tax credit to lower your monthly premiums.

new hire pamphlet

If a work injury occurs

California law guarantees certain benefits to employees who are injured or become ill because of their jobs.

Any job related injury or illness is covered. Types of injuries include, but may not be limited to, strains, sprains, cuts, cumulative or repetitive traumas, fractures, illnesses and aggravations. Some injuries from voluntary, off duty, recreational, social or athletic activity may not be covered. Check with your supervisor or Keenan & Associates if you have any questions.

All work related injuries must be reported to your supervisor immediately. Don't delay. There are time limits. If you wait too long, you may lose your right to benefits. Your employer is required to provide you a claim form within one working day after learning about your injury.

It is a misdemeanor for an employer to discriminate against workers who are injured on the job or who testify in another employee's case. Any such employee may be entitled to compensation, reinstatement and reimbursement for lost wages and benefits.

Workers' compensation benefits include

Medical Care – All medical treatment, without a deductible or dollar limit. For dates of injury on or after 1/1/04 there is a limit of 24 chiropractic, 24 physical therapy and 24 occupational therapy visits. However this limit does not apply for post surgical treatments. Costs are paid directly by Keenan & Associates, through your employers workers' compensation program, so you should never see a bill.

If emergency treatment is required go to the nearest emergency room or contact 911.

Keenan & Associates will arrange medical treatment, often by a specialist for the particular injury. Preferred Provider Networks may be utilized for physicians as well as medical care centers.

If you have health care coverage you are eligible to treatment with your personal physician or medical group should you become injured on the job. If you are eligible, **before you are injured**, you must notify your employer **in writing** and provide your employer **written** documentation from your personal physician or medical group that they agree to be predesignated. Your personal physician must be your regular primary care physician who previously directed your medical treatment, who retains your medical history and records. You may only predesignate your primary care physician if they are a family practitioner, general practitioner, board certified or board eligible internist, obstetrician-gynecologist, or pediatrician. Your personal physician may be a multispecialty medical group composed of licensed doctors or osteopathy providing medical services predominantly for non-occupational illness and injuries.

Your employer may be using a Medical Provider Network (MPN), which is a selected group of health care providers to provide treatment to workers injured on the job. If you have predesignated a personal physician prior to your work injury, then you may receive treatment from your predesignated doctor. If you have not predesignated and your employer is using and MPN, you are free to choose an appropriate provider from the MPN list after the first medical visit directed by your employer or Keenan & Associates. If you are treating with a non-MPN doctor for an existing injury, you may be required to change to a doctor within the MPN. For more information, see the MPN contact information on reverse side.

If your employer **does not** participate in a Medical Provider Network (MPN) you may be able to change your treating physician to your personal chiropractor or acupuncturist. Generally your employer, or Keenan, has the right to select your treating physician within the first 30 days after your employer knows of your injury or illness. After your employer, or Keenan, initiates treatment you may, upon request, have your treatment transferred to your personal chiropractor or acupuncturist. To be eligible you must notify your employer **in writing prior to being injured**. However, a chiropractor cannot be your treating physician after receiving 24 chiropractic office visit.

Your employer will provide you with a form to use an optional method to predesignate your personal physician.

Contact Keenan & Associates if you plan to change physicians at any time.

Payment for Lost Wages - If you're temporarily disabled by a job injury or illness, you'll receive tax-free income until your doctor says you are able to return to work. Payments are two-thirds of your average weekly pay, up to

April 2014

Keenan & Associates

a maximum set by state law. Payments aren't made for the first three days unless you are hospitalized in an inpatient basis or unable to work more than 14 days.

If the injury or illness results in permanent disability, additional payments will be made after recovery. If the injury results in death, benefits will be paid to surviving, eligible dependents.

Rehabilitation – **For dates of injury on or after 1/1/04 -** you may be entitled to a ***Supplemental Job Displacement Voucher***, which entitles you to a voucher for educational training.

How to obtain additional information

Contact your employer representative or Keenan & Associates if you have questions about workers' compensation benefits. You may also contact an Information and Assistance Officer at the State Division of Workers' Compensation. You can consult an attorney. Most attorneys offer one free consultation. If you decide to hire an attorney, his or her fee will be taken out of some of your benefits. For names of workers' compensation attorneys, call the State Bar of California at 415-538-2120.

Department of Workers' Compensation Information and Assistance Offices

You can get free information from a state Division of Workers' Compensation Information & Assistance Officer. The phone numbers are listed below. Hear recorded information by calling toll-free 800-736-7401 or visit www.dwc.ca.gov.

Anaheim	714-414-1804
Bakersfield	661-395-2514
Eureka	707-441-5723
Fresno	559-445-5355
Goleta	805-968-4158
Long Beach	562-590-5001
Los Angeles	213-576-7389
Marina Del Rey	310-482-3858
Oakland	510-622-2861
Oxnard	805-485-3528
Pomona	909-623-8568
Redding	530-225-2047
Riverside	951-782-4347
Sacramento	916-928-3158
Salinas	831-443-3058
San Bernardino	909-383-4522
San Diego	619-767-2082
San Francisco	415-703-5020
San Jose	408-277-1292
San Luis Obispo	805-596-4159
Santa Ana	714-558-4597
Santa Rosa	707-576-2452
Stockton	209-948-7980
Van Nuys	818-901-5367

Keenan & Associates adjusting locations

Torrance
800-654-8102

Eureka
707-268-1616

Pleasanton
925-225-0611

Rancho Cordova
800-343-0694

Redwood City
650-306-0616

Riverside
800-654-8347

San Jose
800-334-6554

Anyone who knowingly files or assists in the filing of a false workers' compensation claim may be fined up to $150,000 and sent to prison for up to five years.
[Insurance Code Section 1871.4]

April 2014

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